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PSYCHIATRIC FACILITIES AND SOCIAL CASE WORK
SERVICES IN A HOSPITAL SETTING:

A Review of Developments in the
Vancouver General Hospital
(1915 - 1950).

by

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ABSTRACT

Vancouver General Hospital was the first general hospital in the Province of British Columbia to establish psychiatric facilities for care of the mentally ill. The trend toward psychiatric wards and psychiatric clinics in general hospitals began during World War I because of public awareness of the need for facilities to care for mentally ill patients. In 1915, Vancouver General Hospital opened its first psychiatric ward; five years later, a psychiatric clinic was established.

The aim of this study is to show what Vancouver General Hospital has contributed to psychiatric care for the mentally ill. The study is concerned with disclosing the adequacies of the hospital, as well as the inadequacies in terms of service to the patients and to the community.

The information concerning the development of psychiatric facilities at Vancouver General Hospital was obtained from annual reports of Vancouver General Hospital, from the Survey of Vancouver General Hospital by the Joint Committee in 1932, and from personal interviews with the Director of Vancouver General Hospital, the Chief Staff Psychiatrist of the hospital's psychiatric department, the psychiatrist of the psychiatric ward and clinic, the hospital's first

social worker, and two nurses affiliated with the first psychiatric ward and clinic. Information on the development of psychiatric facilities in the City of Vancouver was obtained by personal interviews with the head social worker of the Provincial Mental Hospital.

The case material and statistical information in the study were secured from 225 records of the Social Service Department of Vancouver General Hospital. The records cover a three year period, 1947 through 1949. The number of social service records for this period totaled 450. A sample was made of every second record and 225 records were obtained.

The most significant finding in the study indicates that the Psychiatric Department of Vancouver General Hospital has been handicapped in its effort to serve the mentally ill and the emotionally disturbed. The hospital is without sufficient personnel and adequate facilities to meet the demands of the community.

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CHAPTER I

THE FIRST UNIT: WARD X

Provision for the care of the mentally ill in British Columbia began in April, 1906, when the House Committee resolved "that accommodations be provided for two 'D.T.' Wards. . ."¹ The wards lacked sufficient accommodation for the number of patients and by September of that year, the House Committee protested against the great number of alcoholics sent in from the city jails. No additional provisions for delerium tremens patients were made until October 15, 1908, when padded cells were provided in the basement of the Vancouver General Hospital.

Vancouver General Hospital originated in 1902, by special legislation when the City Hospital was incorporated and transferred from the control of the City Council to the Corporation of the Vancouver General Hospital. Construction of the hospital began the following year. Funds were secured by special grant from the Provincial Government, from donations by firms and individuals, and from the city. The first unit of Vancouver General Hospital was completed and occupied in January, 1906.

The Board of Directors of Vancouver General Hospital approved its plan and objectives a year later. One

¹ Minutes of the House Committee of the Board of Directors, Vancouver General Hospital, April 24, 1906.

of its objectives provided that:

Persons suffering from disease deemed to be incurable or who are lunatic or insane will not be admitted.²

The shortage of adequate facilities for the care of the mentally ill in British Columbia created a problem for the hospital. Because of provincial grants to the hospital, any resident of the province was eligible for admission upon recommendation by a physician. Although the hospital did not admit the obvious mental patient, some gained admittance because of other illness.

Some physicians recognized the need for psychiatric facilities for the patient with acute mental disorder and advocated early treatment as a preventive of permanent confinement in a mental hospital. It was also their belief that early treatment would decrease the number annually committed to mental hospitals.

In the plans, provisions were made for (1) a "D.T." ward at Vancouver General Hospital, (2) early treatment for the mentally ill, and (3) the isolation of disturbing patients on wards. These factors contributed to the establishment of Ward X.

In the summer of 1915, Ward X replaced the padded cells provided for patients with delirium tremens. The ward was considered a marked improvement over previous

² Report of the Vancouver General Hospital Survey Commission--Hospital Situation of Greater Vancouver, April 25, 1950, p. 46.

facilities because it was large, well lighted, and airy. It was composed of sixteen rooms located in the basement of the hospital, and it was for the accommodation of patients who remained in the hospital for a considerable length of time.

As the service and administration of Ward X progressed, the hospital encountered the problem of caring for the incurable patient. This problem was studied and discussed; however, nothing was accomplished. Ward X serviced the incurables, alcoholics, drug addicts, acute mental cases, and cases of an undiagnosed contagious nature. No provision was made for segregation of cases, and those of contagious and destructive nature were not removed until after diagnosis.

The need for segregation and isolation of cases became increasingly pronounced. Vancouver General Hospital felt the need for a psychiatric department where new cases could be kept under observation. There were many cases where early diagnosis and treatment would have prevented committal to the Provincial Mental Hospital. Cases of this nature were unsuitable for admission to wards in the main hospital and it was damaging to the curable patient to remain on Ward X with incurables.

In order to ease the pressing situation, Marpole Annex of Vancouver General Hospital was opened in 1917. Ward X discontinued care of chronic patients and it was

converted into a psychiatric department for observation, diagnosis, and care of those responding to treatment. The observation section took care of alcoholics, drug addicts, mental cases, and cases of minor or doubtful contagions in for diagnosis. Cases diagnosed as mental disabilities were discharged to the Provincial Mental Hospital in Essondale. Cases of infectious nature were removed to the appropriate infectious cottage.

The increasing number of patients admitted to the hospital became a source of worry and expense for the Observation and Isolation Sections. Because of the limited number of rooms, unsanitary conditions prevailed. It was difficult to keep the rooms vacant long enough for cleaning and renovating. A staff of cleaners worked all hours, and scarcely did a week-end pass that the staff did not have to work. The rooms were unattractive and poorly located. The location of the rooms was unsatisfactory because of their close proximity to other wards. Frequent disturbances in the rooms by the patient in a maniac state had a bad effect on some of the patients on other wards.

Unfavorable conditions on Ward X continued to exist despite the Mental Hygiene Survey of British Columbia made by the Canadian National Committee of Mental Hygiene in 1919. The National Committee included in its recommendations a provision for the establishment of a

Psychopathic Hospital. (Reference has previously been made to the advisability of establishing a Psychopathic Hospital in connection with the Vancouver General Hospital.)

The National Committee's chief arguments for its recommendation were taken from arguments formulated by the Mental Hygiene Committee of the New York State Charities Aid Association.³

- (a) Such a hospital is an integral part of a complete provincial hospital system, and without it the system goes lame.
- (b) Such a hospital will check the rapid increase in the number of the insane by heading off the stream at its source.
- (c) Such a hospital, by preventing and curing cases of mental disease in incipient and early stages will prevent their becoming chronic insane patients, and will save the state the expense of continuous care of chronic cases for a long term of years in regular provincial hospitals.
- (d) This hospital, by receiving and caring for recent and acute cases of insanity, will diminish the number annually committed to other provincial hospitals and so relieve the overcrowding in these hospitals.

In November, 1929, a survey was made of Vancouver General Hospital under the auspices of a joint committee of the City Council, the Hospital Board of Directors,

³ "Mental Hygiene Survey of the Province of British Columbia," Canadian Journal of Mental Hygiene, Vol. 1, April, 1920. P. 51.

and the Provincial Government. The committee recognized need for better facilities for the mentally ill and recommended a special hospital for the neurotic and the psychotic. It proposed building a psychiatric hospital on ground owned by the Vancouver General Hospital. The hospital was to be in the immediate charge of a specially trained resident physician and under the general control of the Metropolitan Hospital Board. The survey aroused interest of various civic groups. Plans for construction of a well-equipped hospital on Little Mountain were made, but the trend toward psychiatric wards in general hospitals was one factor which prohibited completion of this project. The long period of depression also had its effect on building a new hospital. There was less money in circulation and people were cautious about spending. Plans for the new psychiatric hospital were discarded and new plans were made for improving Ward X to accommodate the increasing number of patients who were unable to pay for private medical care.

Ward X was enlarged to care for thirty-two patients. There were nineteen single bedrooms and six bedrooms with accommodations for two patients. One room was reserved for police cases.

The ward had two wings that were referred to as the long and short corridors. The long corridor contained locked and barred rooms and the short corridor was composed of open rooms.

The rooms were constantly in demand and segregation of cases was difficult. The ward continued to serve alcoholics, mental cases, police cases, irrational hospital cases, and non-psychiatric cases. A few of the locked rooms on the long corridor were reserved for the most violent cases and police cases. For protection of the violent patient, all furniture except a mattress and chair was removed from the room. In some instances, the strait jacket and hand cuffs were used on the violent patient. Police cases, regardless of the nature of the illness, were kept in locked rooms under guard. No provision was made for the separation of patients according to age. An eighty year old man with gonorrhea shared a room with a twelve year old boy with the same disease.

All cases that were undesirable on the hospital wards were transferred to Ward X. Cancer and kidney ailments constituted a large portion of the non-psychiatric group. These patients were removed because of the offensive odor frequently accompanying the disease. Some patients in this group later developed mental illness. A male patient with an advanced stage of cancer of the lip was placed in Ward X because the disease had spread over the lower portion of his face. The disfiguration of his face and the unpleasant odor were disturbing to other patients. The patient eventually became irrational and developed mental

illness because he could not accept the agony of pain, disfigurement of his face, and the unpleasant odor.

The patient sat for hours looking at himself in a mirror. He worried because his wife did not visit him and was unable to accept the fact that his condition was a contributing factor toward her being unable to visit him.

The hospital discontinued admission of drug addicts because they created an administrative problem. It had become a habit for the drug addict to come to Ward X for medical treatment because it was advantageous for him to seek refuge in a hospital for three or four weeks to escape the police. Medical care was also advantageous because it decreased the amount of drugs utilized by the patient, thereby making it less expensive for him after discharge from the hospital. Cure for the drug addict required long-term treatment, but the ward was unable to accommodate long-term cases.

In many instances, treatment for the drug addict was futile because Ward X, located in the basement, was easily accessible to the public. The barred windows with fly screens were located at ground level, and the window protection did not prohibit friends of the drug addict from supplying the patient with additional drugs during the night. Holes in the fly screen window and the condition of the patient on the following day were conclusive evidence that the patient had been supplied with additional drugs.

In 1934, Ward X went under new management. The first social worker was added to the staff and a new head nurse was also employed. The head nurse was experienced in handling the psychiatric patient who displayed violence. The strait jacket and handcuff method was abolished during her period of service on the ward. Administration of the ward improved; however, care for the patient on Ward X, from the nurse's point of view, was laborious because of the lack of a trained staff. The nurse was assisted by two staff psychiatrists who administered medical care to the patient.

Ward X continued to be an observation ward for the alcoholic and the mentally ill. The only treatment given the patient to assist him in recovery was Metrazol. Metrazol, a heart stimulant, was given intravenously to render the patient unconscious and to produce a convulsion. When the patient did not respond favorably to treatment, he was committed to a mental hospital.

In 1938, electro-shock therapy was introduced. It was felt that electro-shock saved a few patients from being sent to Essondale, but conditions on Ward X did not provide the kind of environment conducive to the patients' recovery. Ward X was considered "a step from home to Essondale."

In the last years of its existence, Ward X acquired a bad reputation in the city. This was partially due to

its location being below ground level, its unattractive physical appearance, and the type of patients on the ward. The location of the ward was disturbing to the patients, and to the relatives who visited there. Ward X was dark, dingy, and pungent. Ventilation was bad. The condition of many of the patients necessitated frequent scrubbing of the warped wooden floors. The disinfectants used for scrubbing and the dampness of the ward gave it a continuous unpleasant odor. The doors rattled, and the screams and groans of some of the patients added to the ward's reputation of being noisy. The heavy wire-cage windows were obvious to the public as well as to the patient, and gave it the appearance of a basement dungeon. Indeed, when the patient complained of his surroundings, it was regarded as evidence that he was getting better!

Dissatisfaction with Ward X facilitated the case for improvement in administration, care, housing, and treatment of the mental patient on a new psychiatric ward. The construction of the Semi-Private Pavilion in 1944 provided for discontinuation of Ward X, and a new psychiatric ward was established, which became known as Ward R.

CHAPTER II

SUBSEQUENT DEVELOPMENT: WARD R

Ward R was opened on October 15, 1945, and has remained in existence to the present time. It is a psychiatric ward, admitting only the patient with symptoms of mental disorder. Attached to the ward is a psychiatric clinic located in the Out-Patient Department of Vancouver General Hospital. Short-term cases are retained on Ward R for diagnosis and treatment. Cases requiring long-term treatment are discharged to the Provincial Mental Hospital in Essondale or to a private hospital for the mentally ill. Ward R is regarded as "a clearing house" for the Provincial Mental Hospital. Its intake during the period of this study averaged sixty-five cases a month; and, because of the large turnover, treatment for the patient is limited to a maximum of fourteen days. On an average, Ward R certified seventeen of the sixty-five patients to a mental hospital every month. A majority of the certified patients go to the Provincial Mental Hospital.

The ward is composed of twenty-six rooms located in the west wing on the first floor of the main building of Vancouver General Hospital. Designed in an "L" shape, it has a normal capacity for twenty-eight patients. Seven rooms with two beds in each are located on one wing

of the ward, and fourteen locked rooms on the other wing. Thirteen of the locked rooms have single beds. One locked room, with two beds, is reserved for police cases. The ward is clean and has adequate light and ventilation. A comfortable sun room at the west end of Ward R is utilized by patients to relax, read, or visit with relatives or other patients.

Located near the entrance of the ward is a consulting room which is used for staff conferences and for interviewing relatives of the patients. The remaining rooms are: the staff office, the treatment room, the kitchen, and the utility room.

Staff

Ward R has a staff of six psychiatrists who are assisted by interns; three registered nurses; and a full-time social worker. The services of the psychiatrists, who also maintain a private practice, are free on Ward R and in the psychiatric clinic. The psychiatrists visit the hospital daily to see their respective patients. When an emergency case is admitted to the ward, the patient is examined by an intern and assigned to a staff psychiatrist. The hospital does not prohibit the private psychiatrist from using Ward R for his private patient; however, this practice is used infrequently as the private psychiatrist generally refers his patient to a staff psychiatrist.

The registered nurse in charge of Ward R assumes a large portion of responsibility for the ward because there is no resident psychiatrist. When the staff psychiatrist is not available, the service of the intern is utilized. General routine nursing is performed by student nurses.

The social worker, upon request of the psychiatrist, interviews the patient for the purpose of obtaining a case history. When the patient is unable to discuss himself, relatives are interviewed. In some instances, both the patient and the relatives are interviewed.

The ward has no clinical psychologist; but recently it has utilized the service of the University of British Columbia's Psychology Department. Testing of the patient, who has been referred to the department by the staff psychiatrist, is done in the hospital. The test, generally the Rorschach Test, is given by university students under the supervision of a psychology professor and is used by the psychiatrist to substantiate his diagnosis. The validity of these tests has been considered highly reliable.

The hospital's forty-fourth Annual Report expressed satisfaction with the psychiatric ward.

Ward R, which was formerly the gynecological department, has been reconstructed

and is now a modern psychiatric ward. Old Ward X is no longer used for housing patients.⁴

In previous annual reports, the hospital had advocated more adequate facilities for a psychiatric ward. As early as 1916, the committee desired segregation of cases and special accommodations for them. The establishment of Ward X in 1917 was some improvement; however, its adequacy remained for only a short duration. Increased efforts had been made toward the improvement of Ward X. According to the nineteenth Annual Report:

The Observation and Isolation Sections continue to be a constant source of worry and difficulty, and are inadequate in every sense of the word to carry on the very great demand of this branch of work. The situation of the Observation Section is not desirable, and the rooms are limited in number so that it is often difficult to vacate them for cleaning and renovating purposes. The lack of sufficient number of rooms as well as the type of construction, greatly increase the cost of administration, as the patient is moved frequently and when discharged the room must be sterilized at once.⁵

The twenty-sixth Annual Report had made reference to the Royal Commission's recommendations on mental diseases. The administration stated that its problem of caring for cases of the mentally ill was constantly increasing and facilities for giving proper attention and treatment to the cases were inadequate.

⁴ Annual Report of Vancouver General Hospital. "Report to General Superintendent," 1945. P. 18.

⁵ Annual Report of Vancouver General Hospital, "Report of Medical Department," 1920. P. 45.

Vancouver General Hospital, being without funds to handle its problem of overcrowdedness, has depended upon governmental appropriations for enlarging and improving its facilities. The time element involved in granting extra appropriations had been a factor that contributed to the retardation of the hospital's advancement. The hospital's many efforts to gain a suitable psychiatric ward came to fruition when its Semi-Private Pavilion was constructed. The enlarged hospital provided available space for establishment of Ward R.

Admissions and Referrals

Admission to Ward R is granted in several ways. Preference is given to the patient showing symptoms of acute mental disorder. Cases referred from the emergency ward receive secondary consideration, followed by medical staff referrals. If the room reserved for police cases is occupied, additional police cases are last to receive consideration. Ward R admits both the private and the public case.

The patient referred by his family physician or the psychiatrist for admission to Ward R enters directly from home or from the psychiatric clinic. The ward is in continuous use and when there is no bed available, the patient is sent home pending notification that a bed is available for him. The seriousness of the illness is

given consideration.

The most significant factor regarding age distribution (Table 1) is that the majority of patients admitted to the psychiatric ward are between forty and sixty years of age; whereas, the largest group of patients admitted to the psychiatric clinic are between the ages of twenty-five and forty.⁶

Table 1. Age-Distribution of 225 Adult Psychiatric Patients Admitted to the Vancouver General Hospital

Locale and Age	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
<u>On the Ward:</u>						
Under 25	7	8	15	6.8	6.5	6.7
25 to 40	11	13	24	10.6	10.7	10.6
40 to 60	12	14	26	11.7	11.5	11.6
60 and over	14	9	23	13.6	7.4	10.5
<u>In the Clinic:</u>						
Under 25	16	18	34	15.5	14.7	15.1
25 to 40	16	28	44	15.5	23.0	19.2
40 to 60	15	21	36	14.6	17.2	16.0
60 and over	12	11	23	11.7	9.0	10.3
TOTAL	103	122	225	100.0	100.0	100.0

Source: Compiled from social service records of Vancouver General Hospital for the years 1947-49.

The intake of Ward R was composed of referrals from several sources. The ward received cases from (1) the physician, (2) the police, (3) the other wards,

⁶ Two hundred twenty-five social service records were used in this study, of which 88 were ward cases and 137 were clinic cases. Records of the social service department were used rather than the records of the psychiatric department because of the unavailability of the psychiatric department records and the inconsistency of record keeping on the psychiatric ward.

(4) relatives, (5) social agencies, (6) the Girls Industrial School, and (7) the juvenile home. The majority of patients admitted to the psychiatric ward were referred by physicians (Table 2).

Table 2. Sources of Referral of 88 Patients
Admitted to the Psychiatric Ward

Source of Referral	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
Physician	21	19	40	47.7	43.2	45.4
Police	11	10	21	25.0	22.7	23.9
Ward Cases	7	8	15	15.9	18.1	17.0
Relatives	4	2	6	9.1	4.6	6.8
Social Agencies	0	3	3	0	6.8	3.4
Girls Industrial School	0	2	2	0	4.6	2.3
Juvenile Home	1	0	1	2.3	0	1.2
TOTAL	44	44	88	100.0	100.0	100.0

Source: Compiled from social service records of Vancouver General Hospital for the years 1947-49.

Treatment

Ward R is a diagnostic psychiatric ward. It admits only the patient with acute mental disorder and retains him until his illness is diagnosed. The patient with acute mental disorder may be given therapy treatment, provided it will improve his condition. Electric shock therapy, insulin shock therapy, and bromide toxication therapy are administered on the ward. The lobotomy is also performed. The most significant fact about treatment distribution (Table 3) is that there is no record

for the great majority of patients. However, electric shock is the treatment most frequently used.

Table 3. Treatment Distribution of
88 Adult Ward Patients in
Vancouver General Hospital

Treatment	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
Insulin	2	0	2	4.6	0	2.3
Electric shock	4	8	12	9.2	18.2	13.6
Insulin and electric shock	1	2	3	2.2	4.6	3.4
Bromide toxication	0	1	1	0	2.2	1.2
Psycho-therapy	0	3	3	0	6.8	3.4
No record	37	30	67	84.0	68.2	76.1
TOTAL	44	44	88	100.0	100.0	100.0

Source: Compiled from 88 social service records of Vancouver General Hospital for the years 1947-49.

Electric shock is induced by the passage through the brain of a prescribed quantity of electricity of a prescribed voltage for a designated length of time.

The number of treatments for improvement of the patient depends upon the physical condition of the patient and the severity of his illness.

Insulin shock therapy is used most frequently with the schizophrenic patient. Insulin shock is produced by injecting insulin into the patient over a period of two weeks. The amount of shock and the depth of sleep induced depends on the procedure, the patient, and the seriousness of the illness.

Bromide toxication is used as a nerve depressant with the alcoholic and the drug addict. The bromide drug is administered by the mouth or rectum, after emptying the stomach, to induce free perspiration. Bromide toxication therapy requires excellent nursing care. The patient must not be left alone because attempts at suicide are frequent. Restraint of the patient is avoided unless the patient becomes maniacal. Nursing care for the patient requires endless patience, tact, and understanding.

The lobotomy is a highly specialized branch of brain surgery. The operation consists of the severing of certain connections in the brain to relieve the patient of the anxiety which is the predominating cause or symptom of his illness. The majority of the lobotomy cases are referred to Vancouver General Hospital by the Provincial Mental Hospital. The lack of adequate facilities for the lobotomy at the Provincial Mental Hospital made necessary the transfer of responsibility to Vancouver General Hospital. A few patients on Ward R are given the lobotomy if deemed advisable for the patient. Before the lobotomy is performed, the diagnosis of three psychiatrists must indicate that the lobotomy is the best treatment for improvement of the patient. Consent of the patient's family must also be obtained.

Types of Patients

Classification of the patient with mental illness on Ward R is as follows:⁷

1. The Psychogenic Group
 - a. Psycho-neurosis
 - b. Psychopath
 - c. Manic depressive
 - d. Schizophrenia
 - e. Involutional melancholia
2. The Organic Group
 - a. Epilepsy
 - b. Mental deficiency
 - c. General paresis
 - d. Cerebral syphilis
 - e. Senile psychosis
 - f. Cerebral arteriosclerosis
3. The Toxic Group
 - a. Alcoholics
 - b. Drug addicts
4. The Endo-Toxic Group
 - a. Cancer
 - b. Huntington's chorea
 - c. Kidney
 - d. Hyperthyroidism
 - e. Tuberculosis
 - f. Diabetes

Treatment for the psycho-neurosis group is limited on Ward R because the illness is regarded as less severe than the illness of the other groups. Their stay in the hospital is temporary and after they are discharged, they are allowed to go their own way unless they are in conflict with the law. The patient desiring treatment after

⁷ Lawson G. Lowrey, Psychiatry for Social Workers. New York: Columbia University Press, 1950.

G. A. Davidson, Psychiatrist, Vancouver General Hospital. (Interview)

discharge from the hospital is seen by the psychiatrist as a private patient. The patient who is unable to pay for additional treatment is referred to the psychiatric clinic and the social worker for follow-up treatment.

Ward R is without facilities to care for the psychopathic group; therefore, treatment for this group is less successful. The behavior of this group is never serious enough for certification to a mental hospital; however, their behavior frequently involves them in serious difficulties with the law. They are often sent to correctional institutions.

Treatment of the manic-depressive group on Ward R is highly successful, at present. In the depressed stage of the manic-depressive patient, the individual sleeps poorly, is selfish, and temperamental. He loses all interest in his family, friends, and employment. He feels worthless and may commit suicide. Treatment for long periods of depression is electric shock. It will decrease the depression in four out of five cases.

The depressed phase of the manic-depressive may be substituted by over-activity, which is known as the manic phase. When the individual is overactive, his aggression is freer; however, the depressed phase is regarded as the more basic illness. Psychotherapeutic treatment is given

to enable the patient to understand his feelings more fully and to teach him better ways of relating himself to people around him.

The schizophrenic group constitutes the largest group of mental illnesses. Schizophrenia is a disease of early life which occurs between the ages of fifteen and thirty. Prognosis for the schizophrenic is poor; however, the employment of shock therapy, occupational therapy and physio-therapy has stimulated more hope for this large group of patients. Generally, the patient admitted to Ward R and diagnosed as schizophrenia is certified to the Provincial Mental Hospital.

The involutional melancholia group constitutes a smaller number of patients as compared with the patients of the other groups admitted to Ward R. Menopausal syndrome is applied to this group because the illness occurs between the ages of forty and fifty. The patient becomes irritable, depressed, remorseful, bitter, and pessimistic. Accompanying these moods are physical symptoms such as hot flashes, cold shivers, dizziness, headaches, cardiac palpitation, anxiety attacks, nausea, fatigue, insomnia, and loss of appetite. The symptoms may vary from mild to severe, and if severe enough, commitment to a mental hospital is advised. Some medication is given this group and psycho-therapy is utilized if the illness is of a mild nature.

Treatment for the epileptic and the mental deficient group on Ward R is principally diagnostic. Its purpose is to study the patient's behavior, to determine the extent of mental impairment, and to decide whether the patient should be certified to a mental hospital or to a hospital for the mentally deficient. Medication is given the epileptic to bring his convulsions under control. The epileptic patient is referred to the Neurology Clinic in the Out-Patient Department for continued treatment, provided he does not have a private physician.

The general paresis, cerebral syphilis, senile psychosis, and the cerebral arteriosclerosis groups are, on the whole, unwanted on Ward R because Ward R functions on a short term basis while the majority in these groups require long-term treatment. The increasing number of the senile psychosis group constitutes a problem as to what can be done for and with the aged. The patients from all of the groups are admitted to Ward R because admission to the Provincial Mental Hospital is limited. Treatment includes medication, food, and general care before the patient is returned to his community.

Alcoholism is not a psychiatric diagnosis but it is a form of behavior found in a number of psychiatric disorders. In acute cases, the patient suffering from a toxic psychosis at the time of admission to Ward R usually recovers from the psychosis shortly after bromide

toxication treatment. However, his basic psychiatric problems remain and he will need the therapeutic facilities of general psychiatric service. Additional treatment is given the patient if dietary and nutritional deficiencies accompany excessive use of alcohol. The alcoholic of long standing develops chronic mental disturbance that will require certification to a mental hospital.

The absence of a psychosis with the drug addict constitutes more of a problem than in the treatment of the alcoholic. The drug addict is a violator of the federal law and is detainable on that basis. The number of drug addicts as compared to the number in the early years of Ward X has declined considerably. The federal laws restricting free access to narcotics and the bromide toxication treatment given this group on Ward R has been successful in causing the decline.

The endo-toxic group is accepted for treatment on Ward R because a physical illness is involved. The patient is admitted to Ward R from other wards in the hospital. Treatment for the patient of the endo-toxic group depends upon the nature of the disease and the extent of the illness.

Commitments

When the patient in any of the above-mentioned groups does not respond to treatment, certification to a mental

hospital is advised. There are two procedures for certifying a patient to a public or a private mental hospital. The patient may sign a voluntary commitment form which is co-signed by a psychiatrist; or a relative of the patient may sign a commitment form which requires the signature of two psychiatrists.

Administration of the ward appears adequate.

Every effort is made to keep the ward clean, and there is sufficient help to assist in making the patient comfortable; however, the hospital administration recognizes that although Ward R is an improvement over Ward X, the need for more rooms, a larger staff, and more adequate treatment facilities continues to exist.

CHAPTER III

THE PSYCHIATRIC CLINIC

The establishment of a psychiatric clinic at the Vancouver General Hospital was the result of several contributing factors. The interest of a few psychiatrists stimulated the hospital clinic to relieve the demand and needs for admission to the psychiatric ward. Many of the patients admitted to the ward for observation and treatment were suffering with minor disorders and did not require hospitalization. It was felt that a psychiatric clinic could treat the patient with minor disorders, thereby allowing more opportunity for admission of the mentally ill patient to the psychiatric ward.

The psychiatric clinic was to function as a diagnostic and treatment center. All cases except the emergency case and the hospital cases were to be admitted to the clinic for diagnosis and treatment unless ward service was necessary. It was thought that the clinic would have less public stigma than the psychiatric ward and, because of this fact, the patient would respond more favorably to treatment. Also, utilization of a psychiatric clinic would be less expensive both for the patient and the hospital.

Following World War I, there was a definite trend toward utilizing psychiatric facilities for the care of

the mentally ill and the emotionally disturbed war veteran. Studies were made of the psychotic, psychoneurotic, and the delinquent soldier during the war. The studies revealed that the illness of the soldiers was generally caused by early disturbances in childhood. The result of the studies was the recognition of psychiatry. This movement had some effect on the establishment of a psychiatric clinic.

Although the Vancouver General Hospital did not render service to the veteran, it recognized more and more the need for psychiatric facilities to care for the patient suffering from mental disorders.

The increasing interest of the departments of education, health, welfare, and corrections and other governmental agencies in trying to understand human behavior was another contributing factor. These departments realized that psychiatric diagnoses and consultations on their cases would enable them to cope with human problems in their own field.

The first psychiatric clinic began operation in 1920 in the Out-Patient Department of the Heather Street Annex Building. The wooden building was a temporary construction originally used by the government to care for disabled veterans. The clinic had two psychiatrists who attended the clinic on alternate weeks. Services of the psychiatrists were free, since both psychiatrists had private practices.

Patient attendance in the clinic indicated a need for psychiatric service. The survey of the Vancouver General Hospital, by the Joint Committee in 1929, provided statistics for the service in the clinic. During the month of October, 1929, four clinics convened. Ten new cases were interviewed and eleven readmittance cases were given consultation. Because the committee disapproved of the location, administration, and facilities of the Out-Patient Department, recommendations for improvement were made.

The location was inconvenient for the patient as well as for the hospital staff. The committee felt that the Out-Patient Department should be in or near the main hospital. The temporary constructed building was inadequate for hospital use. It did not have sufficient space and rooms for examining and treating patients.

Administration of the Out-Patient Department was considered poor. There was a wide divergence in administrative structure, responsibility, activity, function, and inter-departmental relationship. There was no uniformity in record keeping. The records were brief. In some cases no record of the patients examined and treated in the clinic was made. When records were made, they were often misfiled or lost.

The department was also without sufficient staff to accommodate its intake, and it did not have adequate equipment with which to work.

Reorganization of the psychiatric clinic was given when provisions for a new Out-Patient Department were made in the Semi-Private Pavilion that was completed in 1944. The psychiatric clinic, like the psychiatric ward, was diagnostic. It continued to operate on a one morning a week basis and to utilize the free service of the hospital's staff psychiatrists.

Admissions

Admission to the clinic was restricted to adults. Diagnosis and treatment of children was provided for by the Child Guidance Clinic that opened in July of the same year. Children requiring institutional care were referred to the clinic for diagnosis and certification. All cases seen in the clinic were by referral. It was necessary for the patient to submit evidence of a recent physical examination before a scheduled appointment to see the psychiatrist was granted. The clinic's service was free. In 1945, the clinic's service was restricted to the patient who was unable to pay for medical care. The age distribution of patients admitted to the psychiatric clinic is shown on Table I.⁸

Staff and Duties

The psychiatric clinic was composed of a psychiatrist and a nurse. The psychiatrist was responsible for the

social history, diagnosis, and treatment of the patient. The nurse scheduled appointments for the clinic, assisted the psychiatrist with the patient, prepared forms, and admitted the patient to the psychiatric ward.

The clinic averaged six patients a week. It was recognized that the clinic's service was unsatisfactory because the psychiatrist was unable to give adequate attention to the cases requiring long-term treatment.

The hospital increased its psychiatric staff to six members in 1945 and appointed a head staff psychiatrist who reorganized the administration for efficiency in the psychiatric clinic and the psychiatric ward. More time was allowed the psychiatrist for diagnosis and treatment of the patient. The clinic's intake was restricted to three patients a week. The psychiatrist saw two new cases and one re-admittance case or two re-admittance cases and one new case.

The clinic continued to operate as a diagnostic clinic one morning a week and each psychiatrist had charge of the clinic for a three month period. In January, 1950, the clinic began operating on the same basis two mornings a week. A psychiatric social worker was added to the staff in 1946 to relieve the psychiatrist of some of his responsibilities. The function of the psychiatric social worker will be discussed in the following chapter.

Referrals

The intake of the clinic was composed of referrals from six sources (Table 4). It received cases from (1) the private physician, (2) clinics in the Out-Patient Department, (3) the public and private social agencies, (4) self referrals, (5) relatives, and (6) probation department. The majority of the patients were referred by clinics in the Out-Patient Department of Vancouver General Hospital.

Table 4. Source of Referral of 137 Patients
Admitted to the Psychiatric Clinic

Source of Referral	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
Clinic Cases	26	38	64	44.1	48.7	46.7
Social Agencies	13	24	37	22.0	30.7	26.4
Physician	12	10	22	20.3	12.8	16.0
Self Referral	7	3	10	11.9	3.9	7.9
Relatives	0	3	3	0	3.9	2.0
Probation Dept.	1	0	1	1.7	0	.8
TOTAL	59	78	137	100.0	100.0	100.0

Source: Compiled from 137 social service records of Vancouver General Hospital for the years 1947-49.

Types of Cases

Diagnoses of the patients seen in the clinic were made in the following categories:

- I. Psycho-neurosis
- II. Psychosis
 - A. Organic
 - B. Functional
- III. Mentally Deficient
- IV. Psychopath

The patients in any of the above-mentioned groups have one common characteristic. Their illness denotes failure to make a satisfactory adjustment of the needs and demands of the human personality to those of the environment. The human being is born into the world with certain instinctive needs which must be satisfied by those about him. When these needs are not met satisfactorily, the human being develops hostility, frustration, hate, and pessimism because he lives in an environment that is difficult and cold toward him. As the human being meets circumstances that cause him to be afraid or to feel frustrated he cannot act normally. His environment has deprived him of love and interest during childhood and inadequate acquaintance with the realities of the world around him. Because of this, the human being is apt to develop into an immature adult who has not developed emotionally and ideationally to meet life. He is afraid and frustrated when he meets unpleasant circumstances. Frequent recurrence of fear and frustration may lead to some mental disorder.

The psycho-neurosis group is a functional disorder of the nervous system. The group is composed of four sub-groups: (1) conversion hysteria, (2) anxiety hysteria, (3) neurasthenia, and (4) compulsion hysteria. In general, the behavior of individuals in the psycho-neurosis groups manifests itself as bodily disturbance

without structural abnormality or as mental disturbance that is distinct from the psychosis group. Their personality is not essentially changed. It reacts to reality as does the normal individual. Their conduct may be inefficient and inadequate, but is not anti-social. Their emotional reaction may be intensified or dulled, but not sufficiently to change the individual basically. Their insight is good and they do not violate ethical standards in the presence of clear consciousness, but they falsely consider their symptoms. Falsification of symptoms indicates the onset or evidence of mental illness.

The illness of the psychosis group is a more intensified form of mental illness. The illness differs from that of the psycho-neurosis group because the reality principle is absent. The illness manifests itself in the behavior, emotional reaction, and ideation of the patient. He reacts erroneously to reality and builds up false concepts regarding it. His behavior responses are peculiar, abnormal, inefficient, or anti-social.

The psychosis group is divided into three main subgroups: (1) organic, (2) toxic, and (3) functional. The organic group includes those in which brain damage has occurred. General paresis, cerebral arteriosclerosis, epilepsy, and feeble-mindedness are common examples.

The toxic group includes all cases in which mental phenomena is supposed to be caused by a toxic agent such as psychoses from alcohol or from drugs. The functional group includes all cases in which an organic or toxic factor has not been ascertained. The functional group has three sub-groups: (1) manic-depressive, (2) schizophrenia, and (3) involutional melancholia.

The manic-depressive patient may be one of five types: (1) the manic, (2) the depressed, (3) the circular, (4) the mixed, and (5) the atypical. The schizophrenic may be one of four types: (1) the simple, (2) the hebephrenic, (3) the catatonic, and (4) the paranoid.

The psychopathic group is not always distinct from the psycho-neurosis and psychosis group. For purposes of classification, these patients are put together because they form a large group. The person of the psychopathic group may be similar to a psycho-neurosis, which another may be similar to insanity and another may be in trouble with the law.

The psychopath generally possesses average or above average intelligence, but by reason of congenital or environmental influence is lacking in moral sensibility. There is a constitutional unbalance in the pattern of mind, but not a disorder of function as is observed in the neuroses and the psychoses. The psychopath cannot be depended upon. His judgment is poor, and he is

easily pleased or displeased. Because of his behavior, the psychopath is frequently regarded as a delinquent and sometimes gets into difficulty with the law.

Treatment

The psychiatric clinic functions well as a diagnostic clinic; however, it is aware of its limitations as a treatment center. The clinic's objective is to tie in the emotional with the physical aspects and to give support to the insecure patient. Thus far, little has been accomplished. Of the 137 cases, only 32 patients received psycho-therapy treatment (Table 5).

Table 5. Number of Patients Receiving Psycho-therapy Treatment in the Psychiatric Clinic by Sex and Year

Year	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
1947	3	11	14	37.5	45.8	43.7
1948	1	7	8	12.5	29.2	25.0
1949	4	6	10	50.0	25.0	31.3
TOTAL	8	24	32	100.0	100.0	100.0

Source: Compiled from social service records of Vancouver General Hospital for the years 1947-49.

The private practice of the psychiatrist and his service on Ward R allow him little time for psycho-therapy. The utilization of the psychiatric social worker for follow-up treatment and psycho-therapy

under supervision of the psychiatrist to some extent has been overlooked. A discussion of the follow-up treatment preformed by the social worker will be discussed in Chapter IV.

The out-patient clinics, the private physician, and the private and public social agencies used the clinic for diagnostic purposes. Some of the referral cases remain with the clinic for psycho-therapy by request of the referor because the patient is apt to respond more readily to treatment. All cases indicating certification to an institution are seen in the clinic unless the patient's behavior warrants using precautionary measures. The diagnoses of these patients are done on Ward R.

Psycho-therapy treatment in the clinic is composed of interviews with the patient by the psychiatrist and the psychiatric social worker. The type of interview depends upon the nature of the patient's illness, his area of conflict, and the strength and weakness of his personality. The types of therapy employed by the psychiatric social worker are insight therapy, supportive therapy, environmental therapy, and counseling therapy.

The clinic does not use group therapy; however, it is frequently prescribed for the patient. Arrangement for group therapy is made by the social worker with a group-work agency for a form of group activity which will be suitable to the needs of the patient.

CHAPTER IV

THE SOCIAL SERVICE DEPARTMENT

In 1912, the Women's Auxiliary of the Vancouver General Hospital, recognizing the need for a social service department, employed a registered nurse to relieve the hospital administration of some of the problems that were not within the realm of the medical field. The department provided food, fuel, clothing, and cash for the needy patients who were discharged from the Vancouver General Hospital. The department's work was regarded by the hospital administration as an experiment, but the need for its service became more and more apparent and each year the social service program was expanded.

The social service department secured employment for the patient who had lost his job while in the hospital. It obtained convalescent accommodations for the discharged patient who had no home to which to return. It provided artificial limbs, braces, crutches, and wheel chairs for the crippled. It supervised foster home care for children and it administered an adoption program.

The scope of the hospital's social service work broadened to the point of being uncontrollable, making it necessary for the program to expand into the city.

In the eighteenth annual report, the social service department stated the following regarding its work:

The linking up of the out-door clinic with the Social Service Department is a broadening feature from which we anticipate a greatly increased usefulness. Ours is not merely a city relief organization but one [which] by its intelligent operation in public health and child welfare plans, seeks to improve general social conditions in our city.⁹

The department's program continued along this pattern until its reorganization in 1932. The new program was the result of the Joint Committee's Survey of Vancouver General Hospital in 1929. The Joint Committee felt that the hospital had no social service department in the true sense of the word. There was an overlapping of service, and donations were being made to patients who were not needy. Suggestions were made for the establishment of a good working relationship with other social agencies in the city. When community resources failed to meet the needs of the patients, it was the responsibility of the hospital's social service department to urge upon the community the need for better agencies and resources for the sick. The need for research in the social service field was emphasized, and the affiliation of the hospital's social service department with the University of British Columbia's School of Social Work was advocated.

⁹ Social Service Annual Report of Vancouver General Hospital, 1917, p. 24.

The Joint Committee recommended a staff of not less than three well trained and experienced social workers, of which group one was to be the head social worker. Supervision and control of the department was to be the direct responsibility of the hospital's general superintendent. This clarification of responsibility was necessary because the Women's Auxiliary had been taxed with responsibility beyond the scope of the organization and the auxiliary's funds had been expended for articles chargeable to the hospital fund.

The social service department began with a desk and a clothes closet in a corridor of the Main Hospital. Because its work proved useful, the department expanded rapidly and was moved to the Out-Patient Department in 1919. The opening of the Semi-Private Pavilion allowed for the accommodation of the staff of social workers in the new Out-Patient Department. The social service office remained in the main building of the Vancouver General Hospital.

The result of the Joint Committee's recommendation for trained social workers was the appointment of a social worker in 1933. Gradually the appointments increased until the present social staff includes a head social service supervisor, a case work supervisor, and seven full-time social workers.

Recognition of the psycho-somatic approach by the medical profession has strengthened the recognition of the social work profession. The medical profession's recognition that social and psychological factors are involved in developing the illness of patients has aided in clarifying the purpose and function of the social worker.

Early in its development, the social work profession was concerned about personality difficulties and social problems of the clients. It developed basic concepts, the techniques of which are used in developing case work skills for handling individual problems.

The year 1935 had marked a definite beginning of social work in the hospital. The social service department became affiliated with the University of British Columbia's School of Social Work. Several years later, a training program for social service students was begun in the hospital. Originally social service had been restricted to a few wards in the hospital, but the need for social service expanded to include orthopedic cases on Ward E, diabetic cases on Wards A and B, and psychiatric cases on Ward X.

The Social Worker on Ward X

The patients in Vancouver General Hospital were classified into two groups: (1) the staff patients,

who were unable to pay for medical care; and (2) the private patients, who were able to pay for medical care. Social service work in the hospital was confined to staff patients and to a few private patients who were referred by staff physicians.

The social worker's function on Ward X was regarded as an experiment during the first few years because the duties of the social worker had not been defined. The social worker was responsible for the social histories of all the staff patients admitted to Ward X.

The psychiatrists obtained the social histories of the private patients unless the private patients were referred to the social worker. Obtaining the social histories constituted the largest part of the social worker's job. The process involved interviewing the patient and his relatives for information that might be useful in diagnosis and treatment of the patient. The social history included the details of the patient's behavior, his family history, the interaction of personalities in the immediate family group, and the attitudes of the members of the family group toward each other and toward the outside world.

The social worker was responsible for interpreting to the patient and relatives the diagnosis, treatment, and prognosis of the patient's illness. This

responsibility required the use of case work skills with relatives who were unable to accept the illness of the patient. Future planning for the patients often involved social service outside of the hospital. It was necessary for the social worker to know the available resources in the community and to plan with the social agencies and relatives so that the patients would make a satisfactory adjustment when they returned to the community.

The social worker assumed responsibility for the placement of patients who had no home to return to after discharge from the hospital.

The service required for certification to mental hospitals was assumed by the social worker. The service involved interviews with relatives in order that commitment forms might be filled out correctly.

The service of the social worker on Ward X was regarded as limited and superficial. Many of the social histories were begun and never completed. Many of the records were misplaced or lost. There was no uniformity in recording social histories because each psychiatrist preferred his method of recording. No effort was made for psycho-therapy with the patients. The over crowded condition in the ward and the private practice of the psychiatrists did not allow time for psycho-therapy treatment.

The Social Worker on Ward R

The inadequacy of the service in Ward X stimulated a desire for better organization and service for the patient on Ward R. The psychiatrists retained the responsibility for taking the social histories of the patients. Social histories for the staff and private patients are obtained by the social worker only when requested by the psychiatrists. Social service records are made of the social histories prepared by the social worker while the social histories prepared by the psychiatrists are recorded on the medical record of the patient.

The social worker has to be aware of all the staff patients admitted to Ward R and the future plans made for them when they are discharged from the hospital. The social worker is utilized on a consultative basis in future planning for the staff patients and in planning the follow-up treatment for discharged patients. Nursing homes, boarding homes, and rooms are located for the patients without families or homes. Relatives of the patients are referred to the social worker by the psychiatrists for interpretation of the patients' illness, particularly when they are brought in on an emergency basis and when they have sudden flare-ups in the ward.

The social worker assumes responsibility for the certification forms and social histories of all patients discharged to the mental hospital.

Some psycho-therapy treatment is being carried on with patients after their discharge from Ward R. The patients are both staff and private patients who are referred to the social worker by the psychiatrists. They are seen by the social worker on the average of once every three months. The extent of psycho-therapy treatment is limited to interviews with the patient. The patient requiring group activity is referred by the social worker to a group work agency.

The social worker on Ward R is also on call on Ward D. The neurology ward does not require regular service of the social worker.

The Social Worker in the Psychiatric Clinic

The duties of the social worker in the psychiatric clinic are more clearly defined than the duties in the psychiatric ward. The coordination of work between the psychiatrist and the social worker in the clinic is greater. The clinic's intake is supervised by the social worker, who schedules appointments for the psychiatrist. Intake for the clinic is three patients a morning. Presently, the psychiatrist usually examines two new cases and one re-admittance case or two re-admittance cases and one new case. A new case is a

patient who is seen by the psychiatrist for the first time. A re-admittance case is the patient who has been advised to return to the clinic for psycho-therapy treatment by the psychiatrist.

All patients examined in the clinic are admitted by the social worker. The social worker interviews the new cases and prepares the social history of the patients who are not referred by social agencies. Social histories of the referrals made by the social agencies are prepared and submitted to the social worker. A recent medical report accompanies each social history.

The patient who shows anxiety regarding treatment in the clinic is interviewed by the social worker who prepares the patient for the psychiatrist. When the patient is ready for psychiatric service, his social history and medical report are reviewed by the psychiatrist before examination of the patient. The psychiatrist consults the social worker regarding the diagnosis and treatment for the patient, provided follow-up treatment is indicated.

The patient requiring treatment on the ward is admitted by the social worker. The patient requiring follow-up treatment in the clinic is seen by the psychiatrist unless he is referred to the social worker. The patient requiring certification to a mental hospital

is admitted to the ward by the social worker for further observation. The social worker prepares the forms, the social history, and works with the relatives until certification of the patient is completed. The social worker in the psychiatric clinic also works in the neurology clinic when social service is requested.

CHAPTER V

ANALYSIS OF THE SERVICES GIVEN

The Psychiatric Department of the Vancouver General Hospital is composed of a psychiatric ward, a psychiatric clinic, a staff of six psychiatrists, and a social worker. The psychiatrists, who have private practices, visit Ward R daily to give free service to the hospital. In addition to the daily service, each psychiatrist gives his services to the psychiatric clinic for a three month period. The social worker assumes responsibility for administration of the psychiatric clinic, while social service on Ward R is rendered at the request of the psychiatrist.

Since the social worker only visits Ward R by request, the 225 social service records used in the study do not reveal a true picture of the service given the patient on the ward. Although the hospital employs the classifications "private" and "staff" patients, no distinction is made between the services rendered. A distinction is made, however, in the method of recording the social histories. The psychiatrists take the social histories for both the private and staff patient unless the patient is referred to the social worker. Social histories taken by the psychiatrist are recorded on the medical records of the patients. Social service

records are made for the social histories secured by the social worker. The utilization of medical records for recording social histories by the psychiatrists makes it difficult to obtain psychiatric records for research purposes without the names and registration numbers of the patients. The inconsistency of record keeping also adds to the difficulty of obtaining medical records for patients given service in Ward R.

The social service records, which are kept by the social service department, are accessible because they are marked "psychiatric."

It should be pointed out that good social histories are time-consuming. The question is therefore raised as to whether the psychiatrists are able to give sufficient time to social histories, since a great deal of their time is consumed by private practice. An adequate social history may necessitate several interviews with the patient, relatives, friends, and others who have had close contact with the patient, since a complete picture of the patient's childhood development, social, economic, and emotional background comprise a vital part of the record.

Treatment for the patient on Ward R is confined principally to shock therapy. Although medication is given, the records used in the study do not indicate

medical treatment. The treatment distribution of 88 ward patients was illustrated on Table 3 of this study.¹⁰ Of the 88 records sampled, 13.6 per cent of the patients received electric shock therapy, 2.3 per cent of the patients received insulin shock therapy, 3.4 per cent of the patients received a combination of insulin and electric shock therapy, while 76.1 per cent of the records failed to indicate any type of treatment. Psycho-therapy treatment was received by only 3.4 per cent of the patients on Ward R. This small per cent can be attributed to the lack of time on the part of the psychiatrist, inasmuch as the psychiatrist is responsible for private, clinic, and ward practices. There is also a lack of facilities for psycho-therapy. The ward has one room that is used by the psychiatrists and the social worker for consultations and interviews.

Table 5 shows that psycho-therapy treatment is used to a greater extent in the psychiatric clinic.¹¹ A higher per cent of psycho-therapy treatment is expected because it is the only treatment given in the clinic. This raises the question concerning the ability of the clinic to give sufficient and adequate treatment to meet the needs of the patient.

¹⁰ Chapter II

¹¹ Chapter III

When the patient is discharged from the ward, there are no subsequent contacts made with the patient unless he is referred to the social worker or to the psychiatric clinic. The majority of patients dismissed from Ward R (Table 6) are returned to their homes.

Table 6. Disposition of Patients
by Ward R

Place Discharged To	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
Home	17	22	39	38.6	50.0	44.3
Mental Hospital	17	17	34	38.6	38.6	38.6
Boarding House	2	2	4	4.5	4.5	4.5
No Record	3	1	4	6.8	2.3	4.5
Infirmary	3	0	3	6.8	0	3.4
Psychiatric Clinic	1	1	2	2.3	2.3	2.3
Social Agency	0	1	1	0	2.3	1.2
Juvenile Home	1	0	1	2.3	0	1.2
TOTAL	44	44	88	100.0	100.0	100.0

Source: Compiled from social service records of Vancouver General Hospital for the years 1947-49.

The psychiatric clinic functions similiar to the psychiatric ward in regard to the discharge of patients. The majority of patients dismissed from the clinic (Table 7) are returned to their homes.

Table 6 reveals that the psychiatric ward operates in closer co-ordination with the mental hospitals than with the psychiatric clinic. Table 7 indicates that the psychiatric clinic operates in closer co-ordination with the social agencies.

Table 7. Disposition of Patients
by the Psychiatric Clinic

Place Discharged To	Number and Sex of Patients					
	Number			Percentage		
	Male	Female	Total	Male	Female	Total
Home	38	52	90	64.4	66.6	65.5
Social Agency	9	13	22	15.3	16.6	15.9
Mental Hospital*	5	7	12	8.5	9.1	8.8
O.P.D. Clinic**	3	2	5	5.0	2.6	3.8
Mental Deficient Hospital***	2	3	5	3.4	3.8	3.6
No Record	2	0	2	3.4	0	1.7
Boarding House	0	1	1	0	1.3	.7
TOTAL	59	78	137	100.0	100.0	100.0

* The patient is admitted to Ward R until certification forms are completed.

** The patient has a physical disorder rather than a mental disorder. He is returned to the O.P.D. clinic for correction of his physical ailment.

*** The patient is certified directly from the clinic.

Source: Compiled from social service records of Vancouver General Hospital for the years 1947-49.

Social histories of the patients in the ward were obtained by the psychiatrist unless the patient was referred to the psychiatric social worker. The social histories were recorded by the psychiatrists on the medical record of each patient. The psychiatric social worker made social service records of the social histories obtained from the patients. When the patient is discharged from the hospital, the medical record is filed in the medical library and cannot be obtained

without the name and hospital number of the patient. The psychiatric ward generally keeps a record of the name, hospital number, date of admission, diagnosis, treatment, and date of discharge of each patient; however, during the year 1949, the procedure was discontinued for eight months. In the psychiatric clinic, social service records were made for all patients attending the clinic because social histories were required before the patients were seen by the psychiatrist.

Illustrative Cases

The cases described in the remainder of this chapter are utilized to illustrate (1) the behavior and characteristics of mentally ill patients admitted to the ward and clinic, (2) the diagnosis of the patient, (3) the kind of treatment given the patient, and (4) the disposition of the patient.

Case Number One

A 38-year-old woman was brought to Ward R for mental observation at the request of her physician. The patient had been noticeably inadequate for a long time. Her condition became worse after she obtained a divorce from her husband. Her attitude on the ward was quiet and cooperative.

The patient was the seventh of