SOCIAL WORKER PARTICIPATION IN THE TREATMENT

OF THE MENTALLY ILL.

A Study of the Current Program at the Provincial Mental Hospital and the Crease Clinic of Psychological Medicine, Essondale, B.C.

by

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ABSTRACT.

Evolution in the improved treatment of the mentally ill has been slow, and even today there is much variation in hospitals and communities. One of the most recent developments towards more effective treatment is the use of the treatment team. The members of this team, as a rule, are: doctor, nurse, psychologist, occupational therapist and social worker. Each one of these professional disciplines shares his knowledge of the patient with the others, so that all areas of the patient's life can be given full consideration. This thesis examines the role of the social worker in the treatment team that works with the mentally ill in two treatment centres - the Provincial Mental Hospital and the Crease Clinic of Psychological Medicine at Essondale, B.C. The study was undertaken to point up the social worker's area of competence and show where it can be used to the best advantage in the mental hospital program.

The material used to evaluate the program was obtained through interviews with members of the social service staff, by attendance at staff meetings, reviewing records of past staff meetings, and by examining reports that have been prepared by various members of the staff on their casework activities. The study was meant to be more of a qualitative analysis and because of this a minimum of statistical material has been included.

An examination of the treatment program shows that the social worker offers casework services to the patient and his family from the time of the patient's admission to the Hospital or the Clinic until long after his discharge. Specifically, this means that social service is available to the patient from the time of his reception; while he is under treatment on the ward; at the time that he is preparing for his return to his home; and also after his discharge in the form of counselling or rehabilitation services. The social worker offers further services in the areas of education and training (of social work and other professional staff); in research, primarily to point out the needs in their own area of the treatment program; and also in community interpretation. Participation, to a limited extent, is seen in hospital administration.

In concluding the study, it was pointed up that there is a need for more participation in the administrative aspects of treatment, the importance of social workers on the wards was stressed, and an increased emphasis on the rehabilitation of the patient was recommended.
I wish to acknowledge indebtedness to the social workers in the Social Service Departments at the Provincial Mental Hospital and the Crease Clinic of Psychological Medicine for their interest and co-operation in the preparation of this thesis.

The direction and encouragement of Miss A. Carroll, Provincial Supervisor of Psychiatric Social Work, Dr. Leonard C. Marsh and Miss Muriel Cunliffe of the School of Social Work is acknowledged with gratitude.
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SOCIAL WORKER PARTICIPATION IN THE TREATMENT
OF THE MENTALLY ILL.
The primary function of the mental hospital is for the care and treatment of persons suffering from mental illness. The efforts of all personnel employed by the hospital, whether in an administrative, professional or clerical position, are directed towards helping these persons to recover from their illness.

The present trend in treatment in the mental hospital is a process that is commonly called the "teamwork approach". The professional personnel who are directly concerned with the treatment, namely the doctor, psychologist, nurse, social worker, and occasionally the occupational therapist, form the team that is working together. Each contributes his specific skill to the treatment so that every aspect of the patient's life - biological, psychological and sociological - is given full consideration in treatment planning. In other words, the patient is treated as a whole. The goal of treatment is seen as return to community living with the fullest utilization of all possible resources for the personal, social and vocational rehabilitation of the patient.

The social worker's specific contribution to this treatment lies in his understanding of the social and emotional factors that are affecting the life of the patient. Embodied in this understanding is a knowledge of human behavior; of psychopathology; of differential diagnosis; of community living and its impact on the individual and his family; of
the inter-play of family life and its impact on the individual; and of the use of the helping relationship and the understanding of what accepting help commonly means to people. Along with these factors he brings to the treatment team, a comprehensive acquaintance with community resources and skill in using them to service the individual and his family.

It has only been since the early twentieth century that the social worker has been able to make his contribution to the treatment of the mental patient during his hospitalization. Prior to this time the social worker's contact was primarily after discharge when the patient was in need of assistance to become re-established in the community. But re-admissions helped the medical profession to see that treatment of the patient alone would not cure his mental illness. Someone was needed who could provide an accurate picture of the external stresses that the patient had to face, and assist in helping him to meet these stresses with confidence. The social worker with his casework skills, was the person to do this.

Historical Background.

The long story of the inhuman treatment of the mentally ill is well known. For over a century and a half the events which worked enlightened innovations are few and far between. The year 1792, when the French Revolution was at its height, is usually regarded as the date that a new attitude was started towards the person suffering from mental illness. It was
in that year, in two different cities, one in France and one in England, that two men were beginning similar reforms in the treatment of mental illness.

In Paris (France) two principal institutions for the mentally ill had been established, the Bicetre for male "lunatics", and the Saltpetriere for females. At this time therapeutic treatment was entirely lacking, but thanks to Phillipe Pinel, a formerly obscure physician, these two institutions were transformed in a manner which resulted in a new approach to the treatment of mental illness. Pinel had the chains removed from the insane and started treatment based on kindness and sympathy. There was a minimum of mechanical restraint and the beginnings of intelligent understanding.

In the same year that Pinel started his reforms, a similar though far less dramatic step, was being taken by the Quakers of York, England under the leadership, of one of their numbers, William Tuke. A building was erected for the care of the insane. The main objectives in this new institution were; to provide a protected environment for the patients; to emphasize employment and exercise that would be conducive to mental health; to treat the patients as guests rather than inmates. Kindness and consideration formed the keystone of the whole theoretical structure.

The influence of Pinel and the Quakers was later seen elsewhere. While Pinel exercised the stronger influence in
the European countries it was Tuke's work that played the more important role in America. A special institution for the mentally ill was opened at Frankford, Pennsylvania in 1817 called the "Friends' Asylum" and it is believed that the original proposal for this institution came from a minister of the Quaker faith, Thomas Scattergood, who had spent six years travelling in Britain, had met Tuke and been very impressed with his institution. One of the first attempts at classification of mental illness was made here.

About the same time as the "Friends' Asylum" opened similar institutions arose in other states. The Bloomingdale Asylum was completed in New York, the leader behind this move being Thomas Eddy, a Quaker merchant who had kept in touch with progress abroad and had written to Tuke about his hospital. One of the interesting features of Eddy's plan was that he insisted on keeping a history of his patients during their stay in the asylum.

About 1830, in America, a vigorous movement started for the erection of suitable state hospitals for the insane. This movement saw its impact in the opening of the State Lunatic Hospital in Worcester, Massachusetts in 1833, and in the following ten years at least nine public hospitals for the insane were opened in the United States.

The year 1841 saw a new figure enter the struggle for improved treatment of the mentally ill in the person of a retired school teacher, Dorothea Lynde Dix. Her career as a
reformer started with the instruction of a Sunday school in the East Cambridge jail in Boston. Her protest against the treatment there, especially of the insane persons who were locked up, started her on a crusade that eventually took her on inspection tours of the mental hospitals in the United States, Britain, Canada and Europe. In nearly every instance, her inspection and campaign led to the erection of a new hospital or the enlargement of an existing one.

All these, significant though they were in themselves, were almost isolated developments. Public understanding, reform on a national scale, and the beginnings of professional training for staff waited until the twentieth century for achievement on the North American continent. The primary step was taken by a former mental patient, Clifford Whittingham Beers. After his discharge he wrote a detailed account of his experiences in several mental hospitals. In his book, A Mind That Found Itself,\(^1\) he was able to bring out some of the shortcomings of the mental hospitals in the United States and expose the conditions under which the mentally ill were made to suffer. This book, now virtually, an American classic, was instrumental in helping to found the Mental Hygiene movement in the United States.

Throughout this period, when work became focused on the improved treatment of the mentally ill, social workers constantly came in contact with the subject of mental disorder in

\(^1\) Clifford W. Beers, A Mind That Found Itself, Doubleday & Company, Garden City, New York - 1908.
its social aspects. Provision for the indigent insane constituted one of their major tasks. There was also the problem of looking after the families of individuals who had been the breadwinners before being incapacitated by mental illness. One of the most serious questions confronting social workers was the readjustment of mental patients returning from hospitals to normal community life. It often happened that a patient, discharged as cured, was unable to readjust himself to community existence. Such a person, unaided, might break down with consequent readmittance to the hospital perhaps permanently this time. The environmental conditions he met upon returning to society were never quite the same as when he was first hospitalized. He was invariably burdened with new handicaps, one of the heaviest of which, was the stigma of insanity with which the patient of an asylum was branded.

Commonly, when a patient had improved enough to be returned to the community, his discharge had to be delayed because of socio-economic difficulties. There might not be any home or family to which he could be sent, or he might find it impossible to get employment. There was no medium or agency through which the recovered patient could be given the initial help and advice to enable him to start on the road of independence.

The first solution to the problem of the care of the discharged mental patient came in the "after-care movement". This movement had been seen first in Nassau, Germany where it
was introduced by a Doctor Lindpainter, director of the Eberbach Asylum, and in France a Société de patronage was founded by a Doctor Falret for the same purpose. A similar society, called the Guild of the Friends of the Infirm in Mind, was established in England. Later, the State Charities Aid Association of New York authorized its committee on the insane "to inaugurate and maintain, for convalescents leaving hospitals who may be friendless, a system of after-care whereby they may be strengthened in health, protected and cared for until able, to support themselves".¹ The plan was held in abeyance until 1906, but at that time the Manhattan After-Care Committee of the State Charities Aid Association was formed and an after-care agent was employed.

The first instance in America of the actual employment of a social worker in a hospital occurred in 1905 when Miss Edith N. Burleigh started her work at the Massachusetts General Hospital under the direction of Doctor James J. Putnam. In the following year, a social worker was employed in the psychopathic wards of the Bellevue Hospital (New York) for the purpose of assisting patients who were recovering from mental illness. In 1913 the Boston Psychopathic Hospital began its Social Service department under the leadership of Doctor E. Southard and Miss Mary C. Jarrett. When the First World War began, it was clear to those who had seen the importance of the social service in civilian hospitals that social workers would be needed for army

hospitals, especially on wards where psychiatric work was being undertaken. To meet this need, plans to enlarge the training course, at the Boston Psychopathic Hospital, for social workers going into psychiatric work, were proceeding, but it was found possible to combine with Smith College in a course of the same type which was given under the auspices of a committee of the National Committee for Mental Hygiene. Similar courses, conceived as emergency measures or as permanent developments of the curriculum, were soon offered by other Schools of Social Work in New York, Philadelphia and Chicago. In Canada the first course was inaugurated at the University of Toronto in 1919.

**Essondale.**

The impact of the new ideas that had begun in the treatment of the mentally ill was also felt in British Columbia. The result was improved treatment in the mental hospitals and also the inclusion of the social worker into the treatment planning.

In 1905 Doctor C.E. Doherty became the new medical superintendent of the Public Hospital for the insane at New Westminster, B.C. He proceeded along lines of practice that were being established in the more modern mental hospitals. All patients were classified according to the seriousness of their illness. After a sojourn in the receiving ward those considered curable were segregated from the so-called incurable; the feeble and the infirm were sent to special quarters, while the convalescents were assigned to quiet quarters with ample libraries, reading and amusement rooms. Absolute rest in bed was encouraged
for the acute cases and the principle was "to see that they receive every care, treatment and attention that the sick should receive."\(^1\) All patients not physically incapacitiated were encouraged to take exercise in the open air, both summer and winter, and regular concerts and dances were held.

The annual report of the hospital in 1907 declared that "kind and humane treatment is enforced in every department; mechanical restraints of all kinds have been abolished; the physically sick receive special diets according to their needs; all engage in open air exercise, both summer and winter, while everything is done during leisure hours to divert the patient from his trouble."\(^2\)

The year 1906 was an important date in the development of the care of the mentally ill in British Columbia because "in that year Henry Esson Young, a medical doctor, became Provincial Secretary and served in that capacity for many years. This able and socially-minded minister made the mental hospital at New Westminster one of his most vital concerns, and he was largely responsible for building the new institution at Essondale, B.C. the name, Essondale, being chosen in his honour."\(^3\) This new hospital was started in 1908 and two years later opened its doors, at first for male patients only.

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In 1919 the Canadian National Committee for Mental Hygiene, founded the previous year, made a survey of British Columbia at the request of the Provincial Secretary. The study was carefully and thoroughly conducted and included an examination of conditions in connection with both the insane and mental defectives. In the foreword to the report the committee stated that it had received the utmost co-operation from those in charge of the various institutions. Its impression was that the people of British Columbia were fully alive to the importance of making social reforms and the province was generally to be congratulated on the progress made in the care and treatment of the insane. In the report the Committee stressed the need for a social service department in connection with the institutions at New Westminster and Essondale. It was felt that a well organized social service department was a primary need, and that the employment of trained social workers would effect a real economy to the government as patients could be placed on probation thus relieving the hospital of the burden of maintenance.

The year 1926 saw Doctor A.L. Crease appointed as Medical Superintendent of the Mental Hospitals in British Columbia, and in the first of his annual reports to the Department of the Provincial Secretary he recommended the setting up of a Social Service department to serve the mental hospitals in the province. It was not until four years later that this recommendation was followed up when, in 1930, the Canadian National Committee for Mental Hygiene installed a social worker,
Miss Josephine Kilburn, in the Provincial Mental Hospital at Essondale for one year at their expense. The chief aim and purpose of this new department was to "secure more detailed information regarding the home life and conditions of the patients which heretofore had not been obtainable. Such information was of value because any contributing factor to the patient's breakdown could be looked into prior to his return home, otherwise his improvement might not be lasting. A follow-up of a patient after discharge and assistance in the re-establishment in the community was another function of the Social Service department." Miss Kilburn's one year of service was enough to convince the government of the value of her services and she was put on the regular staff. With the introduction of the Social Service department a new aspect of treatment was opened up, not only to the patients themselves, but also to their families.

The Social Worker's Role Today.

The functions performed by social workers, particularly in mental institutions, have undergone considerable evolution in their turn. In recent years there has been a good deal of consolidation and clarification of their roles. In the treatment of the mentally ill, the role of the social worker depends in the first place, of course, on the type of mental institution itself; but, in all cases, whatever the role, the goal is the same - return to community living and obtaining an optimum adjustment.

To enable the patient to attain this goal the social worker may have to deal with a wide range of social and personal problems. To enumerate them would be to name the whole gamut of human ills—failures and frustrations, such as unemployment, poor housing, need for money or medical care, need for help in planning for the care of children and help with disturbed interpersonal relationships. In order to help these people, who at least momentarily are unable to cope with their affairs, the social worker must know the tension in their lives, what can be done about it, and how the person or the tensions can be changed. He must also understand how the person feels, how he can be helped with these feelings, and how the person's way of responding serves him in the light of his present life pressures, past experiences, and future aspirations. It is this understanding of the individual and of what the problem means to him that enables the social worker to modify either external or internal pressures, or both, so that the individual may be relieved of stresses and participate in the recovery of self-reliance.

Whether the individual's problem originates in, or is complicated by, the external situation the social worker may be called upon to render services which meet practical reality needs. These services, when rendered with proper regard for feelings, may ease anxieties, give new confidence and enable the individual to manage his affairs competently. In addition to providing concrete services the social worker may be of assistance to the person by helping him to clarify his indecis-
ions, or to discharge feelings, and also to understand feel­
ings that are obstructing constructive action or inducing de­
stuctive behavior. The worker may also help him to understand
his general situation better, or help people who are significant
in the patient's life. The social worker's main contribution
lies in his understanding of human inter-relationships and his
ability to strengthen the healthy aspects of the patient's per­
sonality by helping him to adjust to the realities of a changed
and limited situation.

To enable the professional skills of the social worker
to be most effective in the treatment of the mentally ill it is
important that he participate widely in the hospital program.
Separate professional disciplines in the same place do not in
themselves make a hospital team. Integration is important at
the administrative level for proper program planning, and the
setting of policies within which the treatment teams will oper­
ate. The development, by the medical staff, of a positive
attitude towards social work will depend on their knowledge of
the content of professional Social Work training. This is gain­
ed as much through participation in the administrative aspects
of the hospital as by actual co-operation in treatment services
to patients.

In relation to the direct treatment services to the
patient the social worker should work closely with him from the
moment he enters the hospital until he is finally re-established
in the community. This means that the social worker is in con-
tact with the patient through intake and reception, the treatment program, pre-convalescent care and convalescent care.¹

Intake is the process of making hospital services available to persons in the community who can benefit by hospital care. Its greatest value is seen in the formation of the travelling clinic, but in the hospital itself it has an important function as the social worker on Intake is able to assist in the interpretation of the hospital facilities and program to the prospective patient and his family; assist the family with problems that may arise from the patient's admission to the hospital; to formulate plans, with the assistance of other community social agencies, which might make admission less urgent or occasionally prevent unnecessary or ill advised admissions; and to attempt to establish a relationship with the family that will encourage them to maintain a positive, non-rejecting attitude during the period of care.

Reception is the process of helping the patient to accept his hospitalization, of relieving the fears and threats inherent in the experience of compulsion and restraint. The social worker's function in reception usually includes participation with other hospital personnel in explanation of routine, and helping the patient to understand that the worker serves as a link between him, his family and the community. Also the social worker helps the family with anxiety that surmounts when one of its members enters a mental hospital; helps the family

to understand the treatment used; and whenever possible gathers preliminary evaluative material about the patient, his relationships, his experiences and his illness from either the patient or his family. An understanding person, which the social worker is, who can help the family to realize the necessity of treatment and obtain their co-operation is very important. It is the beginning impressions that help to ease the fears that very often accompany entrance to a mental hospital, and set the pattern for future contacts with the family.

The treatment program usually means every contact that the patient has during his stay in the hospital. This includes the people he meets, doctors, nurses, psychologist, occupational therapists, the other patients, as well as somatic therapies. The social worker is concerned with every aspect of the patient's relationships within the hospital, as well as those with his family and community. Besides regular visits to the patient on the ward, and conferences with other team members regarding the patient's progress, it is the clear cut function of the social worker to prevent any disruption in the continuity of the family-patient relationship. The patient comes from the family and will probably return to it, therefore the social worker has to make regular visits to members of the family to discuss the patient with them, encourage them to visit the hospital, and help them with the problem of any disturbance of familiarity so that they can accept the patient as they find him. It is this latter activity of the social worker that contributes much to reducing the length of the patient's stay in the hospital.
The treatment program, for the individual patient, is usually shaped by the changes in his illness, but the primary treatment plan is formulated at ward rounds, shortly after the patient's entrance to hospital. At ward rounds the members of the treatment team meet together to discuss the best possible plan for the patient's recovery. Each professional discipline concerned presents the information that he has obtained and outlines the role he feels he can play in the treatment plans. When a plan has been formulated it is not rigidly adhered to, but is changed as the necessity is seen by the team members. Changes in treatment plans are usually discussed in special conferences of the team members, the conference being arranged by whichever member feels the necessity for a change.

Towards the termination of treatment the social worker brings services to the patient that will prepare him for his discharge. This pre-convalescent care should be an integral part of the treatment process within the hospital. It consists of discussing with the patient his plans for the future, and his feelings towards leaving the hospital and returning to family and community life. If properly carried out the patient will look forward to his discharge from the care of the hospital.

The social worker brings services of a convalescent or probationary nature to the patient as he leaves the hospital. Convalescent care is the re-establishment of the patient in the community. During this period of convalescent care the patient usually remains the responsibility of the hospital authorities, unless hospital policy states otherwise. The social worker
assists in the discharge of this responsibility by exercising continued supervision of the patients and by attempting to make available all community resources which can help in his readjustment. This might involve such things as interpretation to the family regarding the patient's illness; helping patient to regain his economic security by assisting in locating contacts for work, or encouraging the interest and acceptance of former employees whenever possible. Probation is a function for which the social worker assumes extensive responsibility.

With completion of the social worker's role with the patient it does not mean that his job ends there. He still has important responsibilities, outside of the patient sphere, in education and training, research, and community interpretation.

The primary educational responsibility of the social work department is towards students of Social Work, but within the hospital the social worker must interpret the content of his own professional activities. He should attempt to broaden the knowledge of the medical, nursing and other professional staff in such areas as: inter-personal relationships of parents and children; social and economic stresses and their impact on the family life of the patient; the availability of social, health, employment, recreational, educational, vocational and other community resources.

There are two main areas of research which should be of interest to the social worker in the mental hospital. The first is participation in projects developed by the medical staff...
such as follow up studies of various groups of patients and studies in social pathology. The second is the evaluation of the effectiveness of the activity of the social work department, such as the refinement of procedures in casework, and exploring trends in community relations affecting mental health.

The duties and responsibilities of the social worker both in the hospital and the community place him in a very advantageous position to develop constructive attitudes towards the recognition and treatment of mental illness, and to secure the participation of lay groups in the development of favorable attitudes towards mental hospital care. With patients continually returning to the community there is a real and urgent need for an informed public to develop awareness, acceptance, and understanding of these patients' problems, and the social worker in his daily contacts has a great responsibility to initiate this awareness by explaining the needs of the mentally ill.

Method of this Study.

The evolution in improved treatment of the mentally ill has been slow, and even today it varies from hospital to hospital, community to community according to the needs, finances, staff available, and the degree of enlightenment. As for the social worker, his participation varies similarly, but because of clarification of his function and proper defining of his area of competence he is gradually coming into his own in the field of treatment of the mentally ill.

The present study examines the participation of the
social worker in the programs of two local treatment centers - the Crease Clinic of Psychological Medicine and the Provincial Mental Hospital at Essondale, B.C. Both the hospital and the clinic were included as they are closely related in their physical setting and treatment services to patients. Though the clinic is not actually called a mental hospital, it was designed and equipped to function as a diagnostic and active treatment centre for mental illness. The main types of patients accepted are: early psychotics, psychoneurotics, those with psychosomatic disabilities, and also all psychotics, except those of long standing duration demonstrating marked deterioration, and having a poor prognosis.

The original plan, an historical study, was abandoned as it was felt that a greater contribution could be made by an examination of the present program. Some history has still been included so that the more recent developments could be pointed up. The study has been limited to more of a qualitative analysis, and for this reason a minimum of statistical material has been included.

Evaluation of the social work participation required consideration of, not only the actual job of the caseworker, but of his position as it is affected by the administration of the hospital. It is clarification in the latter area that simplifies the job of the social worker and enables him to use, to the greatest extent, his professional training in the treatment program. For this reason a section dealing specifically with the
administrative set-up has been included.

The material used to evaluate the program was obtained through interviews with the members of the Social Service staff, by attendance at staff meetings, reviewing records of past staff meetings, and examining reports that have been prepared by various members of the staff on their casework activities.

To give a complete picture, and a basis of comparison, the role of the social worker, as it was seen after a study of a number of hospitals in the United States,¹ has been outlined in this chapter. The study will continue with a short outline of the present organizational structure, and then turn to consideration of the administrative aspects, and the actual participation of the social worker in the treatment services. Finally the material will be assessed, and the needs, if any, pointed up.

Social Service Departments.

The Social Service department at the Provincial Mental Hospital gradually increased the number of social workers on its staff following Miss Kilburn's appointment until by the time of her retirement on December 30, 1950 and the opening of the Crease Clinic of Psychological Medicine on January 1st, 1951 there was a total of thirteen workers at the Hospital.

But the opening of Crease Clinic greatly extended the area of responsibility of the Social Service department at the Mental Hospital. The job of the social worker had to be re-

evaluated and consideration given to the division of labour within the department so that participation in administrative work and service to the patients would not only be more effective but also more inclusive.

By the summer of 1951 an Admissions Section had been started in both the Crease Clinic and the Mental Hospital, and by May 1952, a decision was reached whereby the existing Social Service staff was divided into separate Social Service Departments - one in the Mental Hospital, the other at Crease Clinic - and each consisting of an Admissions Section and a Continuing Casework Section.

During this re-evaluation it was seen that up until this time the social worker had been primarily concerned with securing a history of the patient's background, evaluating social data and its relation to the patient's mental concepts, and to a limited degree, working with the patient's relatives and community agencies. The new divisions in the department meant that the above mentioned services were offered plus casework services around admission of the patient, during the treatment period, including pre-convalescent planning, and to some extent after discharge either in the form of probation or referral services.
Chapter II - The Social Worker in Hospital Administration.

The Provincial Mental Hospital and the Grease Clinic of Psychological Medicine at Essondale are part of the Active Treatment Services of the Provincial Mental Health Services. The Mental Health Services are administered by the Provincial Secretary. Between the minister (Provincial Secretary) who passes on broad over-all policies, and the Director of Mental Health Services, (known in 1930 as the Director of Mental Hygiene and Provincial Psychiatry) who is responsible for carrying out and directing these policies for all branches of the Mental Health Services, there is a Deputy Provincial Secretary. This officer serves to interpret government policy to the Director and thereby provides the functional basis for Mental Health Service activities. Likewise all requirements and problems of the Mental Health Services are assessed by the Deputy in conference with Services officers and are presented to the Minister for the government's action.

To assist the Director of Mental Health Services in the administration of his duties, there is a Deputy Director of Mental Health Services, and also a Senior Medical Superintendent. The latter is responsible to the Director for all medical matters within the organization. This medical officer has authority over all hospitals within the Mental Health Services and is particularly concerned with inter-hospital activities. Under the Senior Medical Superintendent come special Medical Superintendents who are appointed to the different
branches in the Mental Health Services. The Provincial Mental Hospital and the Crease Clinic are administratively linked together under a Deputy Medical Superintendent. Clinical work in the two treatment centers is under the direction of a Clinical Director. These two officers (Deputy Medical Superintendent and Clinical Director) are in charge of all medical departments within the Hospital and Clinic. (It is "at this point that a hospital administration chart often breaks down as matters clinical and matters administrative are often interlocked and it is difficult to know the channels through which the staff members can take their problems for clarification".1

There is some broad understanding within the Social Service Department that where such things as finances, accommodation and equipment are concerned they will be dealt with through the administrative line, and all things concerning social work as an integral force will go through the clinical line. Even where this broad policy has been evolved there is still some difficulty encountered by the Social Service Departments. The main problem appears to be that the administrative structure at the Hospital and Clinic is still in process, and clarification is slowly forthcoming as the duties of each person are more clearly outlined.) The Social Service Departments at the Provincial Mental Hospital and the Crease Clinic function within the above administrative structure under the direction of the Provincial

Supervisor of Psychiatric Social Work. A chart of this administrative set-up is seen as follows,

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<td>Provincial Secretary</td>
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<tr>
<td>Clinical Director</td>
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<tr>
<td>Provincial Supervisor of Psychiatric Social Work</td>
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**Figure I - Administrative Structure at the Provincial Mental Hospital and Crease Clinic.**

Although the Social Service Departments, for administrative purposes, come under the Mental Health Services they are actually a part of the Social Welfare Branch of the Department
of Health and Welfare. Social workers are placed at the Hospital and Clinic by the Social Welfare Branch, in lieu of the two centers developing their own social service departments. By this arrangement, patients who have received treatment are able to make use of the existing social service of a family or social assistance nature provided by the Social Welfare Branch, and the Mental Health Services are able to use the Field Service of the Social Welfare Branch for assisting in treatment of patients who do not reside within the city of Vancouver or the Greater Vancouver area. (The Field Service is that part of the Social Welfare Branch that brings services of a generalized nature to the outlying districts in the Province.)

The chief executive of the Social Welfare Branch is the Deputy Minister of Welfare. He is responsible to the Minister of Health and Welfare for the running of the Social Welfare Branch, as well as the administration of all social legislation under the jurisdiction of the Branch. The social welfare services related to other departments - e.g. Provincial Mental Health Services - are also under his administrative direction. In this latter regard the Deputy Minister works in close collaboration with the Deputy Provincial Secretary on matters of policy.

Assisting the Deputy Minister of Welfare with the detail involved in this all-over administration are the Director of Welfare and the Assistant Director of Welfare. These three

1. See Appendix A.
comprise what is called the General Administration of the Branch. The Director and the Assistant Director share the work involved, the former being responsible for releasing all policies with respect to expenditures and services, and the latter being responsible for the personnel of the Branch, office procedures, and standards of professional services.

Because the Provincial Supervisor of Psychiatric Social Work at Essondale is appointed by the Social Welfare Branch, receives personnel from them, and must have knowledge of their policies and services, it is important that she work closely with the General Administration. Diagrammatically the contact between these people would be seen as,

![Diagram]

Figure 2 - Lines of responsibility in the Social Welfare Branch.

She also has duties that extend beyond the Social

1. See Appendix B.
Service Departments at Essondale, as she is responsible for the organization, planning, policies and services of the Social Service Departments at Woodlands School (New Westminster) and the two Child Guidance Clinics operated by the province and centred in Vancouver and Victoria.

Provincial Supervisor of Psychiatric Social Work

Social Service Departments

Woodlands School  Mental Hospital and Crease Clinic  Child Guidance Clinics

Figure 5.- Areas of responsibility of the Provincial Supervisor of Psychiatric Social Work.

The duties of the Provincial Supervisor in all areas of the Mental Health Services are very important, but as this study is primarily concerned with the participation of the social worker at the Provincial Mental Hospital and the Crease Clinic consideration is given only to her work in this area.

The Provincial Supervisor's duties include,

1. Responsibility for the organization, administration and coordination of the social service program within the Provincial Mental Hospital and Crease Clinic. This involves,

   a. Consulting and informing the Hospital and Clinic administration, and the General Administration of the Social Welfare Branch about staff and policy matters, needs within the departments, and the development of the services. Also consulting
and supervising staff in these matters.

b. Making out reports, statistics, and working out schedules and measures to improve the standard of work.

c. Responsibility to see that the policies and procedures that are set down by the Mental Hospital and Crease Clinic administration, with regard to the Social Service Departments, are carried out.

d. Working with other members of the treatment team (doctors, nurses, psychologists, and occupational therapists) on policy and treatment decisions in the areas of shared responsibility. This includes considerable consultation with the heads of specific departments, as well as other members of the treatment team, in regards to case problems and co-ordination of work.

2. Participation in diagnostic and consultative services where a senior person is required to keep in touch with the work being done.

3. To confer on inter-agency policy. This includes interpreting the functions of the Mental Hospital and Crease Clinic to other community agencies, and co-ordination of policy and activities in relation to other community services. An example of this is the integration of the social work student project at the Mental Hospital, which involves consultation with the Supervisor of the student unit.

4. In relation to the social work staff her duties consist of,

   a. Supervision of the casework supervisors in policy matters, handling of staff problems, casework methods and skills, and
major problems in case handling.

b. Assist in the procedure of intake and assignment of cases. This involves consultations with the Supervisor of Casework in Admissions, psychiatrists and individual social service staff members.

5. An interpretive and educational job. This includes the setting up, in co-operation with other social service staff, of teaching and orientation programs for Nurses,¹ Social workers from the Social Welfare Branch and In-Service Training staff.² (In-Service staff are prospective social workers, having no formal training, who take the In-Service Training course of the Social Welfare Branch prior to entering the Field Service. These workers are not employed on the staff at the Provincial Mental Hospital and the Crease Clinic but do have a short period at the Hospital and Clinic where the treatment services and the participation of the social workers in the program is outlined for them.) Also interpreting the Clinic and the Hospital services to professional and lay groups in the community through meetings, articles and lectures.

6. Overall responsibility to organize and introduce methods for social work staff training and development on the job. There are two important methods for staff development being used at the Mental Hospital and Crease Clinic. The first is the weekly staff meeting. These meetings are carefully planned under the

¹. See Appendix C.
². See Appendix D.
guidance of a planning committee of two persons, elected by the staff, plus the Casework Supervisors. Problems are discussed, on a group basis, in administrative matters, on organization of the total social service program, carrying out of the program, and also on daily problems in the social worker's area. Through these meetings the workers are kept up to date on all matters with which they are concerned, and in ways which they can increase their skills and be more helpful to the patient.

The second method of staff development is the orientation program\(^1\) that is now in effect. This orientation of all new staff, which takes six weeks, had to be devised because not all new social workers coming into the service have had experience in a psychiatric setting, and therefore are not in any position to know themselves whether social work in this type of setting is what they want or not. It is important that all newcomers be well oriented in the beginning to offset these deficiencies, and be slowly introduced to the problems or situations that may arise.

With the combined responsibilities that the Provincial Supervisor has in the Mental Health Services as a whole, and also specifically at the Provincial Mental Hospital and the Grease Clinic, it is easy to understand why the division of the Social Service Departments was undertaken as soon as possible after her appointment. New divisions in casework services meant the addition of more casework supervisors who were able to take over

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\(^1\) See Appendix E.
some of the responsibilities for casework supervision, and integration between the hospital and community services. Assisting the Provincial Supervisor with this work are three casework supervisors, one at the Mental Hospital, one at Crease Clinic, and the third is responsible for the supervision of the Admissions casework in both treatment centres. The duties of these supervisors is dealt with in the following sections, but a chart of their relation to the Provincial Supervisor is seen as follows,

![Diagram of Supervisor structure](image)

**Figure 4 - Supervisors at the Provincial Mental Hospital and the Crease Clinic.**

**Participation in Program Planning.**

The organization within the Social Service Departments at Essondale is quite satisfactory, in spite of staff shortages; there is considerable integration and co-operation between the Sections of the Departments; the Departments operate as
a specifically designated administrative unit with the Provincial Supervisor acting on an administrative level which provides direct liaison with the Deputy Medical Superintendent and the Clinical Director of the Hospital and Clinic. With this defined structure it should be possible for the Provincial Supervisor of Psychiatric Social Work to meet her responsibilities for the organization and co-ordination of the social service program so that it fulfills the needs of the patients, and the community that the hospital serves. This is the goal that the Social Service Departments are striving towards, but before it can be accomplished there is one more administrative provision that is required, - "the inclusion of the director of social work in administration staff meetings and participation in discussions of hospital policies which pertain to the treatment and welfare of patients. The responsibility of social service to administration cannot be fully met if the director of the social service department functions on a less well-defined basis." ¹

In evaluating the Hospital and Clinic program in relation to this point, it was found that in some areas, such as clinical matters, the members of the treatment team come together at ward rounds and this results in joint planning and treatment. The Clinical Director sends out memos to a 11 concerned when there are matters in the clinical treatment that are to be

considered, and in any decisions around treatment he informs the individual departments of the decisions that are made. Also the Provincial Supervisor of Psychiatric Social Work and the Casework Supervisors meet with the Director of Mental Health Services from time to time on special matters. But in the general administrative matters that concern the Hospital and Clinic the Social Service Departments are not included. An outstanding example of this is the Hospital Council.

The Hospital Council is an important organization in determining over-all policy. Matters that transcend the fields of several services and require special co-operation and consultation are usually referred to this body for consideration. It is established, by statute, in the Department of the Provincial Secretary and is composed of the Director of Mental Health Services, the Senior Medical Superintendent, the Deputy Medical Superintendent, the Clinical Director, the Director of Nursing, the Chief Psychiatric Male Nurse, the Business Manager, and the Administrative Assistant. These members comprise the permanent or basic Hospital Council and are augmented, when necessary, by the appropriate department heads, e.g. if the subject of the discussion was food the dietician would be present. In this way the Director is assisted in coming to major decisions by the advice and consideration of a group of specialists. Likewise, all departments concerned are kept fully informed and are briefed by the Director and Council in carrying out new techniques and duties. The Hospital Council meets at the call
of the Director. The business at hand may originate in the
Director's office or at the request of a department head or
staff member.¹

From this description of the Hospital Council's struc-
ture and function it is evident that the Social Service De-
partments are only included when matters dealing specifically
with social service are being considered. This may seem logical,
but it is the social worker who has the most direct contact be-
tween the hospital and the community. As the hospital is a
treatment facility of the community it seems important that the
social worker attend the meetings to present the views of the
community, and to point out the needs and resources that are
seen outside of the hospital setting.

Another instance where there is lack of participation
by the Social Service staff is in the noon meetings of the med-
ical staff. These meetings are held daily so that individual
doctors can discuss the treatment of specific patients. The re-
habilitation officer, who is not a member of the Social Service
Departments, is one of the two non-medical persons included in
these discussions, the other being the administrative assistant.
Again in the Thursday evening meetings for medical staff develop-
ment the Social Service Departments are not represented. Doc-
tors, psychologists, and nursing staff attend regularly; but,
only on one occasion was the Provincial Supervisor of Psychiat-

ric Social Work invited. This was to discuss the structure and function of the Departments, and has been the only representation to date.

Exclusion of the Social Service Departments from the Hospital Council and from various staff meetings, at which patient treatment is considered, constitutes a lack of integration between the various departments in the Hospital and Clinic setting. Administration, to be sound, must be the business of the entire staff, as it is "the sum of all their activities and more than that; it is a total operation having implications bigger and broader than the stake of the individuals involved. The ultimate test of its success will be the quality of service which eventuates, and the degree of public response to that service."¹

The Social Service Departments are progressing rapidly and it is possible that with the extension of good casework practice there will be increased recognition of the social worker's contribution in all areas of treatment and program planning.

The final point to consider in the administrative picture is in the cooperation between the two controlling departments - the Social Welfare Branch and the Department of the Provincial Secretary. As there is no defined or established policy between the two the Provincial Supervisor provides the main liaison. It is her job to initiate new areas of social

service to patients through joint planning with the Hospital and Clinic administration, and at the same time to arrange with this administration for clerical staff and whatever space is available for the new service. After this joint conferring with the Director of Mental Health, the Deputy Director and Clinical Director at Essondale, the Provincial Supervisor has to go to the Assistant Director of Welfare and advise as to what the personnel needs will be in the new service. Getting such personnel appointed is difficult because of the shortage of available social workers. The Social Welfare Branch has a difficult time supplying the demand for new workers, and each division of the Branch has to be allotted part of the available supply. The fact that no definite inter-departmental policy for co-operation has been worked out between the Social Welfare Branch and the Department of the Provincial Secretary means that much of the Provincial Supervisor's time is spent interpreting requests of needs and services of one department to the other - time that could be spent in further community interpretation, and helping to work out co-operation and integration in the departments at the Provincial Mental Hospital and the Crease Clinic.

The administration of large institutions such as the two at Essondale is a big responsibility. Maintaining adequate treatment facilities and at the same time carefulness in the spending of public money are prime considerations. Therefore it is important that all departments within the Hospital and Clinic participate as fully as possible in the administrative
aspects so that each realizes its responsibilities. The social worker can be very helpful in giving the administration a clearer picture of the patient and his needs, the needs of the community, and the areas in which the program development would be most helpful to both the patient and the community. The social worker is the person best equipped, by his training, to present the social needs to the administration. In the financial area, it is the social worker who reduces expenses by making it possible for the patient to leave the treatment centre and still have a fully qualified person in touch with him, and to assist him in re-establishment. Cutting down the length of stay also increases the number of patients that can be treated.

Adequate administration of the hospitals should result in properly defined functions, and the integration of each separate department into the total hospital administration. This integration is necessary because in the mental hospital setting there should be a multi-disciplined approach to treatment; to make this possible there must be a similar approach to administration, with proper allocations of responsibility in accordance with skills.
Chapter III - Admissions Procedure and Service.

There is no more important time at which the social worker can offer his services to the patient entering a hospital for the treatment of mental illness than right at the time of the patient's admission. It is then that the social worker can help to ease the fears and anxieties of both the patient and his relatives, which may be more prevalent than at any other period of his illness. So that this service would be available, the Admissions Sections of the Social Service Departments at Essondale were started. First in April 1951, a social worker was designated at the Crease Clinic to handle newly admitted patients and their relatives. In September, of the same year, a worker with similar duties was appointed to the Provincial Mental Hospital. In the latter instance only a part time service was offered as the worker also carried cases in the Continuing Casework Section. By July 1952, a second worker was assigned to this job at the Mental Hospital. He also carried cases in long-term treatment. As the function of this new Section was better understood, by the Hospital personnel, the job of the Admissions worker increased and the need for a full time worker was realized. In September 1952, a social worker was appointed to the Admissions Section at the Mental Hospital on a full time basis.

Similarly, at Crease Clinic, the number of referrals to the Admissions Section had increased. Early in 1953 a second social worker was added to this Section, with a view to in-
creasing to four workers at such time as professional staff became available. Also an Admissions Casework Supervisor was appointed to supervise the caseworkers in the Admissions Sections of both the Clinic and the Hospital.

The present set-up is shown diagrammatically as,

![Diagram](image)

Figure 5 - Admissions sections at the Provincial Mental Hospital and the Crease Clinic.

The Admissions Sections at the Provincial Mental Hospital and the Crease Clinic have three broad functions,

1. A casework service at in-take.
2. A casework service on reception of the patient.
3. A screening service by which patients are selected for continuing social services.

Social Service at Intake.

The services offered by the caseworker at intake consists mainly of interpretation to prospective patients and relatives about the facilities which exist at the Hospital and Clinic.
for the care and treatment of patients; interpreting also to community agencies or individuals inquiring about the treatment and facilities; helping the relative and prospective patient to use other services that exist in the community which might postpone or prevent the admission of the patient. The intake worker may also help the relative and patient himself to understand the facilities of the Hospital or Clinic, and to relieve his anxiety and uncertainty about coming.

Social Service at Reception.

The service of assisting in the reception of the patient into the Hospital or Clinic usually involves outlining the services and facilities to the patient's family, the patient himself, or any interested person who has accompanied him; helping the family with the fears and anxieties that arise when one of its members is about to receive treatment; helping the family to understand this treatment; whenever possible to gather information about the patient, his relationships, experiences, and his illness from either the patient or his relatives; also referring the relative according to the need to the continuing social services, with the idea that through the growth of an understanding, supportive relationship the relative may be helped to understand the patient and to assist in the treatment and rehabilitation.

Screening Service.

At the Mental Hospital and Crease Clinic there are two forms of screening. The first has developed within the Social
Service Departments themselves and involves the social worker making a social diagnosis and ascertaining the ability of the patient and relatives to use the social service available. If the Admissions worker feels that the patient can use further social service contact the case is assigned to a Continuing Service worker, if not the case is closed as far as social service is concerned. The second, which is still in the developmental stage, consists in screening at ward rounds. In the latter case the social worker on Admissions might bring to ward rounds the social diagnosis indicating whether he is of the opinion that social service should be extended or not. This opinion may be changed as each member of the hospital team (doctor, psychologist or nurse) brings what he knows of the patient, the patient's illness or how the patient is responding to treatment. It does happen through the ward rounds that social service may open a case on which they initially did not see where service by the case worker could have been helpful.

In the screening at ward rounds various things are taken into consideration such as types of illness, chronicity and severity, ability of the patient to use social services, resources available for the use of the patient, and whether the patient is going to be short-term and has family resources, for instance, social services would not be extended. Also the non-English speaking patient without relatives, and transients (for example, seamen from other countries who are ordinarily repatriated to their ship) would not be extended services. Previous admissions
of the patient are also considered in the screen to Continuing casework services.

Services to relatives are decided upon and the social diagnosis is made within the Social Service Departments in the Admissions Sections. The service to relatives is considered to be the exclusive responsibility of the social workers and it is their responsibility to decide whether this should be offered.

Although the Admissions Sections in the Hospital and Clinic offer a similar service in intake, reception and screening, there is a difference that should be pointed up. The Crease Clinic is a short-term treatment centre. The maximum period that the patient can remain is four months. Because of this stipulation there is a rapid turn over of patients and the Admissions worker has to be as selective as possible regarding the cases that can use further casework services in the short time available. Also many of the cases have to be referred on to the Continuing Casework Sections before the Admissions worker has seen the relatives or been able to make a full evaluation of the need for social services.

In the Mental Hospital the situation is different. Being a treatment centre where the patient usually remains for a period of several months to years the Admissions worker has more time to contact the relatives, see the patient, and evaluate the situation before referral is made to Continuing Casework Services. This does not mean that the work in this Section is any easier than at the Clinic, but it does mean that screen-
ing to further social services is better and less preliminary material has to be gathered by the worker giving continued services.

**Duties of the Admissions Casework Supervisor.**

Prior to the appointment of a Casework Supervisor for the Admissions Sections, the workers doing the Admissions job were under the supervision of the casework supervisors in the Continuing Casework Sections. Because of the rapid expansion of the work in Admissions the necessity of having a supervisor for this area alone was soon realized by the Provincial Supervisor of Psychiatric Social Work. In January 1953, a Casework Supervisor was appointed for the Admissions Sections in the Hospital and Clinic. Her duties consist of supervision of the casework skills of the caseworkers in the admissions process; responsibility for integrating the teamwork approach within the Hospital and Clinic by interpreting to the medical, nursing, and clerical staff their responsibilities for getting relatives to the Admissions workers so that social services may be initiated as soon as possible after the patient's arrival; responsibility for directing and supervising the Field Service staff of the Social Welfare Branch regarding the admission of patients, and their responsibility to the family at the time of admission; interpreting, to community agencies, the services of the Clinic and the Hospital, also the policy and procedure for admission on behalf of their clients; as well as acting in an interpretive and guidance role to the community agencies. Besides these,
the Casework Supervisor in Admissions has responsibility for the screening of cases into the Continuing Casework Sections. This is facilitated by serving on a screening committee made up of the Provincial Supervisor and the Continuing Caseworker supervisors, and attendance at all ward rounds.

Provincial Mental Hospital.

At the time of the opening of the Admissions Section at the Provincial Mental Hospital the social worker was instructed to assist the duty doctor in any way possible during the actual admissions procedure, and to interview relatives and escorts after the new patient was taken to the ward. He attempted to be present during each admission; and, besides interviewing, he prepared a visiting sheet for the relative or escort, and also completed the "living body receipt" which is a form that has to be completed when a patient is escorted to the Hospital. The committal papers were also reviewed to see if they were in order and if the patient had ever been hospitalized before.

The Admissions worker's function regarding patients who came in by ambulance unaccompanied or whenever escorted only, by police, was primarily clerical although it was sometimes helpful, depending on the patient's condition, to reassure him about his hospitalization and ask about his daily needs.

As the work of the Admissions Section progressed, the clerical functions were taken over by other Hospital personnel and the Admissions worker concentrated on specific casework services in intake and reception, plus screening of cases to Con-
tinuing services. At present the Admissions Section considers its function to be the establishment of a purposeful casework relationship with the patients and their relatives to enable them to accept a long term hospitalization and treatment, and to help them look into the available resources for the rehabilitation of the patient.

The Admissions Section at the Provincial Mental Hospital receives referrals from a variety of sources, 1. The first group, from which the largest number of referrals is received, is the growing number of young patients being treated for mental illness. The majority of these patients arrive from Grease Clinic where the four months hospitalization has proven inadequate. The referrals from this group usually require long-term casework plans with both the patient and his family. When such patients are transferred from Grease Clinic, the Admissions worker discusses the patient with the Clinic's Continuing caseworker, and together they plan the continuation of service to the patient and his family. Often these patients are so disturbed that they are not able to accept casework help on the ward, but the relatives, who have been faced with the problem of committing these patients to the Mental Hospital, need a great deal of help in understanding the hospital's function. Also in these referrals the Admissions worker analyzes the file and prepares a summary, to date, of the work done with the patient. In this way the continuing caseworker at the Mental Hospital has the past work focused for him, and
he is in a better position to continue the work that was started at the Clinic.

2. The second group, from which referrals are accepted, are the older persons who need treatment for mental illness. Included in this group are a number of readmissions where interim information is required. Often these patients have had a remission in their illness for a matter of two or three years, and it is valuable for the doctor and social worker to know what their behaviour was like during this period and also the circumstances that precipitated reoccurrence of their illness.

3. The third group of referrals is through the admission, to the Provincial Mental Hospital, of mentally deficient children, for transfer to Woodlands School. In the past, the policy has been that all children being placed in the Woodlands School had to be admitted to the Mental Hospital and then transferred later. Recently there has been a change in this procedure and now children under six years of age are admitted directly to the School. This has considerably decreased the number of referrals from this source. When children are placed via the Mental Hospital there is usually a brief-service to relatives required at this time. The committal of their child through the Mental Hospital is almost always a most disturbing experience for them, even though valuable help and interpretation has, in many cases, been given to the parents by the workers in the Field Service or other agencies. The Admissions worker helps the parents with their feelings by getting them to discuss their fears about the
committal to the Mental Hospital, and explaining the function and services of the Hospital to them. In some instances the worker has given longer service to parents who have been unable to face committing their child for transfer to the School. Such would be the case when the parents have been seen by the social worker from the Woodlands School Social Service Department, and have accepted the plan for placement of their child in Woodlands School but are unable to accept the committal through the Provincial Mental Hospital.

4. A small group of referrals is received through the doctor in charge of the Alcoholic Clinic at the Hospital. A social history may be required to assist in the assessment of the patient's suitability for participation in group psychotherapy, and a few of these referrals have been transferred to the Continuing Casework Section for casework services to the patient's family. A few referrals are also received from patients committed by Order-in-Council whose families often need very extensive casework support. Order-in-Council patients are prisoners from Oakalla jail or the B.C. Penitentiary who are committed by the Courts for mental examination and treatment.

5. Some referrals come directly from the doctors during the admission of the patient, but these are very infrequent because the Admissions worker gives coverage at the time of the patient's reception.

6. Another group of referrals is made through the doctors at the West Lawn building. (The patients at the Provincial Mental
Hospital are housed in three different buildings, namely "West Lawn" for men patients who are considered chronically ill; "East Lawn" for women patients who are considered chronically ill; and "Centre Lawn" where both men and women patients are admitted and receive treatment until such time as they are discharged or transferred to one of the first two mentioned buildings.) At present, due to staff shortages, there are no social workers assigned to the wards on the West Lawn Buildings, consequently the Admissions Section handles all referrals from this building. In the East Lawn building, regular weekly ward rounds are held and referrals for social services are numerous.  

7. Remaining referrals. The Admissions Section relies a great deal on co-operation of other members of the hospital staff. The Psychiatric Nurses at the Centre Lawn building admitting desk are constantly on the look-out to channel relatives and interested friends to the social worker. The Admissions worker also attempts to make regular visits to the wards. These visits help to develop good inter-departmental relations. Each week the worker tries to interview patients in the Occupational Therapy department as well as on the wards. Some referrals are opened from this source, because patients during the socialization period in Occupational Therapy are often more able to discuss their anxiety about families, their illness, and the future and what it holds for them.

Regularly each week, ward rounds are held on the mens and womens wards in the Centre Lawn building, where the Admiss-
ions worker is stationed. Referrals were commonly made from these ward rounds at one time, but there has been a sharp de-
crease due to the screening of all patients upon Admission, and social service studies have usually been started on selected cases before ward rounds are held.

Disposition of Referrals.

When a relative accompanies a patient to the Hospital, the Admissions worker endeavours to see him at the time of the patient's arrival, but it may happen that further appointments have to be made before all necessary information has been ob-
tained. This may include one or two interviews according to the needs of the case. Cases are therefore held over at the Admis-
sions Section until all the information that is required has been obtained, and from this information the case is then focused for continuing services.

As the social workers at the Mental Hospital are res-
ponsible for all services to patients within the City of Van-
couver and the Greater Vancouver area, the Admissions worker must screen all files and make appointments for interviews ac-
cordingly. This is a routine task which necessitates a summary of the committal papers, and of the information on the file. Ideally the Admissions worker aims to see the files within two or three days following the patient's admission, so that inter-
views with the relatives can be arranged if they are within the stated area, but this is becoming more difficult due to the increasing number of admissions and also the increase in referrals.
When patients are admitted from other areas of British Columbia all first letters to the Field Service are written by the Admissions worker. This also involves a careful summary of all the information on the file so that the Field Service has every assistance in the task of obtaining a social history or other information desired. These cases then remain in the Admissions Section until the Field Service worker replies to the request. When information is received from the Field Service the Admissions worker evaluates the total patient and family situation, and where required initiates casework services through a further letter to the Field Service.

Field Service is often required to give interpretation of mental illness to the patient's family as few relatives accept it without considerable difficulty. If a patient is to return to his home environment casework interviews with the relatives will help to focus rehabilitation plans for the patient. In the area of help to relatives the Field worker is able to give interpretation and support around the anxiety, uncertainty, and guilt feelings that often arise from committing a person to the Hospital, and this is instrumental in helping them to make visits to see the patient later on.

Following the sending of the second letter to the Field Service, these cases are then transferred to the Continuing Casework Section where extended contact with the patient, relatives or the Field may be maintained.

Since the present Admissions Section was organized (September 1952) a monthly average of 115 patients have been ad-
mitted to the Mental Hospital. During the first three months of 1953, referrals to the Admissions worker have been made in thirty-one per cent of newly admitted patients. Of these referrals, thirty per cent have been transferred out to Continuing Services, forty per cent were carried over in the Admissions Section until all information had been collated, and thirty-per cent were closed.

Crease Clinic of Psychological Medicine.

The Admissions Section at Crease Clinic began as a separate entity during April 1951, and because it was a new development there was no attempt to define a rigid policy or procedure. Since that time, it has remained, purposely, as flexible as possible in order that the department can feel its way and develop to meet the needs of the short-term stay that is characteristic of Crease Clinic.

Routine referrals are received in the Admissions Section from the following sources,

1. The admitting desk.
2. The reception desk. (Switchboard.)
3. The medical staff. Both from the admitting desk and from private referral.
4. Upon requests from relatives.
5. From outside agencies and interested parties.

The Admissions worker attempts to give service immediately on request because it is recognized that the needs of the patient and his relatives at the time of admission are usually
The first two sources of referral have operated most efficiently, so that most parties who are admitted during office hours, and accompanied by relatives, are seen immediately by the Admissions worker. Similarly, relatives visiting during the initial period of the patient's stay in the Clinic are carefully screened by the reception desk and referred to the Admissions worker on the occasion of their first visit to the Clinic. By interviewing relatives at the time of the patient's admission into the Clinic the worker is able to obtain social history information, and to help with any feelings of fear or anxiety that arise. On all occasions the Admissions worker informs the relatives that, if further social services are required, another social worker in the Continuing Casework Section will be carrying the patient while he is receiving treatment at the Clinic. This helps the relatives to accept the next worker and speeds the casework process, which is an important factor in short-term treatment.

As a rule the Admissions worker attempts to dictate any information, that he has obtained, within a day or two. In this way the information is available for the doctor, as well as the Continuing Service worker within a few days of the patient's arrival at the Clinic.

Along with the casework services that are offered in intake and reception, the Admissions workers are responsible for directing and supervising Field Services in the procedure for
the admission of patients; also for interpreting, to community agencies, the services of the Clinic and the policies in admissions. Workers in the Admissions Section must also, along with the Admissions Casework Supervisor, attend ward rounds every Monday and Wednesday. The purpose of these rounds is to present the information that has been gathered, by each member of the treatment team, on selected patients. Treatment plans are formulated at this time. If a patient is discussed and the social worker who has been working on the case is visiting in the district, and therefore not available, the Admissions worker must present the information for him, and also channel any communications regarding the patient back to the worker concerned.

It is at these ward rounds that the Admissions Casework Supervisor and the Admissions workers are able to screen further the cases already in Social Service, as well as screening those cases that are referred by the medical staff at the ward rounds. This screening is a very important function because of the severe shortages in staff which means that the social workers cannot be engaged in any area in which there is likely to be little ability on the part of the patients and relatives to use social services. The screening out of the aforementioned depends, of course, upon the fact that the patient has resources in family and friends which are available to him at the point of discharge from the Clinic. If not, services would be extended to him in the best possible way.

At present the Admissions Section at Crease Clinic is
still in a state of evolution. Although the staff has increased there is still not the full coverage of referrals that was hoped for, and some patients have to be referred on the continuing caseworkers before preliminary evaluative material can be gathered. The main reason for this lack is that the two workers now responsible for admissions are on alternate shifts, and thus two workers are never on duty at the same time except on Wednesdays. This will be partly overcome when these workers are relieved of the responsibility of carrying a few of the cases that should be referred to the Continuing Casework Section, and can devote full time to Admissions services. A further complication is seen in the lack of office accommodation. There is still only one Admissions office. Obviously, two interviews cannot be conducted at the same time, and therefore before the hoped-for maximum service can be given there is need for more office space.

Though the work of the Admissions Section, for the above reasons, has been limited it has proved very valuable to the workers in the Continuing Casework Section. Although the evaluation of the social situation by the admissions worker is made hurriedly, it has been found to be most accurate in later work. Early evaluation of the strengths within the patient and his family by the Admissions study allows the continuing caseworker to discuss the case with the doctor and the Casework Supervisor, thus the continuing caseworker begins to work simultaneously with the other members of the team and a time lap-
se is prevented. The patient’s relatives have been found to be more accepting of social services when the Admissions worker has prepared them for Continuing Casework services. Also during the continuing caseworker's day in the district, the relatives who arrive at the Clinic unexpectedly can be seen by the Admissions worker; and the development of the Admissions Section has relieved the continuing caseworker from answering diverse inquiries previously relayed by the switchboard.

The Admissions Section is still a flexible structure, with no attempt to make it static, in the hope that it will gradually evolve towards higher standards of service. It is growing slowly as circumstances in the Clinic setting permit, in the meantime adjusting to other members of the treatment team, and trying to interpret to them the rightful and profitable use of social service in terms of services to patients in the worker's own area of competence.
Chapter IV - Continuing Casework.

After careful screening by the Admissions workers at the Provincial Mental Hospital or the Crease Clinic of Psychological Medicine, patients, who are likely to benefit from a longer period of casework services are referred to the social workers in the Continuing Casework Sections.

The Continuing Casework Section at the Mental Hospital is the hub of the initial social service department that was set up at Essondale. At present there are seven caseworkers and one Casework Supervisor in this section. Of these, the Casework Supervisor and three of the workers have their Master of Social Work training, three have Bachelor of Social Work training, and one is an In-Service trained person who does a differentiated job with patients receiving Old Age Assistance and gives consultation to the clerk working with patients receiving Old Age Security. The Continuing Casework Section at Crease Clinic, as stated previously, was separated from the Continuing Casework Section of the Mental Hospital in May 1952. At present, there are five caseworkers and one Casework Supervisor covering the work in this Section. The Casework Supervisor and one caseworker have their Master of Social Work degree, the remaining four have Bachelor of Social Work training.

A chart of the organization of the Continuing Casework Sections would be seen as,
Provincial Supervisor of Psychiatric Social Work

Continuing Casework Supervisor at Mental Hospital

Continuing Casework Supervisor at Crease Clinic

Continuing Casework Supervisors.

When patients and their families are referred to the Continuing Casework Sections, the Continuing Casework Supervisors take over the responsibility for supervision of the work that is done by the social workers. The duties of these people are extensions of the work that is started by the Admissions Casework Supervisor, and consists in participation in supervision of casework services, interpretation and teamwork. There is a slight difference in their work due to the difference in function between the Clinic, a short-term treatment centre, and the Mental Hospital, where long-term treatment is undertaken.

First in the area of services to casework staff, the Supervisors have responsibility for the supervision of the caseworkers in the Continuing Casework Sections. This involves helping the caseworkers with plans for treatment of the patient while he is on the ward, when rehabilitation is being consider-
ed, and through and following the period of discharge. The discharge planning involves future direct work with the patient or referral to another agency. If the patient is to be referred to another agency in the Vancouver area, the Supervisor is expected to attend such conferences as may be indicated for thorough discharge planning. Should the patient be leaving the Vancouver area, the Field Service of the Social Welfare Branch might be brought into the picture. For example, in the case of a patient leaving the Provincial Mental Hospital, and going to another part of the province, the Field Service would be responsible for his care during the normal six months probationary period. For a patient leaving Crease Clinic, where there is no such probation period, there would be careful screening by the Casework Supervisor so that already excessive case loads of the Field Service are not unnecessarily overburdened with cases from the Psychiatric Services.

The Casework Supervisors also act as liaisons between the Continuing Caseworkers and the Provincial Supervisor, helping to clarify problems in the area of administration, revision of policy, and the extension of services.

Secondly, the Casework Supervisors in the Continuing Sections have duties in relation to the Social Welfare Branch. This may be interpretation, when necessary, of the casework services that are offered in both the Hospital and Clinic; giving information about the admitting of patients, and explaining the discharge services that are offered. The Continuing Case-
work Supervisors must also attend the twice yearly meeting of the Field Consultants of the Social Welfare Branch, for the purpose of discussing policy and co-operation between the Field Services and the Social Service Departments at the Mental Hospital and Crease Clinic. These meetings are held at Essondale.

Within the area of teamwork with other professional disciplines, the Continuing Casework Supervisors have responsibility to initiate inter-agency conferences regarding treatment and services to patients in the Hospital and Clinic, and also between other disciplines (doctors, nurses, psychologists, occupational therapists) within the Hospital and Clinic setting. They also attend ward rounds and present social work thinking in any cases that are discussed. This latter area is primarily the concern of the Continuing Casework Supervisor at the Crease Clinic. Ward rounds at the Mental Hospital are attended, in the majority of cases, by the Admissions Caseworker who does the screening of patients before referral to the Continuing Casework Supervisor. The Continuing Casework Supervisor does attend ward rounds on two specific wards in the women's building, (East Lawn) but in these instances she accompanies the specific worker who is appointed to the ward.

The Continuing Casework Supervisor must also advise the continuing caseworkers of any information that was presented on their specific patients at ward rounds. Once again this is related primarily to Crease Clinic where the worker does not attend ward rounds if it is his day in the district. In such
instances information on patients is given by the Casework Supervisor, and any decisions are relayed back to the caseworker by her. Also the Continuing Casework Supervisor must accompany the caseworker to the Medical Clinic on Thursday morning when patients are presented and their treatment discussed. This Clinic is attended by doctors, psychologists and social workers. If the continuing caseworker, whose patient is being presented, is not able to attend, any information from the social work area is presented by his Casework Supervisor.

The Continuing Casework Supervisors have considerable responsibility in the educational area, and they are assisted in this by the Provincial Supervisor of Psychiatric Social Work, and the Admissions Casework Supervisor. First in Nursing education,¹ they give orientation to all parts of the Social Service Departments and explain the social worker's participation in treatment. Secondly, they are active in the orientation program for the In-Service workers.² Next with regards to Social Work students from the University of British Columbia, they attend and possibly participate in the teaching clinics; and with respect to social workers joining the Hospital or Clinic staff,³ the Continuing Casework Supervisors are responsible for outlining the areas of responsibility of the new workers, and arranging schedules so that the workers can attend ward rounds and

¹. Appendix C, op. cit. p. 29.
². Appendix D, op. cit. p. 29
³. Appendix E, op. cit. p. 30
teaching clinics.

The Continuing Casework Supervisors also act in an advisory capacity at the meetings of the planning committee for the weekly staff meetings; and during Mental Health Week, the Continuing Casework Supervisors, in co-operation with other staff members, are responsible for the planning of Open House at Crease Clinic. The social worker's part in Open House is to interpret, to the public, the function of the Social Service Departments in the treatment of the mentally ill at Essondale.

The Continuing Casework Supervisors also act with the Provincial Supervisor in the formulation of policies.

Continuing Casework Services.

Social workers in the Continuing Casework Sections engage in casework services which can be related to three aspects of the patient's illness. First there are the services offered with regards to the total treatment plan for the patient; secondly the services geared to the pre-convalescent period; thirdly, services given during the convalescent or probationary period after the patient has left the Hospital or Clinic.

Social work contact with the patient on the ward is directed towards building a supportive, understanding relationship, through which the patient is helped to hold onto whatever reality functioning that he may possess. Interest in his wife, children, or parents is kept alive; also the patient is helped to do something about those problems of which he is most aware and concerned. To take a simple example, the social worker often
has patients who are extremely upset about their hospitalization, and convulsive treatment. He helps them to talk about their fears in this area, explains the function of the hospital, and encourages them to discuss their fear of the treatment with their doctor and nurses. By getting the patient to discuss his feelings about the treatment with the medical staff, he usually is more relaxed and does not feel he is being ignored during the actual mechanical treatment period.

Interviews are also directed towards keeping up the family's interest in the patient by allaying the often intense fear of the patient that grew previous to the period of hospitalization. This is done by familiarizing the relatives with the nature of the illness, the treatment, and the Hospital and Clinic routines; by helping relatives with their own feelings concerning mental illness, and by helping them to express the feelings of guilt that they often have concerning their contribution to the patient's illness. Finally through support and clarification the relative is helped to see what he can do towards treatment and the rehabilitation of the patient.

The social worker has an important job during the hospitalization in conferences with the doctors regarding formulation and re-formulation of treatment plans; and also interviews with the psychologists, nursing staff, and occupational therapists in the interests of the patient and his ability to use hospital treatment to the greatest advantage.

Prior to the termination of the treatment the social
worker starts to prepare the patient for leaving the Hospital or Clinic. There is much discussion with the patient on how he feels about leaving the hospital, and returning to his family and former employment. Also the patient is encouraged to make week-end visits to his home so that the break from hospitalization will be gradual, and problems that arise on these visits can be ironed out before final discharge. The pre-convalescent treatment is focused on helping the patient to look forward to his return to community living.

The final period of the treatment where services are offered is during the convalescent or probationary period. Patients are referred for social work help at the time of convalescence more than any other. During this period the social workers help is focused on the re-establishment of the patient in the community; helping the patient to hold onto his treatment gains; helping the patient to become self-supporting through assistance in locating work and accommodation; supporting family, relatives, and friends in understanding the patient and those changes which the illness may have brought about; whenever possible, to help the patient himself to live comfortably with, and settle for, those changes in his ability to plan, of which the illness may have been the cause.

Many of the patients carry with them a varying residual of their illness which necessitates protective family living and work placement, as well as financial help for maintenance. The social worker has an important role in interpreting these
needs of the patient to the community, so that more resources will be opened up to meet these needs.

During the past fiscal year, (1952-53) 675 patients were referred to the Social Service Departments at Essondale for help with problems around discharge. Of this number 297 were from the Provincial Mental Hospital, and the remaining 378 from Crease Clinic. As a rule rehabilitation is not a service that is extended at the Clinic, but because of lack of community resources the Social Service Department has had to extend itself into a necessarily out-patient department.

The continuing caseworker, from the time the patient is referred until his final discharge or closing of social work treatment, is concerned with all aspects of the patient's relationships with medical and nursing staff, with other patients, and with family, friends and the community. The latter three areas are very important today for the period of hospitalization tends to be shorter, more intensive, and given over to specialized and specific treatment methods. Family and community must assume increasing responsibility for the social treatment of the patient following discharge.

Additional Services.

Besides the aforementioned casework functions the social workers, in both the Continuing and Admissions Sections, have definite responsibilities in the areas of education, research, and community interpretation.

In the education and training program within the Hos-
pital it is the specific responsibility of the social worker to interpret the content of his own professional activities. For the past three fiscal years, under Federal Mental Health Grants, twenty-eight social work students have had their field placement in the Provincial Mental Hospital and Crease Clinic. Although direct responsibility for supervision of these students is with the School of Social Work, training Supervisor, plans for the general introduction and orientation to the Social Service Departments, Hospital, Clinic and community agencies were evolved with the participation of the Social Service Departments. Introduction of students to inter-departmental co-operation between Social Service and other departments of the Hospital and Clinic, and the policies relating to this is the responsibility of the Social Service Departments. The Departments attempt to help the students feel at home in the setting by working closely with them, sharing in staff meetings and in special studies.

The Social Service Departments' contribution to the education of non-social work staff, such as nursing has been geared to lecture periods and orientation. The content, of which, has been aimed at the professional activities of the social worker, as well as sharing the knowledge of the Social Work profession in the areas of inter-familial, inter-cultural relationships, present day stresses on family life, and the resources

\footnote{1. Appendix C, op. cit. p. 29.}
within the Social Service field.

Another responsibility of the Social Service Departments in education and training is in the professional development of the Social Service staff. To this end there are regular weekly staff meetings, regular supervision of casework, and access to the important periodicals of the day. The specific content of the educational and training program is determined by the Social Service Departments in conformity with administrative policy.

Research is an important part of the work in the Social Service Departments, although it has been somewhat limited due to shortages of staff and the rapid expansion of the social work program into the treatment planning area. Nevertheless there have been some important studies undertaken. Recently a survey was made by the social workers of their own participation in initiating conferences between psychology and social work in the area of planning for treatment of patients. The conclusions reached were interesting and informative. It was found that the Psychology Department were very willing to co-operate, and that conferences to date had been very meaningful to both members of the team. Also, that in any conference held with a medical doctor present he tended to dominate and sway the treatment plan. Lastly, that as a whole the Psychology department had been used very little in an integrative way, but a beginning had been made in initiating such team conferences. This was encouraging as the team approach to psychiatric treatment is essential.
A study was also made by the social workers, of the rehabilitation process.¹ The method of case analysis was used. The study consisted of surveying the present situation regarding rehabilitation, the difficulties encountered in time consumed, the element of emergency, duplication of ground covered, resources available and their use, resources lacking, the frustrations and failures that were met, and the reasons for the latter. The aim was to point out present and future needs, the needs for evaluation and selection on the part of the medical and social service staffs, and if possible to evaluate the legitimacy of a request for a special person on the staff to deal with rehabilitation. This study was successfully completed and the appointment of a person for rehabilitation shown to be most necessary. It is hoped that more such studies will be undertaken as the work of the Departments increase, as they might be very valuable in pointing up duplication of services as were found in the rehabilitation process.

The social worker has an important contribution to make in community interpretation. He is the main liaison between the hospital and the community. As he goes about his work learning the functions and services of local agencies, securing information from different sources, and enlisting the help and interest of various people, he has an opportunity to work towards

¹ British Columbia, Annual Report of the Mental Health Services, Queens Printers, Victoria, 1952, p. 51
a better understanding of the general program of the mental hospital or clinic, and towards better working relationships. Often in carrying out social plans, the social worker finds limitations in community resources. Aiding in the development of these resources is a responsibility of the social worker. He can do this by participating in the activities of the community and helping to point out needs and how they can be met.

Much of the social worker's participation in interpretation is through work with Councils of Social Agencies, Community Chests, and other civic or professional organizations involved in community planning. In such groups he helps to coordinate the hospital services with other community resources, points up the need for new hospital and related services, and helps in developing them as community requirements are understood. The social worker also contributes in interpretation through relations with individuals, representation on committees, and in public speeches and appearances. The skill of the social worker in dealing with families and other individuals, who influence the patient, is especially adaptable to interpreting, to the community, the needs of the mentally ill.

Continuing Casework Section at the Mental Hospital.

Patients entering the Mental Hospital, who are transferred from the Admissions to the Continuing Casework Section, are always the ones who are expected to benefit from long term treatment. The primary responsibility of this Section lies in bringing services to the patients while in hospital with prob-
ation services as the final goal.

Though the usual plan in Continuing Casework Services at the Mental Hospital has been for the worker to carry approximately forty patients, with these patients being on a variety of wards, there have been very significant developments in two special instances, which were new to the Continuing Casework Section. This was the appointment of two social workers to work specifically on two special wards. It might be pointed out here that this was an important development as the appointment of social workers to specific wards is a goal that has been set for the future developmental program of social work at Essondale, and these two instances were the first attempts at establishing such a program. A social worker operating at this level works closely with the charge nurse, psychiatrist, psychologist and occupational therapist, and this can be considered the ultimate in present teamwork in mental hospitals.

The following two reports of social workers on specific wards illustrates its value to the patient, and the movement to integration which was possible in some patients because of the nearness to them of this service.

**Continuing Services on H-5. (A Continued Treatment Ward)**

In November 1952, at the request of the psychiatrist in charge of the ward, a social worker was assigned to work with the patients on H-5. This ward is classed as a long-term, or continued treatment ward, and is in the Women's building. (East Lawn) Much of the treatment program is directed towards
helping the patient to assume work responsibility within the Hospital, such as in the Nurses' homes, in the kitchen, on the wards, and in Industrial Therapy. The 175 patients on the ward consist of "burnt-out" schizophrenics, extremely deteriorated schizophrenics, mental defectives, epileptics, and lobotomy patients who have shown no improvement since being operated on some time ago. Of these 175 patients only 12 receive active treatment, and this is electro-convulsive therapy when needed.

Cases are opened by the social worker in several ways. A patient may ask to see the worker. Usually the request is either to leave the Hospital or to help her obtain outside employment. In many cases the patient is not well enough for discharge and in such instances the worker attempts to bring services to the patient in other areas, as services around money, clothes, or visits to relatives. In order to bring these services, the worker must interpret to the patient the nature of social services, and then an attempt is made to encourage the patient to use them.

Cases are opened also by referral from the ward psychiatrist at ward rounds. These rounds are attended by the Clinical Director, ward psychiatrist, nursing supervisor of the building, charge nurse on H-5, the occupational therapist, the Continuing Casework supervisor and the social worker. These ward rounds are an important example of teamwork in treatment planning.

The charge nurse on H-5 may make the referral. This
is done when a patient has asked her to get in touch with the worker, or requests some special service within the responsibility of Social Service.

All 175 cases have not been opened on H-5, but because of the way in which referrals come, often by the patient herself, all 175 are potentially active cases. At present forty cases have been opened, thirty of which are being given an active treatment service.

Although there are extremely deteriorated schizophrenics and old lobotomy patients who do not move from the ward, there is a fairly good discharge rate. Over December, January and February about one patient was discharged every ten days, and in these cases the worker gives a rehabilitative service. Some of those to whom the worker is now trying to bring a rehabilitative service are perhaps best described as "dispossessed". This is something that can easily happen to people who have been in the Hospital for a long time, and where relatives and friends are no longer interested. Sometimes what would seem to be lack of interest is perhaps more correctly seen as an attitude of hopelessness in which the relatives feel there is nothing that they can do for the patient. To awaken the family's interest in helping the patient has been part of the social worker's responsibility. If relatives are not available such places as selected foster or boarding homes would be most beneficial, especially to patients who may continue to have a residual of their illness but could still function fairly well outside.
One of the main points that has come up in this ward worker experiment has been the need for selected homes for rehabilitation purposes.

Treatment services brought to ward H-5 by the social worker can best be illustrated by actual case presentations,

Miss L. is a 22 year old girl whose diagnosis was given as schizophrenia with suicide and escape tendencies. Because of the latter she could not be given parole privileges. She was referred to the social worker at ward rounds. It was hoped by the Hospital team that some day she would be able to have more freedom, possibly parole; as a beginning of this, the social worker was asked to encourage the patient to attend Occupational Therapy classes. The social worker made regular visits to the patient, was successful in getting her to attend these classes, and she is beginning to show more interest in her surroundings than previously.

Mrs. W. is a 35 year old woman whose diagnosis was given as simple schizophrenia. This patient was well enough to work in the Nurses' homes, but was not well enough to be discharged. She had a sister living in the city and was anxious to have her visit the Hospital. The social worker visited the sister at her home and found her quite discouraged and unhappy about the patient's condition. It was necessary for the social worker to see the sister several times and give her considerable support, and interpretation. The woman was finally able to come to the Hospital to visit the patient. The result has been a
much happier relationship between the patient and her sister, and also improvement in the patient's attitude towards her hospitalization.

Miss B. is an epileptic, fifty years of age. She was also diagnosed as paranoidal schizophrenic. This patient was extremely apathetic and hostile, and she refused to take part in Occupational Therapy, or in any of the ward activities. She was referred to the social worker at ward rounds, and it was hoped that the worker might help to draw her out of her hostile apathy. The worker visited her regularly and was able to establish a good casework relationship. Through this relationship and the specific service of answering a letter for the patient, she was finally able to attend Occupational Therapy classes, and her hostile attitude is slowly diminishing.

The teamwork on H-5 is very important in planning for the patients. A review of the patient's progress is made at ward rounds in which the worker, along with other members of the Hospital team, presents information and contributes ideas which will increase the knowledge that each member has of the patient and help them in treatment plans. The social worker's primary responsibility has been four fold: (a) to establish a casework relationship so that the patient can move in a meaningful way to activities (such as Occupational Therapy); (b) to act as a liaison between the Hospital and the patient's relatives; (c) to bring to the psychiatrist pertinent information regarding family relationships; (d) to secure and bring into play rehab-
ilitative sources for the patient.

Continuing Services on E-5. (A rehabilitation ward.)

In September 1952, the Provincial Supervisor of Psychiatric Social Work and the Continuing Casework Supervisor at the Provincial Mental Hospital in co-operation with the ward psychiatrist decided to appoint a social worker to concentrate specifically on ward E-5. This ward is primarily for female patients who are being prepared for entrance back into the community. There are usually 25 to 30 patients on the ward, and they are sent here from all parts of the Hospital. The women all have certain privileges, such as being able to walk outside during the day, and there are various activities on the ward itself. For this reason some of the patients who have been in the Hospital for a number of years find it very difficult to leave since, in their view, they have all the comforts that the outside world can provide with none of the stresses.

The organization of the social service participation began with a meeting of nursing, psychiatry, and the social worker. The function of the Social Service Department was interpreted to the other disciplines at this time with emphasis on the rehabilitation aspect. Following this the social worker was introduced to all the patients on the ward, and the psychiatrist explained the role that the social worker would be playing in their future plans.

It was arranged with the Charge-nurse on E-5 that the social worker receive a list of the patients on the ward each
time it was made up. This allows her to read the files of any new patients before seeing them, and also to discuss, with her Supervisor, the role that she will be playing in each patient's treatment. The psychiatrist is also consulted on the patient's readiness for rehabilitation services, and together the psychiatrist and social worker discuss the occupation that will best fill the patient's needs. The worker then makes arrangements for regular weekly visits to the patient, and concentrates on helping the patient with her feelings concerning discharge from the Hospital, the work she would like to undertake, and also with any other problems that arise in the social worker's area of treatment.

The rate of planning is at all times discussed with the psychiatrist and the nursing staff. It is these regular meetings with the members of the treatment team that makes it possible to determine exactly when the move from the Hospital can be made. Any decisions are given to the Clinical Director who sets the date for the patient's move to "Vista".1 (The Vista Rehabilitation Home is located in Vancouver, and is operated under the Provincial Mental Health Services. It is used as the first step in giving selected female patients an opportunity to adjust away from the Hospital or Clinic, preparatory to a more permanent plan being made for them.) It is important that the social worker be notified of the specific date that

the patient is leaving for the Vista Home, as a summary of the patient's history has to be forwarded, and also the worker has to explain the function of the Vista to the patient. Once the patient has been moved she is not visited by the social worker for a couple of days; this allows her some time to become adjusted before further steps for rehabilitation are taken.

With regards to the patient's employment, it is fully explained to her that the social worker will be contacting the Special Placement Division of the National Employment Service, and that necessary information will be given to the special placement officer there. In this way, the patient is helped to feel that she will be meeting someone at the Employment Service who understands her situation. The move from the Hospital is a big step for most of the patients; although they may have accepted the proposed appointment to the National Employment Service while in the hospital, doubts often arise when they finally move to Vista. Because of these feelings, the social worker usually accompanies the patient on the initial visit; then if the patient does not appear too upset, further visits can be made alone. Visits to Vista are usually made weekly while the patient is there, but following the acceptance of a job the worker carries out the usual probationary visits once a month for six months, unless otherwise specified.

Services that are brought to the patient on E-5 can be seen in the following illustrations:

Mrs. T. was a forty year old woman with four children,
ages ranging from ten to eighteen years. She was diagnosed as a paranoidal schizophrenic and had been in the Hospital for two years at the time of her referral to the social worker. Her husband and children lived in the interior of the province, but refused to help with the patient's treatment in any way, and did not want her to return home. Mrs. T. had become very dependent on the Hospital and refused to participate in any plans for discharge. The social worker visited her once or twice weekly for a period of three months; there was a distinct change in the patient's attitude to leaving the Hospital, and finally she moved to Vista. She was visited regularly by the social worker, and with the help of the National Employment Service, found a job as a housekeeper. She did well at this job and remained at it until she became adjusted to living outside of the Hospital; then she found a job in a laundry, without the help of the social worker or the Employment Service. On the last probationary visit that the worker made, the patient was happy in her new work, and was looking for larger living quarters as her oldest daughter was planning on moving into the city to live with her.

Mrs. F. was a sixty-two year old woman, whose diagnosis had also been given as paranoidal schizophrenic. At the time of her referral to the social worker, she had been in the Hospital for three years. As this was the third committal in twenty years, her husband and five children were no longer interested in her, and would not accept any responsibility for her
care. The patient was aware of her family's feeling and did not want to see them, so plans were made for helping her to be rehabilitated without their help. The social worker visited her on the ward for several weeks, and concentrated on helping her to overcome her fears of leaving the Hospital, and building up her interest in the outside world. Finally the patient was able to move to Vista. She remained there for six weeks, and then moved to a home where she was to work as a housekeeper. This job she found with the help of the National Employment Service, but after two months she found a job as a helper in a boarding house on her own. The patient had formerly had a boarding house and was very happy in this type of work. Regular visits are still being made by the social worker and it appears that the patient will soon be able to be given her full discharge, as she has made a very good adjustment for a person of her age.

Mrs. L. was a forty-four year old woman with a diagnosis of manic-depressive psychosis. She had been in the Hospital for two years when she was placed on E-5 and referred to the social worker for help with rehabilitation. Her husband had died two years previous to her hospitalization, and her son had been looked after by her sister since that time. During her period in the Hospital, the patient had become extremely dependent and was afraid to leave. The social worker visited her once a week for a period of four months, helping her to overcome her fear of leaving the Hospital and building up her confidence. At the
end of this time the patient was able to move to Vista. As she had taken a typing course during her hospital period, she was able to obtain a job as a shipping clerk through the National Employment Service. She also found a room for herself, and completely painted it before moving in. After being on her job for less than a month she has received a promotion, is attending Business school two nights weekly, and making a most satisfactory adjustment. The social worker is, at present, making probation visits, and in each contact the patient has remained cheerful in her outlook, and shows no signs of regression.

The experiment, at the Hospital, in assigning social workers to special wards has shown the importance of having the social worker in close contact with both his patients and the actual members of the hospital team. Being able to work primarily with one doctor dispenses with the ever present problem of social workers and doctors trying to arrange consultation time. If a social worker carries patients on many wards he has to contact the psychiatrist under whom each patient is receiving treatment. The result is much delay in starting social services, and the cutting down of the time that could be given to the patient himself. A specific worker to each ward is a big step towards the "teamwork approach" which is so important in the total push relationship that is necessary in the treatment of mental illness.

**Continuing Casework Section at Crease Clinic.**

When the Social Service Department at Crease Clinic
was separated from that of the Provincial Mental Hospital it was expected, in relation to the average admissions, that during the ensuing fiscal year about 1200 patients would be admitted to the Clinic. Therefore, it was figured that the seven social workers and the Casework Supervisor on the staff could take responsibility for one hundred percent coverage of all patients' needs in the social service while on the wards, and as sixty-five percent (780) of these would be admitted from the Greater Vancouver area the staff of seven would have full responsibility for casework services to both patients and relatives coming from this area.

The remaining thirty-five percent (420) of the patients would come from outside of the Greater Vancouver area, and for this group the staff of seven would undertake casework services to patients on the ward, as well as serving in an informative, supervisory or consultative capacity to the Field Service which would be giving a family service to the relatives of this group.

In December 1952, it was ascertained that since the setting up of the department at Crease Clinic, there had been an average of 101 patients admitted per month, with their treatment periods ranging from six weeks to four months. One of the seven workers had been dealing strictly with admissions, and a second worker was appointed to this section also. The remaining five caseworkers in the Section were to cover all the continuing casework.

In an analysis covering the last three months period
(January - March, 1953) the social workers in the Continuing Casework Section at Crease Clinic have been assigned fifty-one new cases each, almost one new case per working day. As the average length of stay per patient is two months, the demands in skill can be seen when it is realized that during this short time the worker is responsible for casework with the patient on the ward; casework with families; responsibility for the formulation of a convalescent (rehabilitation) plan; liaison with the Field Service in a number of cases; and following the patient's discharge the Continuing Service worker is active with a large number of former patients giving follow-up family and psychiatric social services.

It has been interesting to note that about half of the patients admitted from the Greater Vancouver area are in need of family services from six to eighteen months following their discharge from Crease Clinic. Therefore, the Continuing caseworkers have had to extend their services into an unofficial out-patient department as there are no agencies in the Vancouver area that can meet the needs of such a large group, though some, such as the Family Welfare Bureau of Greater Vancouver, and the Vancouver City Social Service Department have been very helpful when possible.

In the light of the extensive job that the social worker is carrying out in the short-term treatment at the Crease Clinic it can be seen what an important member he is of the treatment team. The other members are concerned with the pat-
ient during his actual period on the ward, but it is the social worker who will be in contact with him from the time of his admission until long after his discharge. With a gradual increase in admissions seen, as the Clinic becomes better known, the social worker's participation will increase accordingly, and though the social worker on Admissions is doing a very important job, it is the Continuing caseworker whose area is being extended from the ward to the community. This means that his time is divided between treatment on the ward and in rehabilitation planning.

It is apparent that some solution will be needed to remedy this situation in the near future, and possibly one of the best ways to do so would be further division of the present Continuing Caseworker Section into two parts, one consisting of ward workers, and the other of rehabilitation workers. This would mean that the Social Service Department at the Clinic would be in three parts,

1. Admissions Section. (Intake and Reception)
2. Continuing Casework Section. (Treatment and Pre-Convalescent)
3. Rehabilitation Section. (Convalescent)

Through this division, the ward worker would become part of ward life the same as doctors, nurses and occupational therapists. Relatives could be seen during their visits to the patient, and both relatives and patient could be helped to feel that the final transfer to the rehabilitation worker would mean that the patient was vastly improved and ready to resume life in the
community. The feeling that transfer to the rehabilitation worker showed improvement in condition would help to make this sort of a goal for the patient and do much towards the building of an early relationship between patient and worker.

The job of the rehabilitation worker would be to help the patient become re-established in the community, carry out any follow-up plans and offer family services if necessary. The division of the Continuing Casework Section in this way would also mean the appointment of a competent fully qualified supervisor to co-ordinate the work of the rehabilitation staff. This person would also play an important part in community education and the bringing together of all possible resources in the community for the use of discharged patients.

The above mentioned plan could also be considered for the Continuing Casework Section at the Provincial Mental Hospital, at such time as fully trained staff is available. The stress should be put on fully trained staff - preferably the Master of Social Work - as in this way the social worker is as qualified as any member of the treatment team that participates in the total treatment of the mentally ill person. Also he will thoroughly understand his own area of competence as differentiated from that of the psychiatrist, psychologist, nurse and occupational therapist. It is this understanding of each other's area that does much to keep the work of the team from overlapping and also to see where each member's contribution adds to the final discharge of the patient.
Rehabilitation Study.

The fact that the present social work staff are constantly aware of the difficulties and time spent in the rehabilitation and convalescent care of the patient is indicated in a recent study that was undertaken, by them, on the rehabilitation process.¹

The purpose of the study was to present the situation confronting social service staff in the rehabilitation process, and to point up some of the needs for present and future changes in policy. A total of 50 cases involving aspects of rehabilitation undertaken in the last six months were studied by a committee chosen from the social work staff. The cases were analyzed under these headings; accommodation, employment, financial, re-admissions, referral to other agencies, referral to field agencies, and vocational training.

Accommodation appeared to be the primary problem in rehabilitation. As Vista can take care of only a limited number of patients there is need for more boarding homes with varied degrees of supervision to be available during the interim period of job hunting. Some patients require constant supervision, some require a boarding home with or without other patients, and some will make best use of completely independent accommodation. At present because of the emergency referral the workers too frequently accept, in desperation, any accommodation which is

¹ Annual Report, op. cit. p. 67.
available, with the result that a patient might find herself occupying a single, bare room in an undesirable downtown district. Readmissions are the natural result of such poor accommodation.

The case analysis revealed a great duplication of service in the area of employment. Each worker interviews the National Employment Service on individual cases, and there is duplication in making individual contacts with various potential employers. Repeated trips into town and to the various offices were found to be time consuming and costly. Greater selectivity was also needed on the part of the doctor and social worker in patients who were placed in jobs, as at present there were too many referrals and hence poor placement and readmission is seen.

At present many patients are without funds on discharge, and funds are urgently required for: (a) immediate payment of board; (b) transportation; (c) fees for job finding through agencies that charge such fees; (d) vocational training.

The lack of funds for any or all of the above severely restricts planning for a patient and forces the acceptance of even unsatisfactory work in order that the patient may subsist. At present, the City Social Service Department co-operates in many cases by providing social assistance for a month or two while the patient, with the social worker's help, explores resources.

Community resources in the form of other agencies are
helpful in some cases and not in others. The problem to date appears to be the need for more cooperation between the hospital and the community to uncover resources for the rehabilitation of the patient through other agencies.

The Field Service has been helpful in rehabilitation, as workers constantly contact them regarding patients returning to their districts. An evaluation of the patient's condition, suggestions as to the type of living and work placements are included. This practice will need to continue on an individual basis.

Vocational training has been used as a resource, in rare instances, but this is limited due to the shortage of funds for such training.

The reasons for the readmission of patients appeared to be mostly poor selectivity of the patients who were to be rehabilitated; insufficient notice given to the social worker so that a study could be made of the patient's chances in the community; because of insufficient time to find accommodation and employment, and the lack of funds.

Some interesting conclusions were arrived at through the case analysis method. First, that a large percentage of the social worker's time was presently taken up in an effort to discover resources for the large number of referrals. When such referrals are received, workers are required to drop their other work and arrange for patient's removal from the hospital. There is no central office in the hospital at present having a know-
knowledge of community resources and workers are required to explore accommodation and jobs on an individual basis. The result is duplication by different workers and by each worker on different cases. Much time is spent on travel, telephone calls and in separate interviews with potential employers or landladies.

The partial remedy for such a situation is the appointment of a senior rehabilitation supervisor on staff. His or her duties would include having available all resources known for accommodation, jobs and funds, and also to act in a public relations capacity to enlarge and increase these resources. This person would then be consulted by individual workers which would eliminate the present duplication and overlapping of work and would free workers to continue with casework services to patients. In short, the rehabilitation worker would have an overall picture of the day to day community resources which would then be available to the social worker whenever confronted with planning for a patient's rehabilitation.

To complete this improved method of rehabilitation there is also need for greater care in discharge planning, and for advance notice from medical staff contemplating discharge of a patient. A careful evaluation of the patient's potentials, abilities and aptitudes should be made before proceeding with discharge planning; this evaluation should be done on a team basis with the medical, social service, and psychology departments acting together. This could be expected to result in the reduction of readmissions. Likewise, social workers could give
better service in the whole area because they would be relieved of emergency rehabilitations and would be able to save much time by turning to the rehabilitation person to discuss resource possibilities.

The above study, by the social workers, is important, not only because it points to improved treatment services to the patient but it also brings out the workers interests in teamwork with other disciplines, community organization and interpretation, and research.
Chapter V - Recapitulation and Assessment.

From this study of the participation of the social worker in the treatment of the mentally ill it is possible to see the importance of such a person's contribution in this area. The social worker's role consists of bringing casework services to the patient from the time of his admission to the Hospital or Clinic until long after his discharge. To enable these casework services to operate at their maximum efficiency, and be of most help, the social worker works closely with the doctor, nurse, psychologist and occupational therapist or as this group is more commonly called "the treatment team." Each function of the social worker's skill is useful in the treatment of the patient only so far as it is purposely related to the skills and services of the other professions.

To continue with this teamwork-in-treatment further, the social worker finds the teamwork aspect important in other areas such as working closely with other community agencies and the Field Services. Interpretation of the role that the community can play in the treatment of the mentally ill is most important; at the same time the hospital social worker has to be aware of the function of community agencies so that referrals are to the best advantage of both patient and agency. The limitations of each agency must be realized so that heavy case loads are not unnecessarily increased, and therefore all services slowed down. Close co-operation between the social work-
ers helps to point out the needs and resources in each specific area, and enables the available resources to be used to the fullest advantage. This aspect of teamwork is most important. Administration.

Within the Hospital and Clinic the participation of the social worker is somewhat limited in the area of hospital administration. This is possibly due to the lack of understanding on the part of the general administration of the contribution that the social worker could make. The extended responsibility in each area of the patient's treatment should make the social worker one of the key member in all and any meetings around hospital policy and treatment planning. What other member of the treatment team is as concerned with as many areas of the patient's treatment as the social worker? From primarily an outside contact he has moved, in the short period since the opening of Crease Clinic, to assume responsibility in reception and admission and on the ward. This completes the cycle of services to the patient - from the time the patient leaves his home environment until he is once again established in society, he has contact with the social worker. This extended contact by the social worker makes him the person most likely to be able to evaluate the hospital program from all angles, and assess the integration of needs and resources.

A step in the direction of accomplishing more participation by the social work staff could be made by the appoint-
ment of an Administrative Supervisor. This person would be con-
stantly on hand to take care of administrative matters whereas
in the present situation the Provincial Supervisor has to spend
several days a month away from the Hospital and Clinic carrying
out her other duties in the Mental Health Services. Releasing
the Provincial Supervisor from some of her administrative duties
at Essondale would allow her to concentrate more on interpret-
ation, to the Social Welfare Branch and the Mental Health Ser-
vices of the requests and needs for services of each until such
time as a definite policy between the two departments can be
formulated. It would also give her more time for community in-
terpretation and the formation of policies with the community
agencies.

Carrying out of the established policies and further
interpretation on an individual basis would, as at present, be
the responsibility of the staff, but it was seen from the des-
criptions of the duties of the Admissions and Continuing Cas-
work Supervisors that they are participating, as much as time
allows, in the job of interpretation, integration and initiat-
on of teamwork especially to departments within the hospital
setting, and to a smaller extent in the community. Therefore
someone in an equally important position, preferably the Provin-
cial Supervisor, should be free to help in this extensive and
important work in the community. The appointment of an Admin-
istrative Supervisor to take over some of her present duties at
the Provincial Mental Hospital and the Crease Clinic would make
this possible.

Additional Services.

Turning to the work that is done in the Admissions and Continuing Casework Sections, the importance of their participation in treatment is readily seen. Additional social workers could be used in both the Admissions Section at the Mental Hospital and Crease Clinic, and plans for these additions have been made for such time as trained professional staff is available.

Social workers on the wards, or to begin with an Admissions worker, is needed in the Mens' Building (West Lawn) where the men patients, who are receiving long-term treatment, are housed. These patients have never known the services of a social worker except in isolated instances where there has been referral from a doctor to the Admissions worker at the Centre Lawn Building. If a plan such as is being carried out on E-5 (Womens' Building) could be established, it would possibly be found that many of these patients could be rehabilitated if an interested, helping person was available to assist them.

Rehabilitation.

The importance of the social worker in the rehabilitation area was shown both in the Continuing Casework and in the rehabilitation study that was undertaken by the staff. The needs that are seen in this area are for some form of subsidized boarding home care, or a type of family care.

The subsidized boarding home care is primarily a need
of the Grease Clinic for patients who have recovered from their mental illness, and are ready to take up their old jobs but lack a place to live, and money for board and lodging until such time as a pay cheque is received. This would eliminate the problem of finding places for the patients to stay and attempting to arrange some form of help until they get established again.

Similar boarding homes were shown to be required at the Mental Hospital, but in this case the need appears to be for some form of family-care service for pre-convalescence. Family-care is the placement of patients with families, other than their own, for care and sometimes treatment. At present patients who assist in housekeeping around the Hospital are not given an opportunity to derive benefits from family-care in which area they could contribute their housekeeping abilities as part of the costs for board and maintenance. Although the responsibility for selection of patients for family-care and their medical supervision under such care belongs to the doctor, the responsibility for finding a suitable home, for interpreting the patient and his needs to the foster family, for maintaining proper standards of care and for helping the patient in his social readjustment is primarily the function of the social worker. Some plan should be worked out between the Social Welfare Branch and the Mental Health Services for the setting up of boarding homes or family-care, as it would help to facilitate the work of the social worker during the rehabilitation period, but primarily it would ease the fear of the patient during his
re-entrance to society, and possibly be a big factor in helping the patient to remain in the community and become successfully rehabilitated.

Summary.

Throughout this study it has been indicated how the participation of the social worker has helped in almost every area of treatment for the mentally ill. If his contribution appears to be less in some areas than others it is primarily due to the lack of personnel to undertake the job or because the teamwork aspect is not in full use. The quality of treatment afforded the patient is wholly dependent on how ably the various professions can work together. Ability to work together involves some knowledge and respect for other professional skills, an awareness of the limitations of one's own professional skill, an understanding of the dynamics of human behaviour, and an ability to work integratively. The relationships of the various professions must be constantly evaluated and purposely developed if treatment is to be adequate.
Appendix A.

POLICY MANUAL

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Crease Clinic of Psychological Medicine

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I. SOCIAL SERVICES, CREASE CLINIC:

Crease Clinic Social Service Department undertook 100 per cent patient coverage during the first year and a half of the Crease Clinic operation. Such services are no longer possible and it has been necessary to institute selectivity for continued case work service. All Crease Clinic admissions are registered with Social Service Index.

In order to cover as many admissions as possible, the Crease Clinic Social Service Department has been separated into two sections - namely: (a) Admissions and Reception Section which includes intake studies and other brief services and initial screening of cases for referral to continuing case work section; (b) Continuing Case Work Section which provides intensive service to patients and families during the period of hospitalization and discharge.

Crease Clinic Social Service Department assumes full responsibility for patients resident in the areas of Greater Vancouver, North and West Vancouver, New Westminster, Burnaby, Coquitlam, Burquitlam, and D. L. 172. Approximately 65 per cent of admissions come from these areas. Patients resident outside these districts are the responsibility of Field Services.

II. RESPONSIBILITIES OF THE SOCIAL WORKER IN THE FIELD:

In view of the fact that the maximum period of treatment offered by Crease Clinic is four months and, according to the Clinics of Psychological Medicine Act, discharge is to be effected within that time, requested service should be given priority and immediate attention. There is further urgency due to the fact that a study of cases has revealed the average length of stay to be closer to two months. Although all patients are discharged in full, follow-up services may be requested on individual cases.

(A) Correspondence.

(i) Address: All correspondence sent out from Crease Clinic Social Service Department is under the signature of the Provincial Supervisor of Psychiatric Social Work. Similarly, correspondence to the Crease Clinic Social Service Department should be addressed to the Provincial Supervisor, Psychiatric Social Work.

(ii) Certified Patients: Letters are sent to the Field Service advising of the admission of those certified pat-
(A) Correspondence. (Cont'd.)

(ii) Persons on whom Crease Clinic Social Service plans to give a brief or continuing service. In some instances, case work services are requested of the Field; in others, the letters merely contain notification of the patient's admission with the suggestion that further services may be requested either on discharge or at some point in the patient's treatment.

Further correspondence is sent to the Field from time to time on certified patients to whom continuing services are being extended and who remain in the Clinic for approximately the four-month period. At the point of the patient's discharge, letters are sent to the Field Service advising of the patient's discharge and of his progress on treatment while at the Crease Clinic. At this time too continuing case work services may be requested for the patient in relation to his emotional and social needs as evaluated during his hospitalization. Periodic reports as to his adjustment in the community will also be requested. The case will subsequently be closed as a psychiatric case following conferences with the doctor in which the Field Service reports and assessment of the patient's adjustment will be given important consideration.

(iii) Voluntary Patients: All correspondence with the Field concerning Voluntary patients is carried out only with the patient's permission. When such permission is secured, the procedure follows that outlined for certified patients.

(iv) Letters of Inquiry From the Field Service Re Former Patients of Crease Clinic: The Field Service from time to time requests information on patients who were previously known to Crease Clinic. Such general information as the patient's name, age, marital status, the dates of admission and discharge, the type of treatment he receives during hospitalization and his condition on discharge may be given without the written permission of the patient. The detailed personal information may be given only when the written permission of the patient has been received and enclosed in the letter of request by the Field Service and in the case of minors with written permission of parent or guardian.

(B) Specific Services Requested.

Patients to Crease Clinic fall into two categories - Voluntary or Certified. The Field Services are responsible for completing the Collection Forms for the Department of Institutional Revenue for all certified patients. Field
Specific Services Requested. (Cont'd.)

Service might be requested to give social service to patients in either category. These services could include:

(i) **Interpretation to the Family of the hospital facilities and treatment procedure.**

(ii) **Obtaining Social History Information.**

(iii) **Offering Case Work Services to the Family upon evaluation of the situation.**

(iv) **Assessing Rehabilitation Resources.** Assessing family and community resources for patient's rehabilitation. In the case of Voluntary admission, the permission is obtained before any request is sent to the Field.

(v) **Advising re Patients already known to Field Service.**
Since it is no longer possible to offer 100 per cent coverage to Crease Clinic patients, there will be patients admitted who are known to Field Service but not to Crease Clinic Social Services. In the event that patients on whom no request for service has been received are already known to the Field Services and pertinent information is on the agency file, Crease Clinic should automatically be notified of this situation. The Crease Clinic Social Service Department will then be responsible for clearing with patient's psychiatrist as to whether this information is desired and in the event of voluntary patients will obtain the patient's permission to make such a request.

(vi) **Follow-up Services.**

(a) **General:** Crease Clinic Social Service Department request for service would specify which services seem to be indicated and would include what information has already been obtained by Crease Clinic Social Service Department. In the event of patients being discharged to the district, follow-up services are requested on an individual basis. Requests for such services are based upon the psychiatric and social assessment of the patient during his hospitalization as well as on the social workers assessment of the patient's family. Should follow-up services be requested on patients for whom no previous service has seemed indicated, a resume of the available material including a copy of the intake history, if such has been obtained, will accompany the request.
(B) **Specific Services Requested. (Cont'd.)**

(b) **Length of follow-up services** will vary with different patients and although the psychiatrists recommendation will be conveyed by the letter, the Field Service worker carrying responsibility for service would be expected to assess and evaluate if a longer period is required.

(c) **Consultation:** The Crease Clinic Social Service Department is available in a consultative capacity and can procure the psychiatrists advice on any psychiatric problems which might arise during this rehabilitation period.

(d) **Reports:** When follow-up services are requested, the Field Service worker is expected to report at intervals on the patient's adjustment. Recommendations from the Field are important factors in deciding when to close the case in Psychiatric Services. With some patients the major problem is found on assessment to be within the area of family services with the psychiatric illness secondary. In such instances, at the time of the patients discharge from the Clinic the suggestion is made by Crease Clinic Social Service Department that the case be closed as a psychiatric one and opened on the basis of family service. In these cases, no further reports from the Field Services are requested. This participation by Field Service is in the area of an out-patient department to a treatment clinic.

(C) **Special Categories of Patients.**

(i) **Patients on Leave:** Certain patients are permitted out of hospital for short visits during their period of treatment. Some of these patients do not return to the Clinic at the expiry of their visit. The Field Services may then be requested to visit and report on the adjustment of such patients as an aid in determining whether the patient may then be discharged or should be returned to hospital.

(ii) **Readmissions:** For certain patients, repeated admissions to the Crease Clinic would not be beneficial; instead, the patient should be committed for a longer period of treatment to the Provincial Mental Hospital. This is usually indicated by letter to the Field Service at the point of the patient's discharge from Crease Clinic. Should there then be some doubt around a situation arising in this category, advisory information may be obtained upon request.
(Cont'd.)

Special Categories of Patients.

There are in addition some patients who may be discharged in full from Crease Clinic and committed under new papers to P.M.H. The Field Service will again be advised by letter of this and of the patient's Mental Hospital number. Future correspondence may then be addressed to the Provincial Supervisor, Psychiatric Social Work, quoting this new number.

(iii) Patients Rehabilitated Through Vista: The Vista is a small mid-way unit situated in Vancouver to which a limited number of women patients may be transferred for a short period of time as an aid in their rehabilitation. During their stay in Vista, the Crease Clinic Social Service worker continues to give supportive services including help with employment and accommodation. There are certain patients who require such a period in Vista as a step in their adjustment to community life but who will later return to their home district. The Crease Clinic worker would keep the Field Service informed and would advise the Field prior to the patient's discharge to the community.

(iv) Patients Rehabilitated Through Rehabilitation Officer: A rehabilitation officer is on the staff of P.M.H. and Crease Clinic to aid selected male patients in employment and accommodation. This is a separate department from the psychiatric social service department.

(v) Patients Requiring Nursing Home Placement: When nursing home placement is to be required upon discharge, we request this service from the area from which patient was admitted. If for psychiatric reasons, the patient should be discharged to a nursing home in Vancouver rather than in the original home area, the same procedure is followed as in the case of a request for social allowance.

(vi) Juveniles Admitted to Crease Clinic: A certain number of juveniles have been admitted to Crease Clinic either directly from the home or through some agency, such as the Boys' Industrial School, Girls' Industrial School, Children's Aid Society and Field Service. Behavior problems are not considered suitable for treatment and should not be sent to the Crease Clinic. It has been the policy to assign these patients for continuing service during their period of hospitalization. Rehabilitation frequently involves a recommendation for foster home placement which is not a function of the Crease Clinic Social Service Department. The Field Ser-
(C) Special Categories of Patients. (Cont'd.)

vice may therefore be called upon to secure such placement and in instances where the child is not a ward of the Superintendent of Child Welfare to obtain permission for placement from the parents. In these instances there would be early and close collaboration between the Crease Clinic Social Service worker and the Field Service; conferences between Field Services and Crease Clinic staff are to be preferred whenever possible. Juveniles admitted to Crease Clinic from B.I.S. and G.I.S. are returned to these schools upon discharge.

(vii) Patients on Social Allowance: Patients who have been in receipt of Social Allowance prior to admission to the Crease Clinic are generally expected on discharge to return to the municipality assuming financial responsibility. In those instances in which the psychiatrist feels it to be in the patient's best interests psychiatrically to reside in Vancouver following discharge, the Field Service in the district from which the patient was admitted to the Crease Clinic will be contacted with a request to arrange that social assistance be administered through the City of Vancouver. The letter requesting such service will be accompanied by a medical certificate from the patient's attending doctor and copies of the letter will be sent to Mr. James Sadler, Regional Administrator, Region I, and to Mr. J.I. Chambers, Administrator, City Social Service Department, Vancouver. As the patient cannot be discharged until such arrangements are completed, it is urgent that such requests receive immediate attention.

(viii) Pregnant Women: If a pregnant woman is admitted to Crease Clinic and expected to be confined while still a patient, arrangements are made for her to be admitted to Royal Columbian Hospital, New Westminster, and New Westminster Social Welfare Branch is requested to make plans for the child. When the woman is married, Crease Clinic Social Service Department communicates with the Field Service to ascertain from the husband or relatives what plans are being made for the child and to direct this plan through New Westminster Social Welfare Branch with a copy to Crease Clinic. In the case of unmarried mothers, arrangements are made for confinement in Royal Columbian Hospital and the plans for the care of the child are made by New Westminster Social Welfare Branch and the district office in the area of the patient's residence.

III GENERAL INFORMATION:

(A) Clothing and Personal Effects.
III General Information: (Cont'd.)

As patients in Crease Clinic are rarely bed patients, they are encouraged to take part in hospital activities, and an interest in their appearance. They are expected to come to the clinic provided with sufficient clothing of their own preference. Storage space is limited. Patients should not bring jewelry or other valuables. Monies and valuables are kept for the patients in the Crease Clinic business office. Patients are able to draw on their account for small purchases.

(B) Tucke Shop and Pennington Hall.

Tucke Shop and Pennington Hall, which has recreational facilities, are for use of patients, their relatives and friends.

(C) Visiting Hours.

Visiting Hours are from 2:00 p.m. to 4:00 p.m. daily. Relatives should be advised to check with the Crease Clinic social worker or the patient's psychiatrist before making the first visit.

(D) Financial Affairs.

The financial affairs of patients certified to Crease Clinic are placed in the hands of the Inspector of Municipalities, Victoria, B.C., while the patient remains in the Clinic. If this freezing of the patient's assets creates a hardship in the family, adjustment may be made through direct application to the Inspector of Municipalities.

(E) Collections.

The Field Services are responsible for completing collection forms for the Department of Institutional Revenue on all patients who are certified to Crease Clinic of Psychological Medicine. Crease Clinic Social Service Department will be requesting case work services for only a small percentage of these patients. In the past, these collection forms were held in the district offices until requests for service were received from the Crease Clinic Social Service Department. Because the Crease Clinic treatment staff cannot complete its selection study within the time limit set by the Collections Department, this will no longer be the case.

(F) Transportation and Escort.

(i) General: Patients are generally expected to be res-
(F) **Transportation and Escort. (Cont'd.)**

...ponsible for their own transportation to and from Crease Clinic.

(ii) **Destitute Patients:**

(a) **Organized Territory:** Under the Crease Clinic of Psychological Medicine Act the area of residence is responsible for payment of costs of transportation to Crease Clinic for destitute patients.

In those organized areas policed by R.C.M.P., responsibility for transporting and escorting the destitute patient is assumed by the R.C.M.P.

(b) **Unorganized Territory:** The R.C.M.P. take responsibility for full costs of transportation and for escorting destitute patients to Crease Clinic.
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(K) Transportation and Escort.
I. SOCIAL SERVICES, PROVINCIAL MENTAL HOSPITAL:

In any one year approximately 3,911 patients are in long-term treatment at the Provincial Mental Hospital. These patients are in residence in the main buildings at Essondale and Coquitlam (East Lawn - Women's Section; West Lawn - Men's Section; the Veterans' Building; and, the Homes for the Aged, Coquitlam.)

During any one year approximately 1,370 patients are admitted to the Provincial Mental Hospital. Some 902 patients are discharged during any one year. The Social Workers in the Social Service Department of the Provincial Mental Hospital are responsible for bringing social services to all patients admitted from Vancouver, and the five outlying districts. These patients constitute from 62 per cent to 65 per cent of the entire patient-group admitted.

The Social Service Department, Provincial Mental Hospital, as presently constituted is able to cover only a selected percentage of the total patient-group in social services, at the time of admission, during treatment and throughout discharge from hospital. Therefore, there will be a percentage of the total patient-group unknown to the Social Service Department, Provincial Mental Hospital and because of this no request for Field Services will be made. However, if the Field Services know of the patient's admission and have information about patients in this latter group, it would be helpful if Social Service Department, Provincial Mental Hospital were notified. This notification is necessary in order that Social Service Department, Provincial Mental Hospital, may clear as to whether the patient is voluntary or committed. In the case of the voluntary patient, it would be necessary for Social Service Department, Provincial Mental Hospital, to have the patient's permission before the information in the Field Service records could be forwarded to the Hospital. When such information about patients and their families is forwarded by the Field Services, it greatly enables Social Service Department, Provincial Mental Hospital, in the selection of patients for social services.

II. RESPONSIBILITIES OF THE FIELD SERVICES:

(A) To the Family of the Mentally Ill Patient.

In the cases of patients who come to the Provincial Mental Hospital from outlying districts, Social Service Department, Provincial Mental Hospital, depends upon the Field Services to bring family case work services to the families of patients who often have had to meet sit-
(A) To the Family of the Mentally Ill Patient (Cont'd.)

situations devastating to their integration as a family - situations which stem directly from the very illness of the patient. Often by the time Field Services become active families may actually be broken, because of the illness of the mother, father and breadwinner. In such instances, Field Services will be in the position of bringing many of the concrete auxiliary services which are brought ordinarily to broken homes. Besides these concrete auxiliary services, the Field Services will bring case work services directed to helping the family members in the area of the emotional trauma directly associated with the patient's illness.

(i) Steps in Helping the Family of the Mentally Ill Patient:

(a) Facilitating Expression of Emotion around the Illness and the Mentally Ill person:

It is well to remember always that the mentally ill family member before his admission to Hospital has been becoming for sometime past less and less familiar and less and less understandable to his family. He may have been verbally and physically aggressive, sometimes assaultive in his home, "different to what he ever was before". This unfamiliar behaviour is distressing to families. If the family members have suffered from the anger and assaultiveness of the patient while he was in the home, they may come to fear, dislike and even hate the patient. From these feelings arises, consequently, the feeling of guilt.

(b) Supporting the Family in its Decision around the Hospitalization:

Very often the actual decision and the actual taking of the final step to committal of the patient may have taxed the strength of the family emotionally and physically. After the committal, family members often feel depressed and sorrowful because of the separation or relieved the latter with concomitant feelings of guilt--guilt which is expressed through over-emphasis on how very necessary it was to commit. "I've tried everything. I couldn't take it any longer. What else could I do." In the light of these feelings, it is not out of the ordinary for a family member to say to the Field Worker, "When you put someone you love in a mental hospital you feel that you need a psychiatrist yourself"; or the member might say, "I feel that I have let him down—that it was a heartless thing to do."
(b) **Supporting the Family in its Decision around the Hospitalization:** (Cont'd.)

The Field Worker, in dealing with the family's feelings either of depression or relief around committal, should attempt to bring support to the family in the decision they have made. Often it is helpful in allaying the anxiety in the depression or the anxiety around relief to share with the family that decisions to commit are always difficult, but that they have made the right decision and that the patient is in the right place to get the treatment he needs for his illness. It is well for the Field Worker to realize that often the family making the decision to commit does so often against the wish of other family members and relatives, and does so, often in the face of severe criticism from community. The Field Worker may find it necessary to continue such supportive contact with the family throughout the patient's total period of hospitalization.

(ii) **Goals in Continuing Case Work Services with Families of the Mentally Ill:**

(a) **Explaining the Hospital to the Family:** Families derive considerable benefit if with this support, some understanding of the hospital set-up, total treatment services and hospital routines is given by the Field Worker. Often after a family member has visited the patient in hospital he will ask the Field Worker more questions which spring from anxiety and fear. Factors such as the patient having to live in crowded quarters, to mix with patients who appear so much worse, or the patient fearing his treatment and pleading to come home; all these might be raised and questioned. The Field Worker might find it helpful to assure the relative that the patient does not, usually, in the initial period of admission, or during the early stages of his treatment, notice the disadvantages of hospital life as much as the well visitor does. Although there are patients on his ward with varying degrees of illness, there will be a patient with whom he can strike up friendship. The nursing care, rest, thorough physical, dental, laboratory tests and neurological examinations should be mentioned as they are reassuring to the relative that the Hospital does care and is interested in treating the patient.

It is sometimes helpful to the relative to explain the therapeutic aspects there are for the patient in sharing and living with others on a
Explaining the Hospital to the Family (Cont'd.)

ward. Sometimes after a visit to patient, the relative may mention that he found the patient discouraged and pleading to return home. In such instances, Field Services will recognize that after a certain period of treatment, mid-way on the road to better health, that it is natural for patients to want to return home. With treatment, happy memories of family life have returned, but however, return at this time is not the best thing for him. The relative can be helped to see the important part he can fill in the patient's treatment by helping him see this also.

Note: The Field Worker may gain this understanding through an orientation or through consultation with Social Service Department, Provincial Mental Hospital.

Continuing to Help the Family with its Problems. Help to the Family in Understanding Mental Illness, and Mental Health Principles.

In any service to a family, the goal is to help the family to meet its problems as they see them; to help them recognize their inherent strengths and apply these to the solution of difficulties. In the case of a family with a mentally ill person, the continuing social work goal is directed to the understanding of mental illness firstly, and the part which feelings of dissatisfaction, uncertainty, frustration and unworthiness in regard to inter-personal and inter-familial relationships play in it. The social service goal is one that enables the family to understand the illness, the feelings and situations which have contributed to it. Often at this point relatives will come to some realization of their possible part in causation of the illness, and then come denials, self-accusation, feelings of shame about having someone mentally ill in the family. Then it is that the Field Worker helps the relative to see the hospital as a place for the treatment of mental illness. The Field Worker will reassure the relative that entering the Hospital is the beginning step in a treatment process, and that with the newer methods of treatment many more patients are responding in such a way as to be able to return to community in time. It is well for the Field Worker to reassure the relative at this time that
Continuing to Help the Family with its Problems, etc: (Cont'd.)

the causes of mental illness are many and varied; that mental illness is not a disgrace; that one has only to look around to see the universality of emotional problems and that it is only a matter of degree in emotional stress between the person in community with emotional difficulties and the person in the Hospital with emotional difficulties. It is true that patients when they are quite ill feel more at ease, more safe and secure in the Hospital after the first strangeness has been overcome. This is often helpful for the relatives to know.

Through further clarification and support the Field Service may bring help to the family to achieve a more satisfactory balance, or mental health outlook, and understanding. In this way, the family is supported and made ready step by step to receive the patient. In the end the patient returns to a better integrated family unit, prepared to receive him with acceptance of the level of the mental health he has achieved from his treatment in Hospital.

Writing up the Social Study of the Patient's Family: How they see the Patient: the Strengths in the Family, and How the Field Services see Themselves Helping.

In the past, social histories have been somewhat of a routine responsibility of the Field Services. With the development of an Admission and Reception Section in the Social Service Department, Provincial Mental Hospital, and because only a percentage of patients admitted are covered by social services, social histories will be requested of the Field Services only for those patients known to Social Services, Provincial Mental Hospital, and whose relatives were not able to be seen by the Admission and Reception Social Worker in the Hospital at the time of the patient's admission, or for the patient who was admitted unaccompanied. The purpose of the social study are to assist the treatment team in the Hospital in the understanding of the patient, to provide the team with diagnostic data and to supply the Field Worker himself with a social diagnosis of the family problem, and possible treatment leads in case work helping of the family during the hospitalization of the patient.
Responsibilities of Field Services to the Mentally Ill Patient.

To do an adequate family case work job the Field Services need to know what is happening to the patient in Hospital, in order to integrate as much as possible interested family members into the patient's treatment plan. It is well to realize that the patient's treatment is a total thing which takes in not only hospital treatment but the understanding and interest of family in his illness and treatment as well as the understanding of community and the development of its willingness to support the patient on his return, Social Service Department, Provincial Mental Hospital, will provide information about the patient in hospital, just as the Field Worker has provided Hospital with information about the patient's family group.

The responsibilities of Field Services to the patient undoubtedly begin at the earliest contact with his family and increase as the patient approaches convalescence. At this time careful planning between Social Service Department, Provincial Mental Hospital and Field Services is essential. At the time of pre-convalescent planning for the patient, the hospital team will see specific needs, both in regard to material assistance and emotional support. These will be interpreted to the Field by letter or if it is at all possible by the conference method. When the Field has been informed, a responsibility exists to inform Social Service Department, Provincial Mental Hospital, as to the possibility of carrying out these plans, as to the availability of resources in the Field as well as to inform as to whatever alternative resources and services exist. Briefly, pre-convalescent planning for the discharge and rehabilitation of the patient is joint planning between Hospital and Field.

Responsibilities of the Field Service in Convalescence (Probation and Rehabilitation.)

(i) Steps in Convalescent Social Services:

(a) Need to Bring Support, Concrete Auxiliary Services, and to clarify Reality. It is in social services directed as to the supervision of the discharged patient during the probationary period and in the rehabilitation of these patients that the responsibility of the Field Services is most focalized on the patient himself. Whenever possible, before the return of the patient to community Social Service Department, Provincial Mental Hospital, has prepared him for transfer to Field Services. At the time of the patient's return to community he is very often in need of strong and consistent
(a) Need to Bring Support, Concrete Auxiliary Services, and to Clarify Reality. (Cont'd.)

support. For some time before he is able to take any positive steps, he may need to be very depend­ent on the Field Worker as well as on his family. Many patients will need a convalescent period on first leaving the Hospital. During this time they will need to have extended to them concrete auxil­liary services such as Social Assistance as well as supportive, and in some instances, enabling case work services. During the early rehabilitation period, social services are not only directed to manipulating the environment in such a way as to make it easy for the patient to find his own way, but they are directed toward clearing what is feas­ible and possible for him to plan and attempt for himself (clarifying what is reality for him).

(b) Need to Recognize with the Patient his Strengths: to Assess Patient's Growth in Ability to Take on Direction of His Own Life. The Field Worker will always be assessing the strengths of the patient in reality functioning and will be helping him to assume as much self-direction as he is capable of. Much of the aforementioned involves basic, generic principles of casework method. In the case of the person who has been mentally ill his illness may have left him out of touch with reality in certain areas. This will mean that the social worker will need to receive from Hospital the aforementioned assessment of the patient's reality functioning. This will be dealt with in the specific cases by correspondence with Social Service Department, Pro­vincial Mental Hospital. In helping patients during the probationary period it is well to remember that it involves slow, careful, steady supportive help. There are no quick results, nor do patients get quickly well, and quickly able to take over the direction of their lives. To help the patient clear away some of his external difficulties, to give him an opportunity to talk about his difficulties, to clear with him what is feasible for him to plan and to do, through this some change in attitude may take place, but usually what is accomplished is that the patient may come to know himself for what he is. In this way he may come to accept himself, under­stand and manage himself better.

(c) Need to Strengthen the Family and Interpret to the Community.

Since probation or convalescent care is the re­establishment of the patient in the community, dur-
(c) Need to Strengthen the Family and Interpret to the Community. (Cont'd.)

ing the period the patient remains for six months a responsibility of the Hospital. The Field Services assist in the discharge of Hospital’s responsibility by supervising the patient, by attempting to make available to the patient all possible community resources which might help in his readjustment, such as interpretation to the family regarding the patient’s illness, helping the patient to regain his economic security by assisting him in locating work and encouraging the interest and acceptance of former employers wherever this is possible.

(D) Responsibilities of Field Services and Social Service Department, Provincial Mental Hospital, in Developing an Integrated Mental Health Service for Patients and Families.

It is helpful if we can see this service as a single unit within which Social Services are brought to patients and their families before the admission period, throughout admission, during treatment (with direct service to the patient on the ward being undertaken by Social Service Department, Provincial Mental Hospital and services to the family being undertaken by the Field). These social services carry on to pre-convalescent planning, and finally throughout the period of convalescent care. Because of the geographical separation of the Social Service Department, Provincial Mental Hospital and Field Services, it is of utmost importance that integration of service be maintained through correspondence. In this way only can adequate minimal social services be brought to patients and families.

The Social Service Department, Provincial Mental Hospital, because it is stationed in the Hospital is in a position to bring together the skills and ideas of other disciplines working with the patient and to integrate with the social services provided by the Field. Each patient and his family is a unique entity. There can be no rule of the thumb way in the provision of service to patients and their families. It is only through the integrated study by both of each individual patient’s situation that the uniqueness can be understood and the needs be met relatively. In order to integrate the patient study and the family study and in order to integrate social work with the patient and family complete sharing must be undertaken by Hospital and Field. Social Service Department, Provincial Mental Hospital, has a responsibility in helping along this integration by giving consultation to the Field on request. This sharing of the study of the patient and his family; thus sharing of the social case work treatment of the patient and his family through frequent
correspondence is the Social Study, and supercedes in value
to the clients the formal information-getting service which
the former Social History Outline requested.

III. SPECIFIC PROCEDURES.

(A) Correspondence.

Letters requesting case work service may be sent from
the Social Service Department, Provincial Mental Hospital to
the Field Service at any point during the patient's period
in hospital. The time at which the request is sent will de-
depend on the time of referral to the Social Service Department.
For those patients who have been selected for social service
during the admission period, the Social Service Department,
Provincial Mental Hospital forwards all information which is
known to the hospital about the patient and his family at
that point. Specific areas of service are indicated in the
letters insofar as these can be determined at the time of
writing. It is always assumed, however, that the Field Ser-
vice will be in a more strategic position to assess the needs
of the family and will give an overall family service in ad-
dition to covering the specific areas as suggested in cor-
respondece. The worker's evaluation of the family situation
and her case work plans should always be included in the re-
ports which are forwarded to the Social Service Department,
Provincial Mental Hospital. Reports from the Field Service
should be sent out to Social Service Department, Provincial
Mental Hospital well within a period of a month in order for
these to be a useful part in the total planning. In some
cases even greater urgency is indicated; in the cases where
immediate reports are necessary this is indicated in the
letter. These reports are discussed fully with other dis-
ciplines in the hospital and the joint thinking of the tot-
al treatment team is included in the acknowledgment of the
reports from the Field.

When patients are discharged on probation, those cases
which have been selected for social service are held open
in the Social Service Department, Provincial Mental Hospital
until the six month probationary period is terminated. The
Social Service Department, Provincial Mental Hospital takes
responsibility for notifying the Field Service when the
probationary period is terminated and when the case is to be
closed as a psychiatric case. Further service is needed for
the patients and their families in most cases, These can
then be transferred to Family Service.

All reports to the Social Service Department, Provincial
Mental Hospital should be forwarded in duplicate as one copy
is retained in the social service files and one copy is des-
ignated for the patient's unit file on which the material
from all disciplines within the hospital is kept. All corre-
pondence from Field Services should be Addressed, Provincial
Supervisor, Psychiatric Social Work, Provincial Mental Hos-
pital, Essondale, B.C.
Letters of Enquiry from the Field Service in regard to former patients of Provincial Mental Hospital.

When detailed personal information is requested concerning patients who were previously known to the Provincial Mental Hospital this information may be given only when the written permission of the patient has been received and enclosed in the letter of request. In the case of minors, written permission must be given by the patient's parents or guardian. Such general information as the patient's name, age, marital status, dates of admission and discharge, the type of treatment which he received during hospitalization and his condition on discharge may be given without the written permission of the patient.

In giving out information regarding a patient, the Field Services will be guided by those fundamental social work principles regarding the rights of the client to confidentiality in his dealings with the social worker and the agency. Therefore, before any information regarding a patient is given to other persons or interested agencies written permission must be obtained from the Medical Superintendent, through the Social Service Department, Provincial Mental Hospital. It is important in the case of a former voluntary patient that permission is obtained from him (if he is well enough to give this) before proceeding to ask for information from the Hospital.

Information which is given to the Field Services during the course of a patient's treatment, and probation is for their use in understanding the patient, his inter-familial relationships and his needs and with this the Field Worker is in a better position to see the family needs for social services of an enabling and treatment nature.

Other professions and other agencies might likely bring services not related so fundamentally to the patient's illness, or his family relationships, or his community relationships; therefore, only selected specific and related kinds of information regarding the patient should be given. Information of a deep personal nature concerning the personal dynamics of the patient should not even be related to the family, or the responsible relative without this first being discussed with the psychiatrist, either in conference which will be arranged by the Social Service Department, Provincial Mental Hospital, or by correspondence, through the Social Service Department.

Specific inquiries by relatives regarding the patient's diagnosis, response to treatment and prognosis are directed through the Medical Superintendent by advising the relative to write himself directly. The medical discipline at the
(B) Provincial Mental Hospital cannot assume responsibility for automatically reporting to relatives around the patient's admission, progress in treatment, etc., but will reply to all written requests for information.

(C) Committal Routines.

Patients between the ages of six and seventy years may be admitted to the Provincial Mental Hospital directly when they are accompanied by properly completed committal forms. For the patients between these specified ages, there is no waiting period.

(i) Ordinary Committal: Ordinary committal forms consist of (1) one "A" form to be signed by a relative or interested person; (2) two "B" forms to be signed by doctors who have examined the patient; (3) one "C" form to be signed by a magistrate.

In most cases the doctors take the responsibility for guiding the patient's relatives in the committal procedures. It is not recommended that Field workers sign Committal Forms.

(ii) Voluntary Committal: Patients may enter the Provincial Mental Hospital at their own request. This type of committal has some disadvantages in that Voluntary Patients may leave the hospital on giving the Medical Superintendent five days notice. The patients are not always well enough to be able to make wise decisions as to the time of termination of treatment.

Voluntary Committal Forms consist of (1) one "A" form filled in, but not necessarily signed by the patient; (2) one "F" form signed by the patient and his doctor.

(iii) Urgency Committal: Patients may be admitted under this form because only one medical practitioner is available. In this situation, the forms required are (1) one "A" form signed in the usual way; (2) one "B" form; (3) one "C" form. These patients are re-examined by the two private practitioners within fourteen days of their arrival at the Provincial Mental Hospital and two "B" forms are completed at this time in the usual way (as in Ordinary Committal).

(iv) Committal by Order-in-Council: Prisoners from Oakalla and the Penitentiary are admitted by Order-in-Council by the Courts. Committal forms "A" and "C" are submitted to the hospital as soon after admission as the Court has the required information. The two "B" forms are completed by two private practitioners at the Provincial Mental Hospital after patient has been examined by them.
(iv) **Supplies of Committal Forms** are to be found in local Court Houses, and local General Hospitals. Provincial Mental Hospital does not supply forms to the Field nor does the Hospital expedite the committals of patients. This is the local doctor's responsibility.

(v) **Admission of Adults Over Seventy (70) years:** The usual committal forms (that is: one "A" form, two "B" forms and one "C" form) are filled out and forwarded to the Medical Superintendent. As in the case of children under six, special consideration is given to the applications of patients who are creating an acute problem in the home or who are dangerous to themselves or others. As vacancies occur, aged people are discharged from the Provincial Mental Hospital and admitted to Home for the Aged. In all cases of patients over 70 there is, however, a waiting list for bed space. Therefore it is important for the Field Worker to complete the social study for the aged person requiring admission and to submit it at once to Dr. B. F. Bryson, Medical Superintendent, Homes for the Aged, and also request that the patient be put on the waiting list. A request should also come from the responsible relative or physician in attendance, and sent on to Dr. B. F. Bryson.

It is usual for the Medical Superintendent, Homes for the Aged, to contact either the responsible relative or the attending physician when a vacancy occurs.

**Note:** The Committal Forms are only valid for thirty days, therefore these should not be completed until the notice of bed space has been received from the Hospital.

The Field Worker's social study of the aged person can be abbreviated: developing the onset of the illness and the patient's experiences and activities prior to the onset. The family should be helped to understand that their aged relative very often may respond in such a way to treatment in the Homes for the Aged so as to lose his disturbance and in the light of this, his hospitalization is not necessarily permanent. With the quiescence of the disturbance the family, if able, should be helped to make other provisions for his care; for example, in the home of relatives, in nursing and boarding homes.

The family should be helped to understand that shock, sometimes both physically and emotionally, might occur very often on the removal of the aged person from familiar surroundings and on his subsequent admission.
(C) Committal Routines. (Cont'd.)

to the Homes for the Aged. With this in mind, the Field Worker should ascertain the family's wish regarding funeral arrangements in the event of their aged relative's death.

It is expected that most patients, 70 years and over, admitted will already be in receipt of Old Age Security. If, however, the social worker should find that the prospective patient over the age of 70 years is not in receipt of Old Age Security and that such patient is eligible for Old Age Security, these facts should be noted and accompany the history which the social worker will send in on the aged person who is awaiting admission to the Provincial Mental Hospital.

The necessary details surrounding a patient's application for Old Age Security is now considered an Institutional Revenue function of the Provincial Mental Hospital and staff has been provided in the Provincial Mental Hospital for this work.

(D) Discharge of Patients.

(i) "On Leave" or "On Visit":

The patient may leave the hospital at the discretion of the Medical Superintendent for short visits. While thus released the patient remains the full responsibility of the hospital. It is sometimes arranged that the patient may be allowed away from the hospital "on leave" for a trial period before probation is decided. In some instances, Field Services might be requested to give services during the visit period.

(ii) Probation:

(a) Ordinary. When the patient is well enough for rehabilitation, he is discharged on Ordinary Probation. The probation period is for the six month period immediately following the date that the probation forms are completed. While on probation, the patient may be returned to the hospital at any time without further committal forms as he remains the hospital's responsibility during this period. Supervision is given the patient and his family during this time by the Social Welfare Branch and information forwarded to the hospital from time to time. At the end of the six months probation period, the patient is "Discharged in Full" and ceases to be the responsibility of the hospital.
(iii) **Discharge in Full:**

Certain patients are discharged in full on leaving Hospital. Field Services may be requested to give continuing Family Services.

**IV. SPECIAL CATEGORIES OF PATIENTS.**

(A) **Patients on Social Allowance.**

Patients who have been in receipt of Social Allowance prior to their committal to the Provincial Mental Hospital are generally expected on discharge to return to the municipality assuming financial responsibility. In those instances in which the psychiatrist feels it to be in the patient's best interests psychologically to reside in Vancouver, following discharge, the Field Services in the district from which the patient was admitted to the Provincial Mental Hospital will be contacted with a request to arrange that social assistance be administered through the City of Vancouver. The letter requesting such service will be accompanied by a medical certificate from the patient's attending psychiatrist and copies of the letter will be sent to Mr. James Sadler, Regional Administrator, Region I, and to Mr. J.I. Chambers, Administrator, City Social Service Department, Vancouver. As the patient cannot be discharged until such arrangements are completed, it is urgent that such requests receive immediate attention.

(B) **Expectant Women Patients.**

If a pregnant woman patient is admitted to the Provincial Mental Hospital and expected to be confined while still a patient, arrangements are made for her to be admitted to the Royal Columbian Hospital, New Westminster, and New Westminster Social Welfare Branch is requested to make plans for the child. When the woman patient is married, Provincial Mental Hospital, Social Service Department, communicates with the Field Services to ascertain from the husband or relatives what plans are being made for the child and to direct this plan through New Westminster Social Welfare Branch with a copy to the Social Service Department, Provincial Mental Hospital. In the case of unmarried mothers, arrangements are made for confinement in Royal Columbian Hospital and the plans for the care of the child are made by New Westminster Social Welfare Branch and the district office in the area of the patient's residence.
(C) **Alcoholic Patients.**

See Order-in-Council #606 dated March 17th, 1952, whereby alcoholics admitted to Hospital are limited to twenty-five and must be admitted during daylight hours. Field Services before contemplating the recommendation of voluntary treatment in Hospital for the Alcoholic must first inquire by letter or telephone (if feasible) as to availability of bed space.

As of August 1st, 1953, a new Order-in-Council introducing Form K, a new form whereby the voluntary alcoholic will enter Hospital for a minimum of 30 days treatment, will come into effect.

(D) **Patients Addicted to Drugs.**

Hospital is not extending admission facilities to this group, unless the patient addicted to drugs is committed as psychotic.

V. **GENERAL INFORMATION.**

(A) **Countersigning Reports.**

All Field Workers reports involving social studies and case work plans which are to be forwarded to Social Service Department, Provincial Mental Hospital must be countersigned by the District Supervisor in the Field. An exception to this might be in those instances when it has been stated that there is some matter of urgency in the Hospital's receipt of the report.

(B) **Clothing and Personal Effects.**

A great many patients in the Provincial Mental Hospital are not bed patients. The development and maintaining of the patient's interest in his personal appearance is an important part of the total treatment plan for him. Patients are expected to come to the Provincial Mental Hospital provided with sufficient and attractive clothing. It is suggested that three sets of washable under garments, three cotton slips and three washable cotton dresses should be provided for women patients. This clothing should be attractive yet durable because the laundry is institutional and there is no dry cleaning establishment. Three durable cotton night gowns, a dressing gown and house slippers are suggested; also one pair of oxford shoes and lyle hose.

Storage space for patients' effects is very limited so that it is important not to exceed this amount of clothing. Patients should not bring jewelry or other valuables. However, should the patient arrive in Hospital in possession of valuables these are carefully listed, placed in containers
(B) **Clothing and Personal Effects. (Cont'd.)**

marked with his name. These containers are held in the vault until the patient's discharge.

(C) **The Patient's Financial Affairs.**

These are placed in the hands of the Inspector of Municipal Affairs, Victoria, B.C., during the patient's hospitalization and depending on circumstances during the probationary period. If the latter creates a hardship for the family, adjustments can be made on application to the office of the Inspector of Municipalities, Victoria, B.C.

(D) **Collection Reports.**

The Field Services are responsible for completing the Collection Forms for the Department of Institutional Revenue for all committed patients to the Provincial Mental Hospital. From this time on, the Social Service Department, Provincial Mental Hospital, will be requesting Field Services for a small percentage of these committed patients. In the past these collection forms were held in the District Offices until the request for service was received from the Hospital. This no longer will be the case because of Social Service Department's policy regarding selection of patients for social services. Therefore, there will be some situations in which a separate visit would seem to be indicated in order to complete the Collection Report. The Treatment staff at the Hospital is unable to complete the selection study within the time limit required by the Collector of Institutional Revenue for receipt of the Collection Form.

(E) **Money Gifts.**

These should not be given to the patients directly. It may be entrusted to the head nurse, or charge nurse or mailed to the Medical Superintendent with some indication that it is for "comforts for the patient". The patient's christian name, surname and ward should be clearly recorded in the letter.

(F) **Parcels.**

All parcels sent through the mail should be addressed to the patient for whom they are intended. Again care should be taken to use christian name, surname and the ward letter--e.g. Mrs. Rose H. Brown, Ward E-4.

The Hudson's Bay Company, Eatons and Woodwards all make deliveries to the Hospital twice weekly and standing orders for extras can be left with these companies by relatives.
(F) Parcels. (Cont'd.)

Parcels containing home-cooking, fruit and wearing apparel are most appreciated by the patients.

(G) Visiting Hours are daily from 2:00 - 4:00 p.m. Relatives may ask to speak to the social worker at this time. Or, if the relative wants to spend some time in discussion with the social worker, he should write indicating the day he intends to visit. The social worker will also arrange appointments for relatives with the patient's psychiatrist.

(H) Consultation Service.

Field workers should feel free to consult the Social Service Department, Provincial Mental Hospital regarding any problems in service to psychiatric patients and their families.

(I) Tucke Shop:

There is a Tucke Shop where patients who have ground privileges may make purchases. This experience in entering a shop again and ordering something desired has a real therapeutic content for the patients. The purchases they make are charged to the patient's "Comfort Allowance". Regular orders may be placed by relatives and friends in person or may be arranged by letter to the Medical Superintendent or through the Social Service Department.

(J) Pennington Hall.

Pennington Hall which has recreational facilities for the patients is also for the use of patients and their visiting relatives. There is an attractive tea room in which patients and relatives can visit together.

(K) Transportation and Escort.

(I) General. Patients are generally expected to be responsible for their own transportation to and from the Hospital. In the case of the committed patient to Provincial Mental Hospital, a responsible relative will often undertake to assume costs.

(II) Destitute Patients.

(a) Organized Territory: Under the Mental Hospital's Act the area of residence is responsible for payment of costs of transportation to the Provincial Mental Hospital for destitute patients. In those organized areas policed by R.C.M.P., responsibil-
(ii) Destitute Patients. Cont'd.)

(a) Ity for transporting and escorting the destitute patient is assumed by the R.C.M.P. Those organized areas having local constabulary take responsibility for the transporting and escorting of the destitute patient.

(b) Unorganized Territory: The R.C.M.P., take responsibility for full costs of transportation and for escorting destitute patients to the Provincial Mental Hospital.
Appendix - B.

Duties of the Provincial Supervisor of Psychiatric Social Work.

1. In the Mental Health Services.
   a. Responsibility for advising the Director of Mental Health Services on all planning regarding the organization of the Social Service Departments.
   b. Responsibility for advising the Director of Woodlands School (School for Intellectually Retarded Children) on the planning of the Social Service Department and social needs throughout the institution.
   c. Responsibility for advising the Director of Child Guidance Clinics on all planning for social services in the Clinics.

2. In the Social Welfare Branch.
   a. Advisory to the Deputy Minister of Welfare, the Director of Welfare and the Assistant Director of Welfare, on standards of mental health services in regards, specifically, to social work services of a preventive nature and social services of a rehabilitative nature, for all children and adults referred to the Mental Health Services.
   b. Responsibility for directing and advising the Field Consultants employed within the Social Welfare Branch of the Department of Health and Welfare on policy and services within the Mental Health Services.

3. In the Community.
   a. To direct and act with all staff of the Social Service Departments in maintaining liaison and encouraging cooperation with all existing community resources in the interests of the mentally ill patient; and to assist in the development of community resources for the patient discharged from the mental hospital. The latter involves co-operatively meeting with other community agencies, evolving policies of inter-relationships and co-operation whereby community services may be brought effectively and with facility to the patient.
   b. Some responsibility for interpretation to agencies and lay groups of the Social Services in the Mental Health Services.
   c. Responsibility for consultation and direction regarding the training of social work students within the various
Social Service Departments of the Mental Health Services. This training is financed under the Mental Health Grant of the federal government, and is directly supervised by the University of British Columbia's School of Social Work.

4. Staff Responsibility.

a. Responsibility for bringing consultation, advice and direction to the administrative social workers in the following units of the Mental Health Services: Child Guidance Clinics (Vancouver and Vancouver Island), Woodlands School (New Westminster), and Crease Clinic and the Provincial Mental Hospital both at Essondale. Also overall responsibility for the development of the whole social service program, as well as advising on standards of social work services and practices.

b. Responsibility for organization and administration of the Social Service Departments at Essondale. Also responsibility for the evaluation, revision, and extension of the social service program so that it meets the needs of patients, community and the developmental changes in the other professional departments such as psychiatry, nursing and psychology which are part of the treatment team.

c. Overall responsibility to organize and introduce methods for social work staff training and development on the job.
Appendix - C.

Outline of Social Work Orientation Program for Nurses (Public-Health, Post-Graduates and Affiliates.)

Social Work in the Setting of the Psychiatric Hospital and Clinic.

I  Introduction: The Team Approach (Working together to a purpose.)

1. Definitions:
   a. The broad field of Social Work or Social Welfare as presently defined by the study on Training for Social Work by the United Nations Economic and Social Council.
   b. Definition of the Social Worker and his function.

   a. Social Services which have grown up to meet the problems.

   Social Work makes use of two principal methods of professional service:
   a. Group action.
   b. Individual help.

4. Methods, Skills and Body of Knowledge used by a Social Worker.
   b. Skills of the Social Worker.
   c. Body of knowledge of the Social Worker.

5. The four main methods of approach to Social Welfare Problems.
   a. Social Casework.
   b. Social Groupwork.
   c. Community Organization.
   d. Research.

II The Social Worker in the Psychiatric Hospital and Clinic Setting.

The organization, administration, policies and services of the Social Work Departments at Essondale.
Outline for Psychiatric Nurses.

1. Definition:

The broad field of Social Welfare as recently defined by the study on Training for Social Work by the United Nations Economic and Social Council.


   b. Early Christian Church - Pauline period.
   c. Social Welfare under the Seignorial System.
      1. The King, church and hostelry.
      2. The manorial system.
      3. Allocation of welfare responsibility after the breakdown of the manorial system.
      5. Relief of need. Almshouse, indoor and outdoor relief, indenture and apprenticeship.
      6. The Puritanical viewpoint on welfare services.
      7. Viewpoint of the Political Theorists.
     10. Era of the Educationalists.

5. The services which have grown up at Federal, Municipal level.

   A study in the administration of a Social Welfare Program.
8. Methods, Skills and Body Knowledge used by a Social Worker.
10. Social Worker in the Psychiatric Hospital and Clinic Setting.
Appendix - D.

ORIENTATION OF SOCIAL WORKERS FROM
SOCIAL WELFARE BRANCH.

**First Day.**

- Commencing Time; 9:30 a.m.
  - Place: Crease Clinic - Office 12.

9:30 to 10:00 a.m. - Review of the Act regarding Clinics of Psychological Medicine and the policy of co-operative services in the Crease Clinic.

10:00 to 10:30 a.m. - Review of the Mental Hospitals Act and the policy regarding co-operative services at the Provincial Mental Hospital.

10:30 to 11:00 a.m. - The Homes for the Aged.

11:15 to 12:00 a.m. - The Woodlands School.

12:00 to 1:15 p.m. - LUNCH

1:25 to 2:15 p.m. - Social Casework to the Psychiatric Patient and his family. Study Room - Crease Clinic.

2:30 to 4:30 p.m. - Study room - Crease Clinic (3rd floor)
  (1) Structures of Social Service Departments.
  (2) Services.
  (3) Responsibilities of the Field.
Specifically the following will be considered: referrals; conferences with the doctor; the intake study; letters to the Field; the Field's responsibility in the intake study; the intake study as a part of an on-going family casework service; the necessity of the Field worker to see the patient as part of a total family situation; the use of casework supervision in psychiatric services; the use of the hospital for consultation centered around the patient, his treatment and his rehabilitation planning.

**Second Day.**

9:30 to 10:30 a.m. - Study Room, Crease Clinic. The Services of Intake and Reception of patients. The responsibility of the Field and Field relationships in relation to this procedure.
10:30 to 11:30 a.m. - Study Room, Crease Clinic. Patient's day in hospital. The work of the Social Worker during the patient's treatment period.

11:00 to 12:00 a.m. - Social Casework to the Psychiatric Patient and his family. Study Room, Crease Clinic.

12:00 to 1:15 p.m. - LUNCH

1:25 to 4:30 p.m. - Demonstration Clinic. (Patients with some form of mental illness will be interviewed by the doctor. As a rule Social Service is active with cases observed.)
Appendix - E.

Orientation of New Social Workers and their Induction into the Social Service Departments of the Provincial Mental Hospital and Crease Clinic of Psychological Medicine, Essondale, B.C.

First Day
- Introduction to Social Service staff, working space, layout of grounds. Brief introduction to totality of services offered in the Mental Hospital, function of the Social Service Departments and relationship to other Hospital Services.

Discussion of rules and regulations regarding confidentiality, keys, behavior and demeanor.

Discussion of mental illness and its treatment.

2. Lunacy Act and Crease Clinic Act.
4. Menninger, W.C., Mental Dynamics.

Second Day
- Further discussion of hospital services; mental illness and its treatment; Social Service responsibilities.

Visit to Crease Clinic wards and services.

Third Day
- Provincial Supervisor of Psychiatric Social Work gives discussion of Philosophy of Psychiatric Social Service at the Provincial Mental Hospital and Crease Clinic.

Attend Ward Rounds.

Study a file for what is in it so worker will get a picture of a particular patient in a mental hospital. File to be discussed from standpoint of all that is in it, all that may be conjectured and deduced, preparatory to further social service activity.

Visit to wards, occupational therapy, Centre Lawn Wards.
Reading: 1. Brown J.T., Psychodynamics of Abnormal Behavior, pp. (162-177), (186-208)
2. Noyes, A.P., Modern Clinical Psychiatry, pp. (14-99)
3. Richardson, H.P., Patients Have Families, pp. (165-232)

Fourth Day

- Study of two case files from the standpoint of dynamic evaluation and determination of Social Service responsibility.
- Reading on specific illnesses.
- Discussion with Supervisor.

2. Psychiatric Social Worker in Essex County.
3. Notes on Social History Taking.

Fifth Day

- Discussion of kinds of therapy used at Grease Clinic and the Provincial Mental Hospital.
- Instructions on statistics, daysheets, reports, dictation. Study more case files.


Sixth Day

- Attend Staff Meeting (Day varies)
  Visit ward to observe Coma insulin.
  Visit Home for the Aged.
  Visit other services, other buildings.
- Further reading and discussion on mental illness and the social worker's responsibility. Discussions on casework techniques; conferences with the physicians and visits to patients.

Reading:
2. How Dangerous to the Community are Mental Hospital Patients, Cohen and Freeman. (reprint)

Seventh Day
- Observe Electro-convulsive therapy.
  One interview assigned.
  Further reading.

Eighth Day
- Attend Ward Rounds.
  Further case study.

Ninth Day
- Observe Insulin therapy.
  Interview assigned.
  Dictation.
  Discussions.

Tenth Day
- Interviews assigned.

Gradual Building up of case-load until orientation period completed.
Appendix - F.

BIBLIOGRAPHY.

SPECIFIC REFERENCES.

Books.


Articles, Reports and Other Studies.


GENERAL REFERENCES.

Books.


Articles, Reports and Other Studies.


