SOCIAL CASEWORK IN THE MENTAL HOSPITAL

A Quantitative Analysis of Social Casework Services at the Crease Clinic of Psychological Medicine, 1953.

by

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ABSTRACT

This study makes a definitive survey of the social services made available to mental patients at the Crease Clinic of Psychological Medicine during the year of 1953. The purpose of the survey was to describe as clearly as possible the actual social services provided by social caseworkers to patients undergoing short-term treatment at a mental hospital.

In order to analyze the nature of typical social casework help, it was necessary to define the specific components making up services to the mentally ill and their families. Since there is apparently no available standard, a special classification of services was devised for the present study. This was achieved by visualizing the social needs of the patient and his family as he moves through his period of hospitalization, from admission to discharge. A questionnaire listing these services was prepared, and was answered by the patients' social workers. The patients studied were the people selected by a routine sampling procedure.

An examination of the casework help to the patients revealed that 25 out of 64, and 29 of their families, received help through face-to-face interviews with the social worker. All the patients were helped through diagnostic planning at ward rounds, and 44 were further assisted through a therapeutic use of social resources by the social worker. The specific services to the patients and the specific services to the relatives were shown to be similar in frequency. In both instances most of the services were aimed at helping people with their discomforts in social relationships.

In conclusion, the study points out some of the problems in the screening of patients for social casework help, including the difficulty of giving effective service with insufficient staff. Also emphasized is the necessity for social agencies to facilitate research through standardization of recording, because of the need for further development in quantitative and analytical evaluation of services which are not clearly understood by the general public, and even by some professional people.
ACKNOWLEDGEMENTS

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

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CHAPTER I

RESPONSIBILITIES OF THE SOCIAL WORKER
IN A MENTAL HOSPITAL

Teamwork in the hospital for the mentally ill is a process whereby all members of the treatment team work together to bring about the treatment and rehabilitation of the patient. Each member of the team is competent to contribute a special understanding of the patient's health and welfare problems through his professional knowledge and skills in some area of human living. At the Crease Clinic of Psychological Medicine in British Columbia (the base from which the present study was made), the team consists of the doctor, the psychologist, the nurse, the social caseworker, the social group worker, and the occupational and recreational therapists.

The contributions that the social caseworker can make in the mental hospital are manifold. They are based on his knowledge of the social, cultural and psychological development and pathology of the human personality, and on his knowledge of social resources. This knowledge differs from that of either the applied sociologist or the psychiatrist. The social caseworker sees a social case as a living event within which there are always economic,
physical, mental, emotional and social factors in varying proportions. A social case is composed of internal and external, or environmental factors.¹ Special skill in interviewing and in the use of social resources are also peculiar to the profession of social work. They are directed in "such a way as to arouse and conserve the psychological energies of the client--actively to involve him in the use of services (casework services) towards the solution of his dilemma."²

In the mental hospital, the goals of the social caseworker are the social treatment of the patient; the rehabilitation of the patient and his family; and the prevention of further mental breakdown in the patient. (Treatment, in this survey, defines the process whereby the patient is helped to overcome or live with his illness. Rehabilitation, on the other hand, represents all the other processes whereby the patient and his family are restored to a more satisfactory adjustment internally and to the community. More specifically, it is the restoration "of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."³)

These three goals of social casework practice--treatment, rehabilitation and prevention--are achieved by

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² Ibid., p. 24.
helping the patient to make constructive change within himself insofar as he is able and willing, and by helping to change, alter or better mobilize the environment for him. The emphasis in many state hospitals is on the second technique of help because of time limitations. Clarification is a casework technique which in most instances can be achieved only through a prolonged intensive casework relationship, in which the patient is supported to recognize and to accept in varying degrees his own and other people's behaviour.

However, with the growth in understanding of mental hygiene throughout the first half of the twentieth century, the social worker's responsibilities have increased considerably from the environmental "after-care" help to discharged mental patients, which was his first responsibility in the mental hospital setting. His responsibilities have grown so that he is now involved at every phase of the patients' and their families' needs. Six types or stages of responsibility may be distinguished.

(1) Admission Services. When the patient first enters the hospital for the mentally ill, the social worker's responsibilities are similar to those of a caseworker in any other hospital. Entering such an institution is often a frightening experience to the mental patient. The hospital is a new setting for him and one about which he has heard many gruesome stories. Further, he is afraid of the medical treatment and may attempt to resist it. He will want to go home, particularly since he often does not, or does not want
to, realize that he is ill. He will feel confused about the reason for his hospitalization, and may become upset by the behaviour of the other patients and by the manner of life in an institution. The caseworker attempts to reassure him against these fears, helps him make a more satisfactory adjustment to the hospital, and tries to gain his co-operation in treatment.

(2) **Diagnostic Services.** Another responsibility of the caseworker within the mental hospital is to help himself and other staff members arrive at a comprehensive diagnosis. The social worker achieves this by a diagnostic study which he obtains through a casework relationship with the patient and his relatives. This study includes the patient's marital, vocational, educational and religious adjustments, achievements and failures; the patient's childhood experiences; the patient's social environment--its strengths and weaknesses; an assessment of the inter-relationships between the patient and his family as well as other groups of people; and the history of the present illness. Through this diagnostic study, the caseworker arrives at a social diagnosis which is of assistance in planning for future social casework services to the patient and his family with a view to meeting unmet social needs. The social study and the social diagnosis also give the treatment team an accurate assessment of the patient's personality and social environment, and thereby facilitate the team's diagnostic services, and treatment and rehabilitation plans for the patient.
(3) Treatment Services. Although some authorities seem to doubt the usefulness of the social worker participating in the treatment process,¹ the writer is convinced that the social caseworker is competent to take on some treatment responsibilities. The criticisms of his contributions perhaps arise out of a lack of public awareness of the caseworker's ability for helping people. His skill of starting with the client, and moving at the client's speed, as well as his skill of working with people under environmental-hospital pressures, is particularly important with mental patients, and is often overlooked by critics.

The social worker offers understanding. He shows a friendly interest in the patient. He helps the patient hold on to reality by stressing real things, but does not disclaim the patient's delusions. Instead, he accepts them as being real to the patient; moves on to more factual material as soon as possible; and attempts to get the patient interested in environmental realities again. This is in keeping with his professional competency, i.e. the social worker works only with those problems of which the patient is conscious: he avoids unearthing unconscious thoughts from the patient.

The patient is further helped to express his feelings; and if he is strong enough emotionally, he is encouraged to look at his attitudes and problems a little more

searchingly, so that he will have a better understanding of himself and his situation, and will know how to handle himself next time he is under stress. He will be helped to think more clearly about his future and will be encouraged in any reasonable decision that he makes. If needed, he will be helped in building up a sense of personal worth by support from the social worker and support stimulated by the caseworker in the social environment. The latter is achieved by gaining the interest of relatives and others in the patient.

Direct environmental help to the patient on the ward is also an important factor in the work of a psychiatric hospital social worker. The mental illness hampers the patient in meeting reality situations, and in facing his responsibilities to himself and to others. Consequently, the social caseworker often finds it necessary to lessen the burden for the patient by assuming some of the patient's responsibilities.

(4) Pre-convalescence Services. As soon as the patient recovers sufficiently to discontinue the medical treatment, further services are offered to him. Besides the services given to the ill person during his treatment period, the social worker at this time has an integrative job in looking at all existing resources in the community, and using the resources which will be most beneficial to the patient on his return to society. These social resources will be used in a way that is diagnostically related to the
underlying problems of the patient, and can be made available to the patient and his relatives at any time during his treatment and rehabilitation.

Another integrative job of the social caseworker during the period of pre-convalescence is that of knitting together all the services which exist in various departments of the hospital to the use of the patient. The emphasis, as before, remains client-centered. The patient plans for himself; and the social worker encourages and stimulates him to think of all the possibilities open to him, and supports him in his decisions. The social worker also helps the patient with problems and anxieties which so often accompany the patient's thoughts about his discharge from the hospital. In addition, if the patient needs and wants further casework services after discharge from the hospital, he is made aware of any follow-up services that are available to him.

(5) Convalescence Services. When the patient is eventually discharged from the hospital, he leaves a protective environment for the bustle, irritations and problems of society. Many of the patients find this return to community and family life extremely difficult and threatening. To help them retain the gains they have made at the hospital and to help them make further gains, it has been found that preparing them for these stresses and for the follow-up services is of immeasurable value. Although the Act Relating to Clinics of Psychological Medicine of British Columbia makes no provis-
ion for an extension of casework services to the discharged patient, such services are in fact given to selected patients. These services are either made available by the Crease Clinic social worker if the patient is living in the Greater Vancouver area, or by the provincial Social Welfare Branch of the area in which the patient lives if the patient lives outside the Greater Vancouver area. In either case, a social worker gives supportive and sustaining help.

In addition to giving casework help to the patient during the convalescent period, the Clinic social worker confers with the patient's doctor about the patient's progress and adjustment at home. Reports on the patient's progress from the Social Welfare Branch workers are discussed with the doctor too, and a written statement on the results of this discussion is sent back to the Branch as part of the general consultation service to the Field worker.

(6) Family Services. The social worker also has responsibilities to the patient's family, for their welfare is an important factor in the patient's rehabilitation. First, the support of the family can be a sustaining, beneficial influence to the patient while he is in hospital. Secondly, the patient will eventually return to his family in most cases, and the necessity often arises of the need to help improve family relationships to prevent future mental breakdowns of the patient. Thirdly, the illness of one of its members often has a devastating effect on the family.
When the patient enters the hospital, relatives are frequently more confused and upset than he is. They may be afraid of and may not understand the patient's illness. They may have needless fears that the patient is being "put away for life," or may need help to face the fact that the patient will remain ill for an extended period. They may feel responsible for the patient's breakdown, and may be affected by guilt feelings about committing the patient to the hospital; or they may show relief at getting rid of the responsibility of caring for the patient, and may decide to break all ties with him because they find his bizarre behaviour too painful to face again. All these feelings and attitudes have a disrupting influence on the patient and the effective functioning of the family. The social worker can give realistic assurance and support to the family, and encourage it to participate actively in the treatment and rehabilitation of the patient. He is also in the position to help the family with the material and emotional issues which it may encounter.

These issues that may confront the patient's family are many and varied. They may centre around the acceptance of the patient and his illness; they may centre around the problems which may have always been present in the family, and have been instrumental in contributing towards the patient's mental breakdown, and are, perhaps, having an incapacitating effect on other members of the family; or they may be the direct result of the separation of one of the members of the family--i.e. the patient--from the total unit. Through
casework support and clarification, the social worker is often able to help the family cope with these problems so that they can lead a more satisfactory life for themselves and for the patient. He can also make available to the family other social services such as Social Assistance and foster home care.

To summarize, the social caseworker has responsibilities both to the patient and the patient's family. His services are primarily aimed at the treatment and rehabilitation of the sick person, and at the prevention of the recurrence of the patient's illness; but to achieve this, help has to be extended frequently to the family, too. There are four common "casework processes or groups of techniques" used by the social worker to help people.

**Casework Techniques**

First, there are the techniques which are applied through the interpersonal relationship developed between the client and the social caseworker. These are the techniques which form the services which are of an emotionally supportive and sustaining nature for the client. Supportive and sustaining help includes such techniques as reassuring the patient, accepting his behaviour, showing understanding and friendliness, supporting and encouraging, sympathizing, and other utilized means in interviewing—all to help the client.

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gain strength and mobilize his own resources to help himself.

Secondly, there are techniques involving clarification of the client's conscious problems. These techniques are the ones used in helping the client to understand himself and his environment. Through this knowledge, which in casework is usually self-acquired, the patient is helped to modify his attitudes, to adjust to his surroundings, and to be able to meet stress situations realistically.

The third type of techniques comprises those used in giving information to the client. In the mental hospital, giving information is an extremely important function of the social worker. He is not only called upon to explain to the patient and relatives the functions of the Social Service Department, but must often be able to give information on various aspects of hospital life. The many misunderstandings which exist about mental illness and mental hospitals have to be dealt with. In addition, the caseworker advises the patient and his family of social resources in the community. He may inform the patient's family of financial help it can receive from other social agencies and may refer it to the proper agency for assistance; or he may advise the patient how to get vocational counselling, how to go about finding employment, how to continue with his education, how to get further casework services when he is discharged from the hospital, etc.
Environmental help, a fourth technique, can be divided into two categories. It can be either psychologically enabling as well as being helpful in other ways, or it can be helpful to the client without necessarily being psychologically enabling. The former is a casework service; the latter is an incidental service. The skilled caseworker will attempt to make all environmental services into enabling experiences for the client, because as a professional person his services should be compatible with a sound social diagnosis.

All the four casework processes listed above have one thing in common. They are aimed at helping the client help himself. The social caseworker's professional goal is to help the individual to better adjustments in his social relationships with others.\(^1\) Every patient is an individual, different from other individuals. He has his own combination of strengths and weaknesses, or turmoil and harmony. Similarly, every family is unique in its constellation and its interaction of members. "Individuality" has become the motto of social workers because they have realized the dangers inherent in pigeon-holing and generalizing, and because they believe that the uniqueness of each individual is often a vital part of his innate dignity and infinite worth as a human being.

The Crease Clinic of Psychological Medicine

The Crease Clinic of Psychological Medicine is part of the British Columbia provincial mental hospital system.

The Clinic has been designed and equipped as a diagnostic and active treatment centre for the mentally ill.\(^1\) To ensure that it shall carry out the intended function, statutory provision has been made limiting the duration of a patient's treatment period to four calendar months, commencing with the date of admission. If at the end of the treatment period in the Clinic, the medical staff is of the opinion that the patient requires additional treatment, there is a statutory provision to permit the patient to be certified for committal to the Provincial Mental Hospital in accordance with the provisions of the Mental Hospital Act.\(^2\)

Procedure for the admission to the Crease Clinic has been kept as simple as possible. Admissions are of two types: (1) certification by two medical practitioners; and (2) voluntary application by the patient, approved by a physician on the basis that he is of the opinion that the patient's condition is such as to render the patient capable of making voluntary application for treatment. The first, or regular admissions, are somewhat more common than the voluntary ones.\(^3\)

Since the maximum period of treatment in the Clinic is limited to four months, physicians are requested to certify for admission only those patients who, in their opinion, have

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\(^1\) What follows is a partial summary from the Policy Manual of the British Columbia Social Welfare Branch.

\(^2\) British Columbia, Revised Statutes of, ch. 207.

\(^3\) According to the British Columbia Annual Report of the Mental Health Services for 1953, there were 687 regular admissions and 534 voluntary admissions between April 1st, 1952 and March 31st, 1953.
a reasonable prospect for recovery and discharge in the four months' period. Specifically, the following types of patients are considered acceptable for admission to the Clinic:

1. early psychotics,
2. patients with psychoneurosis,
3. patients with psychosomatic disabilities, and
4. all psychotic patients except those who have been ill for a long time, and those demonstrating marked deterioration and having a poor prognosis.

On the other hand, some types of patients are considered unsuitable for admission and treatment in the Crease Clinic. These include: patients with senile dementia, patients with arterio-sclerotic dementia, mentally defective people, chronic recurrent psychotics, drug addicts without psychosis, and alcoholics without psychosis. In this connection, the Act Relating to Clinics of Psychological Medicine empowers the person in charge of the Clinic to decline to admit any person to the Clinic, if there are adequate reasons, notwithstanding the fact that the person has been certified under the Act.

**Crease Clinic Social Service Referral Policy**

In practice, most hospitals find it difficult to offer adequate social services because of unavailability of trained personnel which precludes staffing to recognized standards, and because of financial limitations within the total administration. Many patients and their families may
never see a caseworker. Others could possibly use a more intensive casework relationship, but the social worker, because of high caseloads, is too pressed for time to offer it.

At the Crease Clinic, because of this shortage in personnel, the process of screening patients for casework services has become important. If all the patients were to be covered by the Social Service Department, casework services would be spread so thinly over the general population of the Clinic, that patients would not benefit through them. The attempt to give complete social service coverage was, therefore, abandoned soon after the Clinic was opened, though it is a goal at which the Social Service administration is still aiming. For the present, the policy of offering services to the patients most likely to profit from them has been adopted, but in practice such a policy is often difficult to follow.

Referrals to the Department come from various sources. Most referrals are made during "ward rounds." Other patients are referred directly by the patient's doctor at the Clinic, by the nurse, or by some community agency. In some cases, the patient himself or his family may request

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1 The Social Service Department at the Crease Clinic consists of the administrator, two supervisors and six case-workers. The number of patients admitted to the Clinic between April 1st, 1952 and March 31st, 1953, was 1221.

2 "Ward rounds" is a periodic meeting of members of the treatment team. During these meetings newly admitted patients are discussed diagnostically, and treatment and rehabilitation plans for these patients are decided upon.
casework services. In addition, some patients or relatives are seen by the intake worker at the time the patient is admitted to the Clinic.

**Purpose and Assumptions of Present Study**

The present survey is one of a series of studies being conducted on the Social Service Departments of the Provincial Mental Hospital and of the Crease Clinic of the Psychological Medicine at Essondale, British Columbia, by Master of Social Work students at the School of Social Work at the University of British Columbia.\(^1\)** It makes the assumption that casework help is frequently of value to the patient and his family in the treatment and rehabilitation process. The responsibilities which the social worker assumes for the patient's social adjustment are very similar to the responsibilities of the doctor for the patient's physiological conditions. One of the tenets in medicine is to use all the available medical knowledge and skill on the patient, knowing that neither this knowledge nor skill will always cure the patient. Mr. A. may prosper from insulin therapy, while Mr. B. will remain unchanged from identical treatment. Similarly, social workers

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\(^1\) Mr. Gerald Pepper, at present himself a social worker at the Clinic, has already completed a general study of the history and the organizational structure of the Departments in his *Social Worker Participation in the Treatment of the Mentally Ill*, Master of Social Work Thesis, University of British Columbia, 1953. Two other studies are being conducted concurrently with this survey. The first, an examination of the Social Service referral policy and practice at the Crease Clinic, is being performed by Mr. Eugene Elmore. The second, a study by Mr. Murray Sutherland, is a survey of rehabilitative social services and resources available to male patients discharged from the Crease Clinic.
have the responsibility of bringing to bear their knowledge and skill on the patient, although they are at the same time aware that some of the patients are not perhaps capable of benefiting from or actually will refuse casework services. Both professions have their failures in treatment, and both professions are continually re-evaluating these failures and attempting to develop their knowledge and skills to decrease the number of people who cannot be effectively helped.¹

The purpose of the present study is to examine quantitatively the social casework services which were given to a representative group of patients and their families at the Crease Clinic up to the time of their discharge. By "social casework services" this study denotes all the services which the social worker offers to the patient and his family, and which are aimed at helping both the patient and the family attain a happier adjustment to each other and to society.

Criteria of Selection

In selecting patients for the measurement of social services at the Clinic, two criteria were emphasized. The first criterion was to get a sample which would be representative, yet small enough for careful case analysis within the time at the writer's disposal. The second criterion, in deference to the fact that Crease Clinic is a young flexible institution with constantly changing administrative policies, was to select as

¹ Of particular interest in this regard is Failures in Psychiatric Treatment, edited by Paul H. Hoch, published by Grune and Stratton, New York, 1948.
To keep the sample small and representative, the selection was limited to patients admitted to the Clinic within a six months' period, choosing every tenth patient admitted during that span of time. April 1st, 1953, to September 30th, 1953, was chosen as the period from which the sample was selected, because it ensured that all the patients were recently admitted, but at the same time ruled out the possibility of the patient not having yet been discharged from the Clinic.

During the above-mentioned period, 636 people were admitted to the Crease Clinic. The patients are listed by name in the Clinic's Admission Book according to the date of admission. By selecting every tenth patient admitted between April 1st and September 30th, 1953, the sample thus obtained consists of 64 people, and is probably representative of the range of services given but not certifiably of the total Clinic population.

Information on these patients was taken from a number of sources. The Social Service Department's records were used for the preliminary information. These records usually supplied sufficient information to make it obvious that a satisfactory classification according to social work diagnosis was impossible. However, in attempting to analyze the social services given to patients, the Social Service files were found

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1 The Crease Clinic was opened on January 1st, 1951.

2 The season of the year from which the sample has been selected has possibly some distorting effect.
to be lacking in the specific information being sought, and of necessity another way of getting the required information had to be devised. A questionnaire which asked for the pertinent information was prepared (Appendix A). It was answered by the patients' social workers. The information so obtained was supplemented by and checked against the information gleaned from the Social Service records.
CHAPTER 2

SOCIAL SERVICES FOR THE PATIENTS
AT A MENTAL HOSPITAL

The people who come to the Crease Clinic do so for the primary purpose of securing treatment for their illness. The treatment, as noted in the first chapter, is the combined effort of a number of disciplines—nursing, medicine, psychiatry, social work, occupational and recreational therapy, theology, and psychology. All the patients get a variety of services from members of these disciplines. For instance, the doctors and psychiatrists give medical and psycho-therapeutic services, the clergymen give spiritual services, and the psychologists further treatment through their assessment of the patient's personality. Social services are a part of this total treatment programme. The first chapter has outlined the responsibilities of the social worker in this programme, as well as listing the casework processes used in helping people. The present chapter will examine the social services which are used in meeting the social worker's responsibilities to the patients and their relatives.

Not all patients get social services. There are three main reasons for this. Firstly, the Clinic is a short-term hospital. Many of the patients stay only a brief period,
and are discharged before the social worker has the opportunity to see them. In other cases, the patient is discharged suddenly, and without the knowledge of the social worker. Secondly, some patients, because of the nature of their illness, resist or are unable to respond to social casework. Thirdly, as mentioned previously, the Social Service Department has insufficient staff to give adequate services and at the same time offer casework help to all the patients at the Clinic. At the present time, the Social Service Department tends to select for casework the patients to whom it can be of greatest assistance in the shortest possible time. Out of the 1221 patients admitted between April 1st, 1952, and March 31st, 1953, 573 were referred to the Department for brief services. Of these, 318 were served by the Admissions Section of the Social Service Department, and received casework services of an enabling and supportive nature over a brief period. Eleven hundred patients were referred for continued social casework services. However, only 508 of these patients were served by the Department because of the reasons listed above.

Out of the 64 patients in the present sample, all received some social services; but these varied considerably from person to person. Approximately 45.4% (or 29 of the patients and their relatives) received only immediate diagnostic planning services at ward rounds. The other 56.6% of the group

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1 For a full description of the differences between brief and continuing social services, see Gerald Pepper, op. cit., pp. 51-55, 61-68.

2 Figures from British Columbia, Annual Report of the Mental Health Services, 1953.
Table 1. Direct Social Services to 64 Mental Patients and Their Families

(Crease Clinic, 1953)\(^1\)

<table>
<thead>
<tr>
<th>Direct Social Services</th>
<th>Patients Receiving Services</th>
<th>Percentage of Patients Receiving Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Services to Patients only</td>
<td>6</td>
<td>9.3</td>
</tr>
<tr>
<td>Direct Services to Relatives only</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>Direct Services to Patients and Relatives</td>
<td>19</td>
<td>29.7</td>
</tr>
<tr>
<td>No Direct Services</td>
<td>29</td>
<td>45.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

(or 35 patients and their families) received services through the face-to-face casework relationship. Table 1 indicates the direct social services (or the services emanating from the face-to-face relationship between the caseworker and the client) given to the patients and their relatives. In six cases, direct services were extended to the patient and not to the relatives. In ten other cases, the relatives received direct social services, but the patient was not seen by the social worker. A full integration of services to the patient and his relatives was achieved with 19 patients, because both the patient and his family were receiving direct services. Such integration,

\(^1\) The source for Table 1 and all the tables that follow is a sample count of the patients under study.
however, is frequently impossible because either the patient is too ill for direct services or the patient's family lives outside the Greater Vancouver area. In the latter instance, an integrative job is occasionally achieved through the local Social Welfare Branch.

Classification of Services

What are the specific services which the caseworker provides for the patients and their families? The goals of the social worker at the mental hospital, previously mentioned, were seen to be the treatment, and rehabilitation of the patient, as well as the prevention of further mental breakdown of the patient. The problems of the patients and their relatives have also been pointed out. It now remains to describe and measure the social services. They can be described under three headings: (1) direct services to patients; (2) direct services to patients' relatives; and (3) indirect services to patients and their relatives.

"Direct services to patients" are those services which are given through the interviews between social worker and patient. Similarly, "direct services to patients' relatives" are those services which are obtained by the relatives of the patients through casework interviews. "Indirect services" are those services which are for the welfare of the patient or his relatives, and consist of a diagnostic use of social resources within or outside the Clinic. This division of casework services is not altogether exclusive except by definition, because, for example, direct services to the patient could be
considered as indirect services to the patient's kin. As a classificatory device, however, the division proved very useful.

Direct Services to Patients

Direct services to patients as defined for this study includes all the services which the social worker provides through the medium of the interview between the patient and the worker. These services have been divided for the purpose of analysis into four groups.

I. Support around anxieties related to hospitalization. This includes help with fears concerning the physical setting of the hospital, e.g. the locked doors; fears about the medical treatment; anxieties about the staff; and anxieties about the other patients.

II. Support around anxieties related to family problems during hospitalization. This concerns mainly help with those fears of the patient which are caused by the break-up of the family because of the illness of one of its members. Specifically, these anxieties are caused by financial problems, difficulties about the care of children, and immediate problems in family relationships.

III. Support around anxieties related to discharge plans. When the patient is ready for discharge, planning for his future becomes an important part of the social worker's job. This consists of environmental and emotional support. "Environmental support" covers a wide range of practical needs, namely: employment, housing, housekeeper services, financial
problems, and social and recreational matters. The second, "emotional support," consists of helping the patient cope with his fears related to the loss of hospital security, and to resuming family relationships. It also includes preparation of the patient for follow-up services made available by the provincial Social Welfare Branch or by the Social Service Department of the Crease Clinic.

IV. Casework services based on the emotional needs of the patient. This category of services may seem to be somewhat of a "catch-all" category, because the caseworker's work should at all times be based on the emotional needs of the client. However, the phrase, as used here, does not have such a broad scope. It refers only to those services which help the patient accept environmental reality, help him clarify conscious problems in interpersonal relationships, and help him accept his personal limitations.

Of all these four categories of direct services to the patient, the most frequent services are the ones "based on the emotional needs of the patient" (Table 2). Twenty of the 25 patients receiving direct services received help in accepting environmental reality. This is not surprising because

1 "Follow-up" services are casework services extended to the patient after his discharge from the hospital.

2 Group work services based on the emotional needs of the patient are being offered at the Clinic since February, 1954. However, at the time the patients under study were hospitalized, there was as yet no group worker at the Clinic.
Table 2. Classification of Direct Social Services to 64 Patients, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Direct Social Services to Patients</th>
<th>Number of Times Service Given</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Support around anxieties related to Hospitalization:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) the physical setting (e.g. locked doors)</td>
<td>14</td>
</tr>
<tr>
<td>(2) the medical treatment</td>
<td>20</td>
</tr>
<tr>
<td>(3) the staff</td>
<td>11</td>
</tr>
<tr>
<td>(4) other patients</td>
<td>14</td>
</tr>
<tr>
<td><strong>II Support around anxieties related to family problems during hospitalization:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) financial problems</td>
<td>10</td>
</tr>
<tr>
<td>(2) care of children</td>
<td>12</td>
</tr>
<tr>
<td>(3) immediate troubles in family relationships</td>
<td>22</td>
</tr>
<tr>
<td><strong>III Support around anxieties related to discharge plans:</strong></td>
<td></td>
</tr>
<tr>
<td>(a) Environmental</td>
<td></td>
</tr>
<tr>
<td>(1) employment</td>
<td>9</td>
</tr>
<tr>
<td>(2) housing</td>
<td>4</td>
</tr>
<tr>
<td>(3) housekeeper services</td>
<td>4</td>
</tr>
<tr>
<td>(4) financial problems</td>
<td>10</td>
</tr>
<tr>
<td>(5) social and recreational</td>
<td>21</td>
</tr>
<tr>
<td>(b) Emotional</td>
<td></td>
</tr>
<tr>
<td>(1) anxiety related to loss of hospital security</td>
<td>3</td>
</tr>
<tr>
<td>(2) fears about resumption of family relationships</td>
<td>8</td>
</tr>
<tr>
<td>(3) preparation for follow-up services</td>
<td>14</td>
</tr>
<tr>
<td><strong>IV Casework services based on the emotional needs of the patient:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) help in accepting environmental reality</td>
<td>20</td>
</tr>
<tr>
<td>(2) help in clarifying conscious problems in interpersonal relationships</td>
<td>18</td>
</tr>
<tr>
<td>(3) help in accepting personal limitations</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total direct social services to patients</strong></td>
<td><strong>232</strong></td>
</tr>
</tbody>
</table>
most mental patients present difficulty in their ability to function in relation to their individual reality situations, and need help in this area. Help in accepting personal limitations was extended to 18 patients because such difficulties are also common amongst mental patients. Clarification of conscious problems in inter-personal relationships was another frequent service. The patients are often persons who have never been able to feel comfortable with other people. Their social life has been unhealthy and unhappy, which is probably an added stress, if not the main one contributing to their eventual mental breakdown.

These difficulties in social relationships are obviously given much attention by the social worker at the Crease Clinic. In discharge planning, 21 of the 25 patients getting direct services discussed social and recreational difficulties and plans for alleviating such difficulties with the caseworker. Of the other environmental discharge services, financial and employment problems were most frequently discussed. However, in both these instances, only two-fifths of the patients receiving direct social services got such help. Planning around housing and around housekeeper services were even less frequent. The infrequency of the latter is probably because only families in which the mother is ill seem to be in need of housekeeper services.

Also surprisingly infrequent was help with anxieties of the patient about discharge from the Clinic. Less than three-fifths of the patients receiving direct services were
prepared for follow-up services of the provincial Social Welfare Branch or of the Social Service Department itself. Fears of resuming family relationships were discussed with only eight patients, while loss of hospital security as a problem came to the attention of the caseworkers with only three patients.

Work with clients who were fearful about hospitalization and all its implications was launched into more frequently. The medical treatment caused, numerically, the greatest anxieties. Here, twenty or four-fifths of the patients needed reassurance and support. The conflict with and the fear of other patients, another major matter, was discussed with the social worker in three-fifths of the cases receiving direct social services. Of similar frequency was casework support to overcome the frustrations and fears of patients about living in a hospital with locked doors and with somewhat regimented group living. The staff, also, was a source of anxiety to patients. First, there were the people who because of their illness felt persecuted or fearful of people generally; and secondly, there were complaints by some patients of not getting enough attention from the staff. Eleven people received some form of service from the caseworker in this area.

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1 A careful selection policy has been instituted for screening patients for convalescence services. This was necessary because between 68% and 75% of all patients entering the Crease Clinic are from the Vancouver area, and thereby direct responsibility for offering follow-up services lies largely with the limited social service staff of the Clinic. Other reasons why so few patients are prepared for follow-up services are, amongst others, (1) the precipitous discharges of some patients, (2) the decision of the treatment team that such services should not be given, and (3) the lack of social resources in the patient's home community.
A natural consequence of the hospitalization of these people was the break up of their families. Most patients are members of a family, and become anxious about what their absence means to it. This is reflected in the request for social services at the Crease Clinic. Almost all the patients who received casework help had anxieties about immediate problems in their family relationships (22 of the 25 patients). Twelve of the patients sought help with the care of their children. Family financial problems were not very often discussed since most of the patients were hospitalized for only a short period during which many of them were probably entitled to sickness benefits from their employer, or were cared for in some other way. Only ten patients discussed their financial difficulties with the social worker.

The above services are the direct social services to patients extended by the social workers of the Crease Clinic to the 64 patients comprising the sample under study. Many of the services most frequently given have something in common—they centre around relationships with other people. Such services are:—help in clarifying conscious problems in interpersonal relationships, help with immediate and future anxieties around family relationships, support in accepting environmental realities, help with difficulties with the staff and other patients, and support in planning social and recreational contacts upon discharge from the Clinic.

Less frequent are services concerned with concrete matters such as financial problems, housing, housekeeper ser-
vices. Compared to the work of the first caseworkers employed in mental hospitals, the social worker's job today is becoming more and more psychologically supportive. The early mental hospital social workers were mainly concerned with after-care and its associated problems, such as housing and employment. Though these remain an important task for the social worker, his job has increased with the greater knowledge and skills which the profession has accumulated through the years. The abstract aspects of his work—many of the services that flow out of the client-social worker relationship—are demanding an increasing amount of the caseworker's time.

**Direct Social Services to Patients' Relatives**

Direct social services to patients' relatives include all those services which the caseworker gives through the medium of the interview to the relatives. These services have been divided for the purpose of analysis into the following four groups.

**I. Support around anxieties related to the patient's hospitalization.** This group of services consists of casework help with fears the relatives have about the physical setting of the hospital and its effect upon the patient, and support to lessen the fears concerning the medical treatment.

**II. Help around the inability to accept the patient's illness.** This concerns the discomfort relatives often

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feel about committing the patient to a mental hospital, their uneasiness about being the "cause" of the patient's breakdown, their shame at having mental illness in the family, and their concern about the symptoms of the patient's illness.

III. Support around social problems in the home.
This includes help with financial problems of the family, help with problems around the care of children in the family, and help with difficulties in family relationships (disharmony between family members).

IV. Casework services based on the emotional needs of the patient's relatives. Again this group might appear to be a "catch-all" category for all the services which have not been covered in the other three groups, because casework services should be based on the emotional needs of people. However, for the purposes of the present study, the category has been delineated to include only support about personal anxieties, support in accepting the patient as he or she is, help in clarifying conscious problems in interpersonal relationships, and preparation for follow-up services.

As with the patients, among the most frequent services extended to the relatives was "casework help based on their emotional needs." Clarifying the relatives' conscious problems in interpersonal relationships occurred in twelve cases. More frequently extended was help with personal anxieties. These involved a considerable amount of work on the part of the social worker since, as some of the social histories indicate, the relatives often have numerous personal
difficulties which have a bearing on the patient and his illness. Because these personal difficulties usually cause difficulties for the patient upon his discharge from the Clinic to his family, relatives were prepared in thirteen cases for the follow-up services of the provincial Social Welfare Branch or of the Social Service Department at the CREASE Clinic.

The most frequent of the "casework services based on emotional needs" proved to be support to relatives in helping them understand and accept the patient as he is. Of the 29 groups of relatives receiving direct social services, 23 were helped in this way. Understanding and accepting the patient on the part of the relatives improves the social relationship between the patient and his family. It helps the family overcome their reluctance to visit the patient, and helps them be a constructive force in the patient's rehabilitation.

Understanding and accepting the patient is impossible without understanding and accepting his illness. The symptoms of mental illness create much concern for the patient's relatives, and in 20 cases this was discussed with them by the social worker. They are usually baffled by and afraid of what is happening to the patient, and are often fearful of what he may do. Almost as frequently given attention by the social worker are the relatives' feelings of discomfort about having committed the patient to the Clinic. They feel that they are deserting the patient at a crucial time in his life, and that they have done an injustice to him. They are also concerned about what the patient thinks of them for having him
Table 3. **Classification of Direct Social Services to Relatives of 64 Patients, Crease Clinic, 1953.**

<table>
<thead>
<tr>
<th>Direct Social Services to Relatives</th>
<th>Number of times Service Given</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Support around anxieties related to patient's hospitalization:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) the physical setting</td>
<td>9</td>
</tr>
<tr>
<td>(2) the medical treatment</td>
<td>21</td>
</tr>
<tr>
<td><strong>II Help around inability to accept patient's illness:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) discomfort about committal</td>
<td>18</td>
</tr>
<tr>
<td>(2) discomfort about being &quot;cause&quot; of illness</td>
<td>11</td>
</tr>
<tr>
<td>(3) shame at mental illness in family</td>
<td>8</td>
</tr>
<tr>
<td>(4) concern about symptoms of illness</td>
<td>20</td>
</tr>
<tr>
<td><strong>III Support around social problems in the home:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) financial problems</td>
<td>8</td>
</tr>
<tr>
<td>(2) care of children</td>
<td>10</td>
</tr>
<tr>
<td>(3) disharmony in family relationships</td>
<td>25</td>
</tr>
<tr>
<td><strong>IV Casework services based on the emotional needs of the relatives:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) support around personal anxieties</td>
<td>21</td>
</tr>
<tr>
<td>(2) support in understanding and accepting patient as he/she is</td>
<td>23</td>
</tr>
<tr>
<td>(3) help in clarifying conscious problems in interpersonal relationships</td>
<td>12</td>
</tr>
<tr>
<td>(4) preparation for follow-up services</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total direct social services to relatives</strong></td>
<td><strong>199</strong></td>
</tr>
</tbody>
</table>
"locked up."

Discomfort about being the "cause" of the patient's illness, and shame at having mental illness in the family are not as frequently encountered by the social worker, but are more serious indications of weakness in the family structure than the former two problems. Discomfort about committal, and concern about the symptoms of the patient's illness are quite natural occurrences and a sign of family solidarity. The patient is ill and his family is concerned about him. However, discomfort about supposedly being the cause of the patient's mental breakdown, indicates self-depreciation on the part of the relatives or actual serious disharmony within the family. Eleven groups of relatives had such discomforts. Further, the caseworkers, working with the sample under study, helped eight families overcome their shame at having mentally ill members. The preoccupation with "the disgrace" of having mental illness within the family is again a sign of lack of strength within the family, as well as indicating an unhealthy attitude to the patient. The family, in cases like this, is apt to see the patient as someone harming them rather than seeing him as someone in need of their continuing interest and assistance. It is perhaps an indication of them losing sight of the patient as a person.

In the group of services centred around the social problems in the patient's home, the most important category was that of help with difficulties in family relationships. Over five-sixths of the families receiving direct social ser-
vices were helped in this manner. It indicates that the families receiving casework help frequently have considerable internal disharmony. The care of the children needed the social worker's attention in only ten cases of contact with relatives, while financial problems were of even less significance—because of other sources of financial assistance, and because many patients are not the bread-winners of the families receiving the services.

In looking over the figures of Table 3, which lists the direct social services to the relatives, the outstanding item appears to be the number of relatives receiving help to alleviate their personal anxieties. Besides the service of helping to lessen the fears the relatives have about the health and welfare of the patient, a most common service offered by the Social Service Department is support to reduce personal fears and to reduce conflicts in family relationships. As with the services to the patients, here again much of the social worker's job centres on the discomforts of the individual in his adjustment with himself and with other people.

Generally, the services to the patient and the services to the relatives of the patient are not much different, although the individualized problems are to a degree. For instance, the illness and the hospitalization of the patient does not mean the same thing to the patient as it does to the relative. The patient gets upset by the physical setting of the hospital, while the relatives get upset by speculations of the
effect of the hospital setting on the patient. Most of the services to the patients are aimed at helping them adjust to other people. For instance, planning for the social and recreational life of the patient is a numerically important direct social service to patients at the Clinic. Most of the services to the relatives, on the other hand, are aimed at helping them understand and accept the patient. This, however, frequently necessitates helping the relatives with their personal anxieties. By strengthening the ego of the family members, the patient's family can become a strong source of support to the patient.

The high integration of services to patients and to their families (54.3% of the cases receiving direct social services), and the similarity in frequency and kind of the services offered to the sick and their relatives is indicative of the generic nature of casework. The problems with which clients come to social work agencies have basic similarities, no matter whether the client is a blind man, a person recovering from a mental breakdown, a husband whose wife is mentally ill, a delinquent boy, or an unmarried mother. It is also generic in that the casework method in toto is applicable to all these people in helping them overcome their difficulties in living with other people and with themselves.

There is specific knowledge relevant to the setting which a caseworker employed in a psychiatric hospital should have. He must be familiar with all the aspects of the hospital setting--the treatment regime, the hospital regulations,
etc. However, the over-all knowledge, the skills and techniques of forming a helpful client-worker relationship, and the diagnostic use of social resources remain the same in all branches of social casework. "Support around personal anxieties," "support in helping" people "understand and accept" other people, "help in clarifying conscious problems in interpersonal relationships," "support around problems in the home"—whether environmental or emotional—are familiar to all up-to-date public or private social work agencies. These services are not the sole property of the mental hospital social worker. As a matter of fact, many social workers who do not work in a mental hospital are also involved in the other services more specifically aimed at the mental patient and his relatives. In British Columbia, social workers in the provincial Social Welfare Branch are often called upon to alleviate relatives' anxieties about the hospitalization of the patient, and to help the relatives understand and accept the patient as he is. Also when, after assessment, the primary problems appear to be those with which other social agencies are particularly equipped to deal through stated service policy—e.g. family services ancillary to those brought to patients and families by the social workers in a hospital setting—the patients are referred to the other agency following discharge from the Clinic. This agency continues giving the services which were initiated by the Social Service Department of the Clinic.
Indirect Services

Indirect services to patients and their relatives are all those services which are for the welfare of the patient and his relatives, and consist of a diagnostic use of social resources within or outside the Clinic. These services have been divided into three sections.

I. Consultations with other professional people at the Clinic. Specifically, these consultations took place at ward rounds on which a member of each of the treatment professions is present; and individually with doctors, nurses, psychologists, the rehabilitation officer, and occupational and recreational therapists.

II. Consultations with people outside the Clinic. These consist of any form of communication between the Crease Clinic Social Service Department and casework agencies, group work agencies, employers, the National Employment Services, and boarding home operators with the purpose of helping the patient and his relatives.

III. Diagnostic studies at intake. These studies are a collection of diagnostic facts about the patient's personality development, and social and material environments.

Of the first group of indirect services, the most frequent service of the social worker occurs at ward rounds. Generally, every patient is discussed at ward rounds soon after his admission to the Clinic. It is here that the treatment plans are usually started. Consequently, patients are often referred to the Social Service Department at this time.
Table 4. Classification of Indirect Social Services to 64 Patients and their Relatives, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Indirect Social Services to Patients and their Families</th>
<th>Number of Times service given</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Consultation within the hospital:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) in ward rounds</td>
<td>64</td>
</tr>
<tr>
<td>(2) with doctors</td>
<td>44</td>
</tr>
<tr>
<td>(3) with nurses</td>
<td>24</td>
</tr>
<tr>
<td>(4) with psychologists</td>
<td>6</td>
</tr>
<tr>
<td>(5) with the rehabilitation officer</td>
<td>3</td>
</tr>
<tr>
<td>(6) with the occupational therapists</td>
<td>13</td>
</tr>
<tr>
<td>(7) with the recreational therapists</td>
<td>2</td>
</tr>
<tr>
<td><strong>II Consultations with people outside the hospital:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) with members of casework agencies</td>
<td>18</td>
</tr>
<tr>
<td>(2) with members of group work agencies</td>
<td>1</td>
</tr>
<tr>
<td>(3) with employers</td>
<td>4</td>
</tr>
<tr>
<td>(4) with the National Employment Service</td>
<td>4</td>
</tr>
<tr>
<td>(5) with boarding home operators</td>
<td>1</td>
</tr>
<tr>
<td><strong>III Diagnostic studies at intake</strong></td>
<td>30</td>
</tr>
<tr>
<td><strong>Total indirect services to patients and their families</strong></td>
<td>214</td>
</tr>
</tbody>
</table>
Consultations with the doctors are another frequent and important service. These consultations between the doctor and the social worker keep each informed about the other's tentative diagnoses (medical and social respectively) of the patient, and about the needs of the patient and the needs of his relatives. They co-ordinate their treatment plans so that their work is purposeful and constructive rather than at cross-purposes. Of all the patients comprising the sample under study, 44 were discussed in such consultations. Of these 44, nine patients and their relatives received no further services from the Social Service Department while the patient was in the Clinic, either because it was decided that the patient was too ill to benefit from casework help or because the patient had left the Clinic before the social worker was able to see him. The relatives of these people received no services for reasons not stated.

Not quite as frequent as consultations with the physicians were consultations with nurses. Twenty-four of the patients were discussed with the nursing staff. From these consultations, the social worker and the nurse were able to get a better understanding of the patient, and thereby were able to be of greater help to him. The consultations were particularly useful to the social worker, for the nurse has the opportunity to observe and talk to the patient each day.

Consultations with the rehabilitation officer, the occupational therapists, the recreational therapists, and
the psychologists are not very frequent. The occupational therapists were consulted concerning thirteen of the patients while the recreational therapists were seen only with regard to two of the patients. The purpose of these contacts is to plan ways of introducing and getting the patient interested in occupational and recreational therapy, and to get information on how the patient is making use of these resources. The rehabilitation officer (there is only one at present) was consulted about three of the patients. His job consists of helping male patients who are referred to him to find employment upon discharge from the Clinic. The psychologists conferred with the social worker about six patients. As a result of these consultations, both the social worker and the psychologist get a better understanding of the emotional difficulties of the patient.

The second group of indirect services—consultations with people outside the Clinic—is a more occasional service than the consultations with members of the Clinic staff. Actually, such consultations—by letter, telephone, or face-to-face—often occur after the patient has been discharged, but, in such cases, have not been included in the present study. Eighteen of the patients were discussed with other social casework agencies in order to improve services to the patient and his family. Employers were contacted with reference to four patients seeking employment. Four other patients were discussed with the National Employment Services for the same reason. Only one patient was discussed with a group
work agency. Another patient found accommodations to live in, after the social worker had helped him by contacting boarding home operators.

All these indirect social services to patients and relatives point out the important liaison position that the social worker holds within the mental hospital. He plans with the other hospital staff and with outside social resources for the treatment and eventual rehabilitation of the patient. Through carefully arranged plans he can bridge the gap between the life at the hospital and at home for the patient. Without the indirect social services, some patients would leave the Clinic not knowing where to eat or sleep. Others would not seek the services of another social agency, whereby they are able to find help in obtaining the necessities of life, and help in alleviating the stresses which could drive them to mental illness again.

The indirect social services also show the importance of teamwork, not only between members of the hospital staff, but between the hospital staff and the social resources in the community in which the patient and his family are living. The field social worker of the Social Welfare Branch must be kept informed on the progress of the patient at the Clinic, if he is expected to be of help to the patient and to the family in the home community. Similarly, the district office worker should keep the social worker at the Clinic informed about developments at home so that the latter can realistically reassure and plan with the patient.
CHAPTER 3

PATIENTS WHO COME TO THE CREASE CLINIC

Classification of the Patients

Because the purpose of the present study is a survey of social and not medical services, the original plan, to classify patients according to medical diagnosis, was abandoned. A compromise had to be made, however, to take advantage of the opportunity for cross-classifying patients against the social services received. An attempt was made to formulate a classification based solely on social work diagnoses, and this had to be abandoned for the following reason.

In the first place, all the patients selected for the present study about whom there was sufficient information available, seem to fall into one broad category—that of "emotional inadequacy." Relatives are apt at first to describe the patient as "the last person" they would have believed to become mentally ill. Later, however, they will often see the patient as a person who has always attempted to be self-sufficient, "keeping his problems to himself"—in other words, being unable to form close interpersonal relationships. Or, they will describe the patient as a man who has always been "happy," but who, on closer inspection, has always
been driven to be liked by other people because he felt insecure in his social relationships. Other patients are described by their relatives, "now that we think of it," as always having had an "inferiority complex," being withdrawn, etc. Of course, whether such emotional inadequacy is characteristic of the mental patient alone is doubtful; some form of emotional inadequacy is evident in every man's life because emotional maturity is a matter of degree. Because of this and because of the fact that all patients seem to fall into the "emotionally inadequate" group, the necessity arises to break down "emotional inadequacy" into smaller components if it is to be used for classificatory purposes. Unfortunately, measurement and analysis of the term "emotional inadequacy" tends to be superficial, unless done very carefully. The difficulty lies in trying to determine cause and effect. Each individual case has to be evaluated separately, and precise evaluation necessitates adequate information.

Eventually, two criteria for classification were devised. The first criterion was that simplicity and accuracy should be sought as far as possible. The second criterion demanded that the classification should possibly have some relationship to the services extended by the Social Service Department at the Crease Clinic. The people comprising the group under study were classified in the following ways: according

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to age, sex and marital status; the length of hospitalization; and the condition upon discharge. Of these, sex and age differences had the most obvious correlation with the social services extended, and have therefore been used in cross-classifying the services. Also used for cross-classification with the services, was the condition of the patients upon discharge, as this comes closest to indicating the "finished product" of the work of the staff at the Clinic.

Who Are the Patients?

The group under study consists of 25 men and 39 women--figures that proved to be on the whole proportionate to the admission figures for the period from which the sample was selected (237 men and 399 women). The Crease Clinic has always had more female patients than male, while the Provincial Mental Hospital has consistently had more men than women. Whether female mental patients have a better prognosis for improvement than male patients, and thereby are admitted to the Crease Clinic more frequently, is not known. There is the possibility that women seek psychiatric help earlier in their illness than men. It seems to be culturally un-masculine to go to the doctor with minor troubles, and wives probably have greater difficulty persuading their husbands to see the doctor than vice versa; possibly, also, the bread-winner needs to carry on longer before resorting to medical aid and hospitalization. However, the duration of the illness has frequently a decisive influence on the prognosis.

1 British Columbia, Annual Report of the Mental Health Services, 1953.
The sooner the patient undergoes treatment, the faster and more effective his recovery. One patient, for instance, a man of about 50, who was admitted to the Crease Clinic in 1953, has had bizarre suspicions since 1936. This was the first time he had come under treatment, though for years he had been prowling around his estate with a shot-gun to defend himself from unknown people. After a brief period at the Crease Clinic, he was transferred to the Provincial Mental Hospital because his prognosis was poor.

The age grouping of the patients comprising the sample is also interesting. Over two-thirds of the group are between the ages of 25 and 45. Approximately 60% of the patients are over the age of 35 and only seven are under the age of 25. However, despite the high proportion of older people in the sample, only fourteen had been previously hospitalized in a mental institution. Of these, seven were over the age of 50, which constitutes over 50% of the patients within that age group; six were between the ages of 30 and 50; and one was fourteen years old.

The marital status of the group is as follows: 37 are married, 20 are single, 3 are widowed, 3 are divorced, and one is separated. Of the 20 patients who are single, one-half are over thirty years old, of whom seven are male. Whether these people are single because their emotional instability makes them undesirable partners, or because of their inability

Fig. 1 Age Distribution of a Group of 64 Patients at the Crease Clinic, 1953.

(follows page 46)
Fig. 1. Age Distribution of a Group of 64 Patients at the Grease Clinic, 1953.
to form close personal relationships is uncertain, but the case histories give frequent evidence of such factors. In any case, out of 59 people over the age of 20, fifteen are and always have been unattached—a seemingly high percentage (25%).

Detailed information was available on over half the married people in the sample. Over 50% of these had serious marital difficulties. Here again it was not always clear whether the difficulties arose due to the developing mental illness of the patient or whether the difficulties had existed since the beginning of the marriage. However, the greatest number of marital difficulties centered on either symptoms of mental illness such as accusations by the patient that his marital partner is unfaithful, or on fundamental problems of dependency and submissiveness. The former is a stage in the developing mental illness, while the latter is probably one of the stresses that forces the patient to seek refuge in mental illness. Where marital difficulties seemed to be a contributing factor to mental illness, the social histories show evidence of more basic difficulties in the patient's earlier life. A case in point is that of a 40 year old married woman who was admitted to the Crease Clinic when she was two months pregnant. She was one of sixteen children of an Italian-Indian marriage. She has always felt that everyone looked down upon her and has had very strong feelings of inferiority. During her marriage she had a number of promiscuous relationships, but eventually one of the men she met, fell in love with her. She and this man
decided that she should remain with her husband for six months, after which she would make a decision as to her future. At the end of the six months, instead of making a decision, she became mentally ill. To decide between the two men was too great a strain for her.

The group of divorced people consists of three female patients, all over the age of 35. One patient, a male was separated from his wife shortly before he was admitted to the Clinic. The two widows and the one widower of the sample are over the age of 45. The widower was admitted because of hallucinations due to alcoholism, while the two widows were admitted in an emotionally depressed state.

The condition of the patients upon discharge is of interest. According to the physicians' assessment, two of the patients had recovered, 51 had improved, 8 were unimproved, and three were unclassified at the time of discharge from the Clinic. The category "improved" seems to consist of patients whose condition has improved, but who still manifest a varying degree of symptoms of their illness.\(^1\) As opposed to the recovered patients, who appeared to show no symptoms of their past illness upon discharge (the manic-depressive patients and the alcoholics with psychosis are often classified in this category\(^2\)), the improved patient may still be seriously dis-

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\(^1\) The clinical files of the patients indicate this.

turbed upon discharge, and may have to be re-admitted to the hospital soon after his return to his home.¹ Patients suffering from schizophrenia frequently seem to fall into this group or the "unimproved" group, as do many of the patients suffering from a serious psychoneurosis.² Out of the 8 unimproved patients, six were schizophrenic and two were classed as psychoneurotic (three were single and five were married).

The "unimproved" patients would appear to be those patients whose condition upon discharge remains unimproved from a psychiatric point of view. Lack of improvement medically does not always predicate no "improvement" in the social and environmental situation of the patient. Generally, an improvement in the psychiatric condition of the patient will also be noted by the social worker. On the other hand, there are improvements in the patient's economic or social situation whereby the patient is able to return to his home—unimproved from a psychiatric viewpoint. An illustration emphasizing this is the following:

A 34 year old single man, with simple schizophrenia, was referred to the Social Service Department for supportive help to alleviate personal anxieties and for help with discharge planning. His response to medical treatment was unsatisfactory. It did not lead to any tangible results, probably because of the long-term nature of the illness. The social worker, realizing that the patient was unable to mobilize his own resources and to take an active part in planning for his discharge beyond a limited point, requested the relatives to assume financial responsibility, and then approached a family friend

¹ Between April 1st, 1953 and March 31st, 1954, 810 patients were referred for convalescence services from the social worker, according to the Annual Report of the Social Service Department.
² Lawson G. Lowrey, op. cit., p. 194.
to assume supervisory responsibility over the patient. Accommodation arrangements were made prior to the patient's discharge.

The patient is now living by himself and making good use of his limited resources. He has money, is able to budget, and lives on a subsistence level without harming himself or other people. He assumes considerable responsibility for himself; and within his limitations, he functions to the maximum of his capacity, and leads a quiet and seclusive life. Prior to his hospitalization, he was unable to look after himself. He remains a person who will always be in need of financial assistance because of his illness, but it is essential that he be permitted to live on his own in the community if he is at all able to. The social worker was able to help him lead a personally satisfying life outside the hospital despite the handicap of mental illness.

Fortunately, most of the patients leave the Clinic in much better condition than the above patient. The length of hospitalization varies from individual to individual, but the average term of hospital confinement at the Clinic is two months. The degree of improvement is related to the length of hospitalization only when the illness of the patient is taken into consideration, too. The length of hospitalization by itself does not ensure recovery. In some cases—such as the manic-depressive patients—improvement is usually speedy, and often a complete recovery is achieved.¹ In other cases—with schizophrenic and some psychoneurotic patients—improvement is often slow and at times never comes at all.² Residuals of the illness frequently remain in the form of over-anxiety, an inappropriate tendency to become suspicious, inability to hold a job, inability to mix with people, etc.

¹ Lawson, G. Lowrey, op. cit., p. 168.
² Ibid., p. 194.
Out of the eight patients unimproved on discharge from the Clinic (see Table 5), three stayed at the Clinic for four months or more. The three who remained at the Clinic for less than three months were admitted on a "voluntary" basis, which entitled them to have themselves discharged from the Clinic upon their own request. They left the Clinic against the advice of the physicians. The two who remained from three to four months were discharged to the Provincial Mental Hospital because it was obvious that they were in need of a long period of hospitalization.

Table 5. Length of Hospitalization of 64 Patients According to Condition on Discharge from Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Condition of patient on discharge</th>
<th>1 month or less</th>
<th>1 to 2 months</th>
<th>2 to 3 months</th>
<th>3 to 4 months</th>
<th>over 4 months</th>
<th>Total number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovered</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Improved</td>
<td>3</td>
<td>23</td>
<td>11</td>
<td>8</td>
<td>6</td>
<td>51</td>
</tr>
<tr>
<td>Unimproved</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Unclassified</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>27</td>
<td>12</td>
<td>11</td>
<td>9</td>
<td>64</td>
</tr>
</tbody>
</table>

1 Patients unclassified as to condition upon discharge would appear to be those who were at the Clinic for observation only.

2 Seven of these patients were hospitalized for four months and a few days.
Of interest is the great number of patients discharged from the Clinic within the first two months of their hospitalization. Half the patients in the sample fall within this group. Many people would believe that this is an admirable achievement, and there is no doubt that it is, were it not for a limitation which is beyond the control of the Clinic. The scanty few weeks at the hospital do little apart from helping the patient to return to reality from his delusions, psychosomatic ailments, etc. Psychotherapy and long-term casework services are still very limited because of medical and social service staff shortages making such time-consuming help frequently impossible. Physical medication still remains one of the main weapons of attack on mental illness within the Clinic. Early discharge to the home, therefore, necessitates continuation of treatment in out-patients' clinics, and no such clinic has yet been established in British Columbia. At present, the discharged patient has the Social Service Department of the Crease Clinic and the provincial Social Welfare Branch as resources; if these do not suffice, the patient has no alternative but to return to hospital, whereas an out-patients' clinic could help him to hold on to the gains he made at the hospital, and thereby prevent further hospitalization.

In summary, the group of patients under study comprises more females than males. A rather high percentage of the patients are single, and in the older age groups there are more single men than women. The ages of the people in the
group run from 14 to 67, but two-thirds of the patients are between 25 and 45 years of age. Almost all the patients are discharged in an improved condition after an average stay of approximately two months. Most of them leave the Clinic with some residuals of the illness remaining with them. While the patient is still in hospital, it is part of the social worker's job to prepare the patient and his relatives for such limitations; he can also help them to learn to accept these without bitterness, so that they can lead as satisfying a life as possible upon the discharge of the patient.

**Differential Distribution of Services**

The second chapter examined the distribution of social services amongst the total patient group under study. It was noted that although all the patients received social services, some received a very limited number; other patients were served extensively by the Social Service Department. All the patients received the service of diagnostic planning at ward rounds. However, 29 of the 64 patients got no further service while they were at the Clinic, except for further consultations with the patient's physician (in nine cases).

Who are the people who received further casework help, and who are the people who did not? Table 6 shows the distribution of direct social services to patients according to age and sex. The table indicates that whereas approximately 29% of the women over 35 years of age received direct services, 80% of the women under 35 years of age were recipients of direct social services, too. Similarly, of the men
over 35 years of age, only 7% received direct social services, while for the group of men under 35 years of age the figure rose to 45%. In other words, in the sample under study, direct services to patients are more frequently offered to women than men, and to young women than older women.

Table 6. Direct Social Services to 64 Patients According to Age and Sex, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Sex</th>
<th>under 35 years of age</th>
<th>over 35 years of age</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>without services</td>
<td>with services</td>
<td>without services</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>17</td>
<td>30</td>
</tr>
</tbody>
</table>

Are age and sex then factors in the selection of patients for casework help? While age is probably one of the many factors taken into consideration by the Social Service Department in the selection of patients for casework help, sex is undoubtedly not such a factor. Age is taken into consideration to the extent that the older the person, the more "set" he is in his feeling, thinking and behaviour patterns. Consequently, he has greater difficulties in adjusting himself to the environment. His illness, as the social histories indicate, is of
longer duration, and thereby less amenable to treatment.1

Table 7. Social Services to 64 Patients According to Age and Sex, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Social Services</th>
<th>under 35 years of age</th>
<th>over 35 years of age</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>female</td>
<td>male</td>
</tr>
<tr>
<td>Direct Services to Patients only</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Direct Services to Relatives only</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Direct Services to Patients and Relatives</td>
<td>2</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>Indirect Services only</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

In practice, this is borne out by the number of older patients being served through their relatives. Table 7 indicates the integration of social services to patients and their families according to sex and age. It shows a higher proportion of patients over the age of 35 years than under the age of 35 years receiving help not through direct social services to themselves, but through direct social services to

1 Because the length of the illness is related to the prognosis, long-term psychotics are thought not to be suitable for admission to the Clinic as they are likely to need long-term hospitalization.
their families. This indicates that with older patients there is a greater emphasis on helping the social environment adjust to the patient than vice versa. Despite this emphasis on helping relatives adjust to the older patients, more relatives of younger patients get direct social services. These services to relatives of younger patients are also more frequently integrated with the direct social services to the patient. Integration of social services is particularly frequent amongst female patients under the age of 35. Out of 15 women under the age of 35, eleven received social services for themselves, as well as receiving further service through casework help to their families. The frequent integration of services to female patients and their families suggests one of the reasons for the greater frequency of social work help to female patients than to male patients. The unfulfilled responsibilities of looking after the children and the home during the absence of the mother, raises difficulties for the family, and is a source of anxiety to the mother. Of the ten married women receiving direct social services, nine discussed their anxieties about the care of their children with the social service worker. In addition, the families of these nine women also received direct social services. This indicates that need as well as ability to prosper through casework help is the basis on which patients are selected for social services. The family in which the mother is absent through illness frequently presents a more extensive need for services than other situations.
Table 8. Social Services to 64 Patients According to Their Marital Status, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Social Services</th>
<th>Single Patients</th>
<th>Married Patients</th>
<th>Divorced or Separated Patients</th>
<th>Widowed Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Services to Patients only</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Direct Services to Relatives only</td>
<td>2</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Direct Services to Patients &amp; Relatives</td>
<td>7</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Indirect Services only</td>
<td>8</td>
<td>18</td>
<td>2</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>37</td>
<td>4</td>
<td>3</td>
<td>64</td>
</tr>
</tbody>
</table>

There seems to be no other significant association between the marital status of the patients and the social services (Table 8). Three out of every five single patients or their relatives received casework help. The married patients were helped in just over half the cases, while two-thirds of the widowed and one-half of the separated or divorced patients were also served. Direct services to relatives only, were extended more frequently to the families of married patients, indicating that casework help to this group of patients is less frequently integrated perhaps because of the illness of the patient, than for the other groups. This is further borne out by the fact that single patients received direct services more often (50%)
than married patients (30%). More frequent direct services to single people may be owing to the lack of support from a family relationship.

There also appears to be no significant correlation between social services and the length of hospitalization of the patients (Table 9). The persons staying for more than four months and their relatives, were extended social services most frequently (68% of those staying over four months). Patients remaining within the Clinic for less than four months received casework help or were extended social services through their families in approximately half the cases. Direct services to the patients, therefore, show an inconsistent increase with an increase in the length of hospitalization of the patient.

Table 9. Social Services to 64 Patients According to the Length of Hospitalization, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Social Services</th>
<th>Period of Stay</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 month or less</td>
<td>1 to 2 months</td>
</tr>
<tr>
<td>Direct Services to Patients only</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Direct Services to Relatives only</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Direct Services to Patients &amp; Relatives</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Indirect Services only</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>27</td>
</tr>
</tbody>
</table>
Services according to the condition of the patient upon discharge (a psychiatric assessment) again showed no correlation (Table 10). Over half of the improved, unimproved and unclassified patients or their families received casework help. The recovered patients were helped only in half the cases, but the figure for these is far too small to draw any conclusions from. Table 10 also indicates that the "unimproved"

Table 10. Social Services to 64 Patients According to Their Condition upon Discharge, Crease Clinic, 1953.

<table>
<thead>
<tr>
<th>Social Services</th>
<th>Recovered</th>
<th>Improved</th>
<th>Unimproved</th>
<th>Unclassified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Services to Patients only</td>
<td>-</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Direct Services to Relatives only</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Direct Services to Patients &amp; Relatives</td>
<td>-</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Indirect Services only</td>
<td>1</td>
<td>24</td>
<td>3</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>51</td>
<td>8</td>
<td>3</td>
<td>64</td>
</tr>
</tbody>
</table>

patients are served as frequently as other patients. The unimproved patient has few strengths within himself, and the social worker seeks to find for him further strengths in the social environment. Because of this, a higher percentage of unimproved patients' relatives received direct social services than the relatives of the improved.
Summary

An examination of the sample under study revealed that a higher percentage of female patients than male are served by the Social Service Department. It also showed that younger people (under 35 years of age) are more frequently recipients of casework help than older people (over 35 years of age). An examination of social services according to the marital status of the patients, the length of hospitalization, and the condition of the patient upon discharge from the Clinic, (psychiatric assessment) proved that these factors have little visible correlation to the giving of social services to patients and their families.
Summary and Assessment

At the beginning of this study, the responsibilities of the social caseworker in a mental hospital were outlined. They can involve him at every phase of the patients' and their families' social needs. The techniques of helping people with their difficulties in social relationships were described by outlining four different ways of giving help: supportive and sustaining help emanating from the casework relationship, clarification of conscious problems, information-type of help, and environmental help. All these techniques of giving help are aimed at helping the client help himself.

To achieve the purpose of this study—the analysis of social services to mental patients—it was necessary to define the specific services of social workers to patients and their relatives. In other words, the first task was to find out what the social worker does. Only then could a quantitative statement be made as to casework help in a mental hospital.

Since there was apparently no previous classification of social casework as practiced with the mentally ill, a special classification was devised for the present study. This
was done by visualizing the needs of the patient and his family as he moves through his period of hospitalization— from admission to discharge. To avoid the confusion of a long list of unrelated matters, the services were grouped in the following manner: (1) direct services to patients; (2) direct services to patients' relatives; and (3) indirect services to patients and their relatives. Direct services to patients were defined as all those services which were given through the social worker-patient interviews. Direct services to patients' relatives included all the services which were obtained by the relatives of the patients through casework interviews. Indirect services were defined as those services which were for the welfare of the patient or his family, and consisted of the therapeutic use of social resources.

The patients studied were 64 people who were admitted to the Crease Clinic between April 1st, 1953, and September 30, 1953. They were selected by a routine sampling procedure.

The distribution of services among the people comprising the sample was shown to vary considerably from person to person. All of the patients received some form of indirect service. However, only 25 of the 64 patients received direct services, while services to relatives were not much more frequent. The present administrator of the Social Service Department stated that all the patients at the Clinic and their
relatives could benefit from casework help. However, because coverage of all patients by the Social Service Department was attempted at one time and was found to be an unworkable situation for professional casework practice, the policy of selection was adopted. The situation was unworkable because, as was seen in Chapter 2, the tasks of the social worker have increased considerably in the past years with the accumulation of knowledge and techniques. The abstract aspects of his work—many of the services that emanate from the client-social worker relationship—are demanding an increasing amount of the social worker’s time.

Naturally, with this increase, the social worker can no longer carry as large a case-load as he used to, if he is to give the quality of service he is qualified to give. It is largely through a realization of this that there is a continual demand by most social service agencies for more social caseworkers. With large case-loads, social workers find it impossible to give their clients more than sustaining help, which preserves the status quo but does no more for most clients. They have the opportunity of helping only a few selected people regain the strength and social resources needed for a better social and personal adjustment. In the long view, therefore, the condition of too few caseworkers perpetuates the large case-loads. On the other hand, with enough caseworkers, case-loads will be small from the beginning, and will remain so, because people will be helped to stand on their feet rather than be supported indefinitely by one or another social agency—
as is so often the case today. The eventual emotional and financial savings would, it is claimed by some authorities, outweigh many times the cost of the additional salaries incurred.¹ However, until such time when there are sufficient caseworkers available to help all people with critically unsatisfied social and emotional needs, the policy of selection seems to be the only practical solution.

Though administratively expedient, the policy of selection raises a moral question for society, if it should become a permanent measure rather than a temporary priority system for the allocation of scarce resources. Selection results in an arbitrary system of granting social services to individual patients, despite the priorities given to those who can profit most from the services. Obviously, the 39 patients not receiving direct social services have also unmet social needs. They have, ethically, the same right to these public services as the 24 patients receiving casework help. Equal opportunities—whether to education or to mental health—for every Man is the basis of democracy. At present, elementary education is offered to everyone who is capable of learning; however, social services at the Crease Clinic are not made available to everyone who is in need of them and capable of using them.

Social Services are Personal

The study also confirmed that social work is no longer a profession concerned primarily with giving financial and

material aid to people which is so often the concept laymen have of the profession. There is, in fact, surprisingly little done by the Crease Clinic social worker in relieving material needs. The main reason for this seems to lie in the other resources available to the patient and his family in their home community. Employers provide sickness benefits, and public agencies provide financial aid. Furthermore, the patient's hospitalization at the Clinic is frequently not so long as to cause financial embarrassment, loss of employment, and difficulties in finding living accommodations. Of numerically greater importance is the existence of the social and psychological needs of the patient and his family which have been described in this study.

Therefore, instead of being aimed at material needs, most of the services of the social caseworker at the Crease Clinic are directed towards helping the patient and his family make adjustments in their relationships with other people in the social environment. Other numerically important services of the social caseworker were the services related to the hospitalization of the patient. Particularly frequent was casework help with anxieties of the patient and of his relatives about the medical treatment.

Although the individualized problems of the two groups were shown to be somewhat different, the services to patients and relatives were found to be similar. The problems were different in that they were experienced by different people—by the sick person and by his relatives. The similarities of the
services to the two groups exemplified the generic foundations of social work. In addition, it was pointed out that casework services in a mental hospital are not significantly different from the services of other casework agencies. These similarities in services should, however, not be taken as meaning "the same services." The services differ in quality and intensity from person to person and are not an "image" of each other. The personal quality of the casework relationship accompanies each service, which is given in a way that will fit the individual client.

The indirect services to patients and their relatives indicated the integrative position which the social caseworker holds between the mental hospital and the home community of the patient. Through the therapeutic use of social resources, he brings to the aid of the patient and his family resources aimed at the treatment and rehabilitation of the patient, as well as the resources aimed at helping the patient to remain mentally healthy.

The analysis of indirect services also showed the extent of teamwork within the Clinic. There were numerous inter-discipline contacts to achieve purposeful treatment of the mentally ill. "The quality of treatment afforded to the patient" is known to be "wholly dependent on how ably the various professions can work together. Ability to work together involves some knowledge and respect for other professional skills, an understanding of human behaviour, and an ability
to work integratively. The relationship of the various professions must be constantly evaluated and purposively developed if treatment is to be adequate.  

Goals for the Future

At present, the Social Service Department of the Crease Clinic is faced by a number of difficulties. These can be divided into two groups: those caused by insufficient staff, and those caused by lack of community resources. The first, those caused by insufficient staff, are obvious from the results of the study. The severity of the problem is, however, not noticed in the present study as it is only concerned with social services during the patient's hospitalization. Many of the patients leave the Clinic soon after casework help has been initiated, and the greater part of the social worker's job in such cases often follows upon the discharge of the patient. The short-term period of hospitalization at the Clinic creates a high turn-over of patients, and many of the 1200 patients admitted annually are in need of after-care services.

The second group of difficulties of the Crease Clinic Social Service Department, those caused by the lack of social resources, are probably even more serious than the first. There is a need for an out-patient's clinic to which the patient could turn for help after his discharge from hospital. This

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1 Gerald Pepper, op. cit., p. 94.

2 The need for such a clinic and for other social resources is demonstrated in Mr. Sutherland's thesis, op. cit.
would not necessarily relieve the Crease Clinic social worker from the responsibility of after-care services, but would at least be a resource where the patient could get the help which the social worker is not competent to give. At such a clinic the patient would be able to avail himself of psychiatric and other services which are at present only available in institutional settings. Besides the out-patients' clinic, there is the need for supervised boarding homes—particularly for the men—to which patients can move upon their discharge. Among other resources needed, there is the need for services of volunteers to enable the patient to visit his family and vice versa during his hospitalization. The long distance between the patient's home and the Clinic, and the rather high cost of transportation to and from the Clinic, often makes it difficult and costly, and sometimes impossible, for such visits to take place.

Research in Social Work

The end result of research is new knowledge. In social work this means a knowledge of what is being done, of what needs to be done, and how to do it. Through research, the services being given, the effectiveness of these services, the lacks in social resources, the improvement in techniques, etc. can be measured. Evaluative research, particularly, is needed. It is necessary for the following reasons:

(1) It measures the extent of the social service programme, i.e. the adequacy in coverage of the people needing services, and the adequacy of the services in being helpful to
(2) Through periodic assessments, it shows the changes in the social service programme, and thereby makes prediction of future trends possible.

(3) It provides data to the public and to financial appropriating bodies as to the need and usefulness of social services in the life of a community.

The essential steps in evaluative research can be "summarized under five headings: (1) identifying the goals that are being sought; (2) analysing the problems with which the activity," i.e. social work, "must cope; (3) describing and standardizing the activity; (4) measuring the degree of change that comes about; and (5) determining whether the change observed is the result of the activity or due to some other cause."¹

In the present study, the goals of the social worker in the mental hospital were seen as being treatment, rehabilitation and prevention of mental illness. These goals were put into "operational terms" by outlining the responsibilities of the social worker to the patient and his family. Analyzing the problems of the patients and their relatives, and describing and standardizing the activity of the social worker were achieved in one step. The activity, or services, of the social worker were described in Chapter 2 as the counterpart of

each of the needs that the patients and their families might have. Measuring the degree of change that has taken place in the client's psycho-social situation was not attempted in this study. However, the psychiatric assessment of the condition of the patient was used, and found to be an unsuitable index for measuring results in social work. The last step in evaluative research, determining cause and effect relationships, became thereby irrelevant.

One of the prerequisites of evaluative research is the availability of information, i.e. social casework recording must give the pertinent information. The Crease Clinic recording did not lend itself to an analysis of social services to patients and their relatives. The use of a questionnaire such as the one employed for this study is probably less precise than if "provision is made for obtaining measures of results before any services is given."¹

Naturally, the recording at the Clinic was never intended for the purpose of research analysis only. The main purpose of recording is and should remain that of a tool for giving more effective service to the client. However, since research is an integral part of social work, certain adaptations could be made in the recording to facilitate research. Such adaptations could be justified not only for the long-term benefits which would emanate from the research that would then ensue, but from what is, probably, also an efficient casework

practice.

The present and a number of other studies have shown that it is possible to analyze social services adequately into specific components. Standardization into such components is essential for research, and cannot be "achieved without thorough planning beforehand and conscious control and recording throughout treatment."¹ If standardization in recording cannot be justified because of time limitations and high case-loads, periodic summaries and closing summaries of treatment activities should at least be kept. Such summaries are valuable not only from a research point of view, but are also useful as an aid in treatment; they give an accurate assessment of the treatment plan, and of the response of the patient to treatment. Periodic summaries with re-evaluation of the tentative social diagnosis and of the treatment plan are professional practices inherent for constructive service to the client.

From a research point of view, periodic and closing summaries are particularly valuable if the information they contain is standardized. They should include some of the following information: (a) the problem or problems for which the client requests help; (b) other problems which the social worker sees in the client's situation; (c) a tentative social diagnosis; (d) the treatment activities in the past; (e) the reaction of the client to these treatment activities;

(f) evaluation of the effectiveness of and the changes being made in the treatment plan.

The information should be given in a standardized way. For instance, the summary of the treatment plan may consist of a listing of the areas in which help is being planned, e.g. help with financial difficulties, help with difficulties in adjusting to the hospital, etc. It may also consist of the techniques that were planned to help the client, e.g. giving information, reassurance, support, etc. The reaction of the client to the treatment plan can be given for the plan as a whole, e.g. excellent, good, fair, etc.; or, if at all administratively possible, the movement of the client towards the solution or alleviation of each of his problems can be stated.

With all this information available, it would be possible to analyze the problems of the clients who come for help to the agency; the help they need; the services they get; and the effectiveness of these services in assisting them.

* * *
QUESTIONNAIRE USED IN SURVEY

Which of the following services did you extend to.................?
Please check off under the appropriate column for each service listed.

A DIRECT SERVICES TO PATIENT

I Support around anxieties related to hospitalization:

(1) the physical setting (locked doors, etc.)
(2) the medical treatment
(3) the staff
(4) other patients

II Support around anxieties related to family problems during hospitalization:

(1) financial problems (family without money etc.)
(2) care of children
(3) family relationships (immediate anxieties)

III Support around anxieties related to discharge plans:

(a) Environmental

(1) employment
(2) housing
(3) housekeeper services
(4) financial problems
(5) social and recreation

(b) Emotional

(1) anxiety related to loss of hospital security
(2) family relationships (e.g. is my wife going to understand me now?)
(3) preparation for followup services

IV Casework services based on the emotional needs of the patient:

(1) help in accepting environmental reality
(2) help in clarifying conscious problems in interpersonal relationships
(3) help in accepting personal limitations
B  DIRECT SERVICES TO RELATIVES

I  Support around anxieties related to patient's hospitalization:
   (1) the physical setting (food, other patients)
   (2) the medical treatment

II  Help around inability to accept illness:
   (1) discomfort about commitment
   (2) discomfort about being "cause" of illness
   (3) shame at mental illness in family
   (4) concern about symptoms of illness (afraid of the delusions etc. of patient)

III  Support around social problems in home:
   (1) financial problems
   (2) care of children
   (3) family relationships

IV  Casework services based on the emotional needs of the relatives:
   (1) support around personal anxieties
   (2) support in understanding and accepting patient as he/she is
   (3) help in clarifying conscious problems in interpersonal relationships
   (4) preparation for follow-up services

C  INDIRECT SERVICES TO PATIENTS

I  Consultations within the hospital:
   (1) ward rounds
   (2) doctor
   (3) nurse
   (4) psychologist
   (5) rehabilitation officer
   (6) occupational therapist
   (7) recreational therapist
   (8) industrial therapist

II  Consultations with outside resources:
   (1) casework agency
   (2) groupwork agency
   (3) employers
   (4) boarding home operators
   (5) National Employment Services
   (6) other (not including family)

III  Diagnostic studies at intake
BIBLIOGRAPHY

Specific References

Books:


Articles, Reports and Other Studies:


General References

Books:


Articles and Reports:

