SOCIAL CASEWORK FOR IN-PATIENTS IN A VETERANS' HOSPITAL

An Analytical Survey of Social Services Rendered in Relation to the Psychosocial Problems of a Group of Male In-Patients, Shaughnessy Hospital, 1956.

by

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ABSTRACT

The social worker in a medical setting functions as a member of a team, whose aim is to achieve the greatest possible rehabilitation of patients and families handicapped by illness. This study is an examination of psychosocial problems and is an exploratory survey (comparable to others which have been made in different settings) aimed at clearer identification of problems in which the services of the social worker are relevant, and of the nature of these services. It applies in this instance to male hospitalized veterans.

The method used in the survey was to compile pertinent data on district office, hospital, and social service records of a sample group of 50 male in-patients, referred to the Medical Social Service Department, Shaughnessy Hospital, January-June, 1956. The information was extracted from the case records by means of a schedule. Classifications were developed to show the frequency and distribution of (a) psychosocial problems and (b) kinds of social services rendered. A selection of case summaries was used to illustrate further the nature of problems, and the methods used in treating them.

The findings revealed that M.S.S.D. services are being used mainly for those younger hospitalized veterans with fair potential for rehabilitation. There is indication of potential value in extending the services to older veterans. Most requests for service continue to be related mainly to practical problems such as economic and housing needs, as well as for aid with medical diagnosis. The frequency and variety of psychosocial problems indicates need for increased direct service applied to the more intangible psychological problems related to illness and handicap.

Discussion on the implications of the study findings includes possible means of increasing the effectiveness of social services. This requires, among other things, further studies of services related to particular needs, broader interpretation of social services, and demonstration of the effectiveness of intensive or long-term casework in the treatment of patients. Such developments should increase the effectiveness of the over-all programme for the rehabilitation of the veteran patient.

ACKNOWLEDGMENTS

It is with sincere appreciation that I extend my acknowledgment for the very generous help and interest of the many persons who have assisted in this study.

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SOCIAL CASEWORK FOR IN-PATIENTS IN A VETERANS' HOSPITAL

CHAPTER I

SOCIAL SERVICES IN THE TREATMENT OF THE HOSPITALIZED PATIENT

"To cure the human body, it is necessary to have a knowledge of the whole of things."[1] This statement presumably made by Hippocrates some 2400 years ago, has had varying significance in the treatment and care of the ill person throughout the decades. In the last century, the influence of the wars and the emphasis on restoration which has emerged in the field of medicine has influenced the development of services to meet the needs of the sick and handicapped.

The Development of Social Work in Medical Settings

The period from approximately 1850 to 1918, which has been described as the "Machine Age of Medicine",[2] saw advances in bacteriology, the techniques of surgery, radiology and treatment by drugs. The attention of the medical profession was drawn almost wholly to the physical and chemical causes of diseases. The general practitioner, who continued to know his patients as possessors of families, homes and jobs, was likely to take these adjuncts into account when he treated them. The hospital specialist, on the other hand, dealt mainly with the treatment of the

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1. ROBINSON, C. Canby, The Patient as a Person, The Commonwealth Fund, New York, 1939, p. 1.

2. MORRIS, Cherry, Social Casework in Great Britain, Faher and Faher Ltd., London, 1950.

disease for which the patient was referred. At the same time as specialization in treatment institutions increased and new knowledge was being accumulated in the practice of medicine, psychiatry and related technological fields, recognition was being given to the need for creation of new services which would aid in the utilization and integration of these advances. Medical science was achieving success in alleviating many of the physiological ravages that illness creates, but medical practitioners saw that the total welfare of the ill could not be assured through technological and chemical advances alone. Although the first "Lady Almoner"[1] was appointed in 1890 to the Royal Free Hospital in London as an economy measure,[2] this action, instituted by Sir Charles Loch and other members of the London Charity Organization, led to broader concern for the social problems of the ill person. One of the consequences was the establishment, in 1906, of the Hospital Almoners' Council. The functions of this Council were the training of Almoners, promoting their appointment to hospitals and guiding professional policies.[3] From these beginnings until World War II, the Almoners constantly endeavoured to interest the hospital in the social needs of the patients. Through the

1. As pointed out by Dr. Richard Cabot in a paper entitled "Hospital and Dispensary Social Work", reprinted in Expanding Horizons in Medical Social Work, University of Chicago Press, 1955, the English word 'Almoner', which naturally connects itself with the giving of alms, has been supplemented in English usage by phrases like social service, social work, etc.

2. The Lady Almoner's duty was to determine the financial eligibility of patients applying to the hospital dispensary for free care.

3. CANNON, Ida M., On the Social Frontier of Medicine. Harvard University Press, Cambridge, 1952.

influence of the new medical tradition and the efforts of the Almoners in providing for evacuees, the interest of the British Ministry of Health was aroused, and in 1940 a circular to hospitals gave instruction for the Almoners to undertake additional "welfare duties".

In America, even as early as 1864, medical staffs of hospitals expressed a desire to know about the living conditions and family situations of the patients. The "loss of patients" who did not return for treatment and the resultant spread of disease led to the instituting of home visiting as part of the training of student doctors at the New York Infirmary for Women and Children. In other areas home visiting was carried out both by student doctors and nurses in training, mainly to determine what sort of environment the patient lived in and to ensure that he knew how to follow medical instruction. In 1905 Dr. Richard Cabot, Physician to Out-Patients at the Massachusetts General Hospital, secured the support of interested persons to establish a sub-department with a "suitable person to investigate and report to the doctor, domestic and social conditions bearing on diagnosis and treatment".[1] It was his hope that this person would ".....form the link between hospital and the many societies, institutions and persons whose aid could be enlisted". This "suitable person" was Miss Garnet Isabel Pelton, a social worker at the Dennison House Settlement in South Boston. By 1914 the

1. Ibid. p.48.

hospital social workers were sufficiently accepted by the Administration of this hospital to warrant Miss Ida M. Cannon being given the title "Chief of Social Service". Coverage was now extended to in-patients as well as to those attending the clinics. At the National Conference of Social Work in Kansas City in 1918, the American Association of Hospital Social Workers was organized.[1]

Other countries followed the lead of England and the United States, and by the 1930s hospitals in Germany, France, Japan, Denmark, Sweden and the Commonwealth Nations were using the services of Almoners or social workers in providing treatment to the patient. By 1924 there were ten social service departments established in hospitals in Canada.

Psychosocial Aspects of Illness

The concept of disease has enlarged in recent years to include psychosocial theory. It is being viewed as a reaction of the organism as a whole to external and internal impacts which tax its capacity for adaptation. The importance of the influence of the social and environmental aspects of illness and medical care has come into the fore, and recognition is developing for the need of including these factors in the medical curriculum. The teaching of social factors, in medical and psychiatric settings, has involved the use of a wide variety of methods, in-

1. The title of the organization was subsequently changed to "American Association of Medical Social Workers". In the fall of 1955, A.A.M.S.W. amalgamated with the "National Association of Social Workers", and is now known as the Medical Section of this organization. Essentially American, N.A.S.W. is, however, open to membership by Canadian social workers.

cluding lectures, demonstrations, home visits, conferences and discussion of selected cases.[1]

In both the teaching and the practice of medicine there is a growing awareness that illness or handicap involves for the individual his total personality and social situation. Differentiation is made between emotional disturbances which are the cause of physical illness and those which are the result. The meaning of illness is different for each individual and he will react to it in accordance with his own established pattern of behaviour. Ill and handicapped persons have, in common with all other persons, certain basic needs. The most important of these is the need to be loved and wanted and to feel secure, whether one is living with his own family or is living in a substitute family setting. This is as true of the adult or the aged person with a chronic illness as it is of the handicapped child. For most persons, illness, especially that requiring hospitalization, may be an unpleasant, fearful situation which gives rise to anxiety. As Frances Upham points out "the whole experience of illness and care may stir up repressed fears of inadequacy, mutilation and annihilation".[2] The patient may fear the unknown, or, when surgery is required, he may feel further threatened by permanent disability or loss of life. In addition

1. For full description see: Joint Committee on the Teaching of Social and Environmental Factors in Medicine, Widening Horizons in Medical Education, published for The Commonwealth Fund, New York, by Harvard University Press, Cambridge, Mass., 1948.

2. UPHAM, Frances, A Dynamic Approach to Illness, F.S.A.A., New York, 1949. p.15.

to these basic anxieties, the sick person is concerned about his prognosis and the possibility of disablement which may prevent his return to a more or less normal way of living. The patient's tolerance of his state of dependency and experiences of pain and discomfort depends upon his personality and adaptability. For the average, reasonably well adjusted individual, the disadvantages of being unable to manage his own affairs and being in a state of poor health outweigh the advantages of the extra attention from loved ones, the physical care and the security of the hospital setting. For the less well integrated personality, illness may provide satisfactions because of the implications of discomfort, dependency and authoritative milieu. For some patients, hospitalization or treatment may fulfil unconscious needs to be cared for, to punish themselves, or to escape the pressures of everyday living with which they feel unable to cope.

In addition to the recognition of the emotional aspects of illness, emphasis is being placed upon the social factors which influence the patient's treatment. Hospitalization and illness may create economic pressures for the patient and his family, as well as involve the loss of a job or change of vocation. Separation may impose physical as well as emotional strain on patients and their families, depending on the nature and extent of the disablement and convalescence. For some families the change in marital roles, with the wife assuming some or all of the husband's usual responsibilities, may create a severe problem.

The Functions of the Medical Social Worker

The use of the multi-discipline team is the method by which the institution can ensure that the total needs of those patients who are physically and mentally handicapped, and others who have multiple problems - social, psychological, vocational, economic, etc. - will be adequately met. This implies integration of efforts and inter-action between the doctor, nurse, physio-therapist and other staff who are concerned with the treatment and rehabilitation of the patient.[1]

From its early beginnings at the Royal Free Hospital in London, social work has continued to extend itself, in co-operation with medicine, to forward its aim of returning the patient to as full a measure of health and ability to function as a productive member of society as possible. While operating continuously as a member of a professional team in the medical institution, social work has retained its own identity with the practice of social casework, which has for its generic basis, the understanding of man as a bio-chemical organism functioning in a social milieu. It aims at helping the individual and groups to achieve more satisfying adjustments and thus provides a more adequate social environment. As defined by Swithun Bowers, Social Casework "is an art in which knowledge of the science of human relations and skill in relationship are used to mobilize capacities in the individual and resources in the community appropriate for better

1. COOLEY, Carol H., Social Aspects of Illness, W. B. Saunders Co., Philadelphia and London, 1951.

adjustment between the client and all or any part of his total environment".[1] It implies a belief in the essential worth of the individual and concerns itself with various factors - physical, emotional and social - which influence the individual in his reaction to life experiences and, particularly, to the balance between inner and outer forces affecting his response in a given situation.

With recent developments in both medicine and social work, there have been changes in practice within the field, and the function of the social worker in a medical setting is being clarified and re-defined, as Rebecca Frost has concluded from her survey of medical and social work literature.[2] The relationship of the physician-patient-social worker has become closer. The physician and social worker are operating more consistently on a team basis. Social work function in relation to administration has moved to participation in programme planning, policy formulation and standard setting. According to the standards set forth by the American Association Medical Social Workers,[3] the practice of social work in a hospital should embody the major areas of: the practice of social casework; participation in programme planning and policy formulation within the medical institution;

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1. BOWERS, Swithun, O.M.I., "The Nature and Definition of Social Casework: Part III", Journal of Social Casework, Vol.30, No.10, 1949, p.417.

2. FROST, Rebecca, The Changing Emphasis in the Function of the Medical Social Worker, Master of Social Work thesis, University of Southern California, American Association Medical Social Workers, Washington, D.C., July, 1955.

3. A Statement of Standards to be Met by Social Service Departments in Hospitals, Clinics and Sanatoria, American Association of Medical Social Workers, Washington, D.C., 1949.

participation in the development of social and health programmes in the community; participation in the educational programme for professional personnel and social research.

In a hospital setting, the main purpose of which is medical treatment, the primary concern of the social worker is with the social needs and problems as they relate to illness, physical handicap and medical care.

> "Medical social problems exist when either the medical aspects in a case situation impinge on the social, or the social aspects on the medical, or both. The medical social worker's focus is on the inter-action of the two more than on the totality of the medical or the social. This focus on the inter-action is consonant with purpose of the medical care programme which establishes the boundaries of the medical social worker's function."[1]

Thus the medical social aspects of the situation become the focus of attention. In order to help the sick person the social worker must be concerned with a number of things. As defined by Leonora B. Rubinow[2] these are: the medical problem; the kind of person the patient is; his environment; and the resources of the community which are available to him.

In relation to the medical problem, the social worker may assist the doctor by informing him of social and emotional problems which have a bearing upon the illness, and may help the

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1. WHITE, Grace, "Distinguishing Characteristics of Medical Social Work", Readings in the Theory and Practice of Medical Social Work, University of Chicago Press, Chicago, 1954, p.119.

2. RUBINOW, Leonora B., "Medical Social Service", Expanding Horizons in Medical Social Work, University of Chicago Press, Chicago, 1955.

patient to overcome obstacles that stand in the way of his following medical instruction. Such obstacles might be financial handicap, fears related to the illness or difficulties in family relationships. When a permanent disability occurs the social worker may be called upon to aid the patient or his family make the best possible adjustment within the physical and psychological limitations as defined by the doctor. In medical social planning the preventive aspects, as well as the immediate problem, are born in mind. One of the objectives of the worker, as with the rest of the treatment team, is to guard against recurrence or unfavorable progress of the patient's illness.

Miss Minna Field points out the difference in the approach of the social worker to that of the other members of the treatment team and summarizes the value of this approach.

> "The social worker's approach is governed by an attempt to see the problem as the patient sees it, to allow the patient to move at his own pace and to make his own decisions towards a goal that he has helped to set for himself .....Knowledge about the patient as a total human being, which is gained through training and experience, not only helps the social worker to understand the patient's problems but also to sense the strengths within the patient himself and among members of his immediate social circle which can be drawn upon for the solution of these problems. Such sources of strength and support can often be found among members of the family, friends, employers, co-workers as well as social and religious organizations."[1]

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1. FIELD, Minna, "Role of the Social Worker in a Modern Hospital", Social Casework Journal, Vol.34, No.9, November 1953.

Veterans' Rehabilitation Programmes

Rehabilitation and after-care, as used in contemporary practice, "is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable".[1]

Veterans[2] have for many years been recognised as a special group of Canadian citizens with particular rehabilitative needs. The present programme for their rehabilitation had its inception prior to World War I when recognition was given to the economic requirements of certain disabled officers through the payment of pensions by the Government. Provision was made for hospital accommodation, employment and pensioning of the disabled veteran with the establishment of the Military Hospitals Commission in 1915, and the Board of Pension Commissioners in 1916. The amalgamation of these two commissions under The Department of Soldiers' Civil Re-Establishment in 1918 saw the advancement of vocational programmes and the institution of counselling services for the disabled.

As the World War I veterans gradually established themselves in civilian life there was, for a time, a shift in the

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1. This definition was adopted by The National Council on Rehabilitation, New York, at its National Conference in 1946.

