SOCIAL SERVICES FOR MENTAL PATIENTS AND THEIR FAMILIES

An Examination of Social Work Functions, and Criteria for the Establishment of a Social Service Department in a Saskatchewan Mental Hospital (Weyburn).

by

ALEXANDER PETER HEUSER

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

Accepted as conforming to the standard required for the degree of Master of Social Work

School of Social Work

1954

The University of British Columbia

Abstract

This study reviews the procedures, standards, and administrative requirements inherent in the setting up of a Social Service Department in a mental hospital. Recommendations for a future Social Service Department are based upon: (a) standards for adequate social service as recommended by the American Psychiatric Association and other professional personnel, and (b) the experience of some existing departments in Canada. The latter include: (a) the Social Service Departments at the Crease Clinic of Psychological Medicine and the Provincial Mental Hospital, Essondale, British Columbia, and (b) the After Care Department of the Ontario, Hospital, London, Ontario. This study has also incorporated the information and findings contained within four previous Master of Social Work theses, dealing with (a) the analysis of social work services in a mental hospital, (b) administrative aspects of a social service department in a mental hospital, (c) post-discharge problems of mental patients.

The study has examined social work functions in a mental hospital, including: social services rendered during admission, social services rendered during the period of treatment, social services rendered during rehabilitation and convalescence. To ensure effective provision of these social services, the study has outlined "job descriptions" for each social work position within a Social Service Department.

Three selected Social Service Departments were examined on the basis of: (a) administrative structure, (b) personnel, and (c) services rendered. Methods used include direct observation, interviews and correspondence with administrative personnel, an examination of information in annual reports and relevant professional articles.

The projected department is divided into three distinct sections: (a) an Admissions Section; (b) a Continuing Casework Section: and (c) an Out-Patient Section. To ensure adequate administration and service, such a department requires twenty appropriately-qualified personnel: sixteen social workers at the direct service level; three social workers, each as Casework Supervisor of a Section; and one social worker as the Director of Social Service.

* * *

TABLE OF CONTENTS

Page

TABLES AND CHARTS IN THE TEXT

(a) Tables

(b) Charts

.....

ACKNOWLEDGEMENTS

I wish to express my thanks to Mr. J.E. Gamble, Director of the After Care Department of the Ontario Hospital located at London, Ontario; and also to the social workers at the Crease Clinic of Psychological Medicine and the Provincial Mental Hospital, Essondale, British Columbia, for their interest and co-operation in making available the information contained within the present thesis. I want to thank Miss Alice K. Carroll, Provincial Supervisor of Psychiatric Social Work, Mental Health Services, British Columbia, for her help in the formulation of "job descriptions" for social service personnel.

I wish also to acknowledge my indebtedness to Dr. Leonard C. Marsh and Mr. Arthur C. Abrahamson of the School of Social Work for their constructive suggestions and their encouragement.

I also wish to thank Mr. Jack A. Ellis, fellow student, for his proof-reading of the present thesis.

* * *

SOCIAL SERVICES FOR MENTAL PATIENTS AND THEIR FAMILIES

An Examination of Social Work Functions, and Criteria for the Establishment of a Social Service Department in a Saskatchewan Mental Hospital (Weyburn).

CHAPTER 1

CHANGING CONCEPTS IN THE CARE OF THE MENTALLY ILL

The interest, thinking and practice regarding mental illness and psychotic persons, has in the past had a much different origin than psychiatric interest has today. The most striking change in this respect has been the gradual replacement of the custodial concept by the concept of treatment. "If the last decade of the nineteenth century saw the significant change in nomenclature from 'asylum' to 'hospital', the twentieth century has witnessed a transformation in fact as well as in name."[1]

Development of Mental Hospitals and Why They Developed

In ancient times, magical conceptions were associated with the person who exhibited behaviour which differed from that of most people. Irregular behaviour was attributed to evil spirits who invaded the human body and were dwelling therein. Faith was placed in pagan healing gods, whom they felt could expel these evil spirits from the afflicted person. Altars and permanent temples were set up where the mentally ill could go and meet the healing gods and through divine communication be relieved of indwelling evil spirits.

---

[1] Deutsch, Albert, The Mentally Ill in America; Doubleday, Doran and Co., Inc., New York, 1937, p. 440.

"One of the most outstanding of these temples of healing was established at Epidauros in Greece, in the sixth century B.C."[1] It included auxiliary temples and a stadium which seated over twelve thousand persons. Within the sacred enclosure were a bathing pavilion and two gymnasia. On the grounds were a large and attractive grove where the patients walked or sat under the trees. Statues of friendly deities and famous physicians were placed there, as well as tablets inscribed with encouraging accounts of cures already effected. The Holy Precinct was pervaded by an air of sanctity, and special effort was made to preserve an atmosphere of cheerfulness and to arouse hope. Following a period of fasting in preparation for meeting the healing gods, the patient was robed in white; and as darkness fell he made offerings, heard prayers and fell asleep. During the night, a priest in the disguise of a god visited the patient, and with the help of a serpent he would apply a remedy to the patient. When the patient awoke, the priest offered him interpretation of the divine communication which occurred during the patient's sleep.

When Greece came under Roman domination, the tendency toward magic and miracles increased. The visitation of the priest during sleep began to include leaping upon the patient and beating him in a hope to expel the evil spirits.

---

[1] Zilboorg and Henery, A History of Medical Psychology, W.W. Norton and Co., New York, 1941, p. 559.

This particular temple of healing at Epidauros existed and remained in operation for over eight hundred years.

After faith in pagan healing gods faded away, many centuries passed during which time no care whatsoever was provided for the mentally ill person. Until about the fourth century A.D., the mentally ill person or "lunatic" as he was then called, wandered about being the subject of ridicule and physical cruelty. Persons suffering from the more excited states of illness, were often chained to stakes and flogged. Human contact with the mentally ill did not exist.

The first record of an institution being established for the care of the mentally ill, dates back to the latter part of the fourth century A.D.

> The first institution of this kind of which there is a record was called a "morotrophium", or house for lunatics; it was in operation in Byzantium in the fourth century A.D. A similar institution was in existence in Jerusalem, according to a record bearing the date of 491 A.D.[1]

The asylum era was then underway, and in spite of the harsh practices carried on within them, the asylum was a step forward in the care of the mentally ill. The mental patient did have a right to be protected from the ridicule and cruelty of the community. Asylums for the mentally ill did not become common until the twelfth century, and many were actually cloisters.

> Bethlehem Hospital in London is said to be the oldest hospital in Europe which has been in continuous service. It was founded in 1247 but did not "receive lunatics" until 1377, at which time some few patients were transferred from a store

---

[1] Ibid., p. 561.

> house situated near to the palace of the King. Bethlehem Hospital, which later became known as "Bedlam Hospital" following the inception of a psychiatric unit there, was officially under the management of a royal chaplain, a consistent absentee whose duties were performed by the janitor.[1]

Toward the end of the eighteenth century the asylums in most European countries were beginning to emerge from the deplorable state in which they had been for centuries as a result of suspicion, ignorance, and neglect of the mental patient.

Great reformers such as Pinel in France, and Tuke in England ran the risk of they themselves being confined to an asylum, by pleading to the masses and the then existing government bodies for reform within the asylums. In 1793, Pinel after succeeding to gain the government's sanction, liberated over fifty patients from chains and dungeons. Inhuman restraint and confinement began to be replaced by outdoor walks and workshops. The concept of treatment had begun to replace the centuries old concept of detention.

Tuke, a merchant in England, was aroused by the mysterious death of a patient in the York Asylum, when it became known that the relatives were not permitted to visit her. This incident prompted Tuke to approach the Society of Friends in 1792, and as a result the York Retreat was established. A milder more appropriate attitude toward mental patients prevailed here. Restraint and abuse were replaced

---

[1] Ibid., p. 564.

by kindness and tolerance and early forms of occupational therapy. Tuke attempted to make known to the public the nature of the conditions within the asylums. It would seem that with a revelation of such conditions, a revolution in hospital care would be inevitable. Many changes did occur as a result of Tuke's work: incompetent attendants and administrators were discharged of their duties, living conditions in hospitals improved some, and a move was made toward the creation of legislation for the protection of the mental patient. Exposure of wrong attracts interest, but reconstruction depends upon the constant efforts of those who do not forget the emotional impact from the exposure of wrong. For this reason, the first half of the nineteenth century passed before the mental institutions emerged from medieval darkness.

North American Development

Mentally ill persons on this continent were first conceived of as being a public nuisance, and on occasions measures were taken to rid the community of them. The first approach taken toward the mental patient was to have him confined with those persons under custody for criminal or civil offence. The first institutions designated specifically for the care of mental patients on this continent, were erected at Williamsbourg in the United States in 1773, and at Saint John, New Brunswick, in Canada in 1836.

The development of mental hospitals in North America was similar to the development in Europe, with one exception. On this continent, the mental patient was first cared for in jails and almshouses, and later in government sponsored institutions. The mental patient in Europe however, fell to the care of cloisters intermediary to almshouses which were preceded by magical temples of healing; and the government sponsored institution. The process of hospital development on this continent was probably much quicker than in other countries, because it occurred a century later and thus profited from the experiences of earlier reformers. Benjamin Franklin, the Quaker movement, Dr. Benjamin Rush, and Dorothea Dix are the pioneer reformers of the movement toward better hospital conditions in North America.

Toward the end of the nineteenth century thirteen of the foremost mental hospital superintendents in the United States, met and founded what in 1921 became known as the American Psychiatric Association. This organization attempted to formulate standards for mental hospital facilities, as well as hospital personnel. Another aim of this organization was to organize the psychiatric knowledge then available, and to build solidly upon it.

Shortly before the close of the nineteenth century scientific discoveries in medicine, psychiatry, biology, physiology and psychology revealed the interdependence between mind and body. These discoveries stimulated a new

outlook in the approach to mental disorders. Emil Kraepelin and Wilhelm Griesinger classified mental diseases according to their symptoms. Sigmund Freud and his followers opened up new hope for the treatment of mental illness, through the knowledge of the unconscious. Freud's theory of psychoanalysis caused a revolutionary change in psychiatry all over the world. The psychiatric schools of Jung, Adler, and Rank also contributed theories of human behaviour and mental illness. Dr. Adolf Meyer introduced the psychobiological theory of psychiatry. Social psychiatry was taught by such leaders as Southard, Hoch, Gessell, and Karl Menninger.

The contributions of these pioneers of social psychiatry emphasized that mental illness and emotional disturbances are not exclusively due to organic conditions, but are also due to factors in the environment. Counseling and direct modification of environmental stresses gained recognition as a means to the prevention and cure of mental illness.

Until the close of the nineteenth century, mental hospitals did not segregate the acute treatable illnesses from those more chronic cases. Since the turn of the century however, and as a result of an increased understanding of psychiatry, segregation of acute illnesses which require continuous treatment has become an accepted practice. This is being accomplished through the establishment of the cottage type structure of hospital, and also through the use of reception units where intensive treatment is done. The need for further sub-grouping within this broad dichotomy has been

apparent for many years, but is only recently becoming a reality. Separate institutions are being established for the care of epileptic and mentally retarded patients. The most recent sub-group to receive special consideration because of their common need is the senile group. A few provinces--notably British Columbia and Alberta--have separated senile patients from other cases requiring continued treatment.[1] In North American mental hospitals, there have been advances made since the turn of the century in respect to the number and qualifications of hospital personnel.[2] The number of medical doctors has increased, and members from other professions have joined the physician forming the "treatment team." During the first World War, the Department of Soldiers Re-Establishment proved the therapeutic value inherent in occupational therapy programs.[3] The second and third decades of this century mark the introduction of psychologists and social workers into the Canadian psychiatric hospital, although social workers had become a part of the treatment team in American hospitals as early as 1914.

The mental hygiene movement has also played an important role in the development of mental hospital service.

---

[1] Mental Health Services in Canada, General Series Memorandum No. 6, Research Division, Department of National Health and Welfare, Ottawa, July 1954, p. 10.

[2] v. supra, p. 22.

[3] Mental Health Services in Canada, op. cit., p. 13.

In 1904 Clifford Beers recovered from a mental illness of three years' duration. The experiences which he encountered during his three years in a mental hospital, stimulated him on to found an organization for the improvement of the care and treatment of the mentally ill. In 1908 the mental hygiene movement was founded, and one year later the National Committee for Mental Hygiene was formed with Clifford Beers as its Chairman. Since its inception, the National Committee has conducted surveys on existing mental health services and the need for an extension of these services in the community, and has also acted as an advisory committee to government bodies on mental health matters. In Canada, the Canadian Mental Health Association serves in a similar capacity to the National Committee for Mental Hygiene.

During World War I the mental hygiene movement became immersed in the problems of the mentally disabled soldier, and in their attempt to promote mental health in the community--their primary objective, the National Committee sponsored the present Smith School of Social Work.[1] This was the first School of Social Work which offered training for social work practice in relation to psychiatry. Many students graduated from this School with training which enabled them to perform social work in mental hospitals, outpatient psychiatric clinics and child guidance clinics. The mental hygiene movement played a major role in interpreting

---

[1] Deutsch, op. cit., p. 321.

the need for social workers in psychiatric treatment settings, and was instrumental in making it possible for this need to be partially met.

Many innovations in hospital administration have occurred since the turn of the century. Mental hospital management has been placed under the direction of government boards or departments, while hospital personnel matters are dealt with by Public Service Commissions. The procedures of parole and follow-up care have come to be used much more extensively. Boarding out programs are being established for those patients who do not require active treatment but who do have a residuum of their illness.

During the past two decades mental hospitals on this continent have increasingly become a part of the community. Mental hospitals are now being opened for public inspection. They are being used more and more as training centres for mental hygiene, where nurses, internes, psychologists, social workers and volunteers receive training in mental hygiene principles.

Mental hospital development can thus be divided into three phases: (1) From ancient times to the fourth century A.D. This phase was characterized by the magic and superstition which surrounded the mental patient. (2) From the fourth century to the eighteenth century. This phase was characterized by the establishment of asylums, and the state assuming responsibility for the provision of custodial care for the mentally afflicted. (3) From the eighteenth

century to the present time. This might be referred to as the "phase of enlightenment". The mental patient began to be recognized as a sick person, and it began to be realized that a cure could be effected in many cases through proper treatment. During the early part of the third phase the main attention was focused on the improvement of the physical facilities in mental hospitals, and also toward a more humane type of custodial care rather than physical and mental abuse which had been common until after the turn of the eighteenth century. However, toward the end of the eighteenth century the new psychiatric theories set new goals for hospital reformers, and "treatment" became a watchword as well as "better custodial care." This new emphasis on treatment meant that hospital personnel including administrators, doctors, attendants and nurses were faced with having to change their concepts regarding the care of the mentally ill, to a concept which includes treatment and return of the patient to the community.

Psychiatric treatment along with the assistance given by professional social workers and other services, can help many patients recover from their illness. This is not sufficient however. Even though community thinking and feeling toward mental illness has become much more understanding, due in great part to the mental hygiene movement, the patient's return to the community is still a threatening experience for him. The mental patient requires help in returning to the community and also assistance to

remain there. Unless the mental hospital is prepared to enlist the help of members from that profession which is trained to carry the responsibility in this area, that hospital cannot be said to have accepted its complete new role. In actual fact it has remained an institution whose only function is to care for the mentally ill.

Introduction of Social Work Into the Psychiatric Setting

Social work has always dealt with personal and social suffering. Specific personal and social adjustment problems were encountered through direct contact with large numbers of impoverished people. The inevitable result of such a large number of contacts, was the grouping or classification of specific social adjustment problems. When it was realized that social adjustment problems could be classified, the way was paved for the establishment of specific kinds of agencies, designed to study and handle specific kinds of problems. Around the human ills which are the concern of social work have developed many specialized areas of activity.[1] Some of these areas lie entirely within the field of social work itself: the family welfare agencies, with breakdown in family life as the starting point for activity and the maintaining of wholesome family life as the primary purpose; and the child welfare agencies, with the dependent child as the starting point and the insurance

[1] Lois French, Psychiatric Social Work, The Commonwealth Fund, N.Y., 1940, p. 1.

of care, protection, and influences necessary for normal growth as the purpose. Other areas represent combined efforts of social work and other professions; probation which is social work operating in the agencies that deal with delinquency and crime; medical social work, which operates within the field of medicine; and, more recently, psychiatric social work.[1]

In order to avoid confusion of terms, it might be well to state here that psychiatric social work is not a separate and distinct field of its own, but that it is social work practiced in relation to psychiatry,[2] in an agency framework established for the purpose of treating emotional, psychological and nervous disorders. As Dr. E.E. Southard and Mary C. Jarrett state in their book The Kingdom of Evils, it is a "new emphasis rather than a new function". In this study, the writer will use the term "social work", rather than "psychiatric social work".

Dr. Alfred Meyer has stated that "before our present day type of social work was organized, psychiatry here and there had for probably a century done a kind of social work under the name of after-care".[3] In the United States

---

[1] Loc. cit.

[2] Lucas, Leon, "Psychiatric Social Work", Social Work Yearbook, 1951, American Association of Social Workers, New York, 1951, p. 359.

[3] Alfred Meyer M.D., "Historical Sketch and Outlook of Psychiatric Social Work", Hospital Social Service, 5, p. 221, April 1922.

"as far back as 1860" mention was made in the annual reports of several state hospitals, of the recognition of the existence of "social problems" during the post-discharge period.[1] As early as 1894, Dr. Stedman of the American Neurological Association found through the use of a circular letter to association members, that a majority had a definite belief in the great advantage likely to result from after-care.[2] A very explicit statement of the need for social work in the practice of psychiatry was made in 1902, by Dr. Theodore Kellogg, a superintendent of a mental hospital.

> Insanity practically is loss of power of conformity to the social medium in which the patient lives. This power is regained in convalescence gradually, and it is a part of psychotherapy to furnish a normal personal environment to which the patient is to practice adjustment.[3]

These are among the first evidences of the convergence of these two professions--psychiatry and social work--in a combined attempt to relieve mental suffering. It is a point of interest that the need for social work in the psychiatric setting became apparent to the medical profession before social work as a profession specifically offered to help in the treatment of the mentally ill. Possibly this interest in social work on the part of the

---

[1] French, op. cit., p. 33.

[2] Ibid., p. 33.

[3] Southard, Dr. E.E. and Jarrett, Mary C., The Kingdom of Evils, MacMillan, N. Y., 1922, p. 519.

psychiatrist was stimulated by a change within psychiatry itself. With the turn of the nineteenth century, the emphasis in psychiatric thinking turned from the "classical approach"--the diagnosis and classification of mental diseases--to the "dynamic approach"--a concern with the growth and change of the personality in relation to the environmental situation. The emphasis having turned to the development of personality in relation to the environment, psychiatry first began to use social workers for help in understanding the environment.

A corresponding interest was awakening in social work. Social workers saw that the new "dynamic psychiatry" could offer them a great deal of help in understanding attitudes and behaviour--both of which had always been more or less baffling to social workers.

"In the development of a new profession, from time to time new interests come to the front, dominate the scene for a while, and gradually become assimilated into the main body of experience."[1] This has been the process in the development of the broad field of social work. In the days of the Poor Law, pioneer social workers turned their attention to the economic needs of people. This was quite natural, as the economic features of social disorder are the most conspicuous--food and shelter are the most obvious needs.

---

[1] Ibid., p. 517.

As social workers assisted impoverished people with these obvious needs, it became apparent to them that social maladjustment was not the result of external pressure alone. Emotional conflict or internal pressure, and the interrelatedness of internal and external pressures, soon became recognized. Social workers soon realised that

> the individual is tremendously hampered in his attempt at coping with his external situation if he is divided within himself. For example, a person looking for employment will be far less efficient in dealing with his difficult task if there is something in himself that desires to be dependent upon others; he has to fight an internal enemy together with the external one.[1]

When one social need is studied and provisions are established to meet it, other social problems are either unearthed or else have been obvious all along but now in comparison with an answered need become much more apparent. From the very elementary meeting of economic needs of people, social workers moved on to deal with the neglected child; disharmonious marriages; juvenile and adult offenders; the social components of physical illness; since the turn of the century they have been concerned with the social components of mental illness.

Social work as practiced in relation to general medicine came to the fore in the early nineteenth century. Eventually the knowledge gained from the drawing together of these two professions, was assimilated into the main body

---

[1] Waelder, Robert, "The Scientific Approach to Casework with Special Emphasis on Psychoanalysis", Principles and Techniques in Social Casework, Cora Kasius, Editor, Family Service Association of America, 1950, p. 28.

of social work knowledge and thinking. The same process has been taking place between psychiatry and social work. The social work profession has been very much aware of this, as in 1919, the National Conference of Social Work had as their guest speaker, the inspirer of medical social work--Dr. Richard Cabot. In his address to social workers, he said,

> social work is now a new force, new, not in name but in efficiency of energy--the force represented by psychiatric social work.[1] In thirty years, I have never seen anything so important as the eruption of psychiatric social work into social work.[2]

At the first meeting of the National Conference of Social Work, held in 1874, the first subject considered was "The Duty of the State Toward the Insane Poor". This paper was delivered to the conference by a state hospital superintendent.[3] The first organized plan of social work in relation to psychiatry occurred in 1880 in England with the Society for the After-care of the Insane. In the beginnings, it engaged itself giving friendly supervision to discharged patients from mental hospitals. In the United States, the first attempt at organized social work in relation to psychiatry occurred in 1905 with the staffing of a social worker at the Neurological Clinic at the Massachussetts General Hospital in Boston. In 1911 the Manhattan State Hospital

---

[1] By "psychiatric social work", Dr. Cabot means the new psychiatric point of view in social work which resulted from social workers working with psychiatrists.

[2] Southard and Jarrett, op. cit., p. 522.

[3] Ibid., p. 519.

became the first state-hospital to employ a social worker. Within three years, fourteen state hospitals employed social workers, and many were beginning to think in terms of Social Service Departments rather than in terms of a social worker. The Boston Psychopathic Hospital served as a pioneer in this respect. In 1912 the Boston Psychopathic Hospital opened, under the direction of Dr. E.E. Southard. In 1913 Miss Mary C. Jarrett became director of social service and began the organization and definition of function of a new department in the hospital.

One of the first Social Service Departments in a Canadian mental hospital was organized in 1931 at the Provincial Mental Hospital, Essondale, British Columbia. Ontario hospitals first utilized the services of the community welfare workers, made available through local agencies. Because of the pressing need for mental health services within the community and for the provision of follow-up care to discharged patients, the After Care Department at the Ontario Hospital, London, was established in 1949. At the present time, most Canadian mental hospitals have a social worker on permanent staff, but do not have organized Social Service Departments.

With the outbreak of war in 1914, the need for social work in the armed forces became paramount. Most of the very few trained workers transferred from the civilian hospitals to army hospitals. Unfortunately, this transfer of

social work personnel did not reverse itself at the close of the war. During the 1930's and 1940's, child guidance clinics began to be established throughout the United States and were being staffed by young psychiatrists. The child guidance clinic movement attracted a majority of the social workers who had had training and experience in psychiatric work. Many who had served in army hospitals were attracted to community agencies which were offering more generous salaries than were the state hospitals at that time. The consequent result was almost a complete discontinuation of social work practiced in the mental hospital setting. Within the past five years there has been a renewed interest in vitalizing and expanding the treatment services in the state hospitals. Hence, social workers in the psychiatric field are once again directing their attention to work in mental hospitals.

Saskatchewan's Psychiatric Services

There is little recorded about psychiatry in the area now known as Saskatchewan, before the formation of that province in 1905. Until 1914 psychiatric patients from this area were treated at the Brandon Mental Hospital, Brandon Manitoba. In 1914 the first Saskatchewan Hospital was built near the town of Battleford. Due to conditions of over-crowding, it soon became evident that a second institution was needed. The Saskatchewan Hospital, then known as the "Weyburn Mental Hospital", was constructed in Weyburn in 1921.

Upon completion of the building, a special train was chartered which transported about five hundred patients from the institution at Battleford to the new institution. A number of nurses and attendants were transferred to the new institution to provide custodial care for those five hundred patients, some of whom are still hospitalized there.

In 1929 the Government of Saskatchewan appointed the Hincks Commission to study the psychiatric services, and to make recommendations for their improvement. This Commission was led by Dr. Clarence Hincks, Director of the National Committee for Mental Hygiene. Dr. McKerracher, former Director of the Saskatchewan Psychiatric Services Branch, discusses some of the findings of that Commission:

> With approximately 1,000 patients in each institution, over-crowding was stressed as being of major importance. Each hospital had a superintendent, two additional medical doctors, each a ward staff of 110 untrained personnel and one registered nurse. There was no formal training program for nurses....The Commission strongly recommended the construction of a nurses' residence at the Weyburn Hospital, and it also stressed the need for the removal of the mental defectives from the hospital to a suitably constructed institution. Other items on this 1930 blueprint were mental health clinics, psychiatric units in general hospitals, provision for public education in the field of mental hygiene, and for research in psychiatry.[1]

The depression years hampered the fulfilment of many of these recommendations, but during the past fifteen years many new psychiatric services have been made available to the people. Improvements in the two already operating hospitals have been made. Plans for future improvements in the total psychiatric

---

[1] McKerracher, D.G., "Some Historical Aspects of Psychiatric Developments in Saskatchewan", Saskatchewan Psychiatric Services Journal, Saskatchewan Department of Public Health, April, 1952, p. 3.

service program are constantly under consideration.

The "mental hospital program" in 1914 was entirely under the responsibility of the "Department of Public Works". This included construction, maintenance, and therapeutic activities. Following the release of the Commission's Report in 1930, all the psychiatric services of the province were placed under the direction of Dr. McNeill as "Commissioner of Mental Services". In 1931 the "medical and nursing staff" were placed under the direction of the "Department of Public Health", but the maintenance remained a Public Works responsibility. In 1946, however, these responsibilities were also turned over to the Department of Public Health.[1]

By 1946, the Saskatchewan Hospital, Weyburn, had a population of about 2,600 patients. This desperate situation was temporarily relieved by the acquisition of a former Royal Canadian Air Force building near Weyburn, which now accommodates approximately eight hundred mentally retarded patients. This institution is known as the Saskatchewan Training School for Mental Defectives, and is about to be moved from its temporary accommodation to a newly constructed cottage-style hospital. The removal of these patients from the hospital facilitated a decrease in population to about two thousand patients. Since then the population in the hospital has remained fairly constant. Improvements within the Saskatchewan Hospital, Weyburn, include: the purchase of increasing amounts

---

[1] Ibid., p. 5.

of hospital equipment; plans for alterations of the out-dated architectural design of the building; the construction of a new Tuberculosis Unit and also a Nurses' Residence.

There have also been improvements of personnel. The number of doctors has been greatly increased. A Nurses' Training Program has been established within the hospital, with an annual graduation class of Registered Psychiatric Nurses. Occupational, recreational, and physiotherapy departments have been initiated. A Research Unit has been developed within the hospital. A clinical psychologist has been appointed to permanent staff. With the increasing number of graduate nurses and doctors, the ratio of patients to staff has decreased markedly. (See Appendix A.) For example, the ratio between patients and doctors in psychiatric hospitals in Saskatchewan in 1932 was three hundred twenty patients to one doctor. In 1953 however, this ratio had decreased to one hundred fifty patients to one doctor. It is also indicated in Appendix A, that it is only in recent years that physiotherapists, recreational therapists, psychologists, and social workers have been appointed to mental hospital staffs.

Out-patient clinics were also established. The Regina Mental Health Clinic was started in 1947, being the first out-patient psychiatric service to be established in the province. In addition to the one psychiatrist, the Clinic was staffed by one psychologist and one social worker. The McNeill Clinic at Saskatoon was established in the fall of 1949; it was the second full-time out-patient service in the

province. The demands of private practitioners for consultation services led to the establishment of Saskatchewan's first part-time out-patient clinic, and it was established in Moose Jaw in 1948. Other part-time clinics were later opened at Yorkton, Swift Current, Weyburn, Assiniboia, North Battleford and Prince Albert. These clinics,

> have limited their activity to consultation and diagnosis. One of the more successful functions has been the establishment of very good relationships with practicing physicians. Another has been the screening of patients for referral to the different treatment centres.[1]

The Moose Jaw Clinic has since taken on a full-time treatment program, with a staff consisting of two psychiatrists, one psychologist and one social worker.

As a result of the Hincks Commission, a twenty-seven bed psychiatric unit was established in the Regina General Hospital in 1946, as a part of province's psychiatric services program. This unit later became known as the "Munroe Wing". A resident-training program was set up and approved by the Royal College of Physicians and Surgeons.[2] Recently, a new psychiatric unit has been established in the new University Hospital in Saskatoon.

In summary, the two mental hospitals were the only psychiatric services available to the residents of Saskatchewan until the year 1947. Since that time two short term treatment

---

[1] Ibid., p. 7.

[2] Loc. cit.

units and several out-patient clinics have been established. Recorded history indicates that social workers have been included on the treatment team, in the out-patient services and the short term treatment centres since their inception. Social workers were not employed in the mental hospitals until 1950. The first one, Mrs. M. McEachern, was assigned in July 1950 to the Saskatchewan Hospital, Weyburn, so that social services might be provided to the patients and their relatives. The administrative difficulties inherent in having a social worker responsible to the Department of Social Welfare and Rehabilitation, and the Department of Public Health soon became apparent. On April 1, 1951 this position at the hospital was transferred from the Department of Social Welfare and Rehabilitation to the Department of Public Health.

The Area Served

The Saskatchewan Hospital, Weyburn, is located on the north western fringe area of the city of Weyburn, which is situated in the south eastern corner of the province. In actual surface area, the Saskatchewan Hospital, Weyburn, serves about one-third of the province. Because of the sparse settlement in northern regions of the province, the Saskatchewan Hospital, Battleford, serves an area approximately twice as large as the area served by the hospital at Weyburn; although the total population served by each hospital is approximately equal.

The population of Saskatchewan is predominantly rural. The high percentage of rural living people in Saskatchewan, as compared to Ontario and British Columbia, is indicated in Table 1.

Table 1. Rural and Urban Population, Ontario, Saskatchewan, British Columbia, 1951.

Population	Ontario	Saskatchewan	British Columbia
Rural (p.c.)	29.3	69.7	31.9
Urban (p.c.)	70.7	30.3	68.1
Total Population	4,598,000	832,000	1,165,000

Source: The Canada Year Book, 1954.

Only thirty per cent of the population of Saskatchewan resides in urbanized areas. There is evidence that urban stresses are more predisposing to mental illness, and in general, the processes of social and economic adjustment are more complex. It seems that there are varieties of mental illness more likely to be found in rural and isolated areas. These factors will therefore be an influence upon the Saskatchewan caseload.

The population of Saskatchewan, like that of Ontario and British Columbia consists of people of many and varied racial origins. Table 2 shows a percentage representation of the various racial groups, present in all three provinces.

Table 2. Racial Origin Representation in: Ontario, Saskatchewan, British Columbia, 1951.

Racial Origin	Ontario	Saskatchewan	British Columbia
British	67.2	42.3	66.0
French	10.4	6.2	3.6
German	9.8	16.3	4.8
Italian	1.9	0.1	1.5
Jewish	1.6	0.3	0.4
Netherlanders	2.1	3.6	2.9
Polish	1.9	3.1	1.4
Russian	0.4	2.3	1.9
Scandinavian	0.8	7.5	5.6
Ukrainian	2.0	9.4	1.9
Indian and Eskimo	0.8	2.7	2.5
Other	1.1	6.2	7.5
Total	100.0	100.0	100.0

Source: The Canada Year Book, 1954.

The "Anglo Saxon" group has the largest representation in all three provinces, but by comparison, Saskatchewan has the smallest "Anglo-Saxon" representation and the largest representation of other ethnic groups. In Ontario, the groups of French and German racial origins are represented by ten and nine per cent of the total population respectively. All other ethnic groups in Ontario are each represented by less than two per cent of the total population. Like Ontario, British Columbia's population includes only small minority representations.

In Saskatchewan, persons of German racial origin are numerous enough to represent the second largest ethnic group. French, Scandinavian, and Ukrainian groups make up six, seven, and nine per cent of the total population respectively. There are several other groups each having a

representation of less than three per cent of the total population.

The Netherland, Polish, Russian, Scandinavian, Ukrainian, Indian and Eskimo groups are larger in Saskatchewan than either Ontario or British Columbia. This points up the fact that of the three provinces, Saskatchewan has the greatest percentage of total population comprised in minority groups. To the extent that social adjustment is more difficult for persons with different cultural backgrounds, this also will affect the patterns of illness found in Saskatchewan.

Method of the Study

The main purpose of this study is to examine the procedures, standards, and the administrative implications of setting up a Social Service Department in a mental hospital. The Social Service Departments reviewed are: (1) the Social Service Departments at the Crease Clinic of Psychological Medicine and also the Provincial Mental Hospital at Essondale, British Columbia and (2) The After Care Department associated with the Ontario Hospital, located in London, Ontario. A comparative study is made of these departments according to their development, administrative structure, and the services which they render. Recommendations for an anticipated Social Service Department at the Saskatchewan Hospital, Weyburn, are based on this review.

The study will acquaint the reader, and particularly the Administrators of the Saskatchewan Psychiatric Services

Branch with already existing Social Service Departments; and in establishing a Social Service Department at the Saskatchewan Hospital, the Psychiatric Services Branch might profit from the past experience of other Canadian hospitals. It is deliberately intended that this study should serve in part as a handbook for the practicing social worker so that he might better understand his role as a member of the treatment team. Such an exposition should also be an aid in interpreting social work functions to members of other professions.

Because of the great similarity between the Saskatchewan Hospital, Weyburn, and the Saskatchewan Hospital, Battleford, the recommendations made within this study will be equally applicable to the Battleford institution. Wherever specific reference is not required, the study refers to the "Saskatchewan Hospital" rather than to the Saskatchewan Hospital, Weyburn.

The methods of research used in this study include: direct observation by the writer wherever possible; interviews with personnel within these departments; correspondence with administrative personnel within these departments who because of distance were unable to be interviewed by the writer; many other resources were drawn upon, such as other Social Work Theses of the University of British Columbia, annual reports of the various departments and hospitals, and articles in professional journals in psychiatry and social

work. Direct observation was an important method, as the writer served his fieldwork placement in the Social Service Department of the Crease Clinic.

CHAPTER 2

SOCIAL WORK FUNCTION IN A PSYCHIATRIC HOSPITAL

Growth of social work practice in psychiatric hospitals has been slow. Social work has, however, become an integral part of the professional team in the care and treatment of mental illness, in spite of the fact that social work function in such a setting is not very broadly known. An examination of the work which social workers do in psychiatric hospitals shows that their responsibilities may be classified according to the three main phases of the patient's treatment and return to the community. These are: (a) admission and diagnosis, (b) treatment, and (c) discharge and convalescent care.

Factors in Social Adjustment Which Call for Social Treatment

Many of the factors in social adjustment which call for some form of social work help, have been determined by Mr. Ernest Schlesinger,[1] who conducted a quantitative analysis of the services rendered by the Social Service Department, Crease Clinic of Psychological Medicine, Essondale, British Columbia. That study found that the following are the areas with which social workers are concerned, in the care and treatment of the mentally ill:

---

[1] Schlesinger, Ernest, Social Casework in the Mental Hospital, Master of Social Work Thesis, University of British Columbia, 1954.

A. Work With The Patient.

I. Fears and worries about being hospitalized.
   (a) Fear of the physical setting.
   (b) Fear of other patients.
   (c) Fear of the hospital staff.

II. Social problems consequent to hospitalization.
   (a) Financial difficulties.
   (b) Adequate care for dependent children.
   (c) Fear of permanent separation from family and friends.

III. Fears and worries which arise out of conscious real conflicts.
   (a) Fear of accepting unpleasant situations of which he is aware.
   (b) Worry arising out of possible misunderstandings between; husband and wife, parents and their children, siblings, and misunderstandings arising within the social group to which the patient belongs.
   (c) Fear of accepting one's own limitations.

IV. Fears and worries about leaving hospital and resuming former cares and responsibilities.
   (a) Environmental.
      (1) Employment uncertainties.
      (2) Housing difficulties.
      (3) Need for continued help in keeping house, in the case of married women.
      (4) Need for recreational and leisure-time outlets.
   (b) Emotional.
      (1) Fear of loss of safety felt in hospital.
      (2) Fear of being unable to perform one's former job.
      (3) Fear of not being liked by one's family and friends.

B. Work With The Patient's Relatives.

I. Fear of one's relative being placed in an institution about which they know little.
   (a) Fear of the physical setting.
   (b) Fear of their relative being placed among "crazy" people.

II. Shame over having a mentally ill relative.
   (a) Feeling of discomfort about commital.
   (b) Feeling of discomfort about being "cause" of illness.

(c) Shame of mental illness in the family.
(d) Fear and concern about strange behaviour of patient prior to admission.

III. Social problems consequent to hospitalization.
(a) Financial problems.
(b) Adequate care for dependent children.
(c) Fear of patient not returning to them.

IV. Feelings of fear and discomfort in the presence of the patient.
(a) Not knowing how to visit with a mental patient.
(b) Not being able to like the patient as he/she is.
(c) Worry arising out of possible misunderstandings between them and the patient.
(d) Fear of not knowing how to deal with the patient when he/she returns home.

It can thus be seen that the social problems or "reality problems", which hinder social adjustment are ordinary life experiences. They are to the particular person at a particular time in their life, a causation for a degree of incapacitation in social adjustment. The aim of social work is to assist people who are experiencing reality problems, toward a more comfortable social adjustment.

Social Work Function Today

The provision of professional social services to the patient directly, is a relatively new area of social work. As was pointed out earlier in this study, social work first entered the broad field of care and treatment of the mentally ill in England in 1880, in the form of after care programs for discharged patients. In America the first social worker to be staffed by a mental hospital, initiated an after care program at the Boston Neurological Clinic in 1905. This

social worker's responsibilities were soon extended to include another important responsibility of social work--that of obtaining background information about the patient and his social adjustment prior to his admission. Over the years, social workers became more competent to relieve numerous emotional problems of distress, and were able to make a unique contribution toward the treatment of the patient's illness. In progressive institutions for the care and treatment of the mentally ill, social workers were encouraged to participate in the teamwork approach to mental illness.

The growth of Social Service Departments in the mental hospitals has been slow. The reason for this slowness in growth might be attributed to the fact that hospital workers are continually dealing with people whose mental suffering is much more severe than that of people who receive help from other agencies. Such a milieu does tend to have a distressing effect upon hospital workers, as is borne out in the fact that in the United States, only one of twenty social workers will accept a position in a psychiatric setting. Another significant factor which tends to discourage social workers from accepting positions in mental hospitals, is the multi-disciplined structure and the inherent difficulties of promoting collaborative teamwork. The majority of social workers prefer to work in agencies where social work itself is the discipline of authority. The hospital social worker carries large caseloads, and is unable to escape from the

great numbers of legitimate demands placed upon him by physicians, nurses, the patient's relatives and the patients themselves. Because of the great shortage of social workers, suitable rotation schemes to permit provision of social services on week-ends and statutory holidays is often impossible, the result being that a social worker is often called upon during off-duty hours to see anxious relatives, who were unable to visit the hospital during work hours. Because of this, many social workers prefer employment in agencies where demands made upon them are fewer in number, of a less urgent nature and where these demands come from fewer sources. The pronounced stigma formerly attached to mental hospitals resulted in their being constructed in out-of-the-way localities, which appear much less attractive to social workers who can obtain employment in urban centres.

Dr. A.L. Crease was appointed as Senior Medical Superintendent of the British Columbia Mental Health Services in 1926. In his first Annual Report to the Provincial Secretary, he recommended the setting up of a Social Service Department at the Provincial Mental Hospital, Essondale. In 1930, Dr. Crease's recommendation had still not been acted upon, so the National Committee on Mental Hygiene sponsored Miss Kilburn for one year as social worker at the Provincial Mental Hospital. Her duties were to include: securing social information regarding the patient's family, making plans for patients being discharged and providing these

patients with follow-up care. By the close of that year, the hospital administrators were so thoroughly convinced of the value of such a personnel, that Miss Kilburn was made a member of permanent staff. Miss Kilburn did a great deal in laying the firm base upon which the present department has developed. She served as director of that first Canadian Social Service Department in a mental hospital for twenty years. When she retired in 1950 the department consisted of thirteen social workers.[1]

At Essondale, British Columbia, the first noted social worker participation in admission, treatment and convalescent procedures occurred soon after Miss A.K. Carroll's appointment in 1951, as the Provincial Supervisor of Psychiatric Social Work. At that time Admission Sections were established within the Social Service Departments at the Crease Clinic and the Mental Hospital, and casework services were extended to both patients and their relatives. Casework services were extended to include not only admission, but also treatment and convalescent procedures, as well as the customary services of history taking and providing follow-up care.

At the Ontario Hospital, London, the After Care Department was established to provide follow-up care for all patients discharged from that hospital. The only profes-

---

[1] Pepper, Gerald W., Social Worker Participation in Treatment of the Mentally Ill, Master of Social Work Thesis, University of British Columbia, 1954, p. 21.

sional social services which are offered by this department during the patient's stay in hospital, are those which may be given to the patient's relatives. The need for casework service to the patient from the time of admission to the time of referral to the After Care Department, was expressed by the Director of that department in a paper written by himself entitled After Care Program, Ontario Hospital, London. In this paper, Mr. Gamble states:

> The lack of co-ordination between After Care and the Hospital is a major problem. The answer in part at least to this problem is another worker who would participate in admission and reception procedures and would establish a relationship with the patient from the earliest possible moment in his hospitalization and integrate it with his hospital treatment program and his post-hospital treatment from the field worker of the After Care Department.

In a letter received from the Director of the After Care Department, dated January 1955, he states:

> Recently we have added to our staff and to our program the services of a caseworker within the hospital whose function is casework with patients from admission to the point when they leave the hospital and are referred to one of our field workers.

Social Services During Admission

Being admitted to a mental hospital is always a very frightening and difficult experience. Because of the lack of public education about mental health, many emotionally sick people postpone seeking treatment so as to avoid the stigma which public thinking tends to associate with mental illness. Consequently, when admission to a hospital becomes a necessity, that individual's feelings of

failure and shame are enhanced through his failure to overcome his problems secretly. In the case of mental illness, the patient or possibly his relatives very often feel a sense of responsibility for the illness. This contributes usually to the difficulties experienced on or at the time of admission to a mental hospital. In addition, the mentally ill person is often sick because he is hyper-sensitive to life experiences. Because he is very sensitive, and especially so at the time of illness, admission to a strange environment creates many fears within him.

Often the patient's relatives have many reservations in having a family member admitted to a mental hospital. Their reservations may be due to one or several reasons. They may have guilt feelings about the patient's illness and fear that the doctor will "take sides" with the patient against them. They may fear the public's reaction to them, if it becomes known that a member of the family is receiving psychiatric treatment. They may want to rid themselves of the patient, and feel uncomfortable because of this real wish.

At the point of admission, the social worker is competent to offer professional social services, which may be of help to both the patient and his relatives. A warm, accepting, sympathetic, and understanding talk with a social worker at this time may go far in relieving anxiety and fear over admission.

The social worker is trained not only to accept people with their individual difficulties, but also to have a

knowledgable grasp of human behaviour and adjustment problems. The social worker at intake is often the first person who is willing to listen to and accept the patient's problem as the patient sees it.[1] This has been found to be a very effective means for relieving feelings of guilt, fear and hostility; so that both the patient and his relatives are able to participate in the prescribed plan of treatment.

At the time of admission, "it also is important to determine whether any social 'first-aid' measures are necessary. Thus, it is important to know if the patient's family have enough to eat, is properly clothed, has adequate shelter, has economic provision to supply these very basic and essential needs which are necessary for survival and for maintenance of simple dignity while the patient is hospitalized."[2] Should the patient be the parent of dependent children, it is important that the necessary provisions be made for their adequate protection. "These so-called 'first-aid' measures may seem like simple things about which social

---

[1] Should the patient see his problems in terms of a delusional system, the social worker will have received confirmation on this from the doctor, and will not discuss the patient's delusions, but will help the patient to hold on to reality by stressing real things. The social worker will focus the interview onto more factual material as soon as possible and attempt to arouse the patient's interest in environmental realities which are felt not to be too threatening for the patient. This is in keeping with the social worker's professional competency--he works only with those problems of which the patient is conscious.

[2] Abrahamson, A.C., "The Role and Responsibility of the Social Worker in Corrections", Unpublished Paper, School of Social Work, University of British Columbia, pp. 2-3.

workers need feel no apology."[1] The help which a social worker can give both to the patient, and to the patient's relatives in settling the immediate problems which arise out of the patient's temporary absence from the family unit, has proven to be very helpful in enabling patients to enter hospital and accept medical treatment.

Knowledge and skill in social work is not merely a matter of providing social 'first-aid' measures. Screening cases for referral to continuing casework service is now becoming a very important responsibility of the social worker at the time of a patient's admission to hospital. Because of the shortage of social service personnel in mental hospitals and also because not all patients are able to use social work help, it is important that screening be carefully done, so as to ensure the greatest possible efficiency in the provision of social services. At the Crease Clinic and the Provincial Mental Hospital at Essondale, British Columbia, this screening process is carried out by the Intake Social Worker of the Admissions Section. A second screening is done at Ward Rounds, where both the doctor and the social worker participate in the screening process. At the Ontario Hospital, London, Ontario, each case is presented at a General Conference three weeks following the patient's admission. The director of the After Care Department attends these conferences and together with the medical

---

[1] Ibid., p. 3.

staff determines those cases which will likely require, and be able to use social services following discharge.

The screening process involves formulating a 'social work diagnosis'. A social work diagnosis is not a single word or phrase, but rather a descriptive statement which includes at the very least:[1] (a) brief identifying information; (b) the presenting problem and the other stresses of the patient and his family in generalized terms; and (c) a brief personality characterization. The social worker achieves a social work diagnosis through a social study, which is done through a casework relationship with the patient and relevant persons, also through collateral contacts for which the patient has given permission. This social study includes the patient's marital, vocational, educational, religious and psychosexual adjustments; achievements and failures; the patient's childhood experiences; the patient's social environment--its strengths and weaknesses; an assessment of the patient's interpersonal relationships with family members, members of his social group, his employer; and the history and nature of onset of the present illness. A social study and consequent social diagnosis can provide for us "an excellent picture of the individual's social functioning, and social situation, a good picture of one's current emotional functioning including his dominant character traits, symptoms, and

---

[1] Hollis, Florence, "Casework Diagnosis - What and Why", Smith College Studies in Social Work, Vol. XXIV, No. 3 (June 1954), p. 1.

defences. It can throw considerable light on the major social factors which bear on the patient's illness and can give us some useful indication of psychological factors in this development."[1] It can thus be seen that the social work diagnosis is unique onto itself, in that it relies on an understanding of the total family or the social group of which the patient is a member. Interacting forces within the family and social group must be considered along with the interacting forces within the individual, in understanding causation and in setting realistic treatment goals. Because the social work diagnosis focuses attention on the patient's social environment, the social worker can assist the doctor and other hospital disciplines in arriving at a comprehensive diagnosis.

Social Services During Treatment

Treatment of the mental patient commences at the moment when the patient is received into the hospital. At that time, the patient leaves an environment, the demands of which he is no longer able to cope with; and enters into an environment which is less demanding and of a protective nature--the psychiatric hospital. The patient is not merely placed within a physical plant, he is placed in a hospital which is staffed by many people whose energies are concentrated on the treatment and rehabilitation of each patient. Each

[1] Ibid., p. 2.

and every staff member whether he be doctor, nurse, psychologist, social worker, or the gardener, and whether his contact with the patient be casual or planned, is carrying out a treatment function which may have fundamental or superficial value, depending on its meaning to the individual patient. Even simple gestures such as a warm smile or a friendly greeting from any member of the staff often has therapeutic value for the patient. However, "warmth of interest for the patient and a willingness to offer a relationship to him are only conditions to successful treatment".[1] Within this condition for treatment, each discipline with its particular orientation and unique skills must participate in the total treatment plan in order to do an adequate job.

Because treatment of the mentally ill has become a multi-disciplined approach, and also because each of the participating disciplines has sometimes failed to define its own function, the inevitable result has been a lack of inter-disciplinary understanding and acceptance, the consequent result being poor cooperation between all member-disciplines of the treatment team. The failure of each discipline to differentiate "its psychological helping procedures from those available to the other disciplines, has hindered clarification of function based upon

---

[1] Schmidl, Fritz, "A Study of Techniques Used in Supportive Treatment", Social Casework, Dec. '51, p. 491.

the potential and desirable uniqueness of different professional orientations".[1] The following quotation attempts to distinguish between the therapy (psychological helping procedures) practiced by psychiatrists and that practiced by social workers.

> Psychotherapy aims to help the patient achieve a different organization within the self. Through this reorganization and reintegration the patient is enabled to respond to other people, to enter inter-relationships, to manage his situation with a more reliable sense of what is real in himself and in them. Social work, on the other hand, works with whatever powers the patient has to decide and act for himself in his immediate situation.
>
> In a psychiatric setting, we might say that the therapy practiced by the psychiatrist aims to assist the patient to recover and reorganize the power in himself, to get hold of it again; and the social worker helps the patient to exercise this power and learn how to use it in gaining more satisfactory control of his living. The two functions are complementary and equally important. The patient can not stay in the magic circle of therapy even within the hospital: even within the hospital there is an environment which he has to meet and with which he has to cope. Whatever new power is developed within him, he has to find a way of using in behalf of his own recovery. He has to find a way of functioning differently with the new strength, and to leave this to chance may result in an arrest or a relapse of his inner progress.
>
> The social worker really uses the outer necessities for living that confront the patient as the basis for helping him; even as the psychiatrist uses the patient's desire to find a way out of inner fear and pain as the therapeutic dynamic.[2]

---

[1] Coleman, Jules V., M.D., "Distinguishing Between Psychotherapy and Casework", Journal of Social Casework, June, 1949, p. 245.

[2] Marcus, Grace, "A Further Consideration of Psychiatric Social Work", National Conference of Social Work, Columbia University Press, 1946, pp. 339-40.

Of many social casework definitions formulated, the one by Mary J. McCormick is selected because of its clarity:

> The entire process is directed toward the human person and is carried on for the purpose of giving service that contributes to the well-being of that person.... The character of the service itself may vary according to the capacities and limitations of the particular individual for whom it is intended. This means that at times it will embrace the attempt to develop whatever personal resources such an individual possesses for meeting and solving his own problem. At other times, service will be directed toward augmenting those personal resources through the use of facilities that exist within the social order. In either event, the aim of casework is always the same, that is, to preserve human dignity through meeting human needs within the protected setting of hospital.[1]

The social work treatment process has as its purpose the provision of social services which will contribute toward the well-being of the individual, and consequently enable him to meet and cope more successfully with his reality problems. A reality problem may be one or several of the ordinary life experiences, and the social work treatment process used is always essentially the same.

Social work treatment in the field of public assistance begins when the breadwinner of a family is no longer able to cope with reality in the sense that he is no longer able to provide for himself and family. This inability to provide, is to him a reality problem. The social order may offer financial assistance to this family

---

[1] McCormick, Mary J., Thomistic Philosophy in Social Casework, Columbia University Press, N.Y., 1947, p. 3.

through a public assistance agency, so that the immediate reality problem of family finance is met. This however, is only a social first-aid treatment measure. His inability to provide may be the result of factors external to him such as physical incapacitation; or it may be due to factors within him such as worry and fear associated with marital matters, unpleasant interpersonal relationships with fellow workers, fear aroused through misconceptions. Further social services may be provided to this family through the treatment process, so that these more basic reality problems might be overcome, even though they are of an intangible nature.

Social work practiced in direct relation to psychiatry, is essentially the same. The presenting problem is the patient's illness, for which the social order has again provided a particular type of agency--the psychiatric hospital. Similarly to the above mentioned case, there are more basic problems underlying the presenting problem. These may be of an unconscious conflictual nature, with which the social worker does not deal. They may also be conscious reality problems, which in turn may be of a tangible or an intangible nature.

> The life situation frequently presents problems in which all the elements of the conflict are on a conscious level; but in which the individual can not find or decide upon an effective course of act-

> ion. This can result in symptoms as incapacitating as those that arise primarily from unconscious conflict.[1]

Many of these have been enumerated in the earlier part of this chapter. The social worker is concerned with these reality problems which confront the patient in his day to day living, because he uses them as a basis for helping the patient toward a more satisfactory social adjustment.

The social worker offers two broad types of services: (1) tangible services or social first-aid measures and (2) help with conscious emotional conflict. Both types of service are in actual fact inseparable, in that the social worker can not at one time offer tangible services, and at another time carry out social treatment.

> Social workers may render specific services or give suggestions about the handling of critical problems at any point in the treatment contact, but in so doing, it is their primary concern to relieve the patient's feeling which is necessary to enable the patient to utilize these services and suggestions in a growth direction.... Treatment in any case implies a meeting of the needs of the individual. This involves diagnostic skill and the capacity for relationship. The nature of treatment is not pre-determined by the social worker, but is determined by the response of the individual.[2]

Not all patients within psychiatric hospitals are able to use all of the services which a social worker can

---

[1] Welker, Edmund, M.D., "The Effectiveness of the Psychiatric Social Worker in the Treatment Situation", Mental Hygiene, 1947, p. 597.

[2] Towle, Charlotte, "Factors in Social Treatment," National Conference of Social Work, 1936, pp. 179-80.

offer. In some cases, the illness is so incapacitating to the patient, that his potentiality for relationship is almost completely lost until the psychiatrist is able to "assist the patient to recover and reorganize the power in himself."[1] During the time that the illness is as incapacitating as this, the social worker can contribute toward the creation of a condition for successful treatment.[2] He can see the patient on the ward at regular intervals, and by so doing, provide the patient with a regularly occurring personal event so as to help him grasp on to reality. The social worker can offer acceptance and understanding. He can show a friendly interest in the patient. He can help the patient hold on to reality, by stressing real things which are not too threatening to the patient. The social worker does not disclaim the patient's delusions. Instead he accepts them as being real to the patient, moves onto more factual material as soon as possible, and attempts to arouse the patient's interest in environmental reality. This is in keeping with the social worker's area of competency--he deals only with those problems of which the patient is conscious. Along with helping the patient hold on to reality, the social

---

[1] Marcus, op. cit., p. 339.

[2] v. infra, p. 13.

worker offers the patient reassurance that his/her dependents are being cared for, if need be, through social services provided by the social order.

> For example: Mr. X. was admitted to hospital following what the doctor diagnosed as being a 'schizophrenic reaction'. Mr. X. is thirty-five years of age, is married and has an eight year old daughter. In an interview with the patient's wife, the worker learned that the patient is very fond of his daughter. When discussing the case with the doctor, the worker learned that the patient has delusions in regard to his committal to hospital. The patient feels that his wife had tried to poison him by placing poison in his food, but when he refused to eat the food which she had prepared for him, she had two men take him away and lock him up.
>
> When the social worker saw the patient, and was told of these circumstances which he thought had led to his admission, the worker listened sympathetically. However, as soon as could gently be done, the worker advised that he had seen his little girl recently, and that she seems like a very nice little girl. As the patient seemed to grasp on to this, the worker went on to say that Mrs. X. and Joan were both well and are planning to visit him soon.

The social worker must first establish a relationship with the patient, before he can help him to direct newly restored ego-strength into satisfying interpersonal relationships, and more effective courses of action in dealing with his reality problems. A social work relationship implies an emotional interplay between the patient and the worker, or the patient's relative and the worker, which is directed in such a way that the patient or relative experiences acceptance and understanding. As the patient experiences a non-critical atmosphere, he gains a feeling of security which enables him to express his feelings and

attitudes, and by so doing gain self-understanding and self-acceptance. In working with relatives, this accepting and non-critical atmosphere enables them to overcome feelings which have been preventing their acceptance of the patient and his illness.

During the patient's hospitalization, he is still within an environment which places demands upon him, even though it is protective and less complex than that from which he came prior to admission. Even in the hospital environment, the patient experiences reality problems with which the social worker can help him to cope, thus enabling him to participate in the total treatment plan. Through the social worker's help in dealing with reality problems within the protected hospital environment, the patient is enabled to deal with those reality problems associated with normal community living.

> If the social worker can help the patient with the social problems related to work and playing in this protected environment, he may prepare the patient to meet social problems in the wider community, with more understanding of himself and others....Through the social worker's continuous support and acceptance of the patient's 'sick' and 'well' self; through his non-judgmental and understanding attitude, his knowledge of the obstacles standing in the way of the patient's social adjustment, and his help in getting over these hurdles one by one; the patient may gain increased self-confidence and courage to face the world outside.[1]

"It is this relatedness aspect of personal problems to situations which is the concern of social workers."[2]

---

[1] Garland, Ruth, "The Psychiatric Social Worker in the Mental Hospital", Mental Hygiene, 1947, pp. 289-90.

[2] Coleman, op. cit., p. 247.

This however, does not imply that the social worker does not deal with the patient's conscious feelings, and the impact of his personality upon reality situations in which he is a functioning social being. If the patient is strong enough he is helped to look more searchingly at his attitudes so that he will better understand himself in relation to his situations and thus be better equipped to deal with them.

Augmenting the personal strengths within the individual patient and/or relative sometimes necessitates the enlistment of help from community resources on behalf of that individual.

"Mental illness is often all-pervasive, so that help in many social areas is required, with the hospital social worker offering his skills concurrently"[1] with social workers who are working within the framework of various community agencies.

> For example: Mr. S. is admitted to hospital, and the psychiatrist feels that long term treatment is indicated. In an interview with Mrs. S. (patient's wife) shortly after the time of the patient's admission, the social worker finds that in addition to feelings of fear and shame associated with the patient's illness, Mrs. S. and her children are without financial security. On discovering this difficulty within the home, the social worker discusses with Mrs. S., the possibilities of her contacting the local Social Assistance agency with the view to obtaining financial help. It was only with feelings of shame that Mrs. S. didapply for financial help. Mrs. S. was now faced with two reality problems: (1) the fact of the patient's illness and hospitalization, and (2) accepting financial help because of her husband's illness. The hospital social worker

---

[1] Garland, op. cit., p. 291.

offered help in the former, the Social Assistance agency social worker offered help in the latter.

Sometimes the hospital social worker does not work concurrently with the social worker from the community social agency. Instead, he prepares the patient during his stay in hospital so that he might feel free to use the social services of another agency, following his discharge from hospital.

> For example: Mr. A. is admitted to hospital, and re-receives short term treatment. In interviews with the patient and his wife, the social worker learned that for some time there has been considerable marital discord in this marriage. The hospital social worker will only deal with those matters directly related to the patient's hospitalization, at the same time preparing both the patient and Mrs. A., so that they might feel free to accept social work help from a Family Counseling agency following discharge, as both expressed concern over the possible effect of their constant quarrelling upon their three small children.

The social worker is concerned with the patient's interpersonal relationships, consequently, he is interested in the patient's relatives and relevant associates, in so far as their thinking and attitudes affect the patient's mental condition. The social worker can offer acceptance and understanding to the patient's relatives, and thus enable them to express their feelings of fear, hostility and possible guilt in relation to the patient and his illness. Through this release of feeling in a non-critical atmosphere, they are enabled to accept the patient, the illness, and thus help the patient to participate in prescribed treatment procedures. The social worker can help

the relatives in this way, to "make of this ending, a new beginning for the patient and for themselves in bringing about changes which will create a more favorable psychological and social environment."[1]

As Helen Witmer states, to sense what a person is trying to say, to create a situation in which he can say it and to keep one's own feelings and opinions from interfering with another person's expression of emotions and attitudes requires a great skill and disciplined sensitivity and a flexible use of one's relationship with a patient or his/her relative.

The social worker's approach to the patient is unique. Minna Field, Assistant Chief of Social Service at the Montefiore Hospital, New York, describes the social worker's approach as follows:

> The social worker's approach differs from that of the other members of the treatment team, his relatives or his friends. While the very nature of their functions imposes upon the other members of the treatment team the obligation to exercise authority, and while the attitude of family members and friends may be colored by their own emotional reactions, the social worker can remain free from the need to prescribe any particular line of action and from emotional entanglement. Rather, the social worker's approach is governed by an attempt to see the problem as the patient sees it, to allow the patient to move at his own pace, and to make his own decisions toward a goal that he helped to set for himself. Such an approach can be carried out only when it is rooted in the genuine appreciation of the intrinsic worth and dignity of the human being regardless of the stage of his illness or the degree of incapacitation it produces. For the patient, such an approach

---

[1] Ibid., p. 292.

assumes particular significance in the light of an illness that tends to undermine his feelings of usefulness and status.[1]

Social Services During Rehabilitation

Public acceptance of social welfare goals has advanced to include the aims of rehabilitation of all disabled persons. Concern with the problem has been so great, that the word rehabilitation has become very broad in its meaning, including all the various types of help given to those citizens who for any reason are not able to be self-sufficient. "Rehabilitation and after care is more intimately the concern of a hospital or treatment institution because the aim of these agencies of the community is to see the patient through to maximum social integration into the community."[2] A general definition of rehabilitation is the statement made by the National Council on Rehabilitation, New York, to the effect that rehabilitation is the restoration of the handicapped to the fullest physical, social, vocational and economic usefulness of which they are capable.

In a sense, "rehabilitation" in the psychiatric setting is similar and identical to "treatment", in that

---

[1] Field, Minna, "Role of the Social Worker in a Modern Hospital", Social Casework, November 1953, p. 399. This paper was presented at the International Congress of Hospitals in London, May 1953.

[2] Sutherland, Murray S., The Rehabilitation of Discharged Mental Patients, Master of Social Work Thesis, University of British Columbia, 1954, p. 16.

rehabilitation includes the entire process of a patient's treatment in hospital and his return to routine civilian living. Similarly, it could be said that treatment is identical with rehabilitation, because rehabilitation is the result of successful treatment. For the purpose of this study, the term rehabilitation is used to refer to the latter portion of the treatment goal, which includes plans and programs for that period following the patient's discharge from hospital.

There are several factors during this pre-convalescent period and post-discharge period which do point up the need for social treatment. During convalescence, the patient is preparing himself for leaving the protected environment of the hospital and for returning to the complexities of life within a family, vocational, and social setting. There are many reality problems inherent in making the adjustment from hospital living to living in the community. Mr. Murray Sutherland conducted a survey of the post-discharge problems of mental patients.[1]

A majority of patients are discharged directly back to their families or friends with the assistance of adequate social casework before and during the actual rehabilitation placement. The problems of this group may not be primarily associated with their illness but may be

---

[1] Information contained in the three proceeding paragraphs is taken from: Sutherland, Murray R., Rehabilitation of the Discharged Mental Patient, Master of Social Work Thesis, University of British Columbia, 1954, pp. 22-25.

directly associated with the physical disruption of routine family living resulting from the absence in hospital of the housewife, the mother or the bread-winner. The family member's absence from the home may have added problems and responsibilities for a wife or husband, privation for the children; and supportive case-work help is requested in facilitating the family's return to more stable equilibrium.

It has been found, however, that there are many patients who do not possess family, friends, or financial resources; or whose family and friends are disinterested or actually hostile or resentful. These patients require more extensive help and support from the social worker in becoming more securely established in an emotionally healthy environment. This group has a wide variety of needs. First of all, there are a multitude of basic dependency needs which must be met before they are re-established in the community: money, food, clothing, shel-ter, a job, a meaningful relationship with an interested person or persons. For a person who has been hospital-ized for a mental or nervous disorder, the return to the community is often a threatening experience; and to lack the security of friends and adequate finances enhances this feeling of distress and uncertainty, and in turn in-creases the possibility of a relapse and a return to hos-pital. These patients may look to their discharge with

all the insecurity of a person recovering from an illness, or they may prefer to regard themselves as never having been sick, but in either event they are fearful of the rejecting attitudes of society.

There are also many patients who leave the hospital with a residuum of the mental disorder or the upset which led to their hospitalization. These patients have received treatment and have made a certain recovery, enabling them to return to the community; but they have retained a certain mental handicap which adds to their problems of re-establishment. Such patients may retain undue feelings of submissiveness, or depression, or anxiety, or fear of people. Sometimes these feelings are related to an unresolved marital conflict, or an unsatisfactory work adjustment which precipitated the breakdown but remained unsolved. Sometimes the feelings are the end result of years of emotional deprivation or conflict with parents. The inner problems of these patients may be of such severity that they cannot be further reduced by known methods of psychiatric therapy; but they are persons whose life can be made more comfortable by a kinder environment or by the sympathetic understanding and interest of the social worker who continues to see them. This type of patient needs help in meeting the additional stresses of securing accommodation, a job, and of functioning as best he can in our complex society. For such a person with a severe

mental handicap, the psychiatrist sometimes recommends sheltered accommodation, a protected work placement or financial subsidization in maintenance. But if community resources are lacking to make possible the implementation of such recommendations, the social worker must seek out the best available compromise solution and help the patient as best he can to adjust to a limiting situation.

What Do Social Workers Do?

The social work treatment process is a method of assisting persons who are experiencing difficulty in making a satisfactory social adjustment. In a psychiatric setting, the entire process is patient-focused, with the purpose of providing him or her with those social services requisite for a more comfortable way of life. It has been seen that there are many factors in social adjustment, which might at some time call for some form of social work help. It might be restated that these factors in social adjustment which call for social work help are normal life experiences, which are to that particular person at that particular time a cause for temporary incapacitation. The patient's relatives and significant persons in his or her life often require help in making a more comfortable adjustment to the patient and the illness. Social work respects people's rights. Therefore when helping the patient's relatives, the social worker only deals with

those conscious feelings which have a direct bearing on the patient's illness.

At the time of the patient's admission to hospital, the social worker is often able to help the patient feel less frightened of living in a new place. He is often able to help the patient's relatives feel more comfortable about having a family member admitted to a mental hospital, and about the patient's temporary absence from the family unit. The social worker is able to do this by helping the relatives to maintain a standard of living and simple dignity, both of which are essential for survival. This is accomplished through the administering of or arrangement for social first-aid measures such as financial help, care for children, vocational help; to say nothing of the intangible types of help, such as encouragement and reassurance.

During the time immediately following admission, the social worker with his professional orientation toward social living, is able to assist the doctor by contributing toward a comprehensive diagnosis, and the formulation of a total treatment plan.

During treatment, the patient is still a part of an environment, and must conform with certain demands that the hospital environment places on him. The social worker through his acceptance of the patient and support of his

or her strengths, helps the patient overcome little reality problems one by one, until the patient feels capable of dealing with the complexities of a family, vocational, and social setting. The social worker helps the patient to adjust as comfortably as possible to the hospital routine, and serves as a link between the patient and his or her family. As psychiatric treatment progresses, and the patient regains ego-strength, the social worker helps the patient to decide and act for him or herself in relation to the immediate situation.

During rehabilitation and convalescence, the social worker still using the patient's immediate situation as a basis for helping him or her, assists the patient to re-establish him or herself in an environment which is as emotionally healthy as possible. Help is often required in restoring the equilibrium of the family unit which had become disturbed because of the patient's temporary absence. Patients who retain a residuum of their illness need social work help so that the best possible adjustment to a limiting situation can be made.

Social Casework Techniques

The Family Service Association of America, an organization consisting of a representation of all American Family Welfare agencies, has made the statement that

social casework techniques are three in number. They are: (1) environmental modification (2) psychological support and (3) clarification. Some social workers speak of "use of the relationship" as being another technique. The worker-patient relationship is the basis for all social work help, so is therefore a part of the three mentioned techniques.

Environmental Modification

Modification of the patient's environment occurs when "steps are taken by the caseworker to change the environment in the patient's favor by the worker's direct action."[1]

> For example: Mrs. L., a middle aged woman who does not have any children, is experiencing difficulty in making a satisfactory adjustment to the incapacitation of one arm and one limb, resulting from injuries sustained in an automobile accident. Extreme financial insecurity in this family unit arose out of heavy medical expenses and also Mr. L.'s loss of employment. These environmental pressures eventually resulted in Mrs. L. experiencing a mental breakdown and being admitted to a mental hospital. In an interview with the patient, the worker sensed the great fear which the patient had of having to remain in hospital because of her inability to perform her household duties and their inability to pay a housekeeper. The doctor recommended an early discharge of the patient from hospital. In working with both the patient and her husband, the worker was able to help Mr. L. make

---

[1] Hollis, Florence, "The Techniques of Social Casework", Principles and Techniques in Social Casework, Cora Kasius, Editor, Family Service Association of America, 1950, p. 413.

use of an employment service agency, which helped him to locate part-time work.

The worker also helped this family to make application to the local Social Assistance agency for financial help so that they might employ a housekeeper. Through modification of the excessive environmental pressures, which were financial in this case, both the patient and her husband were enabled to work through a reality problem toward a more satisfying social adjustment.

Psychological support

This casework technique involves "supporting the positive, constructive aspects of the personality through guidance, release of tension, and through direct encouragement of attitudes that will enable the client to function more comfortably and realistically."[1]

For example: Mrs. M., a young married woman and mother of three small children was admitted to hospital for psychiatric treatment following an attempted suicide. Psychiatric and psychological assessments indicate the patient to be emotionally immature, especially in the sexual sphere. In spite of her immaturity, it was felt that Mrs. M. was capable of being a good mother. During early contact with the doctor and the social worker, the patient expressed a great deal of hostility toward her husband, and also expressed the fear of having more children. At this time, the patient saw her fear of future pregnancies as being the "only stumbling block" of her marriage. The patient insisted that if she could not be made sterile that she could not return to her family. The worker accepted the patient's feelings of hostility and dissatisfaction, seeing her position as being a difficult one. Through acceptance, the worker helped the patient to discuss her feelings further, and as social treatment progressed, Mrs. M. was enabled to

---

[1] Casework Glossary, Abrahamson, Exner McCrae, School of Social Work, University of British Columbia, (mimeographed), June 1954.

move on to recognize and discuss other reality problems in her marriage, such as poor housing, little opportunity for recreation, and an unsatisfactory interpersonal relationship with her mother-in-law. During social treatment, the worker supported the patient's strengths which were her ability to be a good mother and housekeeper. The worker also helped the patient to see herself as being independent from her mother-in-law and reassured her that she and her husband had the right to make their own decisions.

Clarification

This casework technique attempts to "make clear. It is helping the patient through mutual rational and intellectual discussion to more clearly understand himself, the people with whom he associates, and the circumstances he faces."[1]

For example: Miss R. is a twenty seven year old stenographer, who has been discharged from hospital, but according to psychiatric assessment, retains a residuum of her illness in that she is supersensitive in interpersonal relationships. Miss R. contacted the Out-patient Service worker in her region. She discussed with the worker how she often felt slighted at the office, of how her acquaintances were attempting to drop her, and how they were indirectly critical of her.

The worker helped Miss R. to see that a friend's invitation to a third person to accompany them on a trip to the museum did not mean that the friend was trying to break off the relationship with Miss R. Clarification of misunderstandings were accomplished through the worker and Miss R. discussing each incident carefully; the worker asking questions about details, and about Miss R.'s interpretation of these happenings; to help her re-evaluate them more realistically.

---

[1] Ibid., Casework Glossary.

Evaluation of Social Services Rendered

An evaluation of the various Social Service Departments under examination will show the areas into which social workers are directing their energies; and also the percentage coverage of the total population of the respective institutions. All material related to the Social Service Departments at the Crease Clinic, of Psychological Medicine, and the Provincial Mental Hospital, Essondale, British Columbia, is taken from the British Columbia Mental Health Services Annual Report for the year ending March 31, 1953. The writer regrets not being able to show statistically the work which is being done by the After Care Department of the Ontario Hospital, London, but Mr. J.E. Gamble, director of that department, replied to the writer's request for such information as follows:

> We do not produce any annual reports, as such, from the After Care Departments. However, it may interest you to know that we are now involved in an evaluation of this rehabilitation unit. It is to be a comprehensive survey of our work over the past five years.

Social Service Department, Crease Clinic

Table 3 records the year's work of the two social workers on admissions. Of 1,221 patients admitted to the Clinic, 573 (46.9 per cent) were extended social services at the time of reception into the Clinic.

Table 3. Report of Admissions Section, Social Service Department, Crease Clinic, April, 1952 to March, 1953.

	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Total
Total admissions, Crease Clinic	107	120	119	83	86	92	94	89	88	129	108	106	1,221
Referrals for social-history study	21	25	32	21	29	23	26	17	81	121	99	78	573
Interviews with patients at time of admission	13	25	23	33	21	22	24	20	51	36	32	24	324
Interviews with psychiatrists and nursing at time of admission	25	27	32	26	22	24	28	29	103	101	89	85	591
Interviews with other agencies	15	18	21	28	19	23	20	12	9	7	11	16	199
Brief services to patients and relatives	14	19	10	17	11	12	15	14	54	47	23	82	318
Ward rounds following admission clinics on admission	12	8	8	4	4	8	12	12	8	8	8	12	104

Source: Mental Health Services, British Columbia, Annual Report, for the year ending March 31, 1953.

Some 318 (55.55 per cent) of these 573 patients and their families were carried in the Admissions Section for a short period of time receiving casework services of an enabling supportive nature. The table further indicates that the Admissions Section undertook 591 conference interviews with psychiatrists and nurses, to a furtherance of a collaborative working relationship, in the light of the best possible services for the patient.

Table 4 shows that 1,100 patients were carried actively with the Continued Casework Section. Some 5,155 interviews (49.5 per cent of all interviews) were extended to the patient and his family during the period of hospital care. Of these 5,155 interviews, 1,590 interviews (30.8 per cent) were extended to the patient, and 1,385 interviews (26.8 per cent) to the patient's family. Some

Table 4. Report of Continuing Casework Service Section, Social Service Department, Crease Clinic, April, 1952 to March, 1953.

	Treatment	Pre-convalescence	Convalescence	Total
Interviews with patient	1,590	948	768	3,306
Interviews with family	1,385	368	681	2,434
Conferences with psychiatry	1,635	795	699	3,129
Conferences with nursing	272	236	.....	508
Conferences with other disciplines	48	40	18	106
Conferences with other agencies	225	336	368	929
Total number of interviews	5,155	2,723	2,534	10,412
Total number of patients referred	.....	.....	.....	1,100
Total number of ward rounds and clinics	.....	.....	.....	101

Source: Mental Health Services, British Columbia, Annual Report, for the year ending March 31, 1953.

2,723 interviews (26.2 per cent of all interviews) were extended to the patient and his family in planning for discharge. Of these 2,723 interviews, 948 interviews (34.8 per cent) were directed to the patient, and 368 interviews (13.5 per cent) to the patient's family. Some 2,534 interviews (24.4 per cent of all interviews) were extended to the patient and his family following the patient's discharge in full from the Clinic. Of these 2,534 interviews, 768 interviews (30.3 per cent) were directed to the patient, and 681 interviews (26.9 per cent) to the patient's family.

Social Service Department, Provincial Mental Hospital

Table 5 records the year's activity of the social worker on admissions at the Provincial Mental Hospital.

Table 5. Report of Admissions Section, Social Service Department, Provincial Mental Hospital, April, 1952 to March, 1953.

	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Total
Total admissions, Provincial Mental Hospital	86	105	101	133	112	102	147	101	107	116	101	121	1,332
Referrals for social-history study	32	41	37	51	46	40	61	57	34	48	40	37	524
Interviews with patients at time of admission	7	11	18	20	17	23	42	31	21	14	12	38	254
Interviews with psychiatrists at time of admission	11	9	15	9	6	7	13	18	21	16	8	23	156
Brief social services to relatives and patients	15	20	24	18	21	17	37	25	14	23	20	27	261
Further interviews with relatives	11	29	18	11	30	34	33	37	42	15	17	31	308
Ward rounds following admission clinics on admission	4	6	10	4	4	8	8	12	10	12	10	12	100

Source: Mental Health Services, British Columbia, Annual Report, for the year ending March 31, 1953.

The table shows that an average of 111 patients are admitted to the Provincial Mental Hospital monthly. Some 524 patients (39 per cent) of all admissions are extended social services at the time of their reception into hospital. The table further shows that 261 families received brief case-work service during the early stages of hospitalization. The collaborative function of the social worker at the time of admission is indicated in his 156 interviews held with psychiatrists, and his attendance at 100 ward rounds.

Table 6. Report of Continuing Casework Section, Social Service Department, Provincial Mental Hospital, April 1952 to March 1953.

	Treatment	Pre-convalescence	Convalescence	Total
Interviews with patient	1,116	474	867	2,457
Interviews with family	1,327	270	471	2,068
Conferences with psychiatry	1,341	636	375	2,352
Conferences with nursing	525	258	57	840
Conferences O.T., etc.	138	60	9	207
Conferences with community agencies	42	27	15	84
Total number of interviews	4,489	1,725	1,794	8,008
Total number of patients referred	...	...	...	607
Total number of ward rounds and clinics	...	...	...	108

Source: Mental Health Services, British Columbia, Annual Report, for the year ending March 31, 1953.

Table 6 records the total number of patients (607) referred to the Continuing Casework Section of Social Service Department of the Provincial Mental Hospital. During the treatment period 607 patients and their families received casework services involving 4,489 interviews. Some 24.8 per cent of these were directly with the patient, 29.5 per cent with the patient's family and friends, 29.8 per cent with psychiatrists, 14.7 per cent with nursing, occupational therapy, etc.; and 0.93 per cent with community agencies.

During the period of pre-convalescence, when social casework services are directed toward assisting the patient to formulate discharge plans, 1,725 interviews were extended to the patients and the family. Of these, 27.4 per cent were carried out with the patient, 15 per cent

with the patient's family, 36.8 per cent with psychiatry, 18.4 per cent with nursing, occupational therapy, etc.; and 1.5 per cent with community agencies.

Convalescent care is the re-establishment of the patient in the community. During this period the patients on probation remain the responsibility of the hospital. Some 768 patients were referred to Social Service, involving 1,794 interviews by the social workers directed toward helping these patients. Of these, 37.2 per cent were directly with the patient, 26.2 per cent with the patient's family, 20.9 per cent with psychiatry, 3.7 per cent with nursing, occupational therapy, etc.; and 0.83 per cent with community agencies.

The practicing social worker rendering social services does not work under the direction of a psychiatrist, but contributes the knowledge and skill of his own profession in an independent capacity. Administratively, of course, he makes this contribution as an integral part of the hospital structure and unites his independent contribution with that made by members of other professions to form a related whole to the end of helping the hospital fulfill the purpose of improved health to the patients.

The social work profession is traditional for the emphasis which it places upon social work being practiced within an administrative framework. The social work profession is also noted for the emphasis which it places upon the supervision of those personnel who are on the

direct service level of administration.

In most mental hospitals, rather large social service departments are required. To ensure the most efficient utilization of social service personnel, and to ensure the best possible provision of service to the patient from the time of his admission through to rehabilitation, it is evident that an administratively sound structured social service department is essential.

CHAPTER III

AN EXAMINATION OF EXISTING SOCIAL SERVICE DEPARTMENTS

The main purpose of this chapter is to examine the procedures, standards, and the administrative implications of setting up a Social Service Department in a mental hospital. The Social Service Departments which will be examined are: (1) the Social Service Departments at the Crease Clinic of Psychological Medicine and also the Provincial Mental Hospital at Essondale, British Columbia and (2) the After Care Department associated with the Ontario Hospital, London, Ontario. A comparative study is made of these departments according to their development, administrative structure, and personnel. On the basis of their examination, recommendations can be formulated for an anticipated Social Service Department at the Saskatchewan Hospital, Weyburn.

The Social Service Departments, Essondale

The impact of humane emphasis in the treatment of mental illness was also felt in British Columbia, resulting in newer methods of treatment in the mental hospitals and later the inclusion of social workers on the treatment team.

In 1905 Dr. C.E. Doherty, the new medical superintendent at the Public Hospital for the Insane in New Westminster, attempted to foster and nurture policies and treatment procedures which were being established in more modern mental hospitals. Each department was encouraged "to see that the patients receive the best care, treatment, and attention that the sick should receive."[1]

The year 1906 was important in the development of care for the mentally ill in British Columbia. Henry Esson Younge, M.D., became Provincial Secretary and served in this capacity for many years. This able and socially-minded Minister made the mental hospital at New Westminster one of his most vital concerns. His efforts were largely responsible for the new institution at Essondale, British Columbia.[2]

Dr. A.L. Crease was appointed Medical Superintendent of mental hospitals in British Columbia in 1926. In the first of his annual reports to the Provincial Secretary, Dr. Crease recommended the setting up of a Social Service Department to serve the mental hospitals in the province. Many years prior to this, the need for established social services to the patients and their relatives was

---

[1] Pepper, Gerald W., Social Worker Participation in the Treatment of the Mentally Ill, Master of Social Work Thesis, University of British Columbia, 1953, p. 9.

[2] Clarke, James R., Care of the Mentally Ill in British Columbia, Master of Social Work Thesis, University of British Columbia, 1947, p. 44.

recognized, but at that time, no consideration was given to the possibility of these services being provided by professional social workers. It had been recognized that the family played an important part in the rehabilitation of the patient as early as 1897. It was then felt that the "care and attention arising from family affection was conducive to restoration of mental health".[1] It was not until 1930, however, that Dr. Crease's recommendation was acted upon by the Provincial Secretary. A social worker, Miss Josephine Kilburn, was sponsored at the Provincial Mental Hospital by the Canadian National Committee for Mental Hygiene, for one year.

The chief aim and purpose of this new Social Service Department was to secure more detailed information regarding the home life and condition of the patient which heretofore had not been obtainable. 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.[2] Miss Kilburn's one year of service convinced the government of the value of social services and she was made a member of the permanent staff. A new aspect of treatment was thus opened up not only to the patients, but to the

---

[1] Report of the Medical Superintendent of the Provincial Asylum for the Insane, New Westminster, British Columbia, for the year ending December 31, 1897.

[2] Birch, Sophie, An Aid in the Rehabilitation of Mental Patients, Master of Social Work Thesis, University of British Columbia, 1953, p. 9.

patients' families as well. The Social Service Department gradually increased to a total of thirteen social workers by December 30, 1950, when Miss Kilburn retired.

The Crease Clinic of Psychological Medicine was opened early in 1950. This new treatment centre increased the area of responsibility of the then existing Social Service Department. At this time two problems became paramount for the Social Service Department: (1) the number of social workers in the department was far too few to carry casework responsibility for both the Provincial Mental Hospital and the Crease Clinic; (2) the matter of division of labour within the department became a matter of concern so that participation in administrative work and services 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. In May, 1952 the existing Social Service Department was divided into two separate departments--one at the Crease Clinic, the other in the Mental Hospital. Each department consisted 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 social 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 division in the department meant that the above mentioned services were offered plus casework services at the time of the patient's admission, during the treatment period, including pre-convalescent planning, and to some extent after discharge either in the form of probation or referral services.

The After Care Department, Ontario Hospital, London

The province of Ontario has gone about the provision of mental hospital service, very differently from British Columbia. Rather than having one large institution to serve the entire province, Ontario has distributed smaller hospitals throughout the province, each serving its specified area. They are several in number, but the present study will only consider the Ontario Hospital located in London, and its After Care Department.

In the early years, the Ontario Hospital, London, was operated in much the same way as all mental hospitals. The patient was admitted to hospital and when he had recovered, he was returned to the same environment from which he had come, and in which he became ill. There was no consideration of the possibility that modified environmental factors might prevent the patient's re-admission to hospital.

The first move toward extending mental health services into the community surrounding the Ontario Hospital, London, was made in 1931, with the establishment

of a Travelling Mental Health Clinic. This clinic consisted of one psychiatrist, two psychologists, and two social workers. The purpose of the clinic was detection and prevention of mental illness in its early stages. This travelling clinic is still servicing the geographic area served by the Ontario Hospital, London.

The travelling clinic, because it was the only mental health service in the community, had to take on responsibilities for which it was not created. Since many patients leave the hospital before they are completely recovered from their illness, and also because many discharged patients carry a residuum of their illness; the travelling clinic soon became a post-discharge treatment unit as well as a unit for the detection and prevention of mental illness. The inevitable result was an over-loading of responsibility upon the very limited resources of the travelling clinic.

In about 1945, Dr. G.H. Stevenson, then the Superintendent of the Ontario Hospital, began to consider the possibility of creating a post-discharge treatment unit as such. Dr. Stevenson felt that this treatment facility should be somewhat akin to the travelling clinic in its administrative structure and the personnel included on the team. Its purpose was to facilitate the continuance of treatment following discharge, to offer rehabilitative services; and consequently decrease the number of "relapses and re-admissions to hospital, so that the unfortunate

handicap of mental illness and the cruel and undeserved stigma so long associated with mental illness might more quickly be overcome."[1]

Dr. Stevenson's blueprint for the After Care Department included a psychiatrist as director, junior psychiatrists, psychologists, social workers, and public health nurses. Full time psychiatrists for the After Care Department were unobtainable, so the new department did not conform to the plan which its originator had laid down. In the absence of full time psychiatrists on the team, psychiatrists from the hospital were made consultants to the After Care Department.[2]

> With the support and encouragement of the Ontario Department of Public Health, and with financial assistance from the Ontario Department of Health and the Federal Department of Health, a rehabilitation team was organized at the Ontario Hospital, London, in September 1949, which is known as the After Care Department. It is headed by Mr. J.E. Gamble, M.S.W., a psychiatric social worker.[3]

> In September, 1949, the After Care Department began with two social workers and three public health nurses. Since that time, we have added to our staff a psychologist and have supplemented the number of nurses and social workers, so that now we have on our staff one psychologist, three public health nurses and two psychiatrically trained nurses and three social workers. It is hoped that eventually an occupational therapist will be added to the team, as well as a placement officer.[4]

---

[1] Stevenson, G.H., M.D., "Rehabilitation of the Mentally Ill," Ontario Medical Review, November 1952, p. 424.

[2] Personal interview with Dr. G.H. Stevenson, former Superintendent, Ontario Hospital, London, Ontario.

[3] Stevenson, op. cit., p. 423.

[4] Gamble, J.E., "The After Care Program - Ontario Hospital", October 1952, Unpublished Paper.

The After Care Department is located in downtown London, because its primary purpose is that of meeting the needs of post-discharge patients. A large portion of the Federal Mental Health Grant, allocated to the Ontario Department of Health for the setting up of this "pilot rehabilitation centre for mental patients", was devoted to the purchasing and furnishing of a large home. This house has been converted into offices and interviewing rooms for the After Care Department, as well as club rooms and recreation rooms for discharged patients who might reside within the vicinity.

Comparison of Social Service Departments

In addition to the difference in age and experience of these two departments, they differ markedly from each other in administrative structure. They also differ in personnel make-up. There is also a great difference in department function, as was discussed in Chapter 2.

Administrative Structure. One basic difference between these two departments is the independent nature of the After Care Department as compared with the Social Service Department at Essondale in relation to a provincial program of psychiatric social services, and also in respect to administrative leadership. The After Care Department is associated with the Ontario Hospital, London,

serving patients and their families from this hospital only, whereas the Social Service Departments at Essondale are a part of a provincial program set up for the provision of social services to those referred for psychiatric treatment from the entire population. Administratively, the After Care Department has its own director, who is responsible for the direction of the After Care Department only. By comparison, the Social Service Departments at Essondale, are only a part of the social treatment services of the Provincial Mental Health Services. Within the Provincial Mental Health Services, there are also the social treatment facilities of the Child Guidance Clinics and also the Social Service Department at the Woodlands School for Mental Defectives. All of these social treatment facilities operate as separate units, but each is a part of the total provincial mental health program. All are under the direction of the Provincial Supervisor of Psychiatric Social Work.

Both departments carry similar responsibilities for maintaining liaison with community agencies, so that all available resources might be made accessible for use by the patient and his family. Both departments see their role as assisting the mental patient and his relatives to make a more comfortable adjustment to reality problems which contribute toward mental illness and also those reality problems which arise out of mental illness. If there are resources in the community which will help the patient

and relatives in making a better social adjustment, both departments see a referral to that particular agency as being their function.

Another major difference between the After Care Department and the Social Service Department at Essondale lies in the fact that department personnel are under the jurisdiction of different government bodies. All personnel of the After Care Department are under the jurisdiction of the Ontario Department of Health. Each staff member is a provincial Civil Servant, and is subject to the Civil Service classifications and salary stipulations. Members of the Social Service Department at Essondale are also provincial Civil servants, and subject to Civil Service classifications and salary stipulations. They perform work in the Mental Health Services Division of the Department of the Provincial Secretary, but at the same time are members of the Department of Health and Welfare, Social Welfare Branch. All members of the Social Service Department at Essondale, are under the jurisdiction of the Social Welfare Branch, but are loaned to the Mental Health Services Division. The result of such a dual type of administration is that a great deal of time is spent in interpreting the needs and services of one department to another. All members of the After Care Department are under the jurisdiction of that government department in which they function; this is a more clear-cut type of administration.

Because of geographical distance, centralized mental hospital service such as is found in British Columbia curtails the amount of professional social services which can be given to the patient's relatives. Decentralized mental hospital service such as is found in Ontario, makes it administratively possible for the After Care Department to maintain close contact with the patient's family during hospitalization, and also with the patient following his discharge from hospital.

Within three weeks following admission of a patient to the Ontario Hospital, his case is presented at a general conference at which time members of the treatment team contribute what they know about the patient and his illness, and all participate in deciding upon a treatment plan. The Director of the After Care Department attends these conferences, thus serving as a liaison between the hospital and the After Care Department which operates quite apart from the hospital. Following the conference the director of the After Care Department assigns each patient to a member of the department. Each member of the department is called a "worker" regardless of his professional orientation, and is assigned to a sub-region of the total area served by the hospital. Cases are then assigned on the basis of the patient's having residence within a particular worker's region. The worker maintains a periodic contact with the patient. He will "visit the patient's family with the purpose of understanding the

family background and preventing any economic, marital or other problems consequent to hospitalization".[1] At the time of patient's discharge from hospital, the worker becomes active in working with the patient and is expected to return the patient to his home, and provide all the necessary follow-up services, so as to help the patient re-establish himself in the community. Each worker is expected to provide all those services which each of his patients might require. If a specific type of service is needed, and one which the worker is not professionally trained to give, he is expected to seek guidance from a worker who has been trained to offer that type of service.

In contrast to the After Care Department, the Social Service Department at Essondale is a uni-disciplined department, being staffed by professionally trained social workers, who provide social services to the patient during admission, treatment, and rehabilitation procedures. If the Social Service Department is unable to provide these services, due to distance, the field service of the Social Welfare Branch is responsible for carrying out this service as a part of their defined function. The field service is also a uni-disciplined department, made up of trained social workers.

---

[1] Gamble, loc. cit.

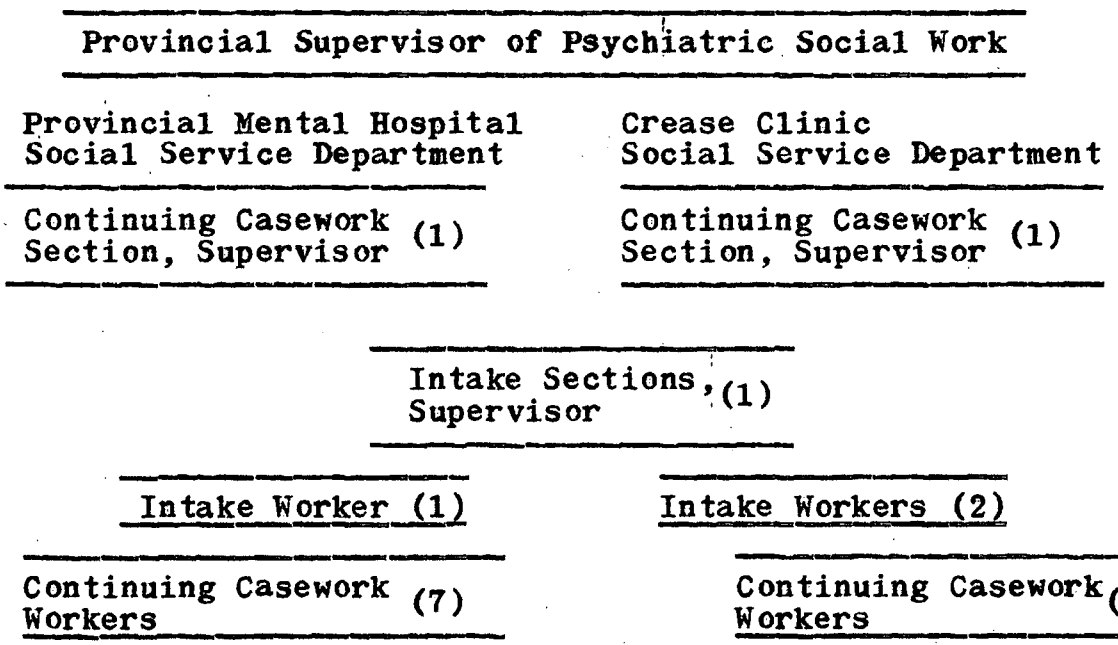
Personnel

A basic difference between the After Care Department and the Social Service Departments at Essondale, is the fact that the former is a multi-disciplined structure, while the latter is a uni-disciplined structure. Figure 1 shows the division of labour within the Social Service Departments at Essondale, and the number of social workers included in each department and section. The qualifications of all personnel are consistent with the recommended standards set down by the American Psychiatric Association. (See Appendix B.)

As indicated in Figure 1, all members of the departments are qualified social workers. It can be seen that the Social Service Departments at both Crease Clinic and the Provincial Mental Hospital are under the direction of one person, the Provincial Supervisor of Psychiatric Social Work. Each department is divided into an Admissions Section and a Continuing Casework Section. One supervisor is responsible for the supervision of the Intake Workers in both Admissions Sections. Both departments have a supervisor who is responsible for the work carried out in each Continuing Casework Section.

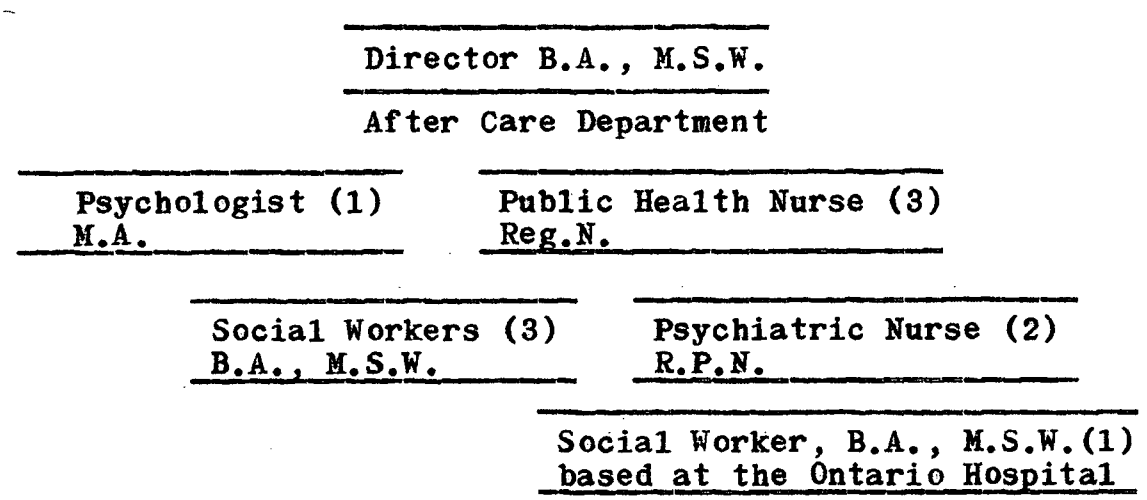
Figure 2 illustrates the multi-disciplined structure of the After Care Department. In addition,

Figure 1. Administrative Structure, Crease Clinic and Provincial Mental Hospital Social Service Departments, showing their uni-disciplined make-up.



Note: It should be noted that the number of social service personnel indicated includes only those positions which are occupied. Several more social work positions have been established, but are as yet vacant.

Figure 2. After Care Department, Ontario Hospital, London, showing its multi-disciplined make-up, numbers of personnel, qualifications of personnel.



it shows the number of personnel in the department, as well as the particular professional orientation of each. The After Care Department operates quite apart from the hospital, but recently one social worker has been placed in the hospital in order that social services might be provided during the admission and treatment procedures. This worker is under the direct supervision of the director of the department.

Figure 2 indicates that the After Care Department is made up of members from four different professions; namely social work, psychology, general nursing, and psychiatric nursing. It is shown that all members of the department are responsible to the director who serves as a liaison between the hospital and the After Care Department.

In summary, it has been found through an examination of these three Social Service Departments, that there are similarities as well as differences between them. All three departments are similar in purpose, although the After Care Department differs from the Social Service Departments at Essondale in respect to the area of concentrated effort; the former placing emphasis on convalescent care, the latter emphasizing the importance of offering social work help to the patient during admission and treatment procedures as well as during convalescence. A further similarity is that both the After Care Department and the Social Service Departments at Essondale have

a director as administrator of the department. In both cases, this person is responsible to the Clinical Director or the hospital Superintendent. There are great differences in these departments in respect to internal administrative structure, personnel, and lines of responsibility of the staff to a government department. Division of labour in the After Care Department is based on geographical sub-divisions, while in the Social Service Departments at Essondale division of labour is based upon the type of service which is given. With the developmental history, administrative structure, standards, and personnel of these departments in mind, the study will make recommendations as to the type of social service department which would be suitable for provision of social services to the patients receiving treatment at the Saskatchewan Hospital, as well as to their families.

CHAPTER IV

A SOCIAL SERVICE DEPARTMENT FOR THE SASKATCHEWAN HOSPITAL

This study has made three assumptions. They are: (1) that there is a need for a Social Service Department at the Saskatchewan Hospital, in fact in any mental hospital; (2) that social work services are of value to the patient in a mental hospital, and are also needed for his family in the treatment and rehabilitation process; and (3) theory is always ahead of practice, and that this must always be the case so that growth and development might occur. As the profession of social work develops, and successfully interprets itself to other better established disciplines, this discrepancy will become narrowed down to a degree wide enough to stimulate research and planning, and narrow enough to prevent feelings of discouragement by its members.

The study will now proceed to project a suitable Social Service Department for the Saskatchewan Hospital. All recommendations made for a future Social Service Department in the Saskatchewan Hospital are based upon: (1) standards recommended by the American Psychiatric Association, and (2) upon the experience of already existing departments which have been examined in this study.

With the possibility of an increasing number of social workers being employed at the Saskatchewan Hospital, the need for a sound organizational structure becomes very apparent.

> Social work should operate as a specifically designated administrative department with a director of social services responsible to the Clinical Director, or in hospitals where there is no such position, on an administrative level which provides direct liaison with the Superintendent of the hospital. This administrative provision should require the inclusion of the director of social work in administrative staff meetings and participation in decisions of hospital policy which pertains to the treatment and welfare of patients. The responsibility of social service to administration can not be fully met if the director of the Social Service Department functions on a less well defined basis.... The practice of social workers being called on... or attending informal or formal meetings, does not produce the most effective kind of administrative relationship. For continuity and effectiveness, especially in the event of changing personnel, a clearly defined administrative structure is considered an essential.[1]

A Recommended Administrative Structure

As the Group for the Advancement of Psychiatry Report suggests, and after carefully examining social service departments in other hospitals, it is recommended that a Social Service Department have a Director of Social Service as its administrator. Since the Clinical Director of the Saskatchewan Hospital, is responsible for all clinical matters, the Director of Social Service should be

---

[1] The Psychiatric Social Worker in the Psychiatric Hospital, American Psychiatric Association, Report #2, 1948.

directly responsible to him.

A suitable Social Service Department for the Saskatchewan Hospital would include approximately twenty social workers, according to recommended standards laid down by the American Psychiatric Association. (See Appendix C.) The recommended number of social workers required for the adequate provision of social work services to patients and their families, points up the need for departmental structures which will ensure integration within the department, and integration of the department with the total hospital structure. If the remaining nineteen social workers were all made responsible to the Director of Social Service, integrated lines of authority and responsibility would be impossible. The result would be the Director's having to settle numerous detailed matters with nineteen different persons, thus leaving himself little time for more complex administrative matters. With such a line structure, no delegation of authority and responsibility could be possible. In addition, there could be no specialization of labour (of services) in the department as a whole.

To ensure departmental integration in a department of approximately twenty persons, it would be essential to have at least three staff members who are directly responsible to the Director of Social Service, and who in turn have several staff members who are responsible to them. An integrated department permits a classification of the

services to be rendered. It was seen at the Social Service Departments at the Crease Clinic and the Provincial Mental Hospital, Essondale, British Columbia, that social work services were categorized as to those of a "Brief Service" nature, and those of a "Continuing Treatment Service" nature. Distinct sections are set up for the provision of these two types of service within each branch of social service activity. A Casework Supervisor is in charge of each, and is responsible to the Provincial Supervisor of Psychiatric Social Work. The After Care Department of the Ontario Hospital, London, differs markedly from the Essondale departments in this respect. All members of the After Care Department are directly responsible to the Director of the department.

There is another major difference between the Social Service Departments at Essondale, British Columbia and the After Care Department, London, Ontario. This is in relation to case coverage in convalescent care (post-discharge care). The After Care Department offers this type of service to all patients discharged from the Ontario Hospital, London. The Social Service Departments at Essondale however, provide convalescent care to only those patients who are discharged to the Greater Vancouver area, relying on the field service of the Social Welfare Branch to provide this service to those patients discharged to other areas of the province.

With a small beginning Social Service Department at the Saskatchewan Hospital, Weyburn, it is obvious that very little work can be done in the community with patients following their discharge from hospital. Scattered settlement and long distances between towns dictate some of the limitations. A direct liaison with the Department of Social Welfare and Rehabilitation will, therefore, be essential, so that their field service might provide a continued convalescent service to patients following hospitalization. The relatives of the patients often require social work help during the patient's stay in hospital, and are an equally difficult group to service, due to geographical distance. In establishing an adequate social service department for the Saskatchewan Hospital, Weyburn, the major problem, and the one which will in all likelihood be dealt with last, is the setting up of a decentralized field service as an extension of the Social Service Department. Convalescent care might then be provided to discharged patients as well as to their relatives. A goal recommended for the future is the setting up of a decentralized field service, as an Out-Patient Section of the Social Service Department. This would involve dividing the area served by the hospital into sub-districts, and assigning one or two social workers to each.[1] Each district would actually represent

[1] The division of the total area into sub-divisions could take the form of the present division of the area into Health Regions.

a caseload. The size of the caseload would be the basis upon which the number of social workers assigned to each sub-district would be determined. The field service would, of course, be responsible to a travelling Casework Supervisor, who would provide each field worker with the necessary consultation and casework supervision. This supervision would also serve as a liaison between the field service and the hospital, and in this way contribute toward co-ordination between the specialized service sections of the department.

The basic administrative principles which have been taken into consideration in laying down this proposed administrative structure for a social service department have been; (a) departmental integration (b) delegation of authority and responsibility (c) specialization of service and (d) co-ordination between specialized services. The proposed administrative structure thus takes the form of a department under the direction of a Director, and consisting of three sections; an Admissions Section, a Continuing Casework Section, and an Out-Patient Section. Each section is under the supervision of a supervisor, who is in turn responsible to the Director. Figure 3 illustrates the recommended administrative structure:

Figure 3. Recommended Administrative Structure, Social Service Department, Saskatchewan Hospital.

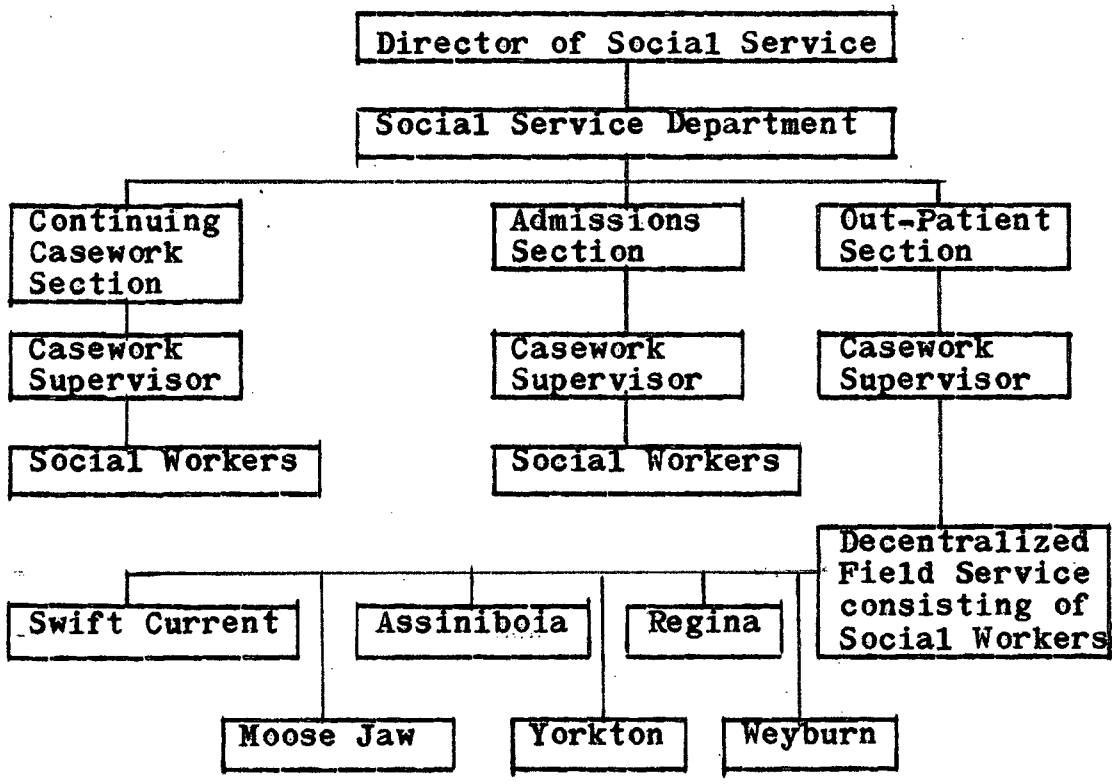


Figure 3 shows the departmental integration, in that only three persons are directly responsible to the Director of Social Service, and each is responsible for only those social workers in the Section of which they are designated Casework Supervisor. With this integrated style of line structure, delegation of authority and responsibility is made possible. The Director of Social Service is responsible for the social work of the whole department, however, he can delegate authority and responsibility to each Casework Supervisor, necessary for the administration of the work of each Section. All three Casework Supervisors

are on the same administrative level, so co-ordination between the three department sections is possible. As indicated in Figure 3 the social workers of the Admissions Section and the Continuing Casework Section carry responsibility for the provision of social services to the patients during their stay in hospital, as well as those relatives who reside within the immediate vicinity of the hospital. Social workers in the Out-Patient Section are decentralized, one or two assigned to each mentioned sub-division depending upon the number of discharged patients residing in that division. Out-Patient Section workers are in the main responsible for provision of social services to discharged patients as well as those families who are unable to visit the hospital during the patient's stay there.

Responsibilities of the Director, Social Service Department

The multiple responsibilities of the Director of Social Services are classified under distinct categories.[1]

---

[1] At present this position is non-existent within the Saskatchewan Psychiatric Services Branch. It should be noted that the incumbent of this position is the key-person in the development and administration of any Social Service Department. Therefore, this person should be a professionally trained social worker, with several years of experience in casework practice, as well as in administration. For the recommended qualifications for the Director of Social Service, see Appendix B.

Administrative Responsibility

(a) Responsibility for attendance at and participation in conferences held by the Clinical Director and the two Senior Psychiatrists on matters of policy pertaining to the treatment and welfare of mental patients. It is the responsibility of the Director of Social Service while attending such conferences, to interpret the unique services which his department can offer, and how it operates as an integral part of the hospital's total treatment facilities.

(b) Responsibility for interpreting to the Clinical Director all planning as regards the internal structure and operation of the Social Service Department.

(c) Responsibility for consulting and planning with the Clinical Director and the Director of Psychiatric Services Branch, on the broader aspects of planning for, and the organization of further social services to patients; such as foster-care programs, a decentralized field service, social work standards and staff qualifications, personnel recruitment, the needs for more extensive social services, and the needs of the social service department; such as clerical facilities, office space, automobiles, etc.

Supervisory Responsibility

(a) Responsibility for bringing social work consultation and direction to all members of the Social Service Department, and especially to the Casework

Supervisors. The Director of Social Service carries the final responsibility for all social welfare work done in the department. He carries responsibilities for the development of the social service program, as well as advising the staff on standards of social work service and practice.

(b) Responsibility to introduce methods for social work staff training and development on the job. This involves preparation of, and participation in informative staff meetings where departmental problems and policy are discussed, with the view to improving the social services available to the patients.

(c) Responsibility for the arrangement for and the supervision of a clerical unit.

(d) Responsibility for participation in the direction of Volunteer programs.

Caseload Responsibility

(a) Responsibility for evaluation, revision, and extension of the social service program so that it meets the needs of patients, patients' families, needs of the community, and the developmental changes in other professional departments such as psychiatry, nursing, and psychology.

Responsibility for Education and Interpretation

(a) Some responsibility for the interpretation of the social worker's role in a mental hospital to other

departments, such as psychiatry, nursing, psychology, physiotherapy, occupational therapy, and recreational therapy.

(b) Some responsibility for the promotion of the teamwork approach to the care and treatment of mental illness.

(c) Responsibility for participation in, and the encouragement of social service staff to participate in the activities of the professional association.

(d) Responsibility for initiating and conducting conferences in which case examples are used to illustrate the role of the social worker in the care and treatment of mental patients.

Community Responsibility

(a) Responsibility to direct and act with all staff members of the Social Service Department in creating and maintaining liaison with all existing community resources in the interest of the mentally ill patient; and to assist the development of community resources for the patient discharged from the mental hospital, as well as their families. This involves co-operatively meeting with other community agencies, evolving policies of interrelationships and cooperation whereby community services may be brought more effectively and with facility to the patient.

(b) Some responsibility for interpretation to community agencies and community groups of the role played

by the Social Service Department as an integral part of the total hospital program.

Research Responsibility

(a) Responsibility for keeping adequate records of all administrative activity within the department.

(b) Responsibility for the keeping of work records, and the preparation of annual reports on department activity and development.

(c) Responsibility for stimulating and performing social research.

Duties of Casework Supervisors

The recommended administrative structure for a Social Service Department at the Saskatchewan Hospital, included three Casework Supervisors, each in charge of a separate section within the department. The study will now lay down recommended job descriptions for the Casework Supervisor positions.

Admissions Section, Casework Supervisor

The Admissions Section includes those social workers who provide social services, as needed, to patients and their families at the point of the patient's admission. The Casework Supervisor's responsibilities for the work carried out by this section are classified in distinct categories.

Administrative Responsibility

(a) Responsibility for maintaining co-ordination between this Section and the Continuing Casework Section as well as with the Out-Patient Service Section.

(b) Responsibility in co-operation with the Continuing Casework Section Casework Supervisor for selection of cases for referral to the Continuing Casework Section.

(c) Responsibility to serve as a liaison between social service administration and the staff. This involves interpretation of problems on the direct service level of administration to the Director of Social Service, and also interpreting to the staff decisions made by the Director of Social Service on matters of policy and personnel practice.

(d) Responsibility for attendance at conferences held between the Director of Social Service and the Clinical Director on specific matters which relate to the work of the Admission Section.

(e) Responsibility for attendance at conferences held between the Director of Social Service, the Clinical Director, and the Director of Psychiatric Services Branch on matters of general policy as they relate to the work of the Admissions Section.

(f) Responsibility for attendance at inter-agency conferences with the worker on the case, when community agencies are involved in social treatment with the patient's family.

Supervisory Responsibility

(a) Responsibility for the supervision of the casework skills offered by intake workers during the admission and reception of the patient to hospital. This service is patient-focused and includes direct interviews with patients and their families at the point of admission serving the multiple purpose of: procuring important history information for immediate use by the doctor and other hospital services; outlining hospital services and facilities to the patient and his family; helping relatives with anxieties which are so acute at the time of patient's admission; helping the family to understand treatment procedures; assessing family problems and preparing the family and the patient for referral to a worker of the Continuing Casework Section; beginning to help relatives to support the patient throughout his period of treatment and rehabilitation; if necessary, also guiding the continuing service worker regarding immediate problems evidenced in the family constellation.

Caseload Responsibility

(a) Responsibility for attendance at Medical Conference, with the purpose of receiving assessments of newly admitted patients, as are given by members of the other disciplines; and also to contribute to the conference, the social worker's understanding and assessment of the patient and his social milieu.

(b) Responsibility for attendance at conferences held by the Director of Social Service for the purpose of evaluating, revising and the extension of the social service program so that it might better meet the needs of patients and their families.

Responsibility for Education and Interpretation

(a) Some responsibility for promoting the team approach within the hospital setting by interpreting to the medical, nursing, and clerical staffs their responsibility for getting the patient's relatives to intake workers so that social services can be initiated immediately.

(b) Responsibility for assuming leadership, if necessary, in conducting informative staff meetings.

Community Responsibility

(a) Responsibility for interpretation to community agencies of mental hospital services, together with policy and procedure for admission on behalf of their clients.

(b) Some responsibility for interpreting the work of social work in a mental hospital to community groups.

(c) Responsibility for case-conferencing with community social agencies when this is indicated.

Research Responsibility

(a) Responsibility for supervising the recording of intake workers' impressions of the patient's problems and an assessment of the family situation.

(b) Responsibility for the keeping of work records, and the added responsibility of using these records statistically to appraise work done, and to recognize areas of unmet need.

(c) Responsibility for co-operation with the Director of Social Service in stimulating and carrying out research projects.

Continuing Casework Section, Casework Supervisor

The Continuing Casework Section includes social workers who provide professional social services, as needed, to patients and their families throughout the patient's stay in hospital. Cases which are referred to this section of the Social Service Department are usually referred following an assessment of the amenability of the patient to social work help. This assessment is usually made by the intake worker, and the Admissions Section Casework Supervisor. Often times, such a referral is a formal request from the doctor in charge.[1] When a case is referred to the Continuing Casework Section, the acute anxieties and social problems consequent to hospitalization have usually been dealt with by the social worker of the Admissions Section. The Continuing Casework Supervisor is thus in charge of the

---

[1] Barsky, Anastasia, Casework in a Veterans' Hospital, Master of Social Work Thesis, University of British Columbia, 1954. This thesis is an analytical study of the nature of referrals to the Social Service Department made by medical doctors. Such a study could be of assistance to a new department in establishing an effective policy of referral to Social Service.

on-going social work service to patients and their families, and has responsibilities which are classified into distinct categories.

Administrative Responsibility

(a) Responsibility for the selection and assignment of cases for continuing casework service in co-operation with the Admissions Section Casework Supervisor. This selection of cases for active social service is necessary because of the impossibility of giving more than a percentage coverage due to limitations in numbers of personnel.

(b) Responsibility to serve as a liaison between social service staff and the Director of Social Service. This involves interpreting problems on the direct service level of administration to the Director of Social Service, and also interpreting to the staff the decisions made by the Director of Social Service on matters of policy and personnel practice.

(c) Responsibility for conferring with community agency officials along with the Director of Social Service, interpreting to them the role of the Social Service Department, and also attempting to create and maintain good liaison between these agencies and the Social Service Department.

(d) Responsibility for attendance at conferences held between the Director of Social Service and the Clinical Director on matters of specific policy, as they relate to the

work of the Continuing Casework Section.

(e) Responsibility for attendance at conferences held between the Director of Social Service, the Clinical Director, and the Director of Psychiatric Services Branch on matters of general policy, as they relate to the work of the Continuing Service Section.

Supervisory Responsibility

(a) Responsibility for the supervision of the casework skills of all social workers in the Continuing Casework Section. The services of this section are patient/family-focused and include direct interviews with the patient and/or relatives during the patient's stay in hospital, serving the multiple purpose of: giving continued support and relief of fears associated with the hospital, treatment procedures, and those social problems within the patient's social environment which are considered to be conducive to the illness; a continued study and diagnosis of the patient's social environment and his way of responding to that environment; formulation of treatment goals from the social work orientation and in collaboration with the psychiatrist and other hospital disciplines; carrying out the social work treatment process which involves skillful administering of tangible and intangible social services to the patient and his family in such a way that they might be helped toward dealing more effectively with their reality problems, and in so doing attain a more satisfactory social adjustment; preparation of the patient and the family

for referral to a worker of the Out-Patient Section; and also guiding the out-patient worker regarding the strengths and weaknesses of the patient and his social environment.

Social Work supervision like social work practice is patient and family focused--the goal being better more effective service to those served. Through supervision, the individual worker is helped to gain a more comprehensive understanding of the social problems with which he is dealing and the dynamics underlying them, to gain a better understanding and use of those psychological helping procedures used by caseworkers, and also to gain a higher degree of self-awareness so that he might remain as objective as possible in discussing other people's emotions and attitudes.

Caseload Responsibility

(a) Responsibility for attendance at conferences held by the Director of Social Service for the purpose of evaluating, revising, and the extension of the social service program so that it might better meet the needs of patients and their families.

(b) Responsibility for attendance at individual case conferences along with the worker on the case, which have been called by the doctor for the purpose of formulating treatment plans.

Responsibility for Education and Interpretation

(a) Responsibility for assuming leadership, if necessary, during staff meetings so as to ensure staff

development, as well as development of policy.

(b) Some responsibility for the interpretation of social work function in a mental hospital to the other professional disciplines.

(c) Responsibility for attending Social Work Conferences and Institutes, so as to maintain an awareness of current social work practices and standards outside of one's own agency. There is a responsibility also to initiate these new practices in one's own agency, thus maintaining the best possible service to those served.

Community Responsibility

(a) Responsibility for interpretation to community agencies of mental hospital services, together with policy and procedures for admission on behalf of their clients.

(b) Some responsibility for interpretation of the function of social work in a mental hospital to community groups.

(c) Responsibilities for meeting with the officials of community agencies, with the purpose of working out social service programs which parallel one another, giving the best possible coverage to members of the community who are in need of some form of social work help.

Research Responsibility

(a) Responsibility for supervising the recording of all social work practice carried out by the members of this section.

(b) Responsibility for the keeping of work records of work done by the Continuing Casework Section, and the added responsibility of using these records statistically to recognize areas of unmet need.

(c) Responsibility for cooperation with the Director of Social Service in stimulating and performing research projects.

Out-Patient Section, Casework Supervisor

The Out-Patient Section consists of all the social workers included in the decentralized field service. The Out-Patient Section Casework Supervisor's responsibilities are classified into distinct categories.

Administrative Responsibility

(a) Responsibility for the reporting of all problems of policy and personnel matters within the Out-Patient Section to the Director of Social Service. He is also responsible for advising the field service staff on all decisions made by the Director of Social Service in regard to social service policy and programs, as well as new developments in the other hospital departments.

(b) Responsibility for promoting co-ordination between the Out-Patient section and other sections of the Social Service Department, so as to ensure the best possible service to those served.

(c) Responsibility for attendance at conferences held between the Director of Social Service and the Clinical

Director on matters of specific policy as they relate to the work of the Out-Patient Section.

(d) Responsibility for attendance at conferences held between the Director of Social Service, the Clinical Director, and the Director of Psychiatric Services Branch on matters of general policy as they relate to the work of the Out-Patient Section.

(e) Responsibility for administrative matters in relation to departmental automobiles, insurance, office equipment and supplies for the various offices used by the Out-Patient Section.

Supervisory Responsibility

(a) Responsibility for the supervision of the case-work skills of all the social workers included in the Out-Patient Section. The service is patient/family-focused and includes direct interviews with patients and their relatives and also significant persons in the patient's life, following the patient's discharge, and serving the multiple purpose of: assisting the patient to develop a feeling of independence from the hospital setting, through helping him to resume former responsibilities within the family vocational, and social settings; helping the patient's family to accept and help the patient toward a gradual resumption of former responsibilities, thus helping the family unit to overcome the state of inequilibrium consequent to the patient's temporary absence; helping those patients who are without family or friend to become re-established in an environment

as emotionally healthy as possible, necessitating the worker's purposeful use of community resources with the view to meeting the basic needs of the patient such as food, shelter, clothing, a job, and meaningful relationships with interested persons; helping the patient who has a residuum of his illness to adjust to a limiting situation, and live as comfortably as possible.

(b) Responsibility for the supervision of the case-work skills of all social workers included in the Out-Patient Section, in their provision of professional social services to patient's families during the patient's stay in hospital.[1] This service is patient/family-focused and includes offering support and relief of fears associated with the patient's committal to hospital; help with immediate social problems consequent to the absence of a family member; interpretation of hospital facilities and help in relief from fears associated with treatment procedures; help with the formulation of plans for the patient's return home; preparation of the family for their referral to other community resources if this is indicated; encouragement and arrangement for financial help, if needed by relatives, to visit the patient while he is in hospital.

(c) Responsibility for the administration and supervision of a foster-home care program. This would include the supervision of home-finding, interpretation of patients and their needs to foster-home operators, and also

---

[1] Those families who are unable to visit the hospital due to geographical distance can receive help from the Out-Patient Section.

responsibility for ensuring proper care of patients who are in foster-home care.

Caseload Responsibility

(a) Responsibility for serving as a liaison between the Out-Patient Section and other hospital departments such as psychiatry, nursing, and psychology on treatment procedures. This would include the obtaining of psychiatric assessments and consultations for use by the field service.

(b) Responsibility for attendance at conferences held by the Director of Social Service for the purpose of evaluating, revising, and the extension of the social service program so that it might better meet the needs of patients and their relatives.

Responsibility for Education and Interpretation

(a) Responsibility for the encouragement of staff development on the job. This would involve the circulation of professional knowledge and literature to each member of the field service. Due to the decentralization of the Out-Patient Section, this responsibility is of great importance.

Community Responsibility

(a) Responsibility for interpreting the Psychiatric Services of the province to the community.

(b) Responsibility for assisting the field service staff to create and maintain co-operative relation-

ships with all available community resources.

(c) Responsibility for meeting with the officials of community agencies with the view to developing programs which parallel each other, so as to ensure the greatest possible coverage of need.

Research Responsibility

(a) Responsibility for keeping records of the work of the Out-Patient Section, and the added responsibility of using these records statistically for the appraisal of work done, and also as a means to recognizing areas of unmet need.

(b) Responsibility for the supervision of the follow-up and continued assessment of patients who have been discharged from hospital, and whose follow-up record would be of value to the Research Unit of the Saskatchewan Hospital.

(c) Responsibility for cooperation with the Director of Social Service in stimulating and the performance of research projects.

Responsibility of a Staff Social Worker

The social worker offers the patient and his relatives assistance with various problems associated with: (1) the patient's social adjustment within the hospital (2) the social adjustment of patient's relatives to the patient's temporary absence from the home, as well as to the patient's illness and (3) the social adjustments

of both the patient and his relatives following discharge, in their attempt to restore the equilibrium of the family unit which had become disrupted through the patient's temporary absence.

The social work treatment process used by the social worker remains the same throughout the admission, treatment, rehabilitation, and convalescent procedures. The social work treatment process also remains the same when dealing with either the patient or his family. The responsibilities of the social worker may be classified under distinct categories.

Administrative Responsibility

(a) Responsibility for promoting sound administrative principles and practices within the Social Service Department, thus improving the services rendered. This involves:

(1) recognition and respect for the proper channels of communication.

(2) acceptance and execution of delegated responsibility as well as authority, in performing assigned professional duties.

(3) promotion of co-ordination between departmental sections, ensuring a smooth flow of work through the department.

(4) contribution toward improvement of hospital services through participation in Social Service

Department staff meetings, and serving on appointed committees designed to study and recommend measures for improvement of hospital service.

(b) Responsibility for the promotion of sound administrative principles and practices within the hospital's total administrative structure. This includes:

(1) conferring with the doctor in charge before offering any form of social work treatment to the patient. Treatment planning should always be a process shared by all members of the treatment team.

(2) sharing with other members of the treatment team all pertinent social information gained through direct interviews with the patient's relatives, and also from collateral sources. This involves the accurate prompt recording of all work done.

(3) recognition of, and respect for the proper channels of communication between the Social Service Department and other hospital departments so as to promote an integrated hospital service.

(4) recognition of, and respect for the lines of responsibility within other hospital departments.

(5) recognition of, and constant care to remain within the social worker's area of competency, at all times respecting the area of competency of the other disciplines.

(6) procuring social information from other community agencies which are also interested in a particular

case, upon the permission of the patient.

(7) supplying information to community agencies regarding a patient, upon the permission of the patient.

(8) conducting inter-agency conferences with guidance from the casework supervisor.

Supervisory Responsibility

(a) The staff social worker does not have responsibility for supervision, other than responsibility as a participant in the supervisory process, which is designed for the purpose of bringing the best possible service to the patients and their families. The social worker thus has a responsibility to make constructive use of supervision.

Caseload Responsibility

(a) The social worker is responsible for the provision of social services to all patients who are assigned to him, and is also responsible for making social services available to the patient's family. He is responsible for providing social work treatment service through a professional relationship with the patient and his family, keeping in mind at all times the rights of the person in receipt of the services. This involves direct interviews with the patient, his relatives, and significant persons in his life, serving the multiple purpose of: procuring

pertinent history information for use by the doctor; outlining hospital facilities to the patient and his relatives; helping the patient and relatives with feelings of anxiety arising out of committal; helping the family to understand and feel more comfortable about treatment procedures; assessing family problems and contributing to a comprehensive diagnosis; provision of social first-aid measures to alleviate social problems consequent to the absence of a member of the family unit; helping with the clarification of misunderstandings between the patient and persons within his social environment; giving continued support and relief of fears associated with the hospital, treatment procedures, and those social problems within the patient's social environment which are considered to be conducive to the illness; a continued study and diagnosis of the patient's social environment and his way of responding to it; formulation of treatment goals from the social work orientation and in collaboration with other members of the treatment team; carrying out the social work treatment process which involves skillful administering of tangible and intangible social services to the patient and his family in such a way that they might be helped toward dealing more effectively with their reality problems and in so doing attain a more satisfactory social adjustment; assisting the patient to develop a feeling of independence from the hospital setting following discharge; helping the patient to resume former responsibilities within the family, vocational,

and social settings; helping the patient's family to accept and help the patient toward a gradual resumption of former responsibilities, thus helping the family unit back to its normal state; helping the patient without family or friend to become re-established in an environment as emotionally healthy as possible, which necessitates the worker's purposeful use of community resources with the view to meeting the basic needs of the patient such as food, shelter, clothing, a job, and meaningful relationships with interested persons; helping the patient who has a residuum of his illness to adjust to a limiting situation and live as comfortably as possible.

Responsibility for Education and Interpretation

(a) Responsibility for interpretation of social work function to members of the treatment team through day to day working relationships with them.

(b) Responsibility for interpretation of the programs of the Psychiatric Services Branch, to community agencies through inter-agency relationships, and in this way helping them to be more aware of those community resources of a psychiatric nature, as well as the proper procedures involved in using these resources.

(c) Responsibility for contributing to findings, evaluations, diagnosis, and treatment recommendations of the hospital team when referring a patient or his family to a community agency.

Community Responsibility

(a) Responsibility to participate in community organization by serving on appropriate community and agency committees as a representative of the Social Service Department.

Research Responsibility

(a) Responsibility for keeping up to date work records.

(b) Responsibility for bringing to the attention of the Casework Supervisor, suggestions as to ways of ensuring better more effective service to patients and their families.

(c) Responsibility for contributing assessments of social environments, when such are requested by the Research Unit. Social work's orientation toward social living enables the social worker to assist the Research Unit by helping them to maintain proportionate focus on environmental factors in mental illness.

(d) Responsibility for conducting follow-up interviews, and the reporting of them to the Research Unit.

(e) Responsibility for constant assessment of community resources in relationship to the needs of mental patients.

In summary it might be emphasized that job descriptions are of vital importance in the efficient management and operation of any Social Service Department. It is seen from this study that every social work position can be

formulated into consistent areas of function, namely, administrative, supervisory, caseload, education and interpretation, community and research responsibility. However, the scope and range of responsibility in each area differs among the different social work job descriptions.

The development of humanitarian aspects in the care and treatment of the mentally ill has been slow. The social and medical reform of the twentieth century appears almost dramatic when compared with social and medical reform which occurred during the period between the sixth century A.D. and the late nineteenth century. Social workers have played a large role in bringing about needed reforms, by adapting its services and professional skills to the alleviation of psychological and social suffering. They all recognize that much more still needs to be done.

* * *

Appendix A

Total Staff and Ratio to Patients, Mental Hospitals in Saskatchewan, 1932 to 1953

(a) Number of patients and staff

Staff	Total Numbers			
	1932	1936	1946	1953
Nurses, graduate	7	14	71	318
Nurses, other	92	178	290	373
Doctors	8	14	15	33
Occupational Therapists	4	6	7	14
Physiotherapists	--	--	--	3
Recreational Therapists	--	--	--	5
Psychologists	--	--	--	6
Social Workers	--	--	--	5
Patients[1]	2,561	3,594	4,302	4,967

[1] It should be noted that the term "patients" is not well defined; that it may mean those persons receiving treatment at a particular point in time, or those persons who have received treatment during a particular period of time--one year for example.

(b) Ratio of patients to staff

Staff	Patients per Staff Member			
	1932	1939	1946	1953
Nurses, graduate	366	256	61	16
Nurses, other	28	20	15	13
Doctors	320	256	287	150
Occupational Therapists	640	599	612	355
Physiotherapists	--	--	--	1,656
Recreational Therapists	--	--	--	993
Psychologists	--	--	--	821
Social Workers	--	--	--	993

Source, Canadian Mental Hospital Statistics, Annual Report.

Appendix B

Recommended Qualifications for Social Service Personnel

The recommended professional qualifications for social workers are as follows:

A. Staff Social Worker

Psychiatric social work positions in psychiatric hospitals should require graduate professional training in a recognized school of social work with major emphasis in psychiatric social work. Where less than fully trained personnel have to be used in Social Service Departments, it is recommended that they be designated by a completely different title which distinguishes them from professionally trained psychiatric social workers. Experience in this sub-professional position should not qualify an apprentice for a psychiatric social work position. Continued employment without professional training is undesirable and educational leaves which encourage the apprentice to complete professional training should be a recognized policy.

B. Casework Supervisor

The Casework Supervisor should have, in addition to a graduate degree with major emphasis in psychiatric social work, a minimum of three years experience, at least one of which shall have been in responsible working relationship with a psychiatrist in a clinical setting, during which time he has demonstrated more than ordinary competence.

C. Director of Social Service

In addition to graduate professional training with major emphasis in psychiatric social work, the Director of Social Service should have had a minimum of five years experience, at least three years of which should be subsequent to professional training during which he has demonstrated leadership ability as well as casework skills. At least two years of the five should have been in a supervisory capacity and at least three years in a psychiatric setting.

Source, Social Work in a Psychiatric Hospital, The American Psychiatric Association, Report #2, 1948.

Appendix C

Recommended Maximum Caseload

The committee on Social Work of the American Psychiatric Association has recommended criteria for a maximum caseload for social workers in a mental hospital.

> The committee recommends one social worker to every 80 annual admissions, plus one social worker for every 60 patients in convalescent status or in family-care.

Statistics from the Saskatchewan Hospital, Weyburn, indicate that approximately 650 patients are admitted to hospital annually, and approximately 440 patients are discharged annually, either "in full" or "on probation". Because of the extreme difficulty in determining the number of patients who are on convalescent status, the writer is assuming that all discharged patients require some form of social work help.

On the basis of the recommended patient-social worker ratio, a Social Service Department which would be approved as adequate for the Saskatchewan Hospital, Weyburn, would include sixteen social workers at the direct service level of administration. Over and above this number, the American Psychiatric Association recommends one casework supervisor for every five social workers, and one social worker who would serve as director of the department.

Appendix D

Bibliography

Abrahamson, A.C., "The Role and Responsibility of the Social Worker in Corrections", Unpublished Paper, School of Social Work, University of British Columbia.

Birch, Sophie, An Aid in the Rehabilitation of Mental Patients, Master of Social Work Thesis, University of British Columbia, 1953.

Casework Glossary; Abrahamson, Exner McCrae; School of Social Work; University of British Columbia; (mimeographed); June 1954.

Clarke, James R., Care of the Mentally Ill in British Columbia, Master of Social Work Thesis, University of British Columbia, 1947.

Coleman, Jules V., M.D., "Distinguishing Between Psychotherapy and Casework", Social Casework, December 1951.

Deutsch, Albert, The Mentally Ill inAmerica, Doubleday Doran and Co., Inc., New York, 1937.

Field, Mina, "Role of the Social Worker in the Modern Hospital", Social Casework, November 1953.

French, Lois, Psychiatric Social Work, The Commonwealth Fund, New York, 1947.

Gamble, J.E., "The After Care Program--Ontario Hospital", Unpublished Paper, The After Care Department, London, Ontario, 1953.

Garland, Ruth, "The Psychiatric Social Worker in the Mental Hospital", Mental Hygiene, 1947.

Hollis, Florence, "The techniques of Social Casework", Principles and Techniques in Social Casework, Cora Kasius, Editor, Family Service Association of America, 1950.

_____, "Casework Diagnosis--What and Why", Smith College Studies in Social Work, Vol. XXIV, No. 3, June 1951.

Lucas, Leon, "Psychiatric Social Work", Social Work Year Book, New York, 1951.

Marcus, Grace, "A Further Consideration of Psychiatric Social Work", National Conference of Social Work, Columbia University Press, New York, 1946.

McCormick, Mary J., Thomistic Philosophy in Social Work, Columbia University Press, New York, 1947.

McKerracher, D.G., M.D., "Some Historical Aspects of Psychiatric Developments in Saskatchewan", Saskatchewan Psychiatric Services Journal, April 1952.

Mental Health Services in Canada, General Series Memorandum No. 6, Research Division, Department of National Health and Welfare, Ottawa, July 1954.

Mental Health Services, Annual Report for the year ending March 31st, 1953, Province of British Columbia, Department of the Provincial Secretary.

Meyer, Alfred, M.D., "Historical Sketch and Outlook of Psychiatric Social Work, Hospital Social Service, April 1922.

Pepper, Gerald W., Social Worker Participation in the Treatment of the Mentally Ill, Master of Social Work Thesis, University of British Columbia, 1954.

Schlesinger, Ernest, Social Casework in the Mental Hospital, Master of Social Work Thesis, University of British Columbia, 1954.

Schmidl, Fritz, "A Study of Techniques Used in Supportive Treatment", Social Casework, December 1951.

Southard, E.E., and Jarrett, Mary C., The Kingdom of Evils, McMillan, New York, 1922.

Stevenson, G.H., M.D., "Rehabilitation of the Mentally Ill", Ontario Medical Review, November 1952.

Sutherland, Murray R., The Rehabilitation of Discharged Mental Patients, Master of Social Work Thesis, University of British Columbia, 1954.

The Social Worker in the Psychiatric Hospital, The American Psychiatric Association, Report #2, 1948.

The Canada Year Book, 1954, Dominion Bureau of Statistics, Information Services Division.

Towle, Charlotte, "Factors in Social Treatment", National Conference of Social Work, Columbia University Press, New York, 1936.

Waelder, Robert, M.D., "The Scientific Approach to Casework With Special Emphasis on Psychoanalysis", Principles and Techniques in Social Casework, Cora Kasius, Editor, Family Service Association of America, 1950.

Welker, Edmund, M.D., "The Effectiveness of the Psychiatric Social Worker in the Treatment Situation", Mental Hygiene 1947.

Zilboorg, M.D., and Henery, M.D., A History of Medical Psychology, W.W. Norton and Co., New York, 1941.

* * *