

STAFF-PATIENT COMMUNICATION IN A MENTAL HOSPITAL

A pilot study of social worker's information-giving and patient's information-receiving in acute treatment units at Riverview Hospital; including a proposed design for a more comprehensive study of staff-patient communication.

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A Thesis Submitted in Partial Fulfillment of the Requirements
for the Degree of MASTER OF SOCIAL WORK in
the School of Social Work

We accept this thesis as conforming to the required standard.

School of Social Work

1967

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ABSTRACT

This study is a formulative exploratory study in the area of communication. It investigates the operation of the social worker-patient communication process with respect to selected variables thought to influence this process.

The study consists of three parts; the original research design, the critique of the original design, and the new design. The project takes place at the Riverview Hospital and involves both Crease Clinic and Centre Lawn units.

The original design is formed around a frame of reference which underlines the need for communication by patients at a mental hospital. Unfortunately, the original design, which involved a study of factors affecting the information flow between social worker and patient, failed to achieve a clear focus in its purpose and problem formulation.

The critique pointed out the various factors influencing the original study and which led to the necessary revision of the study design. It includes a comprehensive outline of the extraneous variables which were encountered in this study and suggests the extent to which they may affect the validity of the study findings.

The new design incorporates the findings and implications of the original design, and was enlarged to include communication between the staff treatment team (doctor, social worker, charge nurse) and the patient. A more specific theoretical frame of reference was developed and in addition suggestions for implementation of the new design are made and can serve as a reference point for any continuing studies in this area.

PREAMBLE

As has been stated in the abstract, this thesis consists of three parts; the original design, a critique of the original design, and a suggested new design. Originally, our aim was to perform a full scale research process on an exploratory formulative level of research design. However, from the beginning we encountered difficulties in posing a statement of purpose in terms of a specific formulation of the problem which we intended to study. As there were five researchers engaged in this project different levels of understanding developed with each researcher tending to develop his own point of view. Difficulties of communication among us subsequently became apparent.

This thesis was conducted within a mental hospital and as a result peculiar problems of implementing the research design were encountered which were unique to this setting. It was necessary for us to establish contact with many staff members from several professions. Implementation of our research design did not permit an explanation of our purpose to the patients adding more confusion to our problem formulation and purpose.

As the study progressed and increased awareness was gained relating to our purpose we realized that many of our original assumptions had been somewhat inaccurate and did not apply realistically to the research design which we were currently in the process of implementing. At this stage, due to the time available for the research project we were not in a position to correct many of the errors and assumptions which we knew to exist. Subsequently we decided to consider our original design as essentially a pilot project, containing a test of the research instruments and a small pilot study of 8 patients.

A second part of our thesis was devoted to a critique of our original

design which enabled us to formally recognize the errors which had been made earlier and at the same time serve as an aid to other researchers who in the future may encounter similar problems to ours. Also the critique suggested a new research design and a more specific theoretical frame of reference.

The section devoted to the new research design embodies the changes recommended in the critique. This section is primarily a framework of what we could have done if we had the necessary time. It is organized in such a fashion that another research study can continue where we leave off.

In summary it was not our original aim to divide our thesis into three broad parts, rather it was used as an organizational method to organize our experience in research which we have gained from this study.

AUTHORSHIP OF THE THESIS

This study was a group project involving five M.S.W. candidates. Each of the five members participated in the preparation and criticism of each chapter and the organization of the thesis as a whole. However, each member was assigned responsibility for the completion of the final draft of one chapter.

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TABLE OF CONTENTS

Chapter I. THE INTRODUCTION

Introduction. Factors Affecting the Flow of Information.	
Relevance of the Study. Alternatives to Research. Research Identification of the Social Work Problem. The Nature of Social Work Information.	
Purpose of the Study. Review of the Literature. Organization of the Research Report.....	p. 1

Chapter II. PILOT STUDY DESIGN AND FINDINGS

Assumptions of the Study. Information Areas. Independent Variables. Level of Research Design. Sampling Procedures. Methods of Gathering Data. Data Collection Instruments. Pre-test of Patient Interview Guide. Pilot Study.....	p. 12
--	-------

Chapter III. CRITIQUE OF PILOT STUDY

Introduction. Study Design. Methods of Data Collection. Study Procedure. Extraneous Variables. Method of Analysis.....	p. 27
--	-------

Chapter IV. THEORETICAL BASIS FOR A NEW DESIGN

Introduction. Theoretical Framework. Role of Information in a Hospital Setting. Information-giving on a Hospital Ward. The Reception of Information on a Hospital Ward. Variables.....	p. 38
--	-------

Chapter V. THE PROPOSED DESIGN

Introduction. The Proposed Hypotheses. Developing a Design Format. Implementation of Design. List of Information Items. The Committee. The Patient Sample. Treatment Team Check List. Patient Interview Guide. List of Variables. Analysis of the Data.....	p. 53
---	-------

Bibliography.....	p. 66
-------------------	-------

Appendix A - Patient Interview Guide.....	p. 69
---	-------

Appendix B - Social Worker Questionnaire.....	p. 71
---	-------

Appendix C - File Information Guide.....	p. 72
--	-------

Appendix D - Social Worker Interview Guide.....	p. 73
---	-------

Appendix E - Organizational Chart of Riverview Hospital.....	p. 75
--	-------

LIST OF TABLES

Table I - Compilation of Data Collected.....	p. 76
--	-------

ACKNOWLEDGEMENTS

This research project was made possible by the kind permission of the administration of the Riverview Hospital, who understandingly offered their staff, patients and facilities to assist in the study. Many individual staff members, too numerous to mention here, offered invaluable assistance and displayed interest in our endeavours.

Our grateful appreciation is extended to the ward social workers, who willingly cooperated in the study and offered helpful suggestions. We wish to thank the charge nurses who gave their cooperation and assistance in spite of very full schedules of their own. We would like to acknowledge the always cheerful and helpful efforts of the stenographic staff, who assisted in the preparation of material, often at short notice. Our special appreciation to the patients who participated in the study by sharing their thoughts and feelings during this difficult time in their lives.

The study would have been more difficult, if not impossible, without the invaluable assistance of our Advisory Committee. Our special gratitude is expressed to Miss D.R. Begg, Miss Bernie Reid and Mr. R.M. Ross, who, together and individually, shared our difficulties and gave freely of their counsel.

Wives and families of the researchers gave in innumerable ways. Their cheerful understanding, encouragement and assistance offered to the researchers added to our resolve and gave us impetus when it was needed.

Finally, special thanks to our supervisor of studies, Dr. Glen Hamilton, who gave of his knowledge of research, advice and support and this we gratefully appreciate.

STAFF-PATIENT COMMUNICATION IN A MENTAL HOSPITAL

CHAPTER I

INTRODUCTION

THE IMPORTANCE OF INFORMATION

Communication between staff and patients in any large institution is surprisingly complex and in order to address ourselves to the study of information in the time available it was necessary to concern ourselves with only a small sub-system of the total communication network - the process of communication occurring between the social worker and the patient. More specifically we decided to focus on the informational component of communication within this specific context.

Schwartz in a study involving Social Research in a mental hospital drew attention to the importance of recognizing blocks and omissions in the communication process which tended to interfere with the transmission and reception of information within a mental hospital setting. "Defects in communicative organization, breakdowns, blocks, distortion, omissions in the transmission of information, the passing on of accurate or inaccurate data, all may contribute to misunderstandings between and among hospital participants. These misunderstandings tend to perpetuate the patients illness". (31, p. 193) Schwartz goes on to suggest that following the removal of blockages to communication the patients anxiety and excitement tend to decrease. Implicit in this is an assumption that the removal or modification of factors hindering the flow of information will enhance the therapeutic course of the patient. These factors or variables may operate independently or combine and act as a totality to influence the information flow between the social worker and the patient. Information flow is manifested in patient interaction with each other in their attempts to gratify their need for information. The dangers of this type of informational

flow is illustrated in the passing on of inaccurate information.

The amount of information received by the patient from the social worker was considered an index of the degree to which the communication process had been affected by specific factors infringing on the process.

This study was partially a result of the recognition that appropriate informational flow between social worker and patient is a necessary correlate of effective treatment. The accurate reception of information by the patient has import not only to the progress of his treatment but also to the efficiency of its application by the social worker.

FACTORS AFFECTING THE FLOW OF INFORMATION

The interrelationship of variables affecting patient receptivity of information is exceedingly complex. The communication process between social worker and patient may depend on such variables as spatial distance, status and value differences. An active organization of past reactions and experiences on the part of the patient was also presumed to be operative in terms of patient reception of information. It was considered important to work toward suggesting relationships and hypotheses among specific factors infringing on the informational flow between social worker and patient. Why has information which would tend to ameliorate patient anxiety not been appropriately received by the patient.

The specific factors affecting informational flow studies in this thesis were chosen in consultation with the supervisory staff of the Social Service Dept. of Riverview Hospital and was not considered to be an exhaustive list, but rather, the selection was based upon those factors which were thought to have the most influence on the reception of information by the patient.

OBJECTIVES OF STUDY

There has been very little research done in this area. Subsequently, it was decided that the general purpose of this study correlated with Polansky's objective of an exploratory formulative research design, in that, "The objective is the identification of sound questions promising concepts and preliminary hypotheses in a field which, as yet, has had limited development and therefore is not prepared for elaborate experimental design to test complex hypotheses". (25, p.51) Initially the objective of this study was to determine the effect of specific factors on patient receptivity of information.

It is to be remembered that our purpose was not to condemn existing processes rather there was an attempt at exploration and suggestion. We were not concerned with those factors which may distort the workers perception of the information to be sent to the patient.

RELEVANCE OF THE STUDY TO DIFFERENT GROUPS

The original research design and purpose was believed to be of importance to a number of sectors of the population. With the institution of a new design and subsequent reorganization of purpose and method we still feel that this thesis as a totality has relevance to a number of groups of people.

Policy makers on the governmental levels are linked in many ways to the administration of the hospital. Individuals involved in planned extension of Mental Health facilities both at Riverview and other areas are naturally concerned with a therapeutic milieu for the patient. This study, purely on an architectural level may enable such changes as office location, to be planned in such a way that informational needs of the patient would be best facilitated. Some Social Work offices are located at a great

distance from the ward served and are not as accessible as those offices which are placed on or near the ward.

The optimum number of Social Workers employed in the two acute areas of the Riverview Hospital, namely Crease and Center Lawn Units is presently under consideration by administration and supervisory staff. Hopefully, this study will have a bearing on the implementation of such plans as these.

Practitioners of client service method are by virtue of their professional status and role within the hospital concerned with the optimum enhancement of the individual patient's social functioning. Other professional groups operating in the hospital are naturally concerned with the Social Worker's effectiveness as part of the treatment team. This study is only concerned with the communication between Social Worker and patient. But by the necessary delineation of treatment function inherent in the Social Worker's role other groups are necessarily concerned with the total treatment of the patient. Better use of time available to Social Workers are of concern to the Social Worker himself in terms of effective and efficient caseloads and also to policy makers and decision makers. The effective reception of information by the patient is one of the main correlates of effective treatment. Enhanced communication and information flow decreases anxiety which increases the patient's accessibility to treatment.

Client groups have a vested interest in the study as it attempts to determine factors which may have a detrimental effect on their progress in treatment. It has been our experience that patients in general are poorly informed as to which staff member is more appropriate to satisfy the patients informational needs.

This study may in general, support reorganization of the Social

Worker's communicative organization, with tentative application to other staff members benefitting the treatment of the patient as a total person. With this facilitation the patient is better able to engage himself in the therapeutic endeavours made, not only by Social Workers, but also by other members of the treatment team.

We believe that this study has value to the researcher who is conducting research within a mental hospital. More and more mental hospitals are being used as research sites by virtue of special advantages inherent in its structure. Schwartz outlines a number of basic reasons for this growth in interest and research activity:

1. Ready accessibility of captive research subjects;
2. Observation is facilitated by virtue of limited physical space
3. A hospital ward may be viewed as a small scale social system
4. Variables may be more easily restricted;
5. Patient feelings are more easily perceived as many patients lack the ability to contain them;
6. An evaluation of deviant behaviour may help explain conventional structured organizations.

Also this study may illustrate the impact of Social Research upon ward staff and other professional sub-systems.

We believe researchers are also concerned with the possible results of this study by virtue of its heuristic exploratory formulative design. The formulation of more fruitful hypotheses being an inherent goal of this study will be useful in other research studies. Definite research problems which are encountered during the period of the study, such as difficulties in defining staff roles and possible skewing of objective data received from mentally disturbed individuals will be illustrative of possible pitfalls to be avoided in future research studies. The literature on information flow

in a mental hospital of this size is not large, hopefully this study will contribute to the general fund of knowledge in this area.

The public at large are manifesting an increasing interest in the treatment of mental patients. Constructive research studies are growing in popularity as there is increased public pressure to reorganize the large mental hospitals. Simply the public at large has a vested interest in mental illness and its treatment. The large number of people who at one time or another will be confined in a mental hospital, (one out of every ten Canadians), are the concern of the public. Possible structural and organizational changes suggested by this study may also incidently reduce the cost of maintaining a large institution such as Riverview Hospital.

ALTERNATIVES TO RESEARCH

There were a number of alternative solutions to the social work problem which was identified in previous discussion and which related to the original research design. We assumed that the basic problem was that of the difficulties in providing information to the patients.

Logically, we may have stated that the patients need for information is not particularly important. Chemical and physical treatment would cure the patient and subsequently he would be able to secure the needed information upon discharge from the hospital. This viewpoint would state that although information may be helpful to patients it is not essential to their treatment regimen in hospital. This solution was contra-indicated by a survey of the literature which stressed the importance of satisfying the informational needs of the patient as an integral part of the total treatment plan.

Another possible solution was identified as providing the needed information to patients through different communication processes. In other words the communicative situation would be improved upon by freeing the

Social Worker of other responsibilities or to otherwise make him more available to give the needed information. The number of Social Workers could be increased. This solution although valid is partially negated by the chronic nature of staff shortages. Another solution became apparent when it was deduced that perhaps it was unnecessary for the Social Worker to give information and that this role may be assigned to another staff member. However, much of the information given by the Social Worker is dependent upon his role which is based upon professional knowledge and experience. Hence this was deemed impractical.

Another possible solution was logically identified in that needed information that a Social Worker gives might be published and issued to patients which would then decrease the amount of contact needed for information giving. This was rejected as a result of the present deleterious effects of staff shortages with subsequent reduction of staff-patient contact at the present time.

Another solution through the use of different communicative processes was seen as relying on other patients to communicate needed information. This no doubt occurs now. Perhaps this could be instituted in a more formal and purposeful manner. However, this may increase the amount of error in the information given; much of the original content and meaning may be lost when information is communicated by ill and untrained people.

RESEARCH IDENTIFICATION OF THE SOCIAL WORK PROBLEM

A certain amount of information may be gathered from the literature. Unfortunately there has been little research in the area of our thesis project. We noted however, that this area has been suggested as one requiring research.

We were uncertain as to what factors were responsible for the

assumed lack of information received by the patients. Our assumption that there was a lack of information was based only on personal experience and readings of communication problems in other hospitals and has not yet been validated by research at Riverview Hospital. We surmised that the original research design would be able to show: the extent of the lack of information reception by patients and secondly the significance of some of the variables which were assumed to be involved. These variables had been selected on the basis of a common sense or rational look at the problem.

On the basis of our collected data we considered it possible to demonstrate trends which would suggest the importance of specific factors in the communication of information. One of the variables to be employed in the original research design was the accessibility of the worker to the patients. This in part, would be measured by the availability of an interview office on the ward. It had been noted from observation and discussion with workers that there appeared to be more work done with patients when there is an office on the ward. It was thought that research should be able to offer some valid data for the confirmation or refutation of this. This in turn may well have an influence on whether or not the Social Service Dept. pushed for Social Work offices on the ward.

THE NATURE OF SOCIAL WORK INFORMATION

Initially it was believed necessary to determine what is information of a Social Work nature within the role of a Social Worker in a mental hospital. It was thought that information of a Social Work nature could be obtained from the professional literature of Social Work and from the supervisory staff of the Riverview Hospital Social Service Dept.

It was deemed necessary to ascertain if this information was in fact communicated to the patients. It was decided to do this by open ended

questions in a semi--structured interview with the patient. It was thought that a sample of 40 to 60 patients would give us a fairly accurate assessment for purposes of chi-square analysis. We would expect that the patients would vary a great deal in terms of the amount of information that they receive. It was thought that these findings could be related to significant variables and hopefully we may come up with suggestions as to what factors are relevant to the high and low reception of information by the patient.

PURPOSE OF STUDY

In this study we were concerned that the patients informational needs falling within the jurisdiction of the Social Workers role were not being completely satisfied. Is information transmitted by the Social Worker being received by the patient? Is this a result of factors affecting the communication process? Besides the obvious factor of needed staff increases the Social Service Dept. of Riverview Hospital wished to know if there were other factors that could be improved or changed in order to improve or enhance the Social Worker's ability to communicate information effectively.

It was therefore our purpose in the original design to evaluate specific factors affecting the informational flow between Social Worker and patient. Through appropriate research procedures we intended to determine if there was any statistical significance in the relationships of these external factors to lack of information reception by the patients. Secondly it was decided that suggestion would be raised as to the implementation of certain plans or corrective actions designed to enhance the Social Worker - patient communication process. Thirdly it was deemed important to suggest, if necessary, further research development in the area of study.

REVIEW OF THE LITERATURE

There is a considerable lack of literature available which applies to our research study. Schwartz has indicated a growing emphasis on the importance of studying communication and the sending and receiving of information within a mental hospital (31) but as yet this has not materialized to the degree where it can be utilized and applied to our research purpose. However, there is a growing literature focussed on the theoretical aspects of information flow as a part of the communication process and where possible we have drawn on this material in our study.

ORGANIZATION OF THE RESEARCH REPORT

Chapter I

The first chapter is concerned with the frame of reference to which the original study design applied. The importance of appropriate information sending and reception is stressed with an emphasis on the effects of enhanced information flow and the factors which affect this enhancement. The objectives and general purposes of the study are discussed both in relation to the study itself but also the relevance of the study to different groups such as policy makers client groups, practitioners etc. The alternatives open to research study are discussed.

Chapter II

The second chapter is concerned with the actual original study design of the project. Assumptions and variables are discussed. The level of research design is identified with the plan of data analysis outlined. Sampling procedures and methods of gathering data are briefly discussed. The questionnaires utilized in the study are illustrated with reference to the preliminary testing of the instrument. The results of the pilot study are described.

Chapter III

The third chapter is concerned with a critique of the original design. An introduction is given. There is a criticism of the methods of data collection as they apply to the original design. The diverse research instruments which have been used are criticized. The extraneous variables - institutional, workers, patients, researchers, are criticized. There is a discussion of the method of data collection and a criticism of this as it applies to the original research design.

Chapter IV

The fourth chapter is concerned with the theoretical framework of the new research design. An introduction is given. The role of information in a mental hospital is discussed with an outline of information giving and reception on a hospital ward. There is a discussion as to the possible effects of independent variables on dependent variables within the context of the new design.

Chapter V

The fifth chapter is concerned with the proposed new research design. The proposed hypothesis and variables are developed. The new design format is discussed. Suggestions are made relating to the implementation of the proposed new design. There is a categorization of informational items. An outline of the proposed patient sample to be utilized is discussed. There is a presentation of the research instrument to be used. Finally there is an outline of how the data collected may be analyzed.

CHAPTER II

PILOT STUDY DESIGN AND FINDINGS

ASSUMPTIONS OF THE STUDY

As has been indicated in Chapter I, this study was concerned with impediments in the communication process between the social worker and the patient, effecting the amount of information received by the patient. The importance of information in the therapeutic interaction between patient and staff has been stressed, pointing out the necessity of an effective exchange between each individual. It was observed that such a process operates between the patients and all staff members, through the various levels of hierarchial positions, but is not as efficient as it should be.

This communicative process can be impeded by numerous factors or variables present in these settings and these variables need to be identified and confirmed before a study of an experimental nature can be designed. We were concerned with the efficiency of this process, but for the purpose of this pilot project, it was decided to concentrate on the quantity, rather than the quality, of the information being sent. We were, also, aware that impediments to the amount of information being received could arise at many points during the process. To limit the examination of the process, certain assumptions were made. We felt that it was not feasible to be concerned with factors which might distort the worker's interpretation of, (29 - 510) or his ability to give information to the patient. We assumed, therefore, that the information-giving aspect of the worker's role was performed efficiently and that the necessary information was being imparted to the patient.

We felt, also, that we were not in a position to examine properly the patient's ability to interpret accurately the information received. In

an attempt to limit the effects of this aspect, we focused the study on that part of the process occurring just before this interpretive phase - the message-received phase. It was assumed that the amount of information received by the patient would be an indication of the efficiency of the communicative process to this point. Any discrepancies in the number of messages received by the patient, when compared to the number of messages sent by the worker, could be related to variables occurring within the institutional setting.

INFORMATION AREAS

Ward social workers are part of a treatment team in the hospital, along with psychiatrists, nurses, occupational therapists, recreational therapists, and each member of the team has assignments to fulfill with relation to the patient's treatment. Some assignments are the responsibility of a particular discipline, while others are shared by two or more team members.

Social workers give certain types of information which involve attitudes and feelings of the patient, relatives and other member's of the patient's community. (24) They are responsible for the imparting of such information because of their special skill and knowledge of the social elements of a patient's life.

To determine the amount of information a patient received from the social worker, it was necessary to identify informational areas exclusively covered by this discipline. For this purpose seven informational areas were developed, which were considered important to the patient's treatment, and should be covered by the social worker in each case.

These seven areas included; role of the social worker; awareness of the team approach; reasons for coming to the hospital (social implications);

financial and legal concerns; family functioning; material-physical aspects of discharge plans; and social-emotional planning around discharge and the patient's return to the community. Definition of each area, to assist in scoring information received from the patient interview, were included in each interview guide, and a copy of this guide will be found in the appendix.

INDEPENDENT VARIABLES

Autobiographies of former mental hospital patients (20) were helpful in suggesting numerous variables. These, plus observations made by some members of the research group while employed in the mental hospital, were discussed with the advisory committee, and a number were identified as being of probable importance to the communicative process.

Although other pertinent variables doubtlessly exist, the following are the independent variables selected for the purpose of this study;

1. Number of contacts between social worker and patient.

Before we were able to examine the effect of independent variables on the amount of information received by the patient, we had to determine if there had been any opportunity for such messages to have been sent. We were interested only in messages of a meaningful nature, of some importance to the patient's treatment, and we defined such contacts as those containing some element of information-giving other than a greeting or exchange of pleasantries. The greater the number of such contacts, the greater the amount of information the patient should have received.

2. Number of previous admissions to a mental hospital. Previous experience as a patient in a mental hospital, either Riverview Hospital or any other, could effect their motivation to receive

information from staff members.

3. Length of time of current admission. This was felt to be important because as the confinement lengthens there are more opportunities for meaningful contacts to have been completed.
4. Type of admission - voluntary or involuntary. The type of admission procedure used with individual patients could effect their receptivity to information given by staff members. An involuntary admission could be a negative experience for the patient, with a possible negative influence on their relationship with staff members.
5. The nature of any previous social work contacts before the current confinement - positive or negative. The nature of these contacts, if any, could influence the patient's receptivity to information offered by the hospital social worker.
6. Diagnosis of the patient's illness at the time of admission. Two very broad categories were felt to be sufficient to describe the illnesses at that time; one, psychotic and the other, nonpsychotic. Psychotic patients experiencing an acute phase of their illness at the time of admission would probably be unable to receive any information before the psychotic aspects of this had begun to wane. Nonpsychotic patients would be able to receive information at the time of admission as they are relatively in touch with reality.
7. Range, high or low, of patient's ability to reach out for information. Some patients reach out for contact with staff, while others are reluctant to initiate this step.

Wards in a mental hospital are extremely busy and shortages of personnel increases the pressure placed on the staff. Patients may have to ask for information verbally rather than wait for the need to be recognized and met by the responsible staff member.

8. Who initiated the first contact between the patient and the social worker? This is closely related to the patients, ability to reach out for information. Some patients, with a high range of ability to reach out, will seek out the social worker and make their requests known. Other patients, with a low range of ability, will wait for the social worker to contact them, or have someone else approach the worker for them.
9. Source of referral of patient to social worker. The prestige which a patient may place on a referral to the social worker would vary with the degree of esteem with which that patient holds the referring person and his position. This prestige would influence a patient's attitude towards the social worker and effect the amount of information she would receive.
10. Location of the ward social worker's office. In Riverview Hospital, ward social workers' offices are either on the ward or off the ward in another part of the same building. This would have an effect on the convenience for the patient in contacting the worker, and also the degree of privacy available for interviews if they were held on the ward in someone else's office, in the lounge or dormitory.
11. The nature of mental hospital experience, if any, of relatives of friends of the patient - positive or negative. All people

have preconceived notions of life in a mental hospital, through literature, movies or reports from others. The nature of these notions would have an effect on the patient's attitude towards hospitalization and their receptivity of information.

12. The nature of the influence of relatives' attitudes towards the patient's hospitalization - positive or negative. The attitude of relatives towards hospitalization will influence the patient's attitude and her receptivity of information.
13. The Socio-economic class of the patient. It was recognized that different socio-economic classes have different value assumptions with regard to mental illness. Any class difference between the social worker and patient could effect the patient's receptivity of information from the worker.
14. Number of children, their ages and whether or not they were at home. This variable would not apply to the entire patient population, but was applicable to young married mothers, the sample population that was chosen for this study. Mothers, with a large family and/or young children, frequently consult the ward social worker for information about the children and their care whilst they are separated from them by their hospitalization.

LEVEL OF RESEARCH DESIGN

Before a field study of an experimental design to test specific hypotheses and to determine priorities among variables could be launched,

such hypotheses needed to be developed. We were certain only of a need for such a study due to the concern of various members of the social service department. A formulative-exploratory study was thought to be needed to develop sound problem formulations, promising concepts and preliminary hypotheses. (25 - 51)

This study was a pilot project to suggest leads for exploration and to develop research instruments to assist in the gathering of necessary data. We were not ready for a descriptive-diagnostic study to assess fully the characteristics of the communicative process as we were not aware of all such characteristics at that time, and we did not feel we would place the necessary emphasis on all the various components. We were, therefore, content to develop testing instruments and to determine their efficiency in gathering data when applied to a sample population.

The control of the recognized independent variables was attempted by a careful selection of the dependent variables in this study. Close attention was paid to the selection of the sample population to insure consistency in the degree of involvement with the ward social workers and the amount of information that should be given. The selection of the ward social workers themselves was important, and only wards with social workers of similar qualifications and experience were included. Long hours of searching and discussion went into the selection of the information areas used to determine the amount of information received by the patient. Direct control of the independent variables, with the use of control groups, was not attempted. These variables were recognized and each case was examined closely to determine whether or not each variable was operating.

The plan of data analysis was statistical in nature. If we were able to determine a high and low range of information received and then compare these dependent variables with a high and low range of operation for

each observed independent variable it should be possible to determine any associations. Statistical significance in each association could be calculated with the use of the chi-square distribution formula.

SAMPLING PROCEDURES.

The sample group was selected on a random basis from a specific patient population of the hospital. This specific group was chosen on the basis of (1) the largest identifiable group of patients having as many characteristics as possible in common and (2) the group with an expected high degree of involvement with the ward social workers. This group was then limited to: (1) patients ready for discharge, thus having completed the most meaningful part of their involvement with the worker; (2) patients who were not suffering from any form of brain damage, as this type of pathology has an unpredictable effect on the person's ability to receive any stimuli, including information; (3) the patient's ability to speak the English language; and (4) residence in one of the four wards chosen for examination in this study.

It was agreed that the largest specific population fitting the above criteria would be the married mothers between twenty and forty-five years of age. This is a group who have a high priority for involvement with the social work department according to hospital policy, due to their concern as to the welfare of their children.

We were interested in gathering the sample from four separate wards, divided equally between the two acute illness units of the hospital patient population. This would allow comparison between the two areas and further comparison between the two wards in each area and the four wards separately. The selected population of young married mothers, on each ward being considered, were large enough to allow random selection

based on the criteria of pending discharge, lack of brain damage and residence on a specific ward.

A sample of forty patients was anticipated - this being the minimum number required before a statistical analysis based on the chi-square distribution could be completed. Data collection was limited to six weeks to allow sufficient time for statistical analysis. It was decided to accept every eligible patient for interview as it was not known just how many patients could be expected from each ward during this period of time.

The cooperation of the charge nurse in each ward was requested, to refer eligible patients to the research team. The charge nurse was required to notify a specified member of this team of any discharges.

METHODS OF GATHERING DATA

The patient would be unable to supply information regarding all the variables we were interested in examining. Other sources of data would be required, and any duplication of information received from more than one source could serve as an authenticity check on these items with a resulting indication of validation with regard to other items. Data was gathered from three sources - the patient, the ward social worker and the patient's file.

An interview guide was administered by a researcher to each selected patient just before her discharge from hospital. An attempt was made to control any possible bias towards social workers on the part of the patient by introducing the interviewer as a researcher from U.B.C., rather than as a student social worker. We were interested in the patient's cooperation, but wanted to keep the focus of the interview away from the social worker as much as possible. This approach could create anxiety in

some patients, but this anxiety would be reduced if the purpose of the study was explained before the interview. We enlisted the aid of the charge nurse to make the suggested introduction and to explain to each patient that this was a study of selected aspects of patient life in the hospital.

The second source of data was a questionnaire on each patient interviewed and was given to the ward social worker for completion. This supplied information pertaining to some of the variables in which we were interested.

A third source of information was each patient's diagnostic and treatment file. A list of selected items was prepared to guide the collection of information, pertaining to the independent variables.

When it became evident that the number of selected patients would not be large enough to provide sufficient data for chi-square analysis, it was decided to use what data we had obtained by 28th February, 1967 to determine if any trends were discernable.

It had been assumed earlier that the social worker covered all the information areas with each patient. At this time the researchers became aware of the fact that this was an inaccurate assumption. Therefore it became necessary to determine how many of the information areas the social worker had covered with individual patients. A Social Worker Interview Guide was prepared and administered to the ward social workers involved. This data would provide us with a basis of comparison to the amount of information received by each patient. This ratio could then be correlated with each identified independent variable.

DATA COLLECTION INSTRUMENTS

Patient Interview Guide (Appendix A)

This guide was designed to provide some structure for the

interviewer and the interviewee, to be certain that all the necessary areas of information were covered, and to insure that each question was asked in an ordered sequence. The exact wording of each question, when asked of the patient, was left to the discretion of the interviewer. He was informed only of the general wording of the question and what information was being sought in the answer. The sequence of the questions was to be adhered to, however, because of the personality of the sample population. It was considered important to begin the interview with the non-threatening questions, proceed to the more threatening material and attempt to finish with less threatening questions again, to lessen the anxiety which may have been raised in each patient.

Role playing was used to familiarize interviewers with the guide and its proper application to the interview. Each group member took turns playing the interviewer and interviewee, and asked all the questions. This permitted some experimentation with various wordings of the questions and eliminated the need for the interviewer to do this with the interviewee during the first interview.

The guide contained questions to determine what information the patient had received in specific aspects of their life, and from whom this information had been obtained. Questions as to some variables were also included. Other questions were of a nature to assist the patient to consider all members of the treatment team, not just the social worker, so that the theme of information being sought would not be too evident to the interviewee. We were concerned with the over cooperativeness of some patients who could be expected to answer questions in the manner they anticipated we would expect, if the questions were too direct as to a specific topic.

Social Worker Questionnaire (Appendix B)

The questionnaire to be completed by each ward social worker

contained eight items. Answers to each item were either multi-choice or of one or two words only. The information to be obtained referred to variables only and did not cover any of the information areas given each patient.

File Information Guide (Appendix C)

File information also pertained to variables and consisted of nine items, answers to each of which could be obtained from the patients' files and noted in one or two words.. This guide was to be completed by the researcher.

Social Worker Interview Guide (Appendix D)

The interview guide, which was developed near the end of the data collection phase, covered the same information areas as given to the patients. The interview was administered by a researcher, who defined each information area, and questioned the social worker as to whether the information had been given, or had been checked if it was assumed that the patient already had knowledge in this area, or was not given or checked by the worker.

PRE-TEST OF PATIENT INTERVIEW GUIDE

After completion of the Patient Interview Guide it was pretested with a group of patients not connected in any way with the four wards previously chosen. The same criteria used to select the sample group were repeated in this selection with one exception - two wards from one acute unit were used instead of one from each unit.

The interview guide was administered to eight patients, during the same afternoon, by all five researchers. The pre-test indicated several changes needed to be made in the guide. A new introduction of the study, by the researchers to the patient, was written, spelling out the stated purpose in more detail. Some questions required clarification and were

rewritten and five questions, covering personal information were added. The sequence of the questions was reordered to provide more continuity.

The other devices, the social worker questionnaire, file information outline, and the social worker interview guide, were not pre-tested, but applied directly to data collection.

PILOT STUDY

The guides and questionnaire were administered to thirteen cases before the data collection time limit elapsed. The anticipated number of referrals did not materialize. There was some initial confusion among the ward social workers as to whom the sample population included, and a small number of non-eligible interviewees were referred. The hospital is located thirty miles from the university and it was not possible for an interviewer to be available on short notice. Some potential interviewees were released almost immediately following the decision to discharge them as they had relatives waiting for them or transportation deadlines to meet. Difficulty was also experienced in notifying the researchers when an eligible patient was discharged. The charge nurses were required to telephone the names of referrals to an assigned researcher, as the researcher was prohibited from contacting each charge nurse by telephone because of a hospital regulation. The charge nurses were all very busy with other duties and such telephone contacts were an added inconvenience. The ward social workers attempted the same responsibility, but they, too, were too busy. A social work supervisor in one acute treatment unit assumed this task, but the time limit was reached before this procedure was fully established. In addition, the population and discharge rate of the sample group were both very low during this period of time.

Of the thirteen patients interviewed only eight were suitable for data analysis. Three of the five rejected were excluded because they did

not meet the age requirement. The fourth was not being discharged within the specified time limit, and the fifth was not included because of incomplete data. The sample obtained was too small for data analysis, but a chart showing the breakdown of the data collected was prepared and is included in this report. This data does suggest there may be some interesting correlations, between the amount of information received and some variables, that warrant further study:

1. Generally a high amount of information was sent by the social worker and there was very little variation between cases.
2. Social workers scored low in the number of patients to whom they gave information regarding financial and legal matters, suggesting these matters do not receive the same attention as the other informational areas.
3. There is a wide variation in the amount of information received by each patient.
4. The ratio of information received/information sent varies from high to low and divides easily into two groups with four cases in each.
5. Comparison of the range of information received/information sent ratio with some variables suggests certain relationships. These include:
 - (a) There is a direct relationship between the patient's diagnosis and the information ratio. The non-psychotic group received more information than the psychotic group.
 - (b) Patients who were also involved in group sessions, as well as individual sessions, with their social worker received more information.

- (c) Patients who reached out for information received more information.
- (d) Patients who discussed their hospitalization with a doctor before admission received more information.
- (e) Patients with no previous mental hospital experience received more information.

CHAPTER III

CRITIQUE OF PILOT STUDY

INTRODUCTION

It is customary in any such critique or evaluation, to emphasize both the procedures and findings involved in the study. As already described, however, the latter were insufficient to suggest many meaningful correlations and instead served more to illuminate the positive and negative aspects of the methodology employed. This chapter, then, will dwell but briefly on the possible inferences or conclusions to be obtained from the results and will instead, focus on the limitations and validity of such findings, as determined by the procedures employed, with a view towards better methodological innovations.

STUDY DESIGN

1. Generally speaking, the purpose or objective of the original study was to determine if certain factors were significantly associated with the level of efficiency of the communication channel between social worker and patient at Riverview hospital.

(a) Communication channel was the term used to refer to the communication process involving transmission of information from social worker to patient.

(b) The level of efficiency of the communication process was defined in terms of a high or low amount of information received by the patient. Thus an efficient communication channel would be one where a patient received a large amount of information from the social worker, while an inefficient channel would be one where a low amount of information would be received.

2. As an index of the level of efficiency of any communication channel the amount of information received is dependent on two main factors. they are (a) the amount of information given, and (b) the efficiency of the total communicative process. In other words, the ability of the transmitter to send the message, the field in which the message is sent, and the ability of the receptor to receive the message. If amount of information received is used as an index, both factors must be taken into account.

3. Unfortunately, the researchers did not distinguish between these two factors at the time of design construction. Three members of the research team neglected the 'amount of information given' as being important, feeling that differences in amount of information received by patients would be due to the variables affecting the transmission and reception phases of the communication process. Thus a very serious procedural blunder was made. The reason why this blunder was made was because the researchers had been forewarned that the hospital administration did not want any evaluation made of their worker's performance. Of course, the amount of information given to patients by social workers would be a direct evaluation of the worker's job performance. The researchers handled this pressure by denying the amount of information given as being of importance.

Two members of the research team did not deny that the amount of information given was important. Instead, they handled the problem of not evaluating the workers by assuming that the social workers gave all information possible. Thus, only the factors affecting the transmission and reception of information could affect either a high or low amount of information received. This assumption (that all information was given by the social workers) was, to say the least, ridiculous. In fact, one of the reasons why the researchers wanted to do the study in the first place, arose out of a concern that the patients were often not given needed information.

Unfortunately, none of the researchers were aware of this discrepancy in assumptions until the end of the study.

4. The variables the researchers selected were thought to affect the outcome of the total communicative process, not because they might affect any particular phase of the process. In other words, the researchers had hunches, based on experience and a reading of the literature, that certain variables or factors might affect the amount of information received by patients.

Because of confusion in the research group as to the most important variable (the amount of information given) the segment of the group that denied (implicitly) the importance of the amount of information given as a significant variable also included (explicitly) variables that they thought would affect the amount of information given (e.g. location of worker's office - on or off the ward). In other words, for fear of evaluating the social work staff, they came to view the amount of information given as both important and unimportant at one and the same time. They saw the amount of information given as important when selecting the variables but not in collecting and analysing the data.

METHODS OF DATA COLLECTION

There were three main sources for the data collected in this study:- the patients, the case files and the social workers assigned to these patient's wards. In turn, these sources of data were used for two purposes:- one being to collect the necessary data to achieve some meaningful correlations and the second being to check the answers from one source with those from another (a validity check).

One of the major problems encountered in the development of these tools for collecting data was closely associated with our failure to

distinguish the quality of purpose implicit in our study design. This confusion among the researchers permitted into all areas of the study but was most noticeable in the area of data collection. Here, the questions which were developed for the questionnaires tended to be vague, undefined and lacking in singleness of purpose. This in turn resulted in findings that lacked validity or applicability.

(i) Patient Interview Guide

The patient questionnaire was developed to determine how much of the information transmitted by the worker was received by the patient and using the results, we hoped to show some relationships to our dependent variables. In practise, several weaknesses evolved in this area. The actual interviewing, however well rehearsed, still permitted for individual variation in conducting the patient interviews. Awareness of the desired responses and the tendency of all researchers to perceive only that which supports ones beliefs (hypothesis) may have resulted in an unconscious leading of the patients in their verbal responses or in a faulty interpretation of them. The semi-structured design of the interview guide facilitated this by permitting greater individual freedom to develop biases than would a more structured approach. The former was chosen mainly because of the uncertainty as to the effect of the patient's illness on her answers or her ability to comprehend the questions. It was reasoned that as professional people, the researchers could be held responsible in the control of their biases while developing an accurate account of the patient's perceptions.

Because of the vagueness of the questions and their generality, the study findings tended to be less indicative than otherwise possible. The responses required from each patient were not clearly spelled out and the scope of the questionnaire was too broad and all-encompassing. Non-specific questions encouraged non-specific responses. Also, if one is concerned with

the efficiency of the communication process or amount of information received, such broad categories are not required.

(ii) Case Files

The file information was collected to test our variables and ascertain the general validity of the patient's responses as well as their perception of reality. In extracting the necessary data from the files however, several errors resulted. When determining the number of previous admissions and length of hospital stay, the units of measurement were overlooked and not decided until after all data had been collected. With respect to the medical diagnosis of the patient, there was little discussion as to what this involved. This resulted in each member using different criteria to determine the reality contact of each patient and thus contribute to the lack of uniformity in data collection. An additional variable that could not be controlled lay in the fact that current recording was often not on the file.

(iii) Social Work Questionnaire

This questionnaire was prepared in order to establish the existence of several dependent and independent variables which we had hypothesized might influence the amount of information received by patients. It was rigidly structured and the questions were non-threatening, thus encouraging few biases from the workers. Its weakness lay however, in the fact that the various terms used in posing the questions were not clarified or defined. (e.g. Verbal accessibility - no clear definition as to how this was to be measured).

(iv) Social Work Interview Guide

It was not until the end of the data collection period that we realized the difficulties in assuming that every worker had given 'all information possible' (all seven informational areas). At this point a social worker interview guide was developed to rectify this situation and

achieve some degree of validation to our former assumption.

Here again it is felt that the workers may have perceived this questionnaire as part of an evaluative research study and thus possibly have biased their answers. Little attempt was made to conceal the fact that we had previously assumed that these areas would be covered by them.

STUDY PROCEDURE

Extraneous Variables

The need to control specific extraneous variables, thus establishing some degree of validity to our findings, presented many difficulties arising at every stage in the development of the study. For convenience and clarity, the more important of these will now be elaborated upon under descriptive headings rather than in chronological order.

(i) Institutional - administration & staff

Within the Riverview Hospital, there are numerous departments and occupations (refer Appendix E) employed in the treatment of patients and these then are organized under a central administration. Although such a system has advantages for those functioning within its power structure, it posed certain difficulties to this study. The number of occupations and the complexity of the administration created an immediate problem of communication between the research team and specific members of the hospital staff whose co-operation was vital in conducting the study. Thus it was necessary to involve the hospital administration, which undoubtedly did not represent a consensus on the part of all relevant people involved with the study and which, through its directives, effectively prevented our direct involvement with other professions in the treatment team. The necessity for such involvement was at several times critical to the research study and its lack quite possibly influenced the study findings. Attempts to meet with the

nursing staff in order to explain the purposes of the study and acquire their support added to their already heavy responsibility as it tended to upset the routine on the wards for which they were responsible. Our one meeting with the nursing staff was therefore hurried and little time was available for them to question the study or gain a feeling for the necessity of such research. This latter fact was quite evident when a ward nurse was required to introduce members of the research team to the patient. Invariably she failed to be accurate or consistent in her approach. This lack of conformity to a previously laid down procedure was observed to initiate in many patients a feeling of insecurity and apprehension as to the purpose of their involvement. The resulting anxiety no doubt influenced their answers to the questions posed by the researchers.

Direct phone contact with the wards to gain information regarding patient discharges could not be permitted, as it was contrary to established policy and might lead to abuses. This restriction affected the study in several ways as we were now required to rely on a third part (social workers) to relay information. These workers were not always aware of discharges which might be decided upon but a few hours beforehand and often they were too involved with their own workload to permit them to contact us regularly about patient discharges. Also, such discharges tended to be more the concern of the ward nurse who was the first to be informed by the doctor of such decisions and therefore in a better position to relay the required information. Later, results showed that many patients were released from the wards studies, without our first being notified, a fact which contributed to the extremely small sample obtained and may have led to a bias in the selection of those who were referred.

Many professions have contact with the patient during his hospitalization and as such constitute potential extraneous variables which might

have considerable influence on the study findings. Doctors, psychiatrists, nurses, etc., are all potential sources of information for the patient and have as part of their function the responsibility to provide such information as is required for treatment. Such an overlap serves to complicate any study which focused on but one of the hospital professions (eg. social work) as it increases the difficulty in determining who gave what information to whom. Since the hospital administration specifically requested that our research be confined solely to the patient and not "interfere" with the other disciplines there was no way in which we could control the effect or prevent the occurrence of these variables and now acknowledge their possible effect on the study findings.

A final criticism lies in the manner in which the study was presented to the hospital advisory committee. As the researchers were confused in the study design this confusion was no doubt passed on to the advisory committee thus preventing them from becoming fully active in the project.

(ii) Workers

From the study findings, we noted that of the 13 patients referred to us, 8 originated from one worker. This figure, obtained over a 6 week period, was inconsistent with the expected result which had been based on the current monthly discharge figures for several preceding months and a previous study. We were therefore led to speculate that our failure to obtain the required sample may have been related to the worker's withdrawal from what was perceived as evaluative research. This reaction might then be associated with their feelings of either anxiety or ambivalence. This latter feeling might in turn be related to the increase the study made in the already heavy work load of the social work staff as well as their lack of awareness as to the purposes and use of the study.

It is also possible that certain biases may have been prevalent in

our sample selection. Perhaps those patients referred by the workers were only the ones with whom casework intervention had been intense and successful. Thus our inability to communicate directly with the wards regarding forthcoming discharges, may have contributed to such a sample bias on the part of the caseworkers. Again, there was no way to control this variable directly and reliance on the professional competence of the worker was a necessity. It would be possible, however, to achieve some indication of variation between actual discharges and those referred, by comparing the study figures with those contained in the hospital's main file.

(iii) Patients

In our attempt to assess the various factors affecting the amount of information received by the patient, we found the patient's illness to be a prominent variable. Not only does the nature of the patient's illness compound the problem of assessing the validity of their answers, but there is also the fact that the illness is often a transitory and fluctuating variable which differs from patient to patient and resists definitive classification. Often, the first few social work contacts are made when the patient is at the acute phase of her illness and little information is retained for this reason. Thus it is difficult for the worker to determine how much information the patient has received and similarly it was difficult for the researchers to determine the extent to which they could rely on the patient's perception of what transpired during those contacts. The only truly adequate method of counteracting this problem would have been to personally observe all worker-patient contacts during hospitalization and in this way have less need to rely on the perceptions and recollections of both patients and workers for whom it is then necessary to infer biases. Such a procedure was however, impractical in this study for many reasons such as: the inconvenience to staff and patient; lack of available time; and

unwillingness of the administration to alter its normal routine.

(iv) Researchers

Within the research team considerable effort was exerted towards control of possible intervening variables. The questionnaire was developed by all members and its purposes gone over in detail to ensure that each was aware of the information they were required to obtain from each patient. Role playing was conducted among the team members and a pretest was run which helped correct many faults in our delivery of the questionnaires. Nevertheless, as has already been pointed out, certain discrepancies did arise in spite of all precautions taken.

Other difficulties in conducting this study were concerned with time and distance. During our data collection period (6 weeks) we had attempted to provide an interviewer for every day of the week but fell short of this goal as classes and field placements conflicted. Several times patients were discharged from the hospital without being contacted, while their place of residence being outside Vancouver prevented us from making a home interview. Such difficulties were further enhanced by such practical requirements as the distances involved in travelling to and from Riverview Hospital. The 32 miles involved prevented easy or quick access to patients whose discharge was imminent.

METHOD OF DATA ANALYSIS

Initially we had decided to use the Chi-square in determining the level of significance of the study findings and calculated the minimum number (40) of patients necessary to validate our results and achieve some meaningful correlations between our variables. This sample was not, however, obtained and to evaluate the data collected, the only alternative was to use percentages. Such results as were obtained by this method are not

conclusive in that the sample itself was not nearly representative of the total population (neither by selection nor number). Nevertheless, a few correlations were obtained and although the validity of such findings is questionable, they are nonetheless indicative of new approaches and modifications to the problem and will be discussed in Chapter IV.

CHAPTER IV

THEORETICAL BASIS FOR A NEW DESIGN

INTRODUCTION

As has been stated in the previous chapter the research group encountered a number of difficulties in clearly formulating the problem to be studied. As a result the main questions of the study were so vague that individual members of the research group interpreted them differently. The design that developed therefore reflected this confusion among the researchers regarding the main questions of the study. There is little doubt that this confusion was perceived by the hospital advisory committee and that this adversely affected the implementation of the study design.

In looking back it seems that a lack of a sound theoretical framework led to the confused research process outlined above. This situation must be remedied in the new study and it is to this purpose that we now direct our attention.

THEORETICAL FRAMEWORK

The Role Of Information In a Hospital Setting

Since the general purposes of the new study are to assess the present situation at Riverview Hospital in regard to patients receiving needed information and to determine the degree of importance of some of the factors believed to be influencing such a situation, then we must first document the role of information in the hospital setting. The theoretical framework that will be employed in explaining this will be that of general behavior systems theory. However, as the reader will soon discover, we have also borrowed certain concepts from communication theory and role theory.

"Systems are bounded regions in space-time, involving energy interchange among their parts, which are associated in functional relationships,

and with their environments." (23,433) Riverview Hospital is such a system functionally interrelated with other systems in society (e.g. governmental, legal, etc.). However, as the above definition suggests, any system, in this case Riverview Hospital, is composed of a number of parts or subsystems. Since this study is concerned with patient reception of information given by staff the two large subsystems that must be considered are the staff system and the patient system. Let us now describe these systems.

The patient system of Riverview Hospital is composed of individuals (male and female) who have been either informally or involuntarily admitted to hospital and who conform to the definition of a 'mentally ill person' outlined in the Mental Health Act. These individuals are assigned to different units and wards within the hospital according to three criteria. They are as follows: (1) type of illness (acute or chronic); sex; and (3) geographical residence. Thus East Lawn Unit is composed of chronically ill female patients; West Lawn Unit takes in chronically ill male patients; North Lawn Unit is concerned with male and female patients manifesting acute physical ailments; Crease Unit deals with acutely disturbed male and female patients from Vancouver City, the Municipalities of North and West Vancouver, and Burnaby, while Center Lawn Unit deals with acutely disturbed male and female patients from all other areas of British Columbia, and Riverside Unit is concerned with male patients from any area of British Columbia admitted to hospital either from penal institutions for a period of psychiatric observation or from courts of law.

The staff system of Riverview Hospital can be broken down into departments or occupations. They include the business or personnel departments, the medical department, the occupational and recreational therapy departments, the nursing department, the social service department, and so on. These departments tend to be the most directly involved with individual patients. But how are these departments interrelated with each

other and with the patient system?

The staff subsystems (departments) are related to each other and to the patient system because they have common goals. If we take the social service department as a point of reference we can soon see that it does not act according to its own whims, but rather attempts to have its functions interrelate with those of other departments so hospital goals such as successful treatment of the patient, protection of the community, and the maintenance of the total hospital system are achieved. Although the individuals of the patient system do not necessarily have the goal of ensuring protection for the community they are concerned with getting better, and once they have been in hospital for awhile they also often become concerned with making sure the system continues to function in a smooth and ordered manner (maintenance of the total hospital system).

The hospital ward may be considered as the unit of social structure where the goals of the hospital are achieved. Although different staff members on the ward have different functions, the result of a complex division of labor, they are all concerned with achieving hospital goals. Furthermore any staff member attempts to integrate his particular functions with those of other staff members so that hospital goals are realized. As far as the goal of successful treatment is concerned, it is assumed that such cooperation will have a greater therapeutic impact on the patient than if each staff member carried out his functions independently. Thus the staff team approach with its collective decision making regarding patients' therapeutic needs while in hospital, is used on mental hospital wards.

In order to achieve patient and hospital goals outlined above both the staff and patient systems on the ward are faced with a number of problems to be solved. For the individual coming into hospital "the problem is adaptation to the role of patient due to physical or psychological illness".

(2, 113) In other words an individual under the stress of a mental disorder must learn what is expected of him (patient role) by the staff system. In a very short period of time he must learn a great deal about a whole new way of living. Of course when the patient learns this, one goal of the hospital-a smooth running ward-has been realized. Conversely the problem that staff must overcome is the lack of understanding the individual has of what is expected of him. It is only when the individual has such an understanding that he is able to take advantage of treatment opportunities provided by the hospital. For instance the patient will not be able to take advantage of treatment measures such as group therapy sessions if staff do not explain that he is expected to attend in order that he might be successfully treated. At any rate this whole process of adjusting to a new environment tends to be a difficult one for patients.

Another problem that patients need staff assistance in overcoming is related "to role changes and possible impairment and loss of role and status due to the assumption of the role of patient....Absence or relinquishment of accustomed habitual roles such as the roles of husband, father, wage earner and so on, can be stressful in addition to the physical and psychological factors which create the role of patient". (2, 113) A third problem that must be faced is the individual's anxiety related to the relinquishment of the patient role and the return to his roles in the community. Since the hospital goal of successful treatment implies the patient's being able to conform to societal roles, the successful transition from patient to community roles is most important.

In order to overcome the above mentioned problems the staff system provides patients with a number of supportive services. Stanton and Schwartz, in their study of need fulfillment on a hospital ward, outline a number of such services the most important of which, for the purposes of this study, are

as follows: (1) provision of someone with whom the patient can discuss his problems; and (2) the provision of information regarding either ward routine or personal matters. (34, 223-242)

It is likely that the informational needs of patients are related to their three stages or phases of hospitalization. Firstly, information is required at the time of their admission. For instance information regarding arrangements made for the care of children, the disposition of belongings brought by the patient to hospital, matters of ward routine (e.g. time of eating, sleeping, taking of medications, etc.), and so on. Secondly, information regarding treatment is required by patients. This would include knowing who the doctor is and when he could be seen, information regarding the nature and prognosis of their illness, the importance of various treatment measures (e.g. group therapy, electroconvulsive therapy, etc.) for their eventual recovery, and so on. Finally, patients require information regarding their discharge from hospital. For instance information regarding problems to be faced in assuming societal roles and ways of overcoming such problems, the importance of taking medication, appointment times for after care services and the importance of such services to successful adjustment in the community, and so on.

As far as information is concerned there is likely an ideal amount that each individual patient should have in order that optimum benefit from hospitalization may be realized. Some particular items of information needed tend to be highly individualized because of unique personal circumstances (e.g. the death of a relative while the patient is in hospital), while others apply to all patients (matters concerning ward routine) or groups of patients (e.g. care of children), because of situations they have in common.

Information Giving on a Hospital Ward

Although staff members have certain functions to perform in relation

to their particular occupational role on the ward, information giving is not solely dependent on role considerations. It is true that a particular occupation may have a responsibility to give certain items of information, but they are not considered to have the exclusive right to give such information. (The exception to this might be the doctor's sole prerogative in giving medical information to the patient). In some ways the existence of such a situation is quite practical. For instance on crowded hospital wards no single occupation has the time to give every item of information to patients for which it is responsible. The assistance of other occupations is therefore necessary. Furthermore the patient population would likely suffer if certain informational areas were made the sole prerogative of a particular occupation to give since many occupations would not be represented on the ward when the patient needed the information (e.g. doctor, social worker). For these reasons the staff treatment team composed of doctor, social worker, and nurse usually develop their own system of information giving. The concern is not so much with who gives the information but rather that the patient gets it from somebody.

However on crowded wards at Riverview Hospital this more informal method of information giving likely has the effect of leaving many patients without needed information since the giving of specific items of information are not the sole responsibility of any particular staff member. In addition it is likely that this informal method leads to certain staff biases in giving information. In other words when responsibility for giving information based on role considerations is 'played down', the personal preferences of staff members for particular patients is allowed to come to the fore. The personal characteristics of the patient (e.g. type of illness, desire to obtain information, socioeconomic status, etc.) also begin to be a more important consideration than does the individual patient's need for information.

Thus some patients get more needed information than others.

It is the opinion of the authors of this study that hospital goals cannot be realized when, in the giving of information, patient characteristics and personal preferences of staff for particular patients are given more importance than the actual needs of individual patients. For instance from reading the literature and from personal experience of the researchers on hospital wards it seems that patients and groups of patients become uncooperative when they are not given information. This may be related to the fact that they have not been informed as to how they might be cooperative, or because they feel that they were slighted in not being given information they considered important. At any rate their uncooperativeness produces many difficulties for staff, and consequently one goal of the hospital-a smooth running ward-is not realized. In addition the lack of information regarding treatment opportunities often makes it impossible for many patients to take advantage of such opportunities. Thus the hospital goal of successful treatment for patients is not realized.

It is for these reasons outlined above that the research group feels that the first purpose of any new study in this area should be to determine the extend to which the staff system (the team composed of doctor, social worker and nurse) on the wards at Riverview Hospital give information to the patient system. This purpose is of particular importance if one is concerned with patients' reception of information, since the amount received (and therefore the amount available for use in deriving benefit from the hospital experience) is dependent to a large degree on the amount given.

As has been pointed out there are a number of factors that affect the amount of information given by the staff system to the patient system. These factors might be divided into three broad categories, realizing of course that each category is so interrelated as to be mutually reinforcing. They

are as follows: (1) psychological factors within the individual staff member system (e.g. his motivation to give information); (2) factors within the total staff system on the ward (e.g. length of time individuals on the team have been working together); and (3) personal characteristics of individual patients (e.g. the degree to which a patient reaches out for information etc.) There are literally dozens of factors that might affect the amount of information given by staff. At our present level of knowledge we can only speculate as to what factors might be more important. The second purpose of the new study becomes one of determining if certain specific factors are significantly associated with the amount of information given by the staff system to the patient system.

The Reception of Information on a Hospital Ward

If one believes that patients need to have certain information in order that they might receive optimum benefit from their hospitalization, the amount of information given by the staff system is only one factor that must be taken into consideration. For even though individuals of the staff team might give all the information needed by a particular patient, that patient might not receive it. In other words there is often a great difference between something sent and something received. Whenever we start considering factors that might affect the way a piece of information is given in relation to the way in which it is received we necessarily require an understanding of communication theory.

As indicated earlier, systems are bounded regions in time-space involving energy interchange among their parts. Communication can be viewed as such an interchange of energy. The parts, for the purposes of this study, are the staff system and the patient system.

Explicit in any transmission of information from individuals of the staff system to individuals of the patient system are at least three elements.

They are the source (staff member), the message (item of information,) and the destination (patient). In the communication process the source first encodes his message. "that is, he takes the information or feeling he wants to share and puts it into a form that can be transmitted." (29,507) Secondly he transmits the information in the form of verbal signals (language). The third step is where the individual for whom the message was intended decodes and interprets the information obtained.

In engineering terms there may be filtering or distortion at any of the three stages. "In human terms, if the source does not give adequate or clear information; if the message is not encoded fully, accurately, effectively in transmittable signs; if these are not transmitted fast enough and accurately enough, despite interference and competition, to the desired receiver; if the message is not decoded in a pattern that corresponds to the encoding...then, obviously the system is working at less than top efficiency". (29, 508)

Of course if the communication system is operating at low efficiency it is highly unlikely that the destination is obtaining needed information. In terms of the mental hospital, if the patient system is not receiving information transmitted by the staff system because of distortion occurring in any unit of the process (source, message, destination), then the patient system will unlikely realize optimum benefit from hospitalization.

Conceivably one could measure the efficiency of any single system of communication (individual staff-individual patient) by noting the difference between what was given as compared to what was received. Similarly, at a higher level of abstraction, one could measure the efficiency of any larger system of communication (ward team-patient system) by calculating the sum of the discrepancies between what each individual staff member gave in the way of information and what each individual patient

received and divide by the total number of informational items given. Although this would be a very difficult assessment to carry out for the whole hospital it would undoubtedly be very very valuable.

Although determining the efficiency of any system of communication involves procedural difficulties, there are even more difficulties encountered when one attempts to account for the reasons why a particular system is operating at a specific level of efficiency. As stated above, distortion may occur at any stage of the communication process. In considering the prospect of transmitting one piece of information one can literally think of hundreds of factors that may affect whether or not the particular piece of information is received by the patient in the form in which it was given. Some, of course, are likely more important than others, and the truth is that at our present level of knowledge we really do not know which ones are the most important. Therefore if one is concerned with somehow finding out why a particular channel is inefficient he must necessarily select distortion factors that are assumed to be important.

The third purpose of the study becomes one of determining the level of efficiency of the communication process between the staff team on the wards and the patients at Riverview Hospital. In other words the degree of difference between what the staff system gave and what the patient system received. The fourth purpose is to determine if certain specific variables or factors are significantly associated with either high or low efficiency.

VARIABLES

The independent variables are the factors that might affect (a) the amount of information given by the staff team on the wards and (b) the extent to which the patient receives the information transmitted by the ward staff team (efficiency of communication). In discussing each variable in turn we

will designate as to whether it affects (a) or (b). The first five variables to be discussed were found to be significantly associated with a high ratio of information received in the pilot study.

1. Number of previous Riverview or other mental hospital admissions.

(a) One would expect that the greater the number of admissions a patient has had to a mental hospital the less information ward staff would give. They would likely assume that the patient already had this information so they would not feel the need to cover much of the same ground.

(b) If the information were given, it is likely that in the case of a patient with a high number of admissions that such information would not be received to the same extent as in the case of the patient with a low number of admissions. The reason for this revolves around the fact that the greater the number of admissions the more likelihood of damaged cognitive processes. Furthermore the greater the number of admissions the more likelihood of a pessimistic attitude towards the possibility of improvement from hospitalization on the part of the patient. Therefore a decreased interest as to what the ward staff have to say.

2. The degree to which the individual patient reaches out for information.

(a) On crowded hospital wards where the staff-patient ratio is low, the amount of information that the staff give to a patient will be to some extent dependent upon the degree to which a particular patient requests information. In a study by Stanton and Schwartz it was shown that the most persistent patients receive the greatest amount of information. (6, 241)

(b) It is probably true that the more a patient reaches out for information the more he or she is likely to receive that information in the form in which it was given. In other words the greater the concern on the part of the patient for a particular item of information, the greater the likelihood that he or she will receive it in the form in which it was given.

3. Psychotic and Non Psychotic

(a) It is likely that ward staff will give less information to a patient who is diagnosed as having some form of psychotic reaction since it is generally felt that the person in such a state is unable to use the information transmitted. Of course the diagnosis changes through the course of a patient's hospitalization, because of the improvement in his or her condition, but this often happens so suddenly that ward staff are unable to give much needed information before the patient is discharged.

(b) There is a greater likelihood, in cases of psychotic patients, that information given will not be received in the form in which it was given. This is due to the fact that there are disturbances in thought with those suffering from psychotic disorders, and such disturbances in thought prevent an individual from correctly perceiving external reality (information given by ward staff).

The two broad classifications of psychotic and non psychotic can be broken down into type of illness (e.g. schizophrenic, neurotic, etc.) and correlated with both amount of information given and received.

4. Frequency of group meetings on the ward.

The concern here is whether a team functioning on a ward which uses to a great extent the technique of group meetings between patient and staff do give more information to patients than does a team functioning on

a ward where such a technique is only minimally used.

(a) The assumption is that the team on a 'high number of group meetings ward' will show up as having given a greater amount of information than the team on a 'low number of group meetings ward'. Where staff time is at a premium the group meeting technique will enhance the amount of information given.

5. Patient understanding of reasons for hospitalization prior to admission.

(a) Patients who have discussed the reasons for their hospitalization with a professional person (doctor, social worker, etc.) prior to admission will be given more information by the ward staff. Such patients will have a more positive attitude towards hospitalization because of their understanding of their need for it, and consequently will have a greater motivation to obtain needed information.

(b) If the motivation to obtain information is greater there is also a greater likelihood that such patients will receive information in the form in which it was given.

6. The patient's attitude (positive or negative) towards certain ward staff (social worker, doctor, nurse) based upon contact with such staff prior to his or her most recent admission to hospital.

(a) The more positive the patient's attitude towards ward staff based on previous experience, the more information he or she is likely to get from such ward staff while in hospital. In other words ward staff tend to give more information to a friendly patient than to one who is more hostile towards or aloof from the ward staff. Often such behavior on the part of the patient towards ward staff is related to a previous positive or negative experience

with such staff.

(b) The more negative the patient's attitude towards ward staff, the less likelihood that he will receive the information given by such ward staff in the form in which it was sent. In other words if the patient dislikes the ward staff he is more likely to 'tune them out' and thus not receive the information given.

7. Informal or involuntary admission

(a) The ward staff will likely give more information to the informally admitted patient primarily because he or she is more cooperative and open to discussion.

(b) It is likely that the individual who sees some need for hospitalization (informal patient) will tend to receive more information given by staff in the form in which it was given.

The reason behind this is that the voluntarily admitted patient has a higher degree of motivation to 'get better' and thus will be open to any information given by ward staff. The greater the motivation the greater the receptivity of information.

8. Length of time in hospital

(a) It is likely that the longer a patient has been in hospital the more information he is likely to be given by ward staff.

9. Socioeconomic status of the patient

(a) The assumption here is that the lower the socioeconomic status of the patient, the less information he will be given by the ward staff. The reasoning behind this is that staff members tend to prefer to interact with patients of their own class background (middle class), and consequently the lower class person is slighted as far as the giving of information is concerned.

(b) The lower the socioeconomic position of the patient the greater

the likelihood that the information given by ward staff will not be perceived by the patient in the form in which it was given. The reason for this is that lower status patients often do not have the verbalability to understand the language in which a particular item of information is transmitted by staff. In addition any successful reception of information (reception of information as it was transmitted) requires that the two parties (staff and patients) share common assumptions as to the nature of things. The greater the difference in class between the two the less likelihood that these assumptions will be shared.

(10) The length of time the team has been together on a hospital ward.

(a) The assumption here is that the longer individual team members have been working together the greater the likelihood that they have developed an effective system of information giving. Thus it is more likely chance that a greater amount of information will be given to all patients on a ward.

(11) Ward morale

(a) The team on a ward with high morale will give more information to patients than a team on a ward with low morale. Stanton and Schwartz have shown that on a ward with low morale individual staff members tend to withdraw from contact with patients. (32, 337-353) Thus less information is given.

CHAPTER V

THE PROPOSED DESIGN

INTRODUCTION

Although this proposed research design might be carried out by any researcher, it has been written particularly with the students at the U.B.C. School of Social Work in mind. Because of the very limited nature of the pilot study, the proposed design may also be generally considered to be at the level of an exploratory-formulative study.

THE PROPOSED HYPOTHESES

From the material presented in chapter four, it can be restated that the main concern of the proposed study is to whether patients are receiving the amount of information they require in order to optimally benefit from their hospitalization. In order to determine what information a patient should receive, we must assume that there is an ideal amount of information that a patient should be given. Then, the amount of information that a patient is given by the treatment team may be compared with this ideal amount. This may be seen as a measure of the theoretical effectiveness of the treatment team to give information. This leads to hypothesis number one.

1. There is a difference between the ideal amount of information a patient requires for optimal benefit from his hospitalization and the actual amount of information given to him by members of the treatment team.

The amount of information that the team states that it gives to a patient compared with the amount of information a patient says he receives can be seen to represent the efficiency of the communication process.

Hypothesis number two will be

2. There is a difference between the amount of information the members of the treatment team say they have given to a patient and the amount of information that the patient says he has received.

A number of factors might be expected to affect the amount of information given by the treatment team and the amount of information received by the patients. Some of these factors are the independent variables referred to in chapter four. On the basis of this, hypothesis number three will be

3. Certain of the following variables will be found to be significantly associated with the hypothesized differences referred to in hypothesis 1 and 2.

Variables.

- (a) number of previous Riverview or other mental hospital admissions
- (b) psychotic or non psychotic
- (c) informal or involuntary admission
- (d) length of time in hospital
- (e) socioeconomic status
- (f) the degree to which the individual patient reaches out for information
- (g) frequency of group meetings on the ward
- (h) patients' attitude (positive or negative) at admission to particular staff (doctor, social worker, charge nurse) based on previous hospitalization.
- (i) length of time the treatment team has been working together on the hospital ward.

(j) ward morale

(k) explanation of reasons for hospitalization given by professional staff in the community before hospitalization.

DEVELOPING A DESIGN FORMAT

The following will be a brief outline of the three major aspects of the proposed design. Under the heading, Implementation of Design, we will discuss the details and procedural aspects of this design.

1. Tabulation of the difference between the ideal amount of information a patient requires for optimal benefit from hospitalization and the actual amount of information given to a patient.

(a) The ideal amount of information required may be obtained by:

- (i) the researchers will develop a list of information items which they believe to be essential for the particular group of patients under study.
- (ii) this list will be presented to a hospital committee composed of two doctors, two nurses, and two social workers. Because their knowledge and experience is greater than the researchers, they will be expected to add to or delete from the list as it would apply to a hypothetical patient in an ideal hospital setting. In addition, they will be asked to distribute the items in the list along a single continuum ranging from "most important" to "least important". From these listings of each of the six members of the committee, the researchers will then be able to determine a weighting for each item on the list.

(iii) for each patient within the sample, the researchers will eliminate those items in the list that are not applicable to his particular case. Thus, for each patient there will be a number of items of information that he should ideally receive and this number may vary from patient to patient.

(b) Determine from the treatment team what information was actually given to each patient in the sample.

(c) For each patient, a ratio or percentage may be determined--- actual. This ratio is assumed to be a measure of the ideal theoretical effectiveness of the treatment team to give information to patients.

2. Tabulation of the difference between the actual information given to the patient and the actual information the patient says he has received.

(a) By interviewing the patient, the researchers will determine the number of items that the patient says he has received from the treatment team.

(b) Thus, for each patient, a ratio or percentage may be determined--- information received. This ratio is assumed information given to be a measure of the efficiency of the communication process.

3. Tabulation of the data regarding each of the variables under study for each of the patients and relating it

(a) to the amount of information given to that patient by the treatment team.

(b) to the amount of information received by that patient.

IMPLEMENTATION OF DESIGN

Before any research can be carried out in the hospital, this design will have to be approved by the hospital administration. Because this design involves personnel from three professions, approval must be obtained from the directors of each discipline for the involvement of their staff. Understaffing and heavy work loads of these personnel make any further demands on their time an imposition unless an obvious value can be seen in this research. Therefore, one of the first tasks of the researchers will be to indicate what values may come from this research and thus generate enthusiasm for it. The second task will be to maintain that enthusiasm throughout the project. The preliminary study has already stimulated an interest in this research problem. Enthusiasm will be easier to maintain if one or more members of the research team are familiar with the personnel, functioning, and routines of the hospital. Because of the nature of the research design, the treatment team will be aware of many aspects of the research and this may positively bias the amount of information given to the patients. On the other hand, because of this awareness, the researchers will be able to share material with them throughout the project. This would be one major way of maintaining enthusiasm. Another major point in the maintenance of interest of the hospital is that the researchers should be far more explicit in their dealings with the hospital administration than those who were involved in the present study. For example, the researchers should take responsibility for developing an agenda for any meeting and giving this to the participants beforehand.

THE LIST OF INFORMATION ITEMS

The first research instrument in this design is the list of information items felt to be essential to the hypothetical patient in an ideal hospital setting in order for him to obtain optimal benefit from his

hospitalization. We are assuming that there is a body of information that a patient requires and that this will vary depending upon the patient's age, sex and circumstances. To arrive at an ideal amount of information to be given, we must postulate a hypothetical patient with the characteristics that will match the patient sample group. In addition, there may be circumstances in the hospital, beyond the control of the treatment team, which might prevent a patient from being given all the information which he should theoretically have. Therefore, in item selection we must postulate an ideal hospital setting (e.g. availability of staff, effective ward organization). Thus, to obtain a list of information items that a patient should ideally be given, it is necessary to ask the committee to consider a case of a hypothetical patient in an ideal hospital setting.

Some of the areas from which items would be included in this list are:

1. Information required on admission

- care and management of other family members
- nature of admission (voluntary, involuntary)
- type of ward patient is on
- important ward routines
- systems of privileges, care of valuables, etc.

2. Information required regarding treatment

- who the doctor is and when he may be seen
- what the nurses responsibilities are
- nature of the illness
- nature of the treatment
- nature of the prognosis

3. Information required regarding discharge

- use of medication

- use of after-care, or other follow-up resources
- the extent to which staff discussed patient's illness with relatives
- what to do if symptoms of illness start recurring
- possible community reaction to a former mental hospital patient.

Before presenting to the committee, the list should be as complete and precise as the researchers are able to make it. Besides the obvious sources (professional literature), it will be very helpful for the researchers to read several patient autobiographies in order to familiarize themselves with the problems and concerns of mental hospital patients. (20)

THE COMMITTEE

Selection of the six committee members would be at the discretion of the directors of each of the three disciplines. However, because of the nature of their task, highly trained persons with considerable experience in a mental hospital setting should be requested. In addition, because of the possible bias, they should be persons who are not members of the treatment teams of any of the wards or units under study. A suggested committee would be:

1. The Clinical Director of Riverview Hospital
2. A Unit Director, not from the units under study
3. The Director of Social Services
4. A Supervisor of Social Work, not from the units under study.
5. The Directors of Nursing
6. A Supervisor of Nurses, not from the units under study.

Because of the time limitations, each member will probably review the list at his own convenience rather than at a committee meeting. It will be the responsibility of the researchers to make clear to the members of the committee

that they are to consider the ideal case rather than what is practical at this hospital.

Besides approving the list of items, the members of the committee will also be asked to rate the items according to their degree of importance for the patient's optimal benefit from hospitalization (i.e. the Q-sort technique). Thus, if there are 40 items, the most important item would be given a value of 40. By averaging the values given each item by the six members, a weighting can be obtained by the researchers that indicates the importance of each item.

THE PATIENT SAMPLE

The choice of a patient group to be studied must be decided before the compilation of the list of information items, since the characteristics of the group will affect the nature of a number of items on the list. In selecting a sample, the following points should be taken into consideration:

- (a) the number of patients required for the study
- (b) the number of wards to be used
- (c) the approximate number of discharges per month of various patient groups
- (d) the researchers' time available to collect data

For example, from our knowledge of the hospital, notwithstanding our pilot study experience, 20 patients per month in the mother-with-children group should be discharged from each ward. However, as marked variations may occur from the estimated number, a large margin of safety in the form of extra time available to collect data should be planned for.

As any sample group will have some individual differences, this will reflect in the appropriateness of the items on the information list as it pertains to each individual patient. Therefore, the researchers will

have to remove for that particular patient those items that are not applicable. This will have to be determined by a review of the patient's file and if the file information is lacking, then by checking with one of the treatment team members. The result then will be an individualized list of information items for each patient.

THE TREATMENT TEAM CHECK LIST

The second research instrument in this design is an instrument for determining what information was actually given to individual patients. Because of demands on staff time, it would appear that a check list, with all its disadvantages would be the most practical instrument. Administering the check list to the doctor and social worker presents no particular difficulty as there is usually one on each ward. However, there may be as many as 20 nursing staff who will have contact with one patient during his hospitalization. Ideally, every nurse on the ward should be contacted more than once in regard to each patient in the sample. One may strongly question whether in fact, the charge nurse knows what information the other nursing staff give to a particular patient, though she would appear to be the best informed. Again, when a patient has been on the ward for 2 months or more, it is very difficult to remember what that patient was told at the time of admission. However, because of the time limitation, the check list can be given only once, only to the charge nurse, and presumably this would have to be at the time of discharge. The researchers must recognize that this will be a weak instrument and that they are measuring only the treatment team members' memories, with all their omissions and inclusions, of what information was given. This check list must be given to each of the three central members of the treatment team for each of the patients in the sample and a compilation of the three lists be made to arrive at a team list of information items reported to have been actually given.

THE PATIENT INTERVIEW GUIDE

The third research instrument in this design is an instrument for determining the information that the patient is aware of having received from the members of the treatment team. Because of individual differences among patients, a questionnaire is not practical. Because of differences among the researchers, a non-structured interview would allow for too much individual variation; thus, a semi-structured interview based on an interview guide would seem to be the most appropriate instrument. This interview guide would be based on all the information items in the individualized list for a particular patient. This hypothetical list is used, rather than the actual list of items that the treatment team gave to the patient, because time limitations would probably prevent drawing up the actual list before the patient leaves the hospital. Therefore, the list of items the patient reports to have received must be checked against the list of items the team report they gave in order to remove from the patient's list those items that they received from sources other than the treatment team. This revised list will comprise the information that the patient says he has received from the treatment team.

Assuming that the patient will accurately report the information they are aware of, provided that the interviewing process is accomplished skilfully enough, it becomes extremely important that the researchers develop a competent and consistent interviewing technique. Several points should be kept in mind:

- (a) the researchers must have a thorough knowledge of the items on the interview guide and the method of scoring to be used,
- (b) because of patient anxiety and possible residual effects of their illness, to avoid communication problems researchers must become proficient at using simple language, slowly spoken.

(c) researchers may be helped to develop a consistency of approach to patients through role playing sessions.

Other practical problems to be resolved by the researchers are: developing a simple, efficient system for being notified when a patient is ready for discharge, developing a simple, logical, and non-threatening explanation for the patient of the researcher's purpose in conducting the interview, and developing for the nurses a short but positive introduction of the researchers to the patient.

THE LIST OF VARIABLES

The fourth research instrument in this design is the development of a list of the variables under study in such a form that information about them may be collected for each patient. Of all the variables listed under THE PROPOSED HYPOTHESIS, variables (a) to (e) may be obtained from the patient's file. It is suggested that the charge nurse may be the best source of information regarding variables (f) to (i). A possible information for variable (k) could be ascertained from the patient.

ANALYSIS OF THE DATA

In discussing the work of the committee, reference was made to the use of a weighting system for all information items (i.e. the Q-sort technique). In discussing the proposed design, reference was made to three lists of information items for each patient:

- (a) the ideal list of information items that could be given
- (b) the actual list of information items reported to have been given by the treatment team
- (c) the list of information items the patient says he has received from the treatment team

A numerical value representing each of the lists may be obtained by adding

the weighted values of each of the items on the list.

Hypothesis one. The theoretical effectiveness of the treatment team in giving information to a particular patient would therefore be represented by the ratio:

$$\frac{\text{weighted value of actual information given}}{\text{weighted value of ideal information}}$$

Hypothesis two. The efficiency of the communication process would therefore be represented by the ratio:

$$\frac{\text{weighted value of information received}}{\text{weighted value of actual information given}}$$

Each of the relevant variables under study may be related to each of the hypothesis by means of the chi square. Since the chi square method is used to compare frequency distributions rather than statistics (37, p.66), the patient sample will have to be divided into two or more groupings. For example, those obtaining highest efficiency-of-communication ratios versus those obtaining lowest efficiency-of-communication ratios.

Likewise, frequencies may be obtained for the data relating to each of the variables under study.

Interesting interrelationships between promising variables may also be examined by the use of the chi square method. However, the sample would have to be sufficiently large to permit this.

There are various possible secondary studies that might be done from the data collected. An obvious one would be to examine the amount and the kind of information which patients reported that they received but which was not given by the treatment team.

Another secondary study that could be done involves the development of the ratio:

$$\frac{\text{weighted value of information received}}{\text{weighted value of ideal information}}$$

This ratio might be compared to each of the other two ratios and may also be related to some of the independent variables through the chi square method.

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APPENDIX A

PATIENT INTERVIEW GUIDE

INTRODUCTION:

Researcher from U.B.C. doing a study on hospital services.
 All responses are confidential. Participation is on a
 voluntary basis and the patient's co-operation is appreciated.

1. Length of time in hospital (V)
2. Who is your doctor?
 Who is your charge nurse?
 Who is your social worker? (only need 3/5)
 Who is your occupational therapist?
 Who is your recreational therapist?
3. Have you had any (meaningful) conversations with each one?
 If so, how many?
4. What do these people do? (role awareness)
- IA #1 5. How did you learn this? (from S.W.)
- IA #2 6. Do these staff members discuss their patients with each other?
 (awareness of team)
7. How many previous admissions?
8. Any friends or relatives hospitalized now or in the past?
 (experience positive or negative)
9. Who discussed your hospitalization with you before your admission?
- IA #3 10. After admission, who talked with you about the affects of your illness on others?
- IA #4 11. Were you worried about money matters either at home or in the hospital? Did you worry about your rights as a patient?
 If so, who did you discuss these with or who would you have discussed them with?
- 11.(a) Did anyone ask you about such matters?
- IA #5 12. Who discussed with you how your family was managing during your absence?
- IA #6 13. Who discussed your plans after discharge with you? (finances)
 (living arrangements)
- IA #7 14. Who discussed with you some of the difficulties you may face with your family and neighbours when you go home?

15. How did your first meet the S.W.?
16. Have you met with any other social workers before coming into the hospital? (essentially neg. or post. attitude)
- 16.(a) During your contact with the S.W. what did you talk about?
17. Age of patient?
18. Marital status? (divorced, sep.)
19. Children: age of each whether at home or not. (under 18)
20. Education, income and occupation of family head.

SCORING OF INFORMATIONAL AREAS

1. Role of Social Worker:
Patient must show some awareness of either the treatment or liaison with the community or family roles of the social worker.
2. Awareness of the team approach:
Any awareness that staff members discuss patients or that a working together occurs among professional staff.
3. Reasons for coming to hospital: social implications:
Patient must have some awareness that she "failed to conform to role obligations" and that others reacted to this role failure. This would include sickness if patient is aware that the illness had negatively affected role functioning.
4. Financial and legal concerns:
This would include any legal and/or financial matters such as comforts allowance, cost of hospitalization, public trustee, family allowance, family finances while patient in hospital, legal rights as a patient, etc.
5. Family functioning:
Any information pertaining to the welfare and functioning of an individual or family group which composes the family in which the patient lives.
6. Material-physical aspects of discharge plans:
This will include finances, living arrangements, etc.
7. Social-emotional planning:
This will include any information regarding adaption to roles, strengthening of roles (agency contact), the facing of negative community attitudes, the facing of interpersonal or emotional difficulties in the family, etc.

APPENDIX B

SOCIAL WORKER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Ward: _____

Please Underline, check, or answer the following:

1. Degree to which patient reaches out for information: High
Low
2. Number of patient-social work contacts while in hospital:
Ans. _____
3. Attitudinal influence of relatives on patient: (a) essentially positive
(b) essentially negative
4. By whom first contact initiated: (a) social worker
(b) patient
5. Location of offices: (a) on ward
(b) off ward
6. Number of social work contacts with relatives:
Ans. _____
7. Specific reason for seeing patient:
Ans. _____
8. Who referred patient to social worker: (a) doctor
(b) patient
(c) nurse
(d) self

APPENDIX C

FILE INFORMATION GUIDE.

1. Number of previous admissions.
2. Diagnosis at time of admission.
3. Type of admission.
4. Birthdate.
5. Marital status.
6. Admission date.
7. Treatment unit.
8. Ward.
9. Probable discharge date.

APPENDIX D

SOCIAL WORKER INTERVIEW GUIDE

For the purpose of this research project, we have interviewed each patient with regards to the following seven information areas. To evaluate the patient's reception and awareness of these information areas, we need the social worker's decision as to whether each information area was covered with the patient.

1. Role of Social Worker:

Patient must show some awareness of either the treatment or liaison with the community or family roles of the social worker.

(a) Did you give an explanation of your role?

YES

NO

(b) If not, did you check to see if they understood your role?

YES

NO

2. Awareness of the team approach:

Any awareness that staff members discuss patients or that a working together occurs among professional people.

(a) Did you give any explanation of the team approach?

YES

NO

(b) If not, did you check to see if they understood the concept of the team approach?

YES

NO

3. Reasons for coming to hospital: social implications:

Patient must have some awareness that she "failed to conform to role obligations" and that others reacted to this role failure. This would include sickness if patient is aware that the illness had negatively affected role functioning.

(a) Did you discuss the social implications of their coming to hospital?

YES

NO

(b) If not, did you check to see if they understood such implications?

YES

NO

4. Financial and Legal Concerns:

This would include any legal and/or financial matters such as comforts allowance, cost of hospitalization, public trustee, family allowance, family finances while patient in hospital, legal rights as a patient, etc.

(a) Did you discuss any financial and/or legal concerns?

YES

NO

(b) If not did you check to see whether they had such concerns?

YES

NO

5. Family functioning:

Any information pertaining to the welfare and functioning of an individual or family group which composes the family in which the patient lives.

- (a) Did you give any information concerning their family's functioning?
- (b) If not did you check to see whether they require such information?

YES	NO
YES	NO

6. Material-physical aspects of discharge plans:

This will include finances, living arrangements, etc.

- (a) Did you discuss the material physical aspects of discharge plans with them?
- (b) If not, did you check to see whether these arrangements were made?

YES	NO
YES	NO

7. Social-emotional planning:

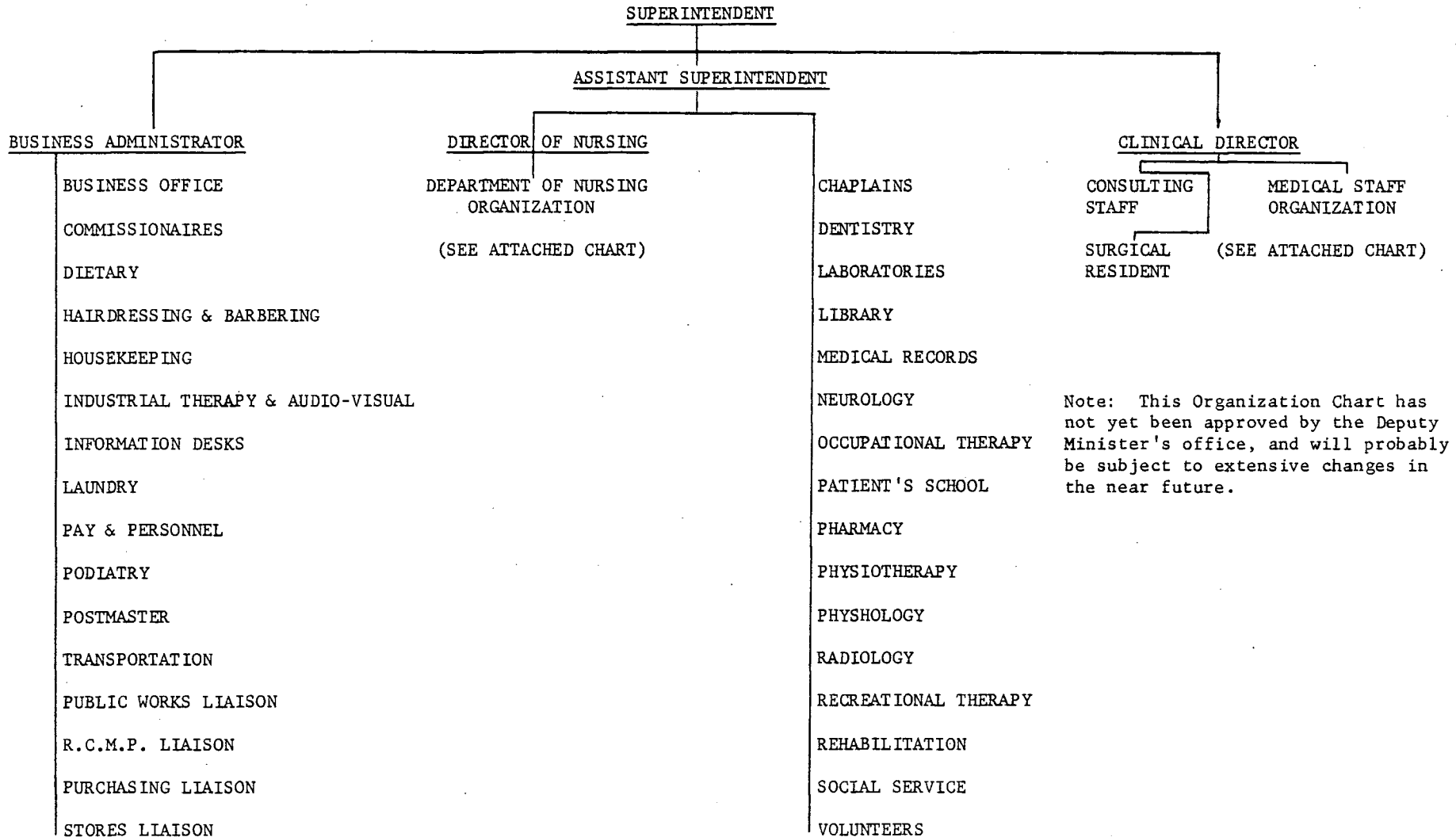
This will include any information regarding adaption to roles, strengthening of roles (agency contact), the facing of negative community attitudes, the facing of interpersonal or emotional difficulties in the family, etc.

- (a) Did you give any information around social, emotional areas of planning?
- (b) Did you check to see if they had information about this area?

YES	NO
YES	NO

APPENDIX E

RIVERVIEW HOSPITAL - ORGANIZATION CHART



December 12, 1966

TABLE NO. I

COMPILATION OF DATA COLLECTED

Patient	#1	#2	#3	#4	#5	#6	#7	#8
Info received score	6	5	4	4	3	2	1	1
Info sent score	7	6	7	7	6	6	5	6
Info Area #1 received sent	1 1	1 1	0 1	0 1	1 1	0 1	0 0	0 1
#2	1 1	1 1	0 1	0 1	0 1	0 1	0 0	1 1
#3	1 1	0 1	1 1	0 1	0 1	0 1	1 1	0 1
#4	0 1	0 0	0 1	1 1	0 0	1 0	0 1	0 0
#5	1 1	1 1	1 1	1 1	1 1	0 1	0 1	0 1
#6	1 1	1 1	1 1	1 1	1 1	1 1	0 1	0 1
#7	1 1	1 1	1 1	1 1	0 1	0 1	0 1	0 1
Age of Patient - Pt.	36	29	25	36	28	41	44	43
Age of Patient - File	36	29	25	36	28	41	44	43
Marital Status (1)	M	M	M	W	M	M	W	M
No. of Children at home	3 0	6 6	1 1	4 4	3 3	3 3	6 6	2 2
Time in Hospital - Pt.	2mns	4wks	2wks	3wks	5wks	2mns	3wks	1mn
Time in Hospital - File	2mns	4wks	2wks	3wks	6wks	2mns	5wks	3wks
No. of S.W. contacts - Pt.	2	2	4	3	2	1	2	0+gr
No. of S.W. contacts - S.W.	4+gr	2+gr	4+gr	3+gr	2	3	2	2+gr
Previous Admissions - Pt.	6	0	0	0	1	5	0	2
Previous Admissions - File	5	0	0	0	1	5	0	2
Referred to S.W. by---	Dr.	S.W.	Nurse	Pt.	Dr.	Dr.	Dr.	S.W.
Who Initiated contact - Pt.	Dr.	Pt.	S.W.	-	S.W.	Pt.	Pt.	Group
Who Initiated contact - S.W.	Pt.	S.W.	S.W.	Pt.	S.W.	Pt.	Pt.	S.W.

TABLE NO. I

Patient	#1	#2	#3	#4	#5	#6	#7	#8
Diagnosis (2)	N	N	N	N	P	P	N	P
Type of Admission (3)	V	V	V	V	V	I	V	V
Person who discussed hospitalization before admission	Dr.	Dr.	Dr.	SW Dr.	None	None	None	Dr.
Patient's ability to reach out for information (4)	H	H	H	H	L	L	H	L
Location of S.W. Office	on	on	on	on	off	on	on	on
Previous S.W. Contacts	None	+	+	+	+	None	+	None
Influence of relatives' hospitalization	+	-	None	None	None	None	None	+
Influence of relatives on Pts. hospitalization	+	+	+	+	-	+	None	-
No. of S.W. contacts with relatives	1	0	1	0	1	3	0	1

(1) M - married
W - widowed

(2) P - psychotic
N - nonpsychotic

(3) V - voluntary
I - involuntary

(4) H - high ability
L - low ability