2. A veteran, as defined in the Statutes of Canada, 1945, is:
(i) "A person who has been on active service in the Canadian forces or in receipt of active service rates of pay from such forces during the war;
(ii) A person domiciled in Canada who served in the forces of (His) Majesty other than the Canadian forces and was so domiciled at the time he joined any such forces for the purpose of war, and who has been discharged from such services."

focus on rehabilitation towards greater consideration of the veterans' treatment and pension needs. The existing departments were absorbed in 1928 into the newly created Department of Pensions and National Health. In the years between World Wars I and II much legislation was executed and many special bureaux and commissions were created to assist the veteran in his efforts toward re-establishment in the community. The War Veterans' Allowance Act, 1930, was enacted to provide a living allowance, analagous to old age pension, to the veteran who had seen service in an active theatre of war and who could no longer meet his economic needs because of age or incapacity. The Veterans' Assistance Commission established in 1936 undertook measures to aid the unemployed and unskilled veteran.

With the advent of World War II, a General Advisory Committee, composed of members of the various Federal Government Departments which would be associated with the rehabilitation of the veteran, undertook a study of all the phases or problems which would arise in the restoration of former service personnel to civil life. The legislation[1] which was enacted as a result of the work of the fifteen subcommittees in respect to such matters as education, employment, land settlement, etc., provided the most comprehensive programme of rehabilitation devised anywhere.[2]

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1. The Veterans Charter, Ottawa, King's Printer, 1947 (with subsequent amendments), is a compilation of the Acts of the Canadian Parliament to assist Canadian veterans.

2. A study of the measures set up by this committee is outlined in Wood, Walter S., Rehabilitation (A Combined Operation), Ottawa, Queen's Printer, 1953.

The Rehabilitation Branch was formed within the department in 1940.

In 1944 the Department of Pensions and National Health was dissolved and the present Department of Veterans Affairs was created.[1] Legislation enacted in that year, and subsequently, has dissolved some of the benefits available to veterans during the post-war years, but in the main rehabilitative resources such as Land Settlement and Re-establishment Credit are still available to veterans. Medical treatment for the pensioner, the War Veterans Allowance recipient and the front-line veteran who is unable to provide it himself is in the nature of a continuing benefit, as is the case with the Pension Act and the War Veterans Allowance Act.

Welfare Services

Under the direction of Lt. Col. Stewart Sutton, a social service programme had been developed during the war by the Army. At the request of Dr. W. P. Warner, Director General of Treatment Services, Col. Sutton undertook a study of the need for social workers in D.V.A.,[2] at the same time as the counsellors of the Rehabilitation Branch were becoming aware of the need for special skills and information in dealing with the social problems presented in their contacts with veterans. The results of the study led to the establishment of the present Welfare Services Branch.[3]

1. Figure 1 shows the Executive, Branch and Administrative organization of the Department of Veterans Affairs at the head office level.

2. D.V.A. and Department of Veterans Affairs are used interchangeably throughout this study.

3. Welfare Services in Vancouver are directed by a Superintendent of Welfare Services who is responsible to both the District Administrator and to the Director General of Welfare Services in Ottawa.

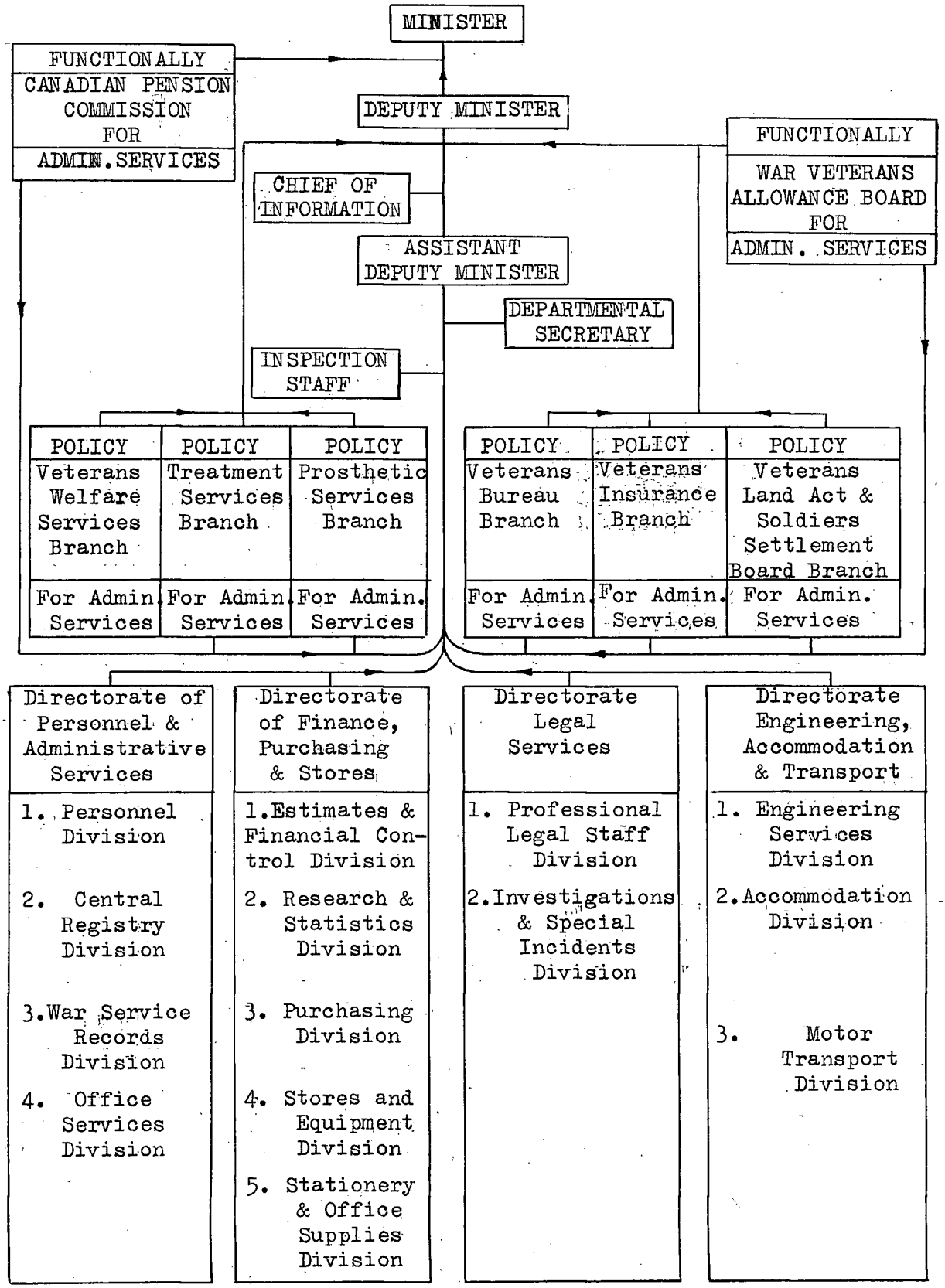

Figure 1: Department of Veterans Affairs: Executive, Branch and Administrative Organization at Head Office.

After a period of experimental work, the policies of the branch, as defined in May 1948, provided for social workers whose main responsibilities were: providing consultation to Veterans Welfare Officers, and not necessarily dealing with social problems at first hand; operating a teaching programme with the object of improving all welfare services; maintaining a liaison with community agencies; providing casework services on a non-continuing basis in respect to social problems which were of concern only to the department; assisting in research in co-operation with the research division. The Branch also assumed responsibility for administering the Assistance Fund devised to meet emergency needs of War Veterans Allowance recipients.

Veterans' Welfare Officers function in the Administrative setting, in the field and in the hospital setting. Those Welfare Officers who work in hospital settings contact all hospitalized veterans to ensure that the patient is aware of benefits to which he is entitled under D.V.A. legislation, and to make known to the proper authorities the situation of any veteran who is not receiving those benefits. Part of their function is to help the hospitalized or outpatient veteran solve problems which do not affect his treatment. These frequently concern social aspects such as housing, finances, and most especially, employment.

Medical Social Services

During the experimental stage, when responsibilities of the Social Service Division were being clarified, a medical social

service unit functioned within the Branch. Consideration was, however, being given to the advisability of all medically oriented disciplines within D.V.A. following a similar chain of responsibility. With the issuance of an administrative order on May 1, 1947, Medical Social Service was separated from Welfare Social Service and established as a separate department, responsible to the Director General of Treatment Services. The general policy to be followed by the Department was set forth in a circular letter[1] which stipulated that each Medical Social Service Department should become an integral part of the hospital set-up, responsible to the hospital Superintendent. Although the departments follow the same chain of responsibility as other treatment personnel within the hospital, they have a direct line of communication, on a consultative basis, with the Director of Medical Social Service, D.V.A.

The function of a D.V.A. Medical Social Service department, as set forth by the Director General of Treatment Services, is consistent with generally accepted standards[2] for social service departments in hospitals; it differs only in the respect that it is authorized to provide services for veterans under D.V.A. medical care.

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1. Circular Letter, 1947-138, December 6, 1947, Medical Social Service - General Policy. Refer to C.L. 1927-122, October 21, 1947.
2. A Statement of Standards, op.cit.

Shaughnessy Hospital Medical Social Service

Shaughnessy Hospital[1] in Vancouver, and Veterans' Hospital in Victoria are the main centres which provide treatment for veterans in the "VA" district which comprises British Columbia. At Shaughnessy Hospital provision is made for patients requiring convalescent care in ancillary units, while domicilliary[2] care is provided in the "Extension", a group of buildings situated on Shaughnessy Hospital grounds. Prior to the official establishment of the Medical Social Service Department at Shaughnessy in 1947,[3] social services had been provided by nurses since the establishment of separate hospital facilities for veterans in the Vancouver area in 1916. Two professionally trained social workers had been employed in the Neuropsychiatric Clinic since 1940.

The medical social service department serves the main hospital and the units which give domicilliary and convalescent care. The present establishment is for seven medical social workers; there are currently two vacancies. Caseworkers are allocated to specific wards within the main hospital and in the other units, such as the Jean Matheson Memorial Pavilion and the

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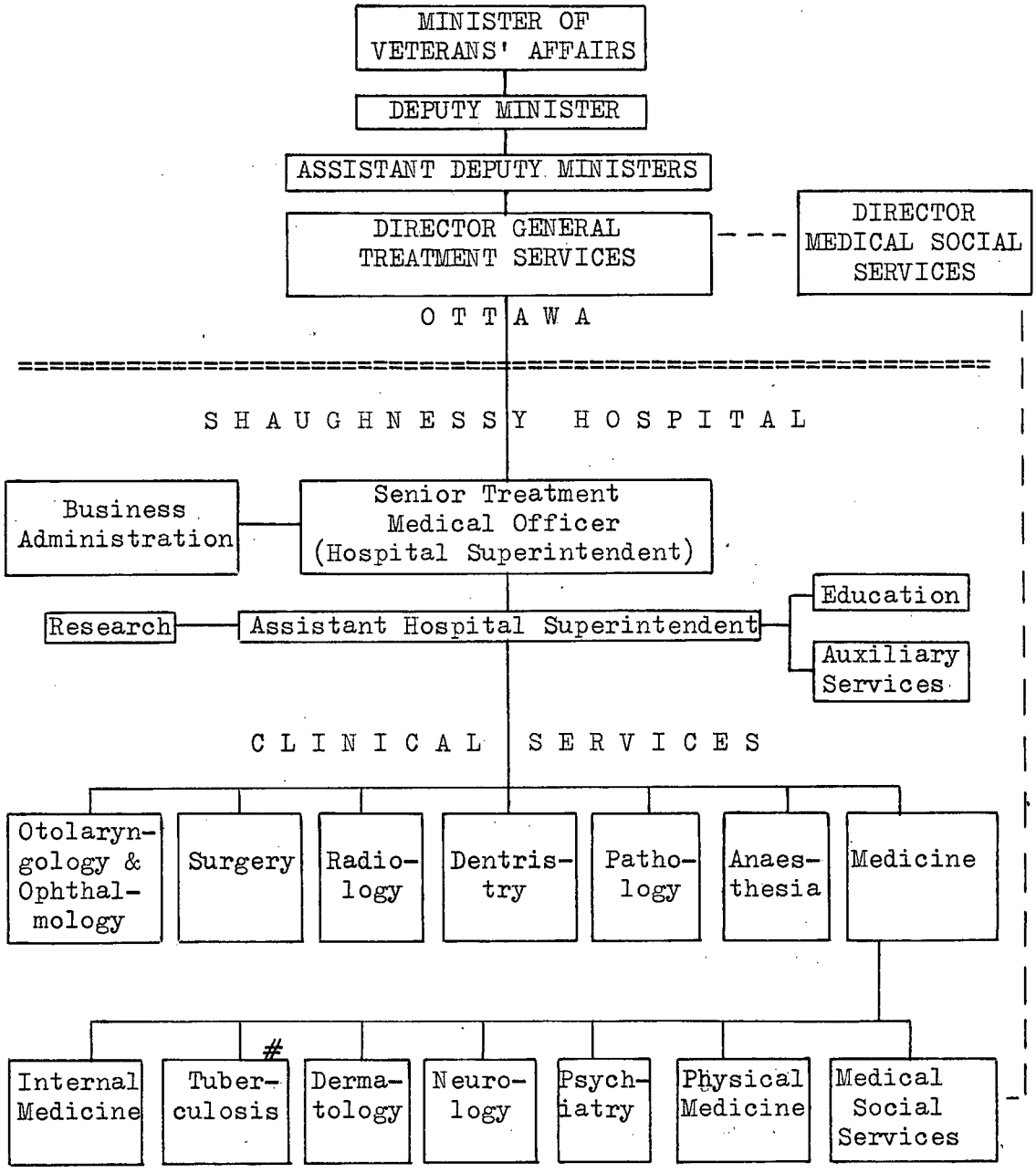
1. A history of the development of Shaughnessy Hospital is given in: CLOHOSEY, Mary E.A.B.E., Social Implications of Re-Admissions of Veteran Patients to Shaughnessy Hospital, Master of Social Work thesis, University of British Columbia, 1954.

2. Domicilliary care is a special service exclusively designed for the veteran who requires total care on a more or less permanent basis. The veteran may receive this care because of infirmity or disablements which have not changed after being treated in the most superior manner possible.

3. Figure 2 shows the position of the Medical Social Service Department within Shaughnessy Hospital.



Since early 1956 patients with active Pulmonary Tuberculosis are treated by Provincial T.B. Control.

Figure 2. The Position of the Medical Social Service Department in the DVA Organization and within Shaughnessy Hospital.

"Extension". The programme of the department has continued to develop since its inception and services are gradually being expanded to cover new areas. Like the other divisions of the Treatment Services Branch, Shaughnessy Medical Social Service has associated itself with the university. Staff members are encouraged to take advantage of the opportunities provided for completion of their professional training. Staff members also participate in the training of social work students both at the university and in the hospital setting. Internships may be provided through D.V.A. to assist students.

The department constantly engages itself in study of the problems of the patients and methods of rendering services on their behalf. In addition to individual case conferences, part of the weekly staff meetings are given over to this study. Considerable evaluative research has been done both in relation to the services offered and to the nature of problems of specific groups of patients. The department's interest in gaining information which would aid in the improvement of its services led to the development of this project. The questions which set the focus of this study are: What services are given in relation to the totality of medical-social problems of the patient? How are the services weighted in relation to the existing problems? What are the problems - presenting, accompanying and underlying - which give rise to the need for social services?

Focus and Method of Study

Social services in Shaughnessy Hospital are extended to both male and female veterans and to some active service personnel. Because of the wide diversity in the types of services requested and given by the department, it was decided, therefore, to limit the study to a survey of the problems and services given on behalf of a particular group of patients so that fairly explicit information could be obtained. Information has been obtained in a previous study[1] regarding veterans receiving service as out-patients. A research project is currently being undertaken with regard to female veterans.

In order to ascertain the nature and frequency of different types of social services extended to veterans in relation to their psycho-social problems, it was decided to review the history of a sample of one-fifth of the male in-patients referred to the M.S.S.D. within a six-month period. The period January 1, 1956 to June 30, 1956, was chosen because this would allow for an assessment in terms of the current resources and programmes available to help meet the problems and because services would probably have been completed by the time this study was initiated. A survey of the Medical Social Service case register for the period chosen revealed that of the 458 new and re-opened cases referred to the department during this time, 257 of these were male in-patients. The cases for study were obtained by selecting every-

1. PATON, John R.D., and WIEBE, John, Medical Social Service in a Veterans' Hospital Out-Patients' Clinic: A Comparative Sample Study of Cases Referred and not Referred for Social Service, Shaughnessy Hospital, 1954. Master of Social Work thesis, University of British Columbia, 1954.

fifth male in-patient referred and were found to total 51. The last case was disregarded in order to facilitate tabulation. The sample represents 11.1 per cent of the total referrals and 20 per cent of the male in-patients referred during this period of time.

A schedule was used to collect all the pertinent information on individual patients which was contained in their medical, district office[1] and social service files. Some limitations were encountered in this method of study. Implications and conclusions drawn from such surveys point up the types of resources and services used to meet some of the needs of specific groups of people, and allow for an assessment of the nature of casework services. As has been pointed out in other surveys,[2] this method does not allow for the weighting of the relative importance of the problems, assessment of the degrees of social disabilities, or for an evaluation of the specific nature of the problems.

The lack of details in some records, and the wealth of information in others, led to difficulties in establishing criteria for evaluation. In some instances, for example, patients' attitudes regarding such matters as education were noted, while, in other cases, no accurate information could be found regarding

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1. "District Office" refers to the local D.V.A. administration office. The service file of veterans living in "VA" district are kept in this office. They contain original documents pertaining to the veteran's period of service as well as copies of other records, correspondence, etc., which pertains to any aspect of medical, legal, welfare or other matters affecting the veteran and his dealings with D.V.A.

2. REED, George A., The Placement of Adolescent Boys: A Survey-Review of the Problems of Adolescent Boys in Care of the Children's Aid Society, Vancouver, B.C. Master of Social Work thesis, University of British Columbia, 1953.

even the school grade attained by the patient. Generally speaking, the pattern of recording observed in the sample group is that of brief summaries. It sometimes happened that no comments were made regarding the specific social circumstances of the patients. Some further discussion will be devoted to this in a later chapter. There were also some limitations inherent in the categories chosen for the schedule. For example, factual information only, concerning data such as employment, was obtained because the schedule did not allow for assessment of individual attitudes concerning these matters. This information was utilized, where recorded, in the assessment of the patient's problems. The files did not always specify the request for service in the categories used. In some instances, more than one reason for referral was stated, thereby making it necessary for the researcher to make an arbitrary decision as to the primary reason.

Classifications have been used to set up a number of tables which will show the frequency of problems and services. A comparison of problems, as seen from the different points of view of those concerned in finding solutions, serves as a basis to show, in part, the kinds of services which can be given, depending on how the individuals see the needs. The material in the survey does not give detailed background information on the problems. The case illustration method is used to show factors entering into the problem picture and the need for service.

CHAPTER II

THE NEEDS AND PROBLEMS OF THE HOSPITALIZED VETERAN REFERRED TO MEDICAL SOCIAL SERVICE DEPARTMENT

One aim of this study was an evaluation of the methods used in treating the social problems of the veteran in-patient who was referred to Medical Social Service. The study of the social situation of the hospitalized veteran and his family can be approached from several different angles. The problems or situation for which the patient may require services can be seen from many different points of view. The possibility of assisting the individual to find a satisfactory solution to his problems depends, in large measure, upon how the patient views himself and his circumstances. It may depend also upon which person in his environment recognizes the existence of a difficulty, and how this comes to the attention of the helping person. The existence of problems for which social work services are requested may come to attention in terms of a presenting problem or a symptom of difficulty. This may differ from and be only the effect of another more deeply rooted problem. Certain needs, pressures and experiences may not be easily recognizable and the patient himself, or other persons in his environment, may have no awareness of these. It may happen that all those concerned in the finding of a solution to the problem are aware of the causative factors as

well as of the symptoms of difficulty. There may be additional difficulties which have an influence upon or aggravate the situation for which the patient or his family requires aid, and which may bear upon the solution of the presenting problem. The objective of the helping person is to define the central problem and the patient's, or relatives', feelings about it in terms of the chief interacting causes. These may be physical, psychological, economic or cultural in various weightings.

Diagnosis of the possible constellation of problems, and methods of dealing with these, is based upon an assessment of the severity of the social reality and the degree to which the patient or his family is troubled by the difficulty. The current social realities of the person requiring help may be examined in several areas such as his physical condition, his achievement, his affectional ties, his environmental circumstances and cultural[1] influences. The individual with a psychosocial problem may be experiencing stress in any or several of these areas, or he may have resources in these areas upon which he can draw to find a solution of his difficulty. In assessing the problems of an individual requiring help, the social worker, or other helping person, may need to have knowledge of the individual's interaction with family, other groups important to him, and with his total community,

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1. As defined by M. J. Herskovits, Man and His Works, A.A.Knopf, New York, 1948, p.17, "Culture is the complex whole that includes knowledge, belief, art, morals, law, custom and other capabilities and habits acquired by man as a member of society."

depending upon the nature of the difficulties with which he needs help. The way in which the individual himself, as well as his associates, reacts to the problem is of primary importance. The individual's behaviour represents his way of meeting his needs within the framework of his environment and the realities he faces. Some of his internal needs may conflict with others, or he may be frustrated in meeting his needs by the external world, and thereby fail to attain a pattern of behaviour which permits him, or his close associates, to live comfortably or constructively in his world. When the individual is unable to attain for himself a satisfactory interaction with persons in his environment, he may request help himself or some person may request it on his behalf.

Referrals to Medical Social Service

Medical social service, practised in collaboration with other professional personnel, is an integral part of the multi-discipline services offered the veteran patient within the treatment institution. Referrals to the department may be made by any member of the treatment team, other D.V.A. personnel, the patient or his relatives, or by some person in the "outside" community. Services may be requested as an aid in planning and administering medical treatment for the veteran, or as a help in resolving social and emotional problems which have a bearing on his medical condition or treatment. The referral process, that is, the way in which a patient is referred, and whether it is done by a person

he trusts for purposes concerned with his welfare, has received no consideration in this study, even though this may have considerable bearing on the problem and the methods which could be used in meeting the patient's needs.

The sources and reasons for referrals of the study group to medical social service are summarized in Table 1. Sixty-two per cent of the referrals were made by doctors, while ten per cent were made by other hospital staff. In recent years, with the allocation of workers to specific wards, certain cases observed by the worker in her rounds, or previously known to the department, may be opened or re-opened routinely at her discretion. Pertinent social history information can then be discussed with the doctor. The smallest number of referrals of the in-patient group (2 per cent) fell within this category of routine coverage. An examination of the total number of cases referred to the department during the period covered by the study revealed a correspondingly low number (2.6 per cent) of referrals obtained in this way. Only six per cent of the patients requested services of their own accord.

The reasons for referrals of the 50 cases studied were divided almost in equal proportions within the five categories set forth in the schedule. One of the main services of the department is to assist the medical staff by obtaining information about the patient's experiences, or social and emotional problems, which may

Table 1: Source and Reason for Referral to M.S.S.D.
(Percentage Distribution)

Source of Referral	Reason for Referral					P.C. of Cases Referred
	Social History	Social Assessment	Economic Problem	Personal & Social Adjustment	Discharge Plans	
Doctor	20	10	8	6	18	62
Other Hospital Staff	-	4	-	4	2	10
Other D.V.A. Personnel	-	-	4	2	2	8
Routine Coverage	-	-	-	-	2	2
Patient	-	-	4	2	-	6
Relatives	-	-	-	6	2	8
Community	-	2	2	-	-	4
Total	20	16	18	20	26	100

Source: Sample count of Medical Social Service Department case records.

have a relationship to his illness. Requests for social history accounted for twenty per cent of the referrals. The discharge of patients from hospital frequently presents problems, especially for the patient who has reached the point where the hospital can offer him nothing more in the way of treatment and when, because of advanced age or physical handicap, he requires some sort of specialized care. When difficulties arise, or are anticipated in the course of discharge of veteran patients, they can be referred to the social service department. Twenty-six per cent of the

study group were referred by five different sources for aid with problems related to discharge. Requests for assessment of the patient's social circumstances as an aid in treatment planning, i.e., his home or environmental circumstances, and the attitudes of his associates toward his disability, accounted for sixteen per cent of the referrals.

The high proportion of patients referred for social history or assessment and for discharge planning indicates that medical staff still tend to think of M.S.S.D., in large measure, as a source of help in planning treatment or after-care for patients. The timing of referrals to M.S.S.D. and the number of times the social worker continued to participate in the patient's treatment has not been assessed. It should be noted, however, that with the majority of referrals for social history or social assessment, the worker's activities were terminated upon completion of this phase of the treatment planning. The comparatively low numbers of referrals made with a view to direct help for the patients indicates that there is room for more use of M.S.S.D. in direct treatment planning and possibly more need for use of psychosomatic approach to treatment planning.

Characteristics of the Study Group

The circumstances of the group were analyzed from the point of view of age, marital status, living circumstances, income and other factors having a bearing on the medical-social problems.

Before examining the general characteristics of the group, some facts concerning veterans and their treatment rights as well as other benefits available to them by virtue of their service in the armed forces should be noted.

Under the Veterans' Charter of Canada provision is made for the treatment of former and active members of the armed services under some 29 different sections, as outlined in the Veterans Treatment Regulations. They may qualify for free hospitalization and care under several sections, such as by reason of a service-connected disability, as recipients of W.V.A., or because of inadequate income and resources. Most of those veterans entitled to free medical care would be allotted the regular comforts allowance of about seven dollars per month while hospitalized. Those receiving treatment for service-connected disability would be entitled to receive full pension rates during their period of hospitalization. Rates are governed by the extent to which such service disablement constitutes a vocational handicap. The dependents of disabled veterans are provided for by an additional monthly allowance. W.V.A. provides for payment of sixty dollars per month to a single veteran and one hundred and eight dollars per month to married veterans. Under W.V.A. legislation no provision is made for dependent children if both parents are living. The maximum income a W.V.A. recipient may receive from any source is one hundred and twenty dollars monthly. Medical benefits are for the veteran only. No medical or dental care is provided for the wives

or children of veterans through D.V.A.

Age: Of the 50 patients under study, the ages ranged from 18 to 92 years. Five broad age classifications were used and it was found that over one third (36 per cent) of the group fell within the 26 to 45 year range. Twenty-four per cent were in the next age grouping of 46 to 65 years. Contrary to what one might expect in a study of a group of hospitalized veterans, only twenty per cent were within the 66 to 75 age range. Eighteen per cent were over 76. The smallest number (4 per cent) were in the 18 to 25 year category.

A census of patients in DVA institutions at midnight on March 31, 1955,[1] showed the greatest number were in the 60 to 64 age group with a median age of 60 years. This showed an increase of 5 years in the median age as compared to the previous census of in-patients in 1950. This indicates that there was probably a substantial increase in the average age of in-patients in the year between the last census and the time the particular veterans studied were referred to M.S.S.D. From these figures, it is obvious that the veterans being referred to Shaughnessy M.S.S.D. fall within the younger age group of hospitalized patients. This fact, coupled with an examination of the reasons for referral, indicates that the department is being used, at least in part, for those patients whose potential for rehabilitation is greatest.

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1. WINFIELD, G.A., M.D., and WELLWOOD, L., "An Analysis of In-Patients, Department of Veterans Affairs, at Midnight, 31 March, 1955", Canadian Services Medical Journal, Queen's Printer, Ottawa, Vol.XII, 1956.

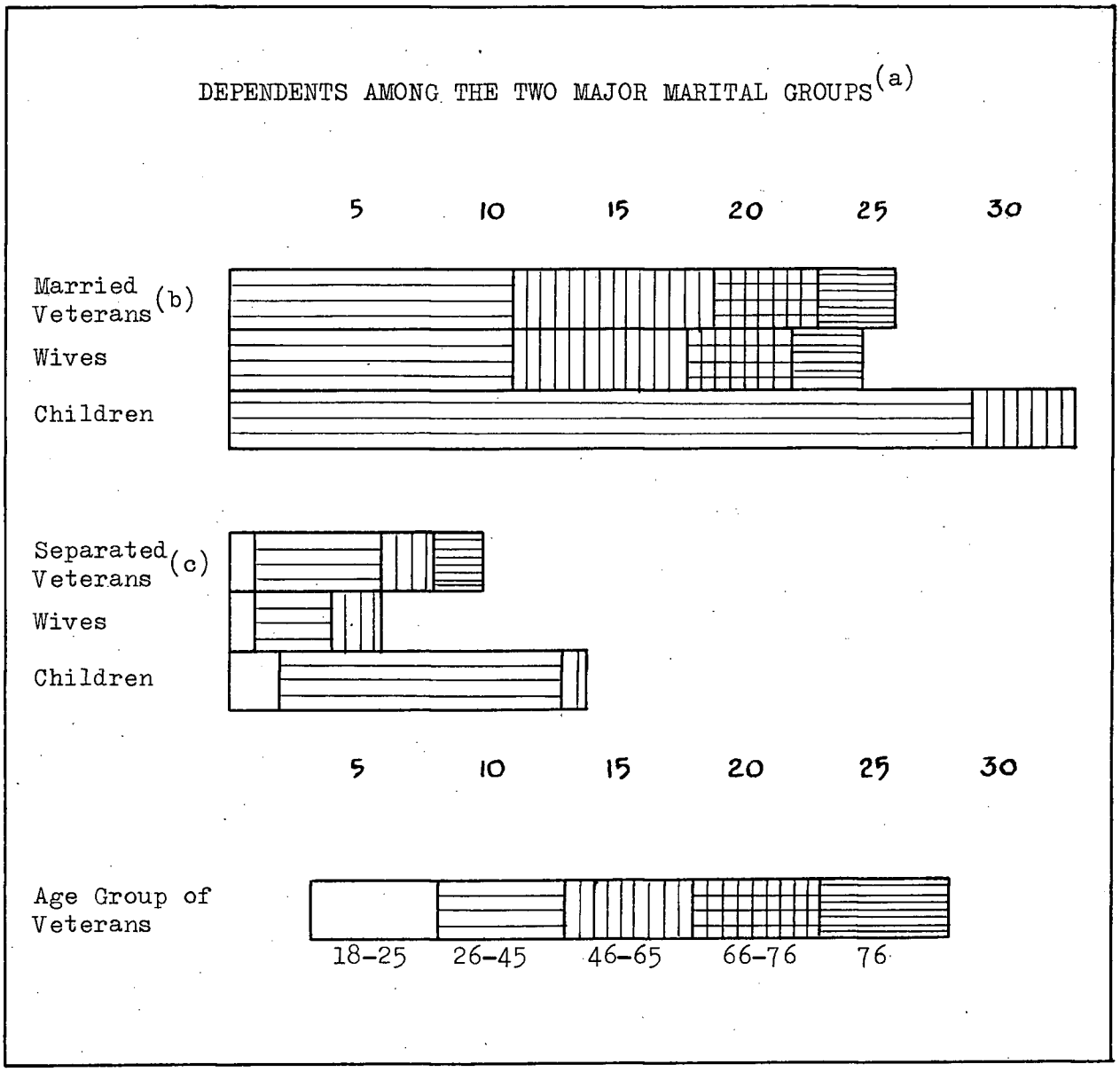
Education: Of the 50 veterans studied it was found that forty-six per cent had received elementary education, thirty per cent had some high school training, and four per cent had attended university. No information was available concerning the educational background of the remaining twenty per cent. Three veterans had additional technical training and one veteran had completed a business course.

Employment Status: The occupational experience of the patients was widely representative, ranging from unskilled manual labour to the practising of professions. Although all the patients studied were unemployed (by reason of hospitalization) at the time of their referral to M.S.S.D., employment was classified according to the usual work situation of the patient when he was not in hospital or according to his work situation at the time of admission. An equal number of veterans were in the two categories of retired and steadily employed, and accounted for fifty-six per cent of the total. Twenty-two per cent were considered medically unemployable by virtue of the degree of disability for which they were receiving pension, or by certification by attending medical staff. Veterans who had irregular work record immediately prior to admission, with frequent periods of unemployment, and job changes, were classified as occasionally employed. Sixteen per cent were in this category. Three patients had been unemployed at the time of admission and had no prospects of employment upon discharge. It is interesting to note that half of the eight

veterans who were receiving treatment for their pensionable disabilities were steadily employed. The three veterans who were classified as unemployed were in the 26 to 45 year age group, were married, and two had dependent children. All had previous hospital admissions, one with five and one with six.

Marital Status: About half of the veterans in the study group (48 per cent) were married, and of these twenty-two per cent were in the 26 to 45 age range. An equal number of veterans fell into the categories of single and separated, with eighteen per cent in each group. The remaining sixteen per cent were in the other three categories, with five widowed, two living in common-law union and one divorced. Sixty per cent of the group listed their wives as dependents, and they had a total of forty-seven dependent children. Three of the veterans in the separated category did not consider their wives as dependents, while six did, although they may or may not have been supporting them. None of the veterans had any other dependents besides wives or children. A breakdown of the veterans' marital status and dependents by age groupings (Figure 3) points up that the married veterans in the 26 to 45 age range had a substantially larger number of dependents than any of the other groups.

Living Circumstances: For the purposes of this study, the term rural was used to designate the living area of any veteran whose usual residence was outside of the Vancouver city limits, and urban as within the city limits. Veterans may come



(a) the sample group of 50 veterans included 9 single men and 5 widowers.
(b) includes veterans living in common-law union.
(c) includes divorced veterans.

Figure 3. Dependents among the two major marital groups (Shaughnessy Hospital, 1956)

from any part of the province to receive treatment at Shaughnessy Hospital. Over half of the study group (58 per cent) were living in urban Vancouver at the time of their admission to hospital. The remainder of the group usually made their home in some location outside the city. This figure is significant in considering the services which can be given to the families of the hospitalized veteran and in many instances to the patient himself. Only eighteen veterans habitually lived in their own homes and five lived in rented houses. Six ordinarily lived in boarding care and four in the homes of relatives. The usual living arrangements of twelve patients fell in equal numbers in the categories of rented apartment, sleeping room, hotel, and no fixed address. Two of the remaining four patients customarily lived in shacks and two were cared for in the hospital's domicilliary units. The housing circumstances of the patient may or may not present problems, depending upon his physical condition and upon how he or his family feel about the accommodation.

Income: Eighteen of the fifty patients were receiving disability pensions. Of these, seven were under 46 years of age, and only two were 76 or over. Seven veterans were receiving pensions for eighty-five per cent or more disability. Twenty-six per cent of the study group were receiving W.V.A., and of these, ten veterans were 65 years of age or more. Only three veterans were in receipt of the maximum amount of W.V.A. Three veterans were receiving both W.V.A. and disability pension. Very little infor-

mation was available concerning the income or financial circumstances of those veterans who were not in receipt of income from some D.V.A. source, except in cases where the patient or his family was experiencing economic difficulties. Four veterans had no income from any source. The total monthly income of nineteen veterans was known at the time of their referral to M.S.S.D. and showed a maximum of four hundred dollars, with an average of one hundred and twenty-seven dollars per month. Since the largest proportion of the study group are married men with dependents, this figure indicates that at least a portion of these families are living on marginal or low incomes, and may be encountering social difficulties, at least in part, for this reason. These figures do not show the numbers of cases nor the degree to which marginal income families are affected by the patient's illness. They do not indicate whether or not the income situations were affected by the receipt of veterans' benefits. These factors were taken into consideration in the assessment of the problem picture in the analysis of the cases.

Relatives: To facilitate an understanding of the nature of the social problems of the group, an examination was made of their family constellations and of the relationships between the members of the veteran's family. Some general characteristics may be noted in relation to the total group. Information was not available on one veteran. Of the remaining forty-nine, only three were unattached or had no near relatives. Twenty-six patients had

wives who were in good health, and six had wives who were ill. Nine veterans had one living parent, and seven had two living parents. Over half of the group (54 per cent) had living brothers or sisters, and one veteran was found to have seventeen siblings. Seventy-two per cent of the group had children, totalling seventy-nine in all.

The relationships between the patient and individual family members, as well as with other persons, were classified as good, fair, indifferent or poor. The assessment was based on the observation of the relationships between the patient and family or others in his environment, as recorded by the social worker. As used here the assessment of relationships pertains to the affectional ties existing between the veteran and his relatives in terms of genuine concern for one another's welfare. The assessment gives no indication of the relative's willingness to assume responsibility for the care of the patient, or to co-operate in recommended treatment plans. Relatives might desire that the patient feel loved and wanted, and be able to meet some of his needs in this regard, and yet be unable to meet other needs because of the influence of external factors, such as economic or housing conditions. In some instances the relatives' positive feelings for the patient might act as a detriment to his treatment because of attitudes of over-solicitousness, etc. No assessment could be made of the family relationships of five of the veterans. Of the other forty-five patients, twelve had poor or indifferent relationships with all relatives, while three of the group had, at best, fair relationships with any

kin. Sixty per cent of the patients had a good relationship with at least one member of his family.

Medical Diagnosis and Treatment Classifications

In considering the social problems of any group of hospitalized patients, the nature of their illnesses is of primary importance, since all planning of services has a direct relationship to the medical condition of the individual. Some indication is given of the degree of disablement, or of the patient's limitations in self-care by the examination of the numbers of patients receiving disability pensions, or in need of domicilliary care (page 31). These factors are affected to a large degree by the patient's and relatives' feelings about the illness - that is, the interpersonal relations and anxieties relating to the illness. The social worker takes these factors into consideration in assessing the total situation. The classification under which the hospitalized veteran qualifies for treatment also has considerable bearing on the nature of his social problems, and the services which he may require. For the purposes of this study, illnesses were classified into the same fourteen categories used in an analysis of DVA in-patients,[1] and the actual diagnoses were obtained from the patients medical record. Where any question arose as to the diagnostic group under which the particular illness should be classified, this was discussed with medical staff.

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1. WINFIELD, G.A. and WELLWOOD, L., op.cit.

The census of patients in DVA treatment institutions taken at midnight March 31, 1955, showed that the largest number (15.2 per cent of the total) were Psychotics, with the second largest group (12.29 per cent) in the category of Diseases of the Circulatory System. The third largest group were receiving treatment primarily for Diseases of the Nervous System and Sense Organs. Psychoneurotics represented two point sixteen per cent of the total departmental load. Of the group of in-patients referred to M.S.S.D., the largest number (22 per cent) had a primary diagnosis of psychoneurosis. The second and third largest groups were receiving treatment for Diseases of the Circulatory System and for Psychoses, and represented eighteen per cent and fourteen per cent of the study group. A breakdown of the primary medical diagnostic groupings by age is shown in Table 2. These figures clearly indicate that social services are requested on behalf of an exceptionally high proportion of in-patients diagnosed as having psychoneuroses. The highest percentage of this group fall in the 26 to 45 age range. The proportions of in-patients referred to M.S.S.D. who are receiving treatment in other medical diagnostic groupings does not differ significantly from those receiving treatment in D.V.A. institutions, except that only four per cent of the study group had Diseases of the Nervous System.

At the time of referral to M.S.S.D., twenty-six per cent of the group qualified for treatment as recipients of W.V.A. The

Table 2. Primary Diagnoses by Age Grouping

Diagnostic Group	Age Groups					Total
	18-25	26-45	46-65	66-76	76+	
Malignant Neoplasms	-	-	1	-	-	1
Respiratory Tuberculosis	-	1	1	-	-	2
Diabetes Mellitus	-	-	-	2	-	2
Psychoses	1	3	1	-	2	7
Psychoneuroses	1	5	4	1	-	11
Diseases of Nervous System and Sense Organs	-	1	-	-	-	1
Diseases of the Circulatory System	-	2	1	6	-	9
Diseases of the Respiratory System	-	1	-	-	3	4
Diseases of the Digestive System	-	1	-	-	-	1
Diseases of the Genito-Urinary System	-	1	1	-	2	4
Diseases of Skin and Cellular Tissue	-	-	1	-	-	1
Diseases of Bones and Organs of Movement	-	1	-	-	-	1
Fractures, Poisonings, and Violence	-	2	2	1	1	6
Total	2	18	12	10	8	50

Source: Compiled from medical records, Shaughnessy Hospital.

majority of these patients were in the older age brackets, although two were under 46. Eighteen per cent were receiving treatment for service-connected disabilities, and over half of these were in the 26 to 45 age range. Eight veterans qualified for treatment in the section of inadequate income or resources, with over half of these in the 26 to 45 age range. Four veterans were qualified under the section where examination and treatment of a service disability is given when there is uncertainty as to the need for treatment in hospital, or as to the primary condition for which treatment is needed. Another four patients were service personnel, treated at the request of the Department of National Defense. Four veterans were classified as domicilliary care patients, in need of treatment while receiving such care, subject to both total physical disability and financial agreements. Three of the group were treated for a non-entitled condition, and were responsible for payment of the hospital account. Three were treated for an emergency condition which did not allow for transfer to another institution, but where the patient could not qualify in any other class. One veteran was being examined at the request of the Canadian Pension Commission, and another received treatment for a disability for which pension is paid by other non-military organizations.

Over half of the patients in the study group (56 per

cent) had had at least one previous hospital admission, with one having had sixteen admissions. Of these, eight veterans had primary diagnoses of psychosis or psychoneurosis. Thirty per cent of the group had five or more previous admissions, and of these, the majority were in the 26 to 45 age group. Of the four veterans aged 76 or over who had previous hospital admissions, three had been admitted five or more times.

Psychosocial Problems

Since so much of this study involved a definition of problems, it was necessary to devise a classification for these which would be adaptable from the point of view of any of those referring the patient or his family, and would have uniform meaning for all the cases. Because this classification was to be utilized in diagnosis of not only the presenting and accompanying problems for which social services were required, but also of the possible underlying or causative factors, it was necessary to choose broad general groupings. It was essential also to ensure that these categories could be ones which were easily recognizable and acceptable from the point of view of any of those persons who might be concerned with the difficulties. They had, therefore, to be stated in non-technical terms, but ones which would identify the specific areas in which the individuals were encountering difficulties. After a careful

examination of the varied problems encountered in the situations of the patients, and the possible contributing or underlying factors, a classification was evolved. Only those problems indicated by some person concerned with the veteran or his family were considered. The assessment of the possible factors underlying the patient's problems was based on information concerning his total situation, and background experiences, as observed from a study of the information contained in the records. The broad categories used for the problems classification were:

I. Economic - Includes insufficient income or resources to meet current needs of the individual or family, such as medical care for patients' families, indebtedness due to unexpected drains on resources, inadequate management of income, and other problems related to financing.

II. Housing - This division includes lack of shelter or accommodation adequate to meet the requirements of the patient or his family. It covered also the need for housekeeping services and boarding care for incapacitated veterans or other members of their families.

III. Vocational - This category covered several items connected with employment difficulties, such as educational training, seasonal or irregular employment, need of a job or different kind of employment. It included employment difficulties engendered by a faulty attitude or psychological problem which was not considered sufficiently incapacitating to warrant W.V.A. or disability entitlement. It covered also physical disability of a degree which required the individual to have sheltered employment.

IV. Physical Disability or Limitations - Included diagnosed conditions of either chronic or acute physiological or anatomical impairment which would constitute a vocational handicap or severely limit the person in self-care or normal living activities.

V. Anxieties re Medical Diagnosis and Treatment Plan - Included in this category were misunderstanding or fear

of illness, medical treatment and lack of acceptance of the medical diagnosis and its implications. It covered also inability to co-operate in treatment recommendations and anxieties connected with the medical setting.

VI. Mental or Personality Disorder - This classification covered conditions of psychosis, psychoneurosis, mental retardation, and severe psychopathology as diagnosed by medical staff. Deviant behaviour such as alcoholism are included in this group as well as the adjustment reactions of late life where these had been indicated in medical diagnosis.

VII. Inter-personal Relations - Covered difficulties in the social and personal interaction between the patient and other persons in his environment and includes discord in marital, parent-child, sibling, and other relationships affecting the adjustment of any of the individuals to the reality situation. Concerns with self, inadequate responsivity in relationship and socialization are included in this category where the individual had not been diagnosed as mentally ill.

Problems of the Veteran In-Patient

The main aim of this study is an evaluation of the kinds of social services rendered on behalf of a group of in-patients, and the weighting of the services in relation to the psychosocial problems. The nature of services which can be given depends in large measure upon the source of referral and how the patient and referring person views the needs and problems. One way of gaining a better understanding of the services and the weighting of these is to examine the problems as seen from the point of view of those persons concerned in assessing the difficulties and in finding a solution. These were the patient, the relatives, the doctor and the social worker. In the

majority of cases all four persons had not been brought into the planning. In some instances, relatives were not available or were not contacted; in others, the patients were not interviewed. The usual procedure in this setting is for the patient's permission to be obtained prior to contact with his family. Sometimes, because of patient's illness or condition, the doctor suggests contact with relatives without the veteran's permission. Sometimes, relatives who had requested social services, or who were seen at the doctor's request, asked that the patient not be informed of the contact. Patients occasionally refused to have relatives seen, and in a few instances, where the medical condition of the patient was not related to the problems, the doctor was not contacted or his view of the social situation was not recorded. For these and other reasons, it was not possible to tabulate the problems as seen by all four persons in every case. Whenever more than one problem was seen in any of the three divisions - presenting, accompanying or underlying - the total number were tabulated in the appropriate categories. Only those problems indicated in the records were considered in evaluation of the need or difficulty for which social services were given. These were tabulated under presenting or accompanying problems in order to make it possible to assess the services, and the weighting of these, in relation to the needs. M.S.S.D. services are rendered not only on the basis

of problems as presented but also as diagnosed by the worker. For the purposes of this study, presenting problems represent the difficulty or difficulties for which the M.S.S.D. is requested to give service. Accompanying problems are those which have a bearing on the immediate need or concern, and which have to be considered in instituting a social treatment plan, and for which a need for services might also be seen. Underlying problems represent the causal factors which have precipitated the situation or difficulties with which the patient or family requires help. The assessment of M.S.S.D. services, and the weighting of these, will be based on the social worker's classification of the major or presenting problem and the secondary or accompanying problem with which the patient or his family was considered to need help. It may be that some problems actually being experienced by the client or his family were not recorded. The study does not attempt to show the method by which social diagnoses are made, but rather, the constellation of problems as seen by the various persons. The statistical material does not show the nature of the problems but represents only the gross categorization.

Presenting Problems: The numbers and percentages of presenting problems with which the veteran or his family required help as seen by those concerned in the 50 cases studied is shown in Table 3. An examination of these figures will aid in understanding

Table 3. Frequency of Presenting Problems as Seen by Patient and Others

Presenting Problems		Patient	Family	Doctor	Social Worker
I. Economic		38.2	18.6	24.0	25.0
II. Housing		23.6	22.2	24.0	21.5
III. Vocational		2.9	-	2.0	1.8
IV. Physical Disability		14.7	14.8	10.0	8.9
V. Medical Treatment Anxieties		5.9	22.2	10.0	16.0
VI. Mental or Personality Disorder		5.9	18.5	20.0	17.9
VII. Inter-personal Relations		8.8	3.7	10.0	8.9
Total	No.	34	27	50	56
	P.C.	100	100	100	100

Source: sample count of Medical Social Service case records.

how the patient and his relatives see their needs. In every case the social worker had made a diagnosis of the presenting problems. This accounts in large part for the greater number seen by the social worker in comparison with the other persons.

Those patients contacted saw the greatest proportion of problems in the area of economic difficulty, while the relatives saw more problems in relation to anxieties regarding the patient's medical condition and in relation to housing. This could be

anticipated since relatives might be more likely to request services if they were concerned about the illness and what this condition will mean to the patient or to themselves. It is usual, for example, that the social worker will be requested by the psychiatrist to contact the patient's nearest relative for completion of a form and for help with understanding the illness of those patients who are committed to the Provincial Mental Hospital. Since such a large proportion of the group were diagnosed as psychotic, it is understandable that the relatives saw more need for help in this area. Relatives might be more likely to be contacted by M.S.S.D. regarding housing for those patients referred for discharge planning, or in need of specialized after-care.

An analysis of the presenting problems for which social services were required, as seen by the doctor in his referrals to M.S.S.D., or in his discussion with the social worker, were seen to be highest in the categories designated as economic, housing and mental or personality disorder; the least number seen to be vocational. These figures are consistent with the doctors' reasons for referrals, since the highest percentage of their requests were for social histories and discharge planning, as well as for economic aid for the patients.

When the social workers' assessments of the presenting problems are examined, in comparison with numbers of problems as seen by others, they are most similar in the categories of vocational and economic. The most statistically significant difference appeared in the category designated as anxiety re medical diagnosis and treatment plan. Sixteen per cent of the total number of presenting problems seen by the social worker were in this category. This figure can be considered to be high in view of the fact that the majority of referrals were for social history and assessment of the social situation of the patients in connection with mental disorders and discharge plans, as well as for economic aid for the patients.

Accompanying Problems: The frequency of accompanying problems in the cases studied (Table 4) indicates that the patients saw the largest number of accompanying problems as being vocational. Coupled with this was their expression of anxiety in relation to medical diagnosis and treatment planning. In most instances these problems were associated with economic presenting difficulties. The patients' families saw a correspondingly high percentage of secondary problems in these two categories.

The highest percentage of accompanying problems as indicated by the doctors were in the category of physical limitation and disability; an almost equal percentage were

Table 4. Frequency of Accompanying Problems as Seen by Patient and Others.

Accompanying Problems	Patient	Family	Doctor	Social Worker
I. Economic	7.2	-	4.3	3.6
II. Housing	7.2	-	4.3	3.6
III. Vocational	32.1	31.0	23.3	20.0
IV. Physical Disability	14.2	16.3	27.7	23.6
V. Medical Treatment Anxieties	32.1	42.0	25.5	32.7
VI. Mental or Personality Disorder	-	5.3	6.4	5.4
VII. Inter-personal Relations	7.2	5.3	8.5	10.9
Total No.	28	19	47	55
Total P.C.	100	100	100	100

Source: sample count of Medical Social Service case records.

in the categories of vocational and anxiety. The latter two were most frequently associated with presenting problems of psychological disorders, with vocational problems affecting the younger veterans particularly.

When the numbers of secondary or accompanying difficulties as diagnosed by M.S.S.D. were tabulated, they were found to be significantly higher than those seen by any of the

other individuals in the category of inter-personal relations. The highest proportion of secondary problems as seen by the M.S.S.D. were anxieties related to treatment planning or medical diagnosis and of physical limitation or disability.

Underlying Problems: The underlying difficulties were seen to be the main factors creating problems for which the patient or his family required social services. These underlying difficulties were generally of long-standing nature, irrevocable or early life experiences of the patient. In any instance where there were problems created by these basic factors which could be dealt with they were indicated as presenting or accompanying difficulty. The frequency of underlying problems is shown in Table 5. In 8 of the 50 cases there was insufficient information recorded, or available concerning the individual's circumstances or background, to enable assessment of the possible underlying factors. While it would have been desirable, an accurate attempt to document diagnostic material would have been outside the scope of this study. In no instance was an attempt made to assess the basic factors where information was available only about the immediate needs with which the patient or his relatives required help. The majority of the patients saw the main problem which led to their need for help as being one of physical disability or handicap. In only one instance did a patient recognize mental or personality disorder

Table 5. Frequency of Underlying Problems as Seen by Patient and Others.(A)

Underlying Problems		Patient	Family	Doctor	Social Worker
IV. Physical Disability		77.0	66.7	35.6	32.6
VI. Mental or Personality Disorder		7.6	-	31.1	30.4
VII. Inter-personal Relations		15.4	33.3	33.3	37.0
Total	No.	13	12	45	46
	P.C.	100	100	100	100

Source: Compiled from D.V.A. Vancouver District Office files and from M.S.S.D. case records.
(A) Insufficient information to allow assessment in 8 cases.

as being the basic cause of a need for service. This is in direct contrast to the large proportion of patients with diagnosed problems in this category. However, in a great many of those cases the M.S.S.D. was called upon to obtain social histories, and the patients or their relatives frequently interpreted the problems to be a result of physical disabilities or war experiences. The inability of the patients and families to recognize the basic factors contributing to their problems is typical of clients in this kind of setting.

The doctors and social workers assessment of these basic factors, where recorded, generally concurred. Difficulties were seen to have arisen out of personality or mental disorders and physical disability or limitation an almost equal number of times. The highest proportion of problems were seen to be related to disturbances in interpersonal or family relations, and these were generally long-standing.

Case Illustrations

The study of problems shows only a gross categorization and does not indicate the specific nature of these. The following case examples will clarify the method of tabulating the problems.

Case 13: The patient, a ninety-one year old veteran of the Riel Rebellion, was referred to M.S.S.D. by the doctor because he and his wife were upset by the patient's confinement in a security section of the psychiatric ward. He had been diagnosed as undergoing "senile changes", and had been transferred to this ward because of his mental confusion and his tendency to wander about the premises.

The couple had been married for sixty-four years. They had never been separated for any length of time until the patient's hospitalization. The patient had formerly had a successful career, and had been living in his own home in the

interior of the province. The patient's wife, still an alert, active woman of eighty-nine years, was living in a Vancouver boarding home, so that she could visit the patient daily. The presenting problems, as seen by the patient's wife, doctor and social worker, were anxiety re the medical diagnosis and the treatment plan for the patient. Both the worker and the doctor considered the patient's physical limitations to be an accompanying problem, since this made other treatment planning for the patient difficult; the underlying factor was the patient's mental deterioration.

Case 20: illustrates a referral by the doctor requesting a social history on a thirty year old man who was diagnosed as alcoholic and for whom psychiatric treatment was being considered.

The patient was a man of above average intelligence, with professional training which he was unable to use effectively because of his drinking problem. He had been married but at the time of the referral had been separated for several years. This young man had alienated himself from his relatives because of his behaviour. He had experienced an extremely disturbed and unhappy childhood, with the loss of his loved father in his early adolescence and disturbed relationship with his mentally-ill mother. The patient had lived with stable relatives and had a good relationship with them until becoming alcoholic in later

years. The presenting problem as recognized by the patient, doctor and social worker was personality disorder. All those concerned saw vocational difficulties as an accompanying problem; both the doctor and social worker saw the disturbances in the patient early inter-personal relations as the factor underlying the present problems.

Case 45: A sixty-eight year old veteran was referred to M.S.S.D. for help with his personal and social adjustment. He was a diabetic whose physical condition was further complicated by mental retardation. The patient was depressed that his common-law wife had left him for the second time while he was hospitalized and had taken with her all his possessions. He was considering taking legal action against her on this account, but he also wished to have her return to him because of his affectionate tie to her, and because of his dependency. The patient had had two previous marriages, both of which had been unhappy ones. There were seven children of the first marriage, two of whom were ill. Patient saw his children occasionally but could not continue satisfactory relationships with them for any length of time. His second marriage had ended after three years of quarrels, separations and re-unions. The patient was able to recognize, to some extent, his inability to maintain good health or otherwise manage his life on his own. The presenting problems, as seen by the patient, doctor and

social worker, were interpersonal relations and housing. The doctor and worker considered the patient's physical limitation as an accompanying problem, and his mental retardation as the underlying factor which could not be changed.

CHAPTER III

SOCIAL SERVICES RENDERED

Social services are generally thought of as those channels of helpfulness that social agencies and their case workers extend to their clients. The problems presented by or on behalf of the clients, their wish for service, and the requirements of the community determine in large part what services are rendered. Social services in a veterans' hospital setting, as in any medical setting, are rendered in relation to the social needs and problems related to the patient's illness, physical handicap, and medical care and are given in collaboration with other professional personnel, within the setting and within the community. The late Ruth Hubbard, a public health nurse, has described what goes into a team relationship and into the giving of services on behalf of an individual as a member of a team. This definition seems applicable to the functioning of a team in the hospital, in a DVA setting or in the larger community:

> "To be part of a team means that one must be extremely well prepared in his own field, that he must see himself in relation to the contribution of others, that he must sense constantly the changing needs of the individuals whom he and the group are serving, that he must accept the corresponding changes in his

> contribution and the contributions of other team members to these needs, that he must have the courage to say what he can do and why he feels that he can do that thing better than another, that he must have the grace to give up what he likes to do if another can do it better. It means further that he must learn to do the things which do not come easily if they can best be done by him for the good of all. It means the will to pull with others and the integrity to withdraw from those parts of an undertaking which are not his. It means the enduring belief that together we can do things which none of us individually could do alone, and that the togetherness makes possible a concept of the job which is greater than the sum of the individual parts."[1]

Social treatment of disability related to illness is often directed, not only to the individual, but to the immediate social group of which he is a part. There is no age at which the group ceases to have a part in the patient's response to his difficulty or to be affected by his problems. The importance of the wider interest group, the community, seems to increase as the person grows older because the opportunities for work, play and recognition are set in a system of conformity and competition. It is the expectation of the community that a man will plan and provide for his family a secure economic and social position, gaining increasing prestige or status, as he develops in skill and responsibility of judgment, and as he increases control of his own affairs. This is the concept of stability so heavily stressed as the basis of a healthy family and community life. For the individual suffering some disabling physical handicap, chronic illness or social problem there are additional factors which may prevent him from achieving this expectation. The way

1. Abstracted from an address, "Inter-Agency Communication - the Mortar for Individual Services", a paper prepared by Stephen L. Angell, for presentation at the National Conference of Social Work, St. Louis, Mo., 1956.

in which the sick person and his immediate group meet the experience of illness, and its effect, is determined in part by what they bring to it. What the environment and community offer them as a means whereby to compensate, to maintain a balance, or to develop their capacity to live within the disabilities, also has an influence.

The Use of Resources

The medical social service department serves as liaison in coordinating the D.V.A. and community resources which are available to help meet the needs of the hospitalized veteran or his family. A comprehensive review of the resources for meeting the needs of the patients and their families would be outside the scope of this study. Some knowledge of the resources available will aid in an understanding of the nature of social services rendered to this particular group. Some consideration has already been given to the resources available within D.V.A.[1] Those patients who have problems in locating suitable housing, who are in financial need and are eligible for aid through D.V.A., and those who are experiencing difficulties in relation to vocational training or job placement, may be referred to the Veterans' Welfare Services. Two D.V.A. special placement officers are attached to the National Employment

1. See Chapter I, pp.13-14.

Service in Greater Vancouver and redeive referrals of those patients who present an employment handicap. An outline of the services which the community of Greater Vancouver has established to meet the needs and problems of its citizens[1] shows there are some fifty-nine community agencies providing family, children's, child-guidance and recreational types of services. The services of any of these agencies can be utilized when the patient's problems relate more specifically to child and family welfare or to recreational needs. Public welfare and social assistance agencies are available to help those patients, and their families, who are in economic stress and who are not eligible for financial assistance through D.V.A. resources. In addition to the Community Chest and public agencies there are some agencies supported by private groups or under religious auspices which offer emergency financial aid or shelter to those who are ineligible for public assistance or whose needs are too urgent to await the establishment of their eligibility.

Patients who reside in rural areas of the province may be referred to the Social Welfare Branch for financial aid, as well as for casework help with other social problems. Members of the veteran's family who are in need of medical care and who are unable to obtain it privately, because of limited income, may be referred to the Out-patient departments of two city hospitals. The Provincial Mental Health Services may be called upon to

1. Directory, Greater Vancouver Community Chest and Council Agencies, October, 1956.

provide psychiatric care for those patients who may not be eligible to receive treatment at Shaughnessy.

The Nature of Social Services

In social work literature it is recognized that medical social casework is the primary concern of the social service department in the hospital.[1] Members of the department have the casework point of view and methods inherent in all their activities. Interviewing and the use of relationship are basic common factors in all casework. It is recognized that change may be brought about in the situations or adjustment of clients by "the application of various casework processes or groups of techniques. In any given case, several different means or methods may be used".[2] The application of social work process and the choice of treatment methods depends on the problem, the aim, the treatability of the person in need of help, and the specific purpose for which the organization exists. The main considerations included in the practice of social casework are the building of professional relationship; the establishment of confidence; the maintenance of focus on specific goals; and the use of practical resources.[3]

1. GOLDSTINE, Dora, Readings in the Theory and Practice of Medical Social Work, University of Chicago Press, 1954.
2. HOLLIS, Florence, "The Techniques of Casework", Principles and Techniques in Social Casework, Family Service Association of America, New York, 1950. p.413.
3. HAMILTON, Gordon, Theory and Practice of Social Casework, Columbia University Press, New York, 1951. Chapter 9.

Every disorder for which an individual or family may require social service help is the result of the faulty interaction of two sets of factors - outer and inner. On this basis, it is possible to make a simple division of casework treatment methods into two broad categories of services - indirect and direct. Many situations are essentially environmental and must therefore be treated environmentally. In the giving of environmental or indirect services, the patient, or family, is helped through an alleviation of the outer problems, by removal or changing of some of the outer tensions and by reinforcing opportunities in the environment for expression of inner needs and by providing the means of restitution. In the giving of practical environmental services or the manipulation of the immediate milieu to further the better functioning of individuals within a specific group, the emphasis falls on helping the client to use, either within the agency or through another agency, the resources necessary to meet the needs. Many patients and their families can manage their own adjustment to change and go on getting and giving satisfaction in social life if they can know what resources are available to them, and how to approach them. In this case, exploration of the need, diagnosis of the problem or situation, and mobilization of the client's efforts to change the situation, through the use of the resources, are the main considerations. Since every case has both psychological and social components, indirect services are given with an understanding of the person

and his emotional reactions. Certain types of cases call for cooperative work between the medical social service department and other community agencies, e.g., a case in which there are serious medical social problems, and where the family has been previously known and has a strong contact with the community agency, or a case in which new problems that arise are the major responsibility of another agency. If the medical social service department is unable to obtain service from an outside resource, it may have to assume responsibility for some form of treatment itself. When an individual applies, or is sent, for a practical service, the social worker may recognize additional or deeper problems. Unless the client wishes treatment in these areas, they cannot be dealt with.

In the giving of direct services or treatment, the purpose of interviewing is to induce or reinforce attitudes favorable to the maintenance of emotional equilibrium and to personality growth or change. The worker's activities are primarily related to the client's subjective realities, his emotional conflicts, feelings, etc. The primary purpose is to effect a better adjustment of the individual to his environment through effecting a better adjustment to himself. In direct treatment, the worker's activities are directed toward the release of tensions or diminution of conflicts that are limiting the individual in the use he is making of himself and

his environment. Tensions may be created for the family, or the patient with physical or mental handicaps, as he attempts to adjust to his limitations and to add himself to his group. Direct help may be needed to aid patients or their families to live with the effects of sickness, or, as an aid to personal development under disability.

When the patient or family require help with inner emotional tensions or difficulties, the emphasis is on the use of the worker-client relationship, but is comprised of related, yet distinguishable, methods of treatment. Individuals may require the sustaining security of another person sincerely interested in their welfare, but may need, or be able to use this help in different forms and at different levels of intensity. 'Listening with a purpose' may sometimes be the form of treatment used to help patients do something constructive with disabilities resulting from inner stress.

The decision of whether help will be offered through the therapy of environmental change or the direct treatment of inner emotional disturbances, and the form of treatment, depends partly on the problem and on what will help the individual the most. In each instance the caseworker is guided by her understanding of the needs of the patient and family, their capacity to use help, and by the limitations of the agency or community resources. Because problems and needs differ for

individuals, both direct and indirect services, and different methods of social casework treatment are used in different cases. They may also be weighted differently in similar cases, according to the diagnosis of the total situation of the patient and family.

With this concept of social casework and its application in a veterans' hospital setting in mind, a classification of services was evolved for use in assessing the social treatment plans applied in the cases under study. Services were divided into indirect and direct services and were classified into the following five categories:

Indirect Services:

A. Explanation and Offer of Service - Information and explanation of M.S.S.D. services and of resources available to meet need is given in every case. In some instances the patient or family sees no need of such service or does not wish referral at the time of contact. In some cases they see no need of service in respect to certain problems, although help may be given in relation to other difficulties.

B. Referral - Included in this category was the direction of either the patient or some member of his family to another resource, such as an agency giving financial assistance. To indicate the type of resource being used, a further breakdown was made within the category into the divisions of Welfare Services, other D.V.A. Hospital, and Community Resource. The social worker, when referring patients to community agencies, generally does this with the knowledge and approval of the medical staff.

C. Economic Aid - Included the obtaining of clothing from the hospital stores or a loan or grant from the Hospital Superintendent's Assistance Fund (not exceeding ten dollars).

D. Social Assessment and Diagnostic Aid to Assist Medical Staff - This category covered the obtaining of information regarding the patient's environment, family composition, and relationships between individual family members or other persons in the environment, as well as data concerning background experiences, attitudes of the patient or those associated with him, and appraisal of sources of care for the patient.

E. Environmental Modification - For the purpose of this study this category covered attempts to modify the patient's or family's situation by provision of a corrective living experience, such as inclusion in a group, or changes of hospital routine.

Direct Services:

F. Supportive Help - Includes casework treatment through the use of relationship to support the strengths of the patient and/or relatives through techniques such as reassurance, permissive attitudes that relieve guilt, and a protective relationship. The relationship is used not to motivate change, but to support the individuals acceptable existing aims and to protect them from undue pressure.

G. Interpretation - Includes explanation of the outer aspects of problems or situations, eligibility rules, medical procedures, implications of illness, etc. It includes also clarification or pointing out on a rational discussion basis, attitudes, feelings and behaviour problems.

H. Counselling - As used in this study, covered the use of relationship to motivate or bring about change in behaviour, through aiding the individual to see causes of behaviour, and to find more satisfactory outlets for the unacceptable behaviour.

Social Services Rendered

The main focus of this study is the assessment of the means used to help those veteran in-patients for whom social services are requested. In this part of the study the social services rendered on behalf of the group were examined

from the point of view of frequency and length of M.S.S.D. contacts, numbers of previous referrals of the patients to M.S.S.D., and the frequency distribution of the different types of services.

Frequency of M.S.S.D. Contacts: The number and frequency of M.S.S.D. contacts with the patients, relatives and other persons, including medical staff, other D.V.A. personnel and community representatives (Table 6) shows the average number of interviews per case to be two point eight. The figures are based on the interviews actually recorded in the M.S.S.D. files. These should be considered only approximate, since, in a few instances, the actual number of contacts was not recorded but information concerning a number of interviews was summarized. Social workers on their rounds may have frequent, brief contacts with patients known to them, but no record may be made of these when no specific service is requested by the patient, although he may actually have gained some help from the interest of the worker. The figures indicate that patients were seen in nearly all the cases studied, and that relatives were seen in over half the cases. In view of the fact that a large percentage of the patients and their families lived in rural areas, the number and frequency of direct contacts with relatives is proportionately high. Contacts were also had with persons other than relatives in

Table 6. Number and Frequency of M.S.S.D. Contacts

Persons Contacted	Number Contacted	Number of Interviews	Average Interviews per Case
Patients	41	88	2.14
Relatives	28	52	1.85
Others	36	89	2.47
Total	105	229	2.18

Source: sample of Medical Social Service case records.

nearly three-quarters of the cases. It is probable that all contacts with referring doctors may not be recorded as interviews because of the established practice of discussing the patient's medical condition and treatment planning with the attending physician unless time will not permit this prior to the patient's discharge. It may be seen that the highest number of contacts per case was with persons other than the patient or relatives. This fact further points up the social worker's use of resources and participation in team planning.

Length of M.S.S.D. Contacts: A study of patients in DVA treatment institutions[1] shows that over twenty per cent of all patients are in hospital less than one month, and forty-three per cent are in hospital less than three months. In the fifty cases examined, ten of these (20 per cent) were active with

1. WINFIELD, op.cit.

the M.S.S.D. less than one week. In eight of these, services were completed in one day. In most instances these patients came or were referred to M.S.S.D. immediately prior to discharge. Of these ten cases, five had economic presenting problems, three had presenting housing problems, one presented problems of personality disorder and one needed help with a major problem of anxiety. The largest numbers of secondary problems in this group were seen to be vocational and physical limitation.

Twenty-five of the cases (50 per cent of the group) were active more than one week but less than one month. Economic problems were the major reason for need of service in eight of these, mental or personality disorder in five, and physical limitations in five. Economic problems were presented in three cases, anxieties in two, and vocational in one. Secondary problems of anxiety were seen in almost half these cases.

The remaining fifteen of the fifty cases were active one month or more. Five of these had major problems of housing. The remainder of this group had presenting problems divided almost equally in the categories of economic, mental disorder, anxieties, and inter-personal relations. The secondary problems of this group were fairly evenly divided.

Previous Referrals: When patients or their families have been previously known to a social service department, certain types of services on behalf of the individuals can be

initiated and completed more quickly, since considerable knowledge regarding the individuals and their situations will have been obtained. Less exploration of the difficulties, strengths and resources for solving the problems may then be necessary. In the cases studied, forty-one of these had not been previously known to the M.S.S.D. Two cases had previously received services on one occasion. Two had been known twice before, and three had been given services three times in the past. One veteran had been referred to M.S.S.D. for help on four previous occasions and one veteran had been referred on five former occasions.

Distribution of Services: An examination of the services rendered in the cases studied showed that a total of 119 services were given. In one case the patient was discharged before any service could be given. According to the classification of services, as direct or indirect in nature, seventy-one of the services fell into the division of indirect services, and forty-eight were considered direct. The distribution of services, as shown in Figure 4, points up supportive help as being the type of social service employed most frequently. This help was given in thirty-six of the cases and frequently accompanied other types of service. The second means most frequently used to help meet the problems of the veterans and their families was referral to other resources. A total of twenty-seven referrals were

DISTRIBUTION OF SOCIAL SERVICES

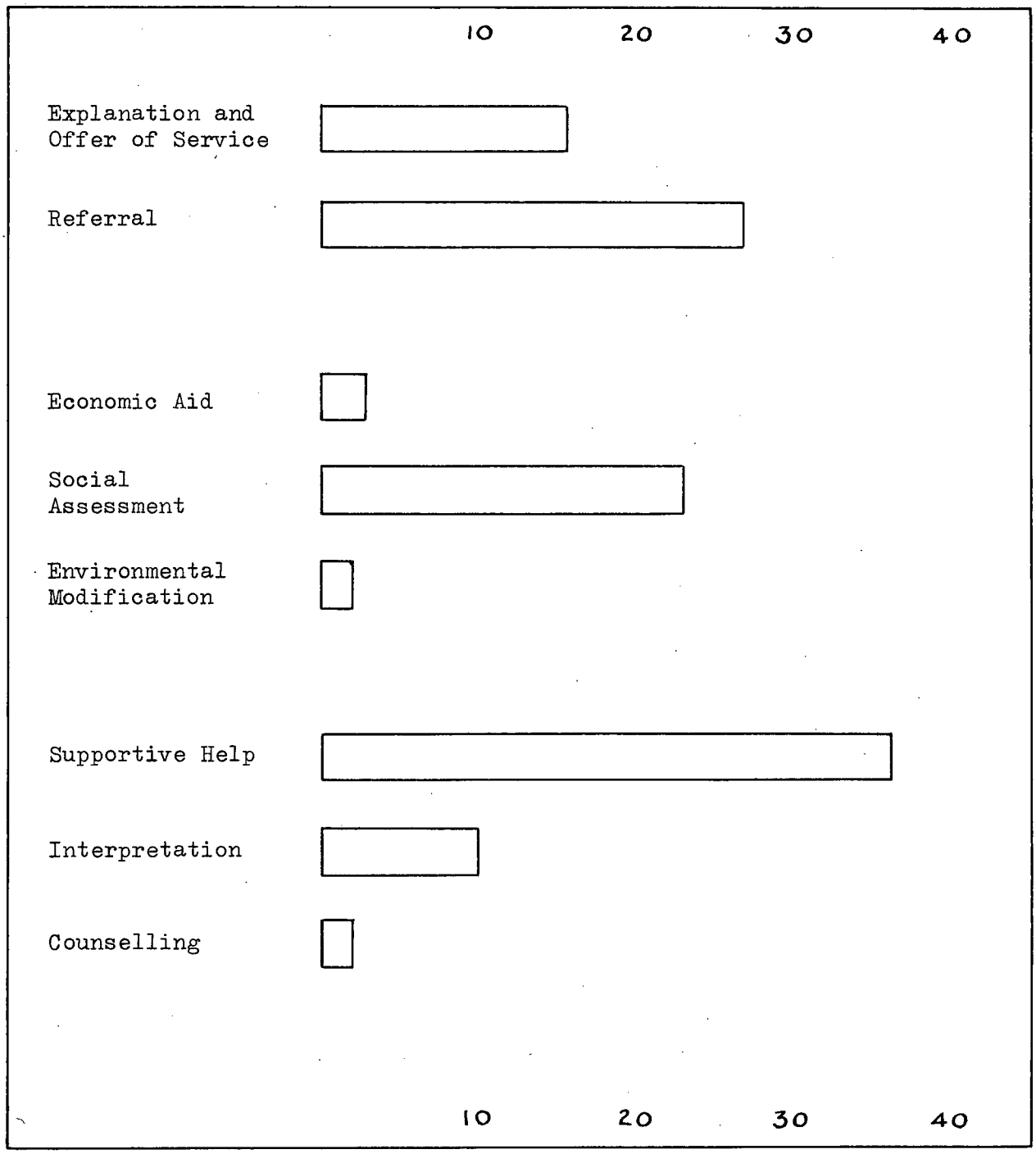

Figure 4. Distribution of Social Services (Shaughnessy Hospital, 1956.)

made. A further breakdown of the referrals revealed that the highest number (14) were to community resources. Twelve referrals were made to Welfare Services and one to another D.V.A. hospital. Social assessment and diagnostic aid to assist the medical staff in treatment planning was a service given on behalf of the veteran and his family in twenty-three of the cases examined. In sixteen cases explanation and offer of service was extended. Interpretation was one means used to help solve the problems in ten of the cases. The types of social services extended infrequently were economic aid, environmental manipulation and counselling.

One of the integral services of a social service department in a medical setting is that of acting in a consultative and teaching capacity to persons other than the client group. Members of the department may participate in conferences concerning a patient known to them or may be asked for advice regarding social planning for particular patients by other members of the hospital staff. While these have not been included in the classification of services in this study, it was noted that these services were given in six of the fifty cases studied.

The Weighting of Services in Relation to the Psychosocial Problems

The distribution of social services rendered in relation to the presenting and accompanying problems, as diagnosed

by M.S.S.D., is shown in Table 7. The highest number of services were seen to be given in relation to problems of anxieties, with supportive help being the method of casework service most frequently used to deal with this problem. Supportive help was offered more frequently for accompanying problems of anxiety than when this was the presenting difficulty. One of the main reasons for this was that when anxiety accompanied problems, such as economic difficulty, and where referral was made to another source there was little opportunity for the social worker to give a more intensive sort of treatment such as interpretation.

The second highest proportion of services was given in relation to problems of mental or personality disorder. Social assessment and diagnostic aid, to assist medical staff, was the type of service most often rendered in relation to this presenting problem. Explanation and offer of service and supportive help were given an equal number of times. Interpretation was employed in two instances where presenting problems were in this category. Where this was seen to be secondary, explanation and offer of service was given in one instance and supportive help in another.

Services were offered a similar number of times in relation to economic and housing problems. The most statistically significant figure with respect to the nature of services employed

Table 7. Distribution of Social Services in Relation to Presenting and Accompanying Problems

Problem			Medical Social Services Rendered								Total Services
			Explanation and Offer of Service	Referral	Economic Aid	Social Assessment	Environmental Modification	Supportive Help	Interpretation	Counselling	
I.	Economic	P	3	9	2	1	-	1	-	-	
		A	1	1	-	-	-	-	-	-	18
II.	Housing	P	-	5	-	9	-	2	-	-	
		A	1	1	-	-	-	-	-	-	18
III.	Vocational	P	-	1	-	-	-	-	-	-	
		A	-	2	-	-	-	-	-	-	3
IV.	Physical Disability	P	1	-	-	4	-	2	-	-	
		A	-	2	1	-	2	-	-	-	12
V.	Medical Treatment Anxieties	P	2	2	-	1	-	7	5	-	
		A	1	-	-	-	-	13	-	-	31
VI.	Mental or Personality Disorder	P	4	2	-	8	-	4	2	-	
		A	1	-	-	-	-	1	-	-	22
VII.	Inter-personal Relations	P	1	2	-	-	-	3	1	2	
		A	1	-	-	-	-	3	2	-	15
	Total		16	27	3	23	2	36	10	2	119

Source: sample count of Medical Social case records.

P—— Presenting Problem
A—— Accompanying Problem

in dealing with these problems is that referral to either Welfare Service or a community agency was the method employed most often in assisting with economic problems while social assessment as an aid to medical staff along with referral were most often required in relation to housing problems. Where these two problems were secondary, services were given only twice and in the same categories for each problem.

Services related to difficulties in inter-personal relations were given an almost equal number of times where this was seen to be an accompanying difficulty as where it was seen to be the presenting problem. Services were given fifteen times in respect to this problem. The majority of these services were of a direct nature. Supportive help was employed most often in helping with this difficulty. Interpretation and counselling were offered five times.

When vocational problems were seen to be either a major or a secondary problem, services were rendered a proportionately small number of times, three in all. This can be accounted for, in large part, by the fact that all hospitalized veterans are interviewed by the Welfare Officers who have responsibility for assisting veterans experiencing problems in relation to employment, unless the patient is medically unemployable and not eligible for assistance through D.V.A. resources. Ih these instances the M.S.S.D. might be called upon to aid the patient at the time of his discharge with problems in this area.

Services were offered in relation to problems of physical disability or limitation twelve times and were found to be most frequent in the category of social assessment, followed by supportive help and environmental manipulation. This latter method of social casework was not employed in respedt to any other problems.

Case Illustrations

The following summarized examples of typical cases[1] provide further understanding of the application of different types of casework service in respect to problems and situation of particular patients or families. The meeting of the needs presented in the case summaries calls for the use of different types of services in a discriminating way.

Case 44 illustrates an instance in which explanation and offer of services was given to a patient's relative, where illness and hospitalization was seen to be a further disruptive factor in an already disturbed family situation.

Mr. A., age 69, a veteran of World War I, was admitted to Shaughnessy Hospital for the first time with a severe condition of "Arteriosclerotic heart disease" some two weeks prior to the referral to M.S.S.D. He and his wife owned their own home and were in receipt of the maximum W.V.A. They had two adult children with whom the patient had good relations. The

1. The summaries were made from case records of M.S.S.D. of Shaughnessy Hospital. Identifying information has been removed in order to safeguard confidentiality.

patient's wife had gone to the district office of Veterans' Welfare Services to enquire whether any assistance would be available to help her purchase medicines for herself. Since she seemed to be emotionally upset about the patient's illness, it was felt she should see the hospital social worker, and a telephone referral was subsequently made. Mrs. A. did not call at M.S.S.D. as suggested but again returned to the district office, at which time she revealed that she was receiving private psychiatric treatment. She seemed to have no recognition of her own mental disturbance but attributed her problems to poor physical health. The M.S.S.D. worker telephoned Mrs. A. who stated that she could not visit the patient or discuss her situation with the medical social worker, in spite of urging, because of her own health. She said the patient "could not go on being ill because she needed him to care for her". Mr. A. died the day following this contact. The social worker noted in the record that the wife will have continuing problems, but as she did not wish to talk directly with M.S.S.D. the case should be closed. Undoubtedly Mrs. A. will require the services of a community agency and will encounter emotional problems because of her dependency. She may require medical or psychiatric services from a community agency, since it seems unlikely she c could continue to pay for private care on her limited income.

Case 49 illustrative of the social service department's use of community resources and of supportive help in relation to insecurities and problems of illness, is the case of Mr. B. This seventy-two year old married veteran, in receipt of W.V.A., was referred to M.S.S.D. by the attending doctor who requested social assessment in connection with possible discharge of the patient. The family had been known to M.S.S.D. in 1950 when a social assessment was requested, and in 1954 when the patient was routinely seen at the time of a hospital admission. Considerable information was available from these previous contacts concerning the family relationships and previous social circumstances. The presenting problem at this time was the patient's physical limitation and need for special care. Mr. B. had been admitted to the hospital for the eighth time, with congestive heart failure, some six months prior to referral. The patient also had a history of T.B. dating back five years. Special precautionary measures needed to be taken in order that the disease would not become more serious or be transmitted to others. In the two weeks following referral, the patient and his wife were both seen once and these contacts revealed an accompanying problem of anxiety concerning the patient's medical condition and treatment planning. The social worker obtained the information that the patient and his wife lived alone in their own home which was all on one

level, thereby making it unnecessary for patient to over-exert himself physically. The patient was noted to be careful in his personal care and the couple took the added precaution of occupying separate sleeping quarters. A good relationship existed between patient and his wife, who was anxious to have him home. In addition to the supportive help given both the patient and his wife in allaying their anxieties surrounding the possible need for continuing hospital treatment, the social worker arranged for Mrs. B. to discuss the patient's condition with the attending physician. A contact was made with the Victorian Order of Nurses who had previously known the family and who were able to contribute valuable information concerning the care the patient might receive in the home, as well as to offer post-discharge services to ensure medical supervision and to provide the necessary injections which Mr. B. might otherwise have to receive at the hospital. The patient was discharged after this information was discussed with the doctors. An earlier referral of this case to M.S.S.D. would have given the social worker more opportunity to have aided in allaying some of the anxieties and fears of the patient and of his wife.

Case 24: this case illustrates the employment of environmental manipulation, supportive help and interpretation to relatives, who were anxious about the treatment planning for patient. Mr. C., a 77 year old W.V.A. recipient, who lived

with his wife in their own home, had been admitted to hospital for the first time one day preceding referral and was being considered for institutional treatment. He required constant supervision because of his mental confusion. The patient's married daughter telephoned to express concern about planning for patient. She had recently been hospitalized and because she anticipated further hospitalization she was unable to assume responsibility for Mr. C.'s care. His wife, age 72 years, was unable to offer the extent of care and supervision which he required. Five contacts were had by M.S.S.D. with the patient's relatives and six with other persons, in efforts to help the family accept their own inability to continue caring for Mr. C. and to co-operate in the treatment plan. Following recommendation for institutional care for the patient and his transfer from an active treatment ward to the "Extension", both the patient's wife and daughter became unduly upset. They considered "appealing the decision to place the patient on this ward". The worker notes that she interpreted "the need to place patients in the most suitable environment", as well as arranging for the wife and daughter to discuss patient's care with the doctor. After this contact the worker notes that the daughter is more accepting of the plan and acknowledges that the family is more upset than the patient. In a later contact, the daughter expressed concern that Mrs. C. was insistent upon coming to the hospital

to assist with Mr. C.'s feeding. In co-operation with the ward staff, it was possible, in this particular instance, to adjust the environment in order to permit the wife to gain some satisfaction and reassurance by contributing in this way to the patient's care, since it did not interfere with regular ward routine, and to help the daughter to see the mother's need to do this.

Case 23: this case is an example of the social worker's employment of multiple direct services and social assessment, which aided the treatment team and the patient in efforts toward rehabilitation, and in the prevention of further social and emotional breakdown of the family. The methods used were supportive help, interpretation and counselling, over a period of six weeks. Seven contacts were had with the patient, two with relatives, and several with other members of the treatment team. The family had been known to M.S.S.D. on one previous occasion. Mr. D., a 34 year old married veteran of World War II, lived in a rural setting with his wife and three children, who ranged in age from 2 to 7 years. He had been admitted to hospital for the seventh time and was diagnosed as being in a "depressive state". He had been unable to work for a period prior to hospitalization and was supporting himself and his family from the assets of a business which he had bought from his brother and resold about one year later. Because the patient believed the

selling price had been too low, bad feeling existed between the brothers. The patient's wife felt the work required was too hard for the patient. Mr. D. had previously been committed for psychiatric treatment at Crease Clinic. He held some residual antagonism toward his wife for having signed the committal form.

The patient contacted M.S.S.D. requesting aid in locating housing for his family whom he wished to bring to the city. The worker notes the difficulties in inter-personal relationships as indicated by the patient's expressed doubts concerning paternity of the children and suspicions regarding relatives' activities. In subsequent interviews, the anxiety of both Mr. and Mrs. D. regarding the patient's illness and prognosis were seen to be an additional difficulty. The efforts of the worker and doctor to discourage the patient's moving his family at this time were unsuccessful. Mrs. D., upon her arrival, assumed that, since the patient had been responsible for bringing the family to the city, he should arrange satisfactory accommodation, although he was ill-equipped to do this. In subsequent interviews, both Mr. and Mrs. D. were aided, through discussion, to work out housing arrangements which would be satisfactory for both themselves and the children. Mrs. D. was able to supply information helpful to the medical staff, concerning patient's recent behaviour. The social worker was able to help the wife understand the nature of the patient's illness

and to give her support in her ability to cope with some of the problems as well as to co-operate in treatment recommendations. In consultation with the doctor, both parents were counselled with respect to difficulties in the marital and child-parent relations, arising in part from patient's illness. The case was closed following the patient's discharge from hospital.

Case 15: the problem of inter-personal difficulties presented in the circumstances of Mr. E., and accompanied by his anxieties related to his condition of physical disability, illustrate the social worker's use of a variety of resources, environmental modification and counselling. There were 15 contacts with the patient and seven with others, in a period of 5 months. Mr. E., a 33 year old veteran of World War II, in receipt of W.V.A., had been transferred at his request from a distant DVA hospital to Shaughnessy. He was receiving treatment for "paraplegia of the dorsal spine, with decubitus ulcer". This condition, resulting from an accident, would severely handicap Mr. E. in self-care and might lead to his confinement to a wheel-chair for the remainder of his life. He had been separated for over a year from his 29 year old wife and four children, who ranged in age from 12 to 4 years. The patient's relatives lived in another province. Mr. E. referred himself to M.S.S.D. with a request for help in drafting a letter pertaining to divorce

proceedings which he had initiated. He hoped to obtain custody of the two older children. A contact with the DVA hospital where the patient had formerly received treatment established the fact that there had been a long history of marital discord, with considerable psychiatric and casework service extended, and culminating in the mutual decision that divorce would be the most satisfactory solution for all those concerned. Through subsequent counselling, and on the basis of the information concerning the patient's instability and failure to assume family responsibility, he was helped to recognize and accept the inadvisability of separating his family. His W.V.A. status in relation to divorce presented some financial complications. Referral to Welfare Services was made to assist in clarifying and making financial arrangements. The patient expressed his hope that he would be able to walk again. With the approval of the medical staff, the social worker supported the patient in his desire to further this possibility. Arrangements were made for him to be referred to the Western Society for Rehabilitation when his treatment at Shaughnessy would be concluded. Since the patient knew no one in the city, it was further noted that his inclusion in a group might prove beneficial. He was subsequently referred to, and became a member of, the Indoor Sports Club, thereby gaining the opportunity for social contacts and activities suitable to his limitations. He was assisted also in obtaining needed clothing.

CHAPTER IV

SOCIAL SERVICES AND THE VETERAN IN-PATIENT

This final chapter contains a review of the philosophy underlying the practice of social casework in a D.V.A. hospital, the findings of the study and some recommendations with reference to the practice and study of social work in Shaughnessy Hospital.

In keeping with one area of its function, the M.S.S.D. engages in research with the aim of improving social services extended to the Veteran patient. The particular theme of this study was to attempt to determine, in some measure, the kinds and weighting of social services in relation to psycho-social problems. Because of the heterogeneous nature of the group of patients served by M.S.S.D., and the limitation of time available to complete the project, it would have been outside the scope of the thesis to explore the services rendered on behalf of the entire clientele. The study was, therefore, limited to an exploration of the services, and factors influencing these, in relation to a group of fifty male in-patients referred to M.S.S.D. during the period January - June, 1956.

Philosophy and Setting

The advancement of specialization in the practice of medicine, and the treatment of the patient in large institutions in the last decade, brought forth the need for the services of staff who could bring to the doctor and the hospital administration, information concerning the patients' social circumstances. On this basis, at the beginning of the century, the practice of social work in medical settings was first given impetus by The London Charity Organization in England, and by Dr. Richard Cabot in America. Social casework, as practised in a medical setting, derives its basic philosophy and body of skills and knowledge from generic social work in its aim of helping individuals to achieve more satisfying adjustments within themselves and to their environment. Since its early beginnings in medical settings, social work has continued to extend itself in co-operation with medicine, and other disciplines, towards the rehabilitation of patients to as full a measure of physical, emotional and social well-being as possible. The changes in the field of health and medical care have tended to influence the practice of social work within the institutions. The concept of the meaning of illness has broadened. With the increasing emphasis on the treatment of the whole person, there is now an attempt toward integration of physical, social and emotional facets. Social workers are

taking more responsibility in clarifying and in participating in the application of this approach. The influence of psychosomatic medicine and the emphasis upon the social and emotional restoration of the handicapped veteran brought forth the request for social service programmes to be added to D.V.A. rehabilitative programmes shortly after World War II.

Rehabilitative programmes to assist veterans were first established prior to World War I, when the economic needs of disabled officers were recognized by the payment of pensions by the government. Programmes were subsequently extended under the Department of Soldiers' Civil Re-establishment to include hospital accommodation, vocational re-training, pensions and other forms of assistance to service-disabled men. Under the Department of Pensions and National Health, and the succeeding Department of Veterans Affairs, established to administer all legislation concerning veterans, rehabilitative measures and benefits have broadened to become one of the most comprehensive rehabilitative programmes ever established for veterans. Welfare Officers attached to Welfare Services Branch have responsibility for ensuring that veterans are aware of all benefits to which they are entitled, and for assisting the veteran with social problems which do not have a bearing on any medical condition for which he may be receiving treatment.

Medical Social Service, established in Shaughnessy Hospital in 1947 as part of the D.V.A. Treatment Services Branch, has responsibility for assisting with problems associated with the illness or treatment of those veterans under D.V.A. medical care. Services are given on behalf of the patient at the doctor's request, or with his approval.

The social workers in D.V.A. hospitals thus enter into a collaborative relationship with other treatment personnel, integrating their individual skills, prerogatives, and professional knowledge into the overall programme. They, thereby, contribute to the effectiveness of the total team in its interest of serving the patient and helping him to achieve the greatest possible rehabilitation.

Review of the Main Findings

The main focus of this thesis was an exploration of the psycho-social problems of the patient group (Chapter II) and of the services rendered by M.S.S.D. in dealing with these needs and problems (Chapter III).

It seems worthwhile to comment on the methods used and the difficulties encountered in making such an exploratory survey. In a setting such as a D.V.A. hospital, the situations of the M.S.S.D. client group are affected by a large number of

variable factors, such as the patients' sex, treatment rights and benefits, medical diagnosis, place of residence, etc. These variable factors present problems in sampling, and in establishing criteria for the evaluation of services, because of the wide range and diverse nature of psychosocial problems. In order to ensure that there are factors common to the sample group, it becomes necessary to limit the study to a particular group of patients and to use broad categories in classifying both problems and services. More complete and more specific classifications of both problems and services, as well as the application of rating scales, would ensure greater reliability of the survey results, and would permit a more accurate evaluation of the problems and the means of dealing with them. The classifications could be improved and further developed by the case study method. Such an approach would also permit a closer examination of the ratios of problems and services per patient within different categories and groups.

For this survey, information was obtained from the patients' district office and hospital files and from M.S.S.D. case records. Classifications were used to set up statistical tables showing the frequency of problems and services. Some difficulty was encountered in establishing criteria for evaluation and analysis of the subject matter because the records are not written with such a purpose in mind. The summary type

recording often did not contain information regarding certain aspects of the patients' social circumstances, attitudes or feelings. For study purposes, the presenting and accompanying problems were seen to be the major and secondary psychosocial problems with which the patient or family required help; the underlying problems as those deep-rooted experiences and other factors out of which the problems have developed. An attempt was made to determine how the persons most concerned with the patients' circumstances and treatment (the patient, family, doctor and social worker) viewed the problem and needs.

An examination of the general characteristics of the patient group showed that a high proportion (36 per cent) were in the younger age group (26 to 45), as compared to the average and median age of those receiving treatment in D.V.A. institutions. Sixty per cent were under sixty-five years of age. About one half of the group were married. An additional twenty-four per cent were separated or divorced. Only three veterans were unattached or had no close relatives. Sixty per cent of the group had good relationships with at least one member of his family. The majority of the group had had at least public school education. More than half of the group (56 per cent) were retired or steadily employed, while twenty-three per cent were medically unemployable. The remaining twenty-two per cent had potential employment problems. Over half of the group were

known to be living on marginal or low incomes. Approximately one third of the patients owned their own homes, and more than half of them lived in the city and therefore could take advantage of the resources available in the urban community. The medical diagnoses, except that of psychoneurosis, corresponded proportionately to those of other patients receiving treatment in D.V.A. institutions. An exceptionally high percentage of patients referred to M.S.S.D. were in this diagnostic group. It was also noted that thirty per cent of the patients had had five or more previous admissions to Shaughnessy.

Two of the main factors bearing on services and on the prognosis for social rehabilitation are the process and reason for referral and the way in which the patient and his family view their needs and situation. The majority of the study group (62 per cent) were referred to M.S.S.D. by the attending physician. Only six per cent of the patients requested services of their own accord; eight per cent of the families requested help; and a very small number (2 per cent) were obtained by routine coverage. The largest proportion of referrals was for assistance with discharge planning, for assessment of the patient's social background or environmental circumstances. A relatively small number of the referrals (20 per cent) were for direct services to aid the family toward a better personal adjustment.

The patients saw the largest number of major problems in the category designated as economic, while the relatives saw more major problems in relation to housing and to their anxiety concerning the patient's medical diagnosis or treatment. Patients and their relatives recognized most need for help in relation to secondary problems of vocational difficulties and anxiety. They considered the contributing factors to be mainly the patient's physical limitations or disabilities.

The evaluation of problems seen by the doctor showed the greatest number of major ones in the categories of economic, housing and mental or personality disorder. They saw physical limitations, anxiety and vocational as the most frequent secondary problems. The most frequent underlying difficulty as seen by the doctors was in the category of physical limitation.

The social workers' diagnoses of psychosocial problems, based on an evaluation of the patient's total situation - medical diagnosis, personality structure, social circumstances and family dynamics - revealed a total of 111 problems. The 56 presenting problems fell mostly into the categories of economic, housing, mental or personality disorder and anxiety. An almost equal number (55) of the secondary problems were seen to be mainly in the categories of anxiety, vocational, physical limitation and inter-personal relations. The highest proportion of underlying difficulties was in the classification of inter-personal

relations. The most significant difference between the social workers' assessment and that of the others was the greater number of times the social worker saw a need for help to be given in relation to anxiety and inter-personal relations.

The assessment of M.S.S.D. services (rendered on the basis of the social workers' diagnosis, and dependent upon the client's wish for service as well as upon the doctor's recognition of needs and approval of the treatment plan) showed that a total of 119 services were given. Study of the frequency of contacts with patients and others, and of the length of time cases were active with M.S.S.D. indicated that an almost equal number of interviews were had with persons other than relatives as compared with the number of interviews with patients per case. A slightly lower number of interviews was had with relatives. The majority of cases were active with M.S.S.D. approximately one month. The largest number of services were of an indirect nature, with referral of the client to appropriate resources being the most frequent of these and social assessment the second most frequent. Explanation and offer of services was given sixteen times. Supportive help was given more often than any other type of service. This method was the one most often employed in giving direct help to patients or their relatives. An intensive type of casework treatment was employed in a proportionately low number of situations.

Evaluation of the weighting of social services in relation to psychosocial problems revealed that services were given most frequently in relation to problems of anxiety, followed by mental or personality disorder, economic and housing. The least number of services was given in relation to vocational difficulties, and in relation to physical limitations. Supportive help was given most often in relation to problems of anxiety, mental or personality disorder and inter-personal relations. Referral to community agency or to welfare services was the method used most often to deal with economic problems. Social assessment was the service most often used in relation to problems of housing and mental or personality disorder.

Implications for Treatment Team and Community

Rehabilitation is essentially a team responsibility, whether that team is operating in a particular setting or in the larger community. All resources existing in facilities within the institution and community, and individual professional operations contribute to the solution of the total problem. It is the professional and ethical responsibility of all concerned with treatment, in a broad sense, to fit and integrate their individual skills into the overall community scheme, so that their efforts may be most fruitful and the best interests of the individuals served. The professional social worker's

responsibility is to render appropriate and helpful social work services to clients within the functions and policies of his employing agency, and to assist that agency in fuller understanding of client needs so that policies may be increasingly helpful to clients.

The M.S.S.D. has this responsibility as part of the DVA programme and team concerned with the rehabilitation of veterans under DVA medical care, as well as to assist in finding a solution to psychosocial problems which the veteran or his family may be experiencing. Failure of any member of the treatment team to carry out his responsibility for ameliorating problems, or for recognizing, and bringing to attention, the situation of those patients experiencing social or emotional difficulties may result in less effectiveness of the total rehabilitative scheme. It may have far reaching consequences, not only for the patient himself, but for the wider community. The success of the rehabilitative programme is also dependent upon the community's provision of adequate resources for meeting the needs of DVA patients and their families, which cannot be met within the existing legislative provisions. The ill veteran, for example, who is worrying about the loss of income to his family during his illness, or about unharmonious relationships in the home, may not respond favorably to medical treatment, thereby requiring his continued hospitalization. His prolonged absence

may lead to the breakdown of family unity. If needed financial, health, recreational, family and child-guidance resources are not available to those families disabled by the absence of the ill veteran, the total community may be affected by breakdown and dependency of the other family members.

The findings, in relation to the particular group of patients studied, pointed up some general and specific implications in regard to the participation of M.S.S.D. in the DVA and community rehabilitative programme for the ill and handicapped veteran. The most outstanding observation, generally, is that M.S.S.D. services are being used for those hospitalized veterans with a fair potential for rehabilitation; that is, the younger patients with fair or good potentiality for returning to the community and those who have dependent wives and children. On the negative side, one needs to consider that there may be many older and possibly unattached veterans who could benefit from M.S.S.D. services, but whose situations are not coming to attention. The people in later maturity who find themselves in a setting ill-suited to provide them with love and affection, and facing a future that appears to be without promise, may react with a feeling of panic or of despair. The Assessment and Rehabilitation unit, to which a social psychologist is attached, gives services to the elderly patients hospitalized in the domicilliary care unit. They might be helped also through the services of a caseworker to find more satisfactions in daily

living, with the ultimate better utilization of other rehabilitative resources.

Another general observation with reference to the use of M.S.S.D. services, is that most requests from medical staff continue to be in the realm of a practical nature; that is, for economic and discharge planning or as a diagnostic aid, with little emphasis or recognition being given to the contribution which the social worker can make to the overall treatment plan in direct, continous work with the patient or his family. When problems are anticipated regarding after-care of a patient, an early referral to M.S.S.D. would provide the caseworker an opportunity for getting to know the patient and for planning with him and his family so that fewer problems would arise. A more valuable service could be offered to both the patient and family in this way, and recurrent illnesses might be prevented. Recognition is made of the social worker's ability to evaluate the environmental factors, family relationships and their effects upon the patient. More recognition of her professional capacity to effect changes in these, through casework treatment, would ensure better service on behalf of the patient, hospital and community.

With reference to specific observations regarding M.S.S.D. services, it may be seen by the frequency of contacts with patients, relatives and others, that communication between services and coordination on a family centered diagnostic and social treatment approach are seen as a key to improvement of the social situation of the patient. The relatively low number of contacts with patients raises

the question as to whether or not a more intensive kind of social treatment might not be given to patients in some of these instances. A certain number of them, who are desirous of service, continue to receive medical treatment for a prolonged period after referral to M.S.S.D., e.g., those patients referred for social assessment. This would depend, in part, on the doctors' awareness of what the social worker can contribute in direct work with the patient.

Another more specific area with implications regarding the effectiveness of M.S.S.D. services, is that of recording. The study revealed that the records do not always bring out significant factors concerning the patients' social circumstances or other matters which have a direct bearing on their problems and on the need for service.

Recommendations

> "The effectiveness of any form of remedial action rests upon comprehension of the full context of the problems, delineation of the objectives, recognition of the full range of approaches required for reaching them and the integration of each approach with the total problem solving operation".[1]

The objective of making M.S.S.D. services as effective as possible, and available to all those patients and their families who are in need of casework help, is a responsibility, not only of the individual caseworker, and M.S.S.D., but also of other treatment staff and of the hospital administration.

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1. COCKERILL, Eleanor, "The Interdependence of the Professions in Helping People", Journal of Social Casework, Vol. 34, No. 9, November, 1953.

The continuing support of administration in advancing M.S.S.D. services and increasing staff, in order to provide for a broader patient coverage and more continuous types of service to be given to those in need of help, is essential to the functioning of M.S.S.D. as a part of the rehabilitative team. Administration can further contribute to better overall patient care, and more effective use of M.S.S.D., through continued provision for programmes of research, student and staff training, and most especially by providing for the inclusion of M.S.S.D. in the teaching programme of the hospital- -in medical ward rounds and interne orientation. This would serve to increase awareness of the social factors in illness, to increase the co-ordination and integration of efforts of the various team members, and to further more effective use of M.S.S.D. The need for greater interpretation of social services to medical staff was pointed up in a previous study.[1]

Doctors have a responsibility for recognizing and bringing to early attention of M.S.S.D. the situation of those patients whose family relations, environmental pressures, or social conditions may be presenting problems or potential difficulty, and thus enable the patient to obtain maximum benefit from medical treatment.

If social workers are to participate more fully and continuously in the long-term rehabilitative treatment of patients, and to

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1. BARSKY, Anastasia N., Casework in a Veterans' Hospital: An Analytical Study of Referrals from Doctors, Shaughnessy Hospital, 1953-1954, Master of Social Work thesis, University of British Columbia, 1954.

give more intensive direct treatment services, it seems essential that they find some other ways of interpretating to medical staff the kinds of services that they are professionally equipped to perform. Much is done on a doctor-worker basis, as indicated by Miss Barsky,[1] but the need of some sort of general educational programme continues to be indicated. A great deal could be accomplished also by improvement of recording techniques. The social worker's assessment of the total situation of the patient and his family, the psychosocial diagnosis, and the treatment needs should be clearly set down, whether they can be carried out or not. Social workers are equipped to deal with many of the psychological manifestations of patients' problems, as well as with the more practical areas of difficulties. Their carrying out of any service on behalf of patients is dependent upon sufficient staff, early referral of cases, and co-operation with other hospital and community personnel. Some consideration might also be given to the keeping of fuller M.S.S.D. records for particular groups of patients to facilitate research which might demonstrate the more effective use of M.S.S.D. Fuller recording of specific psychosocial factors would contribute to clarification and classification of social work methods, and would also lessen some of the difficulties encountered in making surveys of patients' needs and problems.

Certain areas of possible future study were brought to attention in the study of the services rendered in meeting the problems of the patients. A closer examination of the resources available for

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1. BARSKY, ibid.

meeting needs might reveal areas for the development of further D.V.A. and community resources. These study findings indicated that there might be value in a survey, for example, of the economic needs of younger veterans. A need is also seen for additional examination of the basic factors underlying the social disability of the patients and their families. Study[1] of the psychosocial components of the problems of "hard-core families" has revealed important implications for agencies and communities regarding diagnosis, treatment planning and prevention. A study of the overall pattern of psychosocial and health factors operating in the situations of patients repeatedly referred to M.S.S.D. might provide information significant to their needs and treatment. A follow-up study of patients who had received M.S.S.D. casework services over a prolonged period of time might serve to demonstrate the outcome of more intensive types of casework service. Since considerable difference was noted in the way patients and families view their needs for social treatment, as compared to the doctors and social workers assessments, another area for fruitful study might be the preparation of the patient and the process of referral of clients to M.S.S.D.

Conclusions

Developing recognition of the social factors in the rehabilitation of the sick and handicapped veteran has led to the inclusion, and continuous expansion, of social services in the treatment

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1. MARCUSE, Berthold, Long-Term Dependency and Maladjustment Cases in a Family Service Agency, Master of Social Work thesis, University of British Columbia, 1956.

programmes of D.V.A. institutions. The social worker in these settings must function within the framework of social work and medicine, and must accept the responsibility to develop her own ability to establish her unique contribution within the total treatment programme.

This particular study obviously leaves many questions unanswered. It does give some ideas about the kinds of problems for which the M.S.S.D. is requested to give service, what is being done, and which services are most needed. Services and programmes cannot be rationally evaluated or improved without investigations of practices related to need and to problem areas. It is hoped that these findings will stimulate others to undertake additional studies, and will be of benefit, in some small measure, to the patients and their families.

APPENDIX A: SCHEDULE FOR CASE ANALYSIS

IDENTIFICATION: Case No._____ Regimental No._____

AGE: 18 to 25...26 to 45...46 to 65...66 to 75...76 & over...

WAR: Prior to World War I...WW I... WW II... Korea...

RELIGION: R.C....Prot....Hebrew...Other...No Affiliation...

RACE: White...Indian...Negro...Oriental...Mixed...Not Known...

MEDICAL INFORMATION:

% PENSIONABLE DISABILITY: 5-20...25-40...45-60...65-80...85-100.....

TREATMENT CATEGORY: Section..... Diagnosis.....:

CURRENT ADMISSION DATE: ..... No. of Previous Admissions....

PROGNOSIS: Improvement...Chronic...Recurrent...Terminal...Not Known...

BACKGROUND INFORMATION:

EDUCATION: Elementary...Secondary...University...Business...
Technical....Other....Not Known....

EMPLOYMENT STATUS: Retired...Unemployed...Medically Unemployed...
Occasionally Employed...Steadily Employed.....

TOTAL MONTHLY INCOME: ..... Pension..... W. V. A. .....

USUAL LIVING CIRCUMSTANCES: Rural.... Urban....
No Fixed Address...Boarding...Housekeeping Room.....
Sleeping Room...Apartment...Rented House...Own Home...
Relatives Home...Domiciliary Care...Shack...

MARITAL STATUS: Single...Married...Common-law...Separated...
Widowed...Divorced...Not Known...

DEPENDENTS: Wife...Child(ren)...Parent(s)...Sibling(s)...Other....

RELATIVES:	Well	Sick	Dead	RELATIONSHIPS WITH CLIENT: (good, fair, poor, indifferent)
Mother	....	....	....	.....
Father	....	....	....	.....
Step-mother	....	....	....	.....
Step-father	....	....	....	.....
Siblings	....	....	....	.....
Children	....	....	....	.....
Wife	....	....	....	.....

APPENDIX A: (Continued)

MEDICAL SOCIAL SERVICE:

DATE OF REFERRAL: ..... NO. of CONTACTS: Patient...Relative..Other..

NO. PREVIOUS REFERRALS: ... TIME ACTIVE: Days...Weeks...Months...

SOURCE OF REFERRAL: Doctor...Other Hospital Staff...Other DVA Staff...
Routine Coverage...Patient...Relatives....
Community...

REASON FOR REFERRAL: Social History...Social Assessment...
Economic Aid...Discharge Planning....
Personal & Social Adjustment...

PROBLEMS: As seen by 1) Patient 2) Family 3) Doctor 4) Social Worker

	Presenting	Accompanying	Underlying
Economic...	.....	.....	.....
Housing....	.....	.....	.....
Vocational...	.....	.....	.....
Physical Disability...	.....	.....	.....
Anxieties re Treatment...	.....	.....	.....
Mental or Personality Disorder	.....	.....	.....
Inter-personal Relations...	.....	.....	.....

SERVICES:

INDIRECT:	Patient	Relative	Hospital Personnel
Referral Welfare Services...	.....	.....	.....
Other DVA Hospital.	.....	.....	.....
Community...	.....	.....	.....
Explanation & Offer of Service	.....	.....	.....
Social Assessment & Diagnostic Aid.....	.....	.....	.....
Environmental Modification..	.....	.....	.....
Economic Aid....	.....	.....	.....
DIRECT:			
Supportive Help....	.....	.....	.....
Interpretation.....	.....	.....	.....
Counselling.....	.....	.....	.....

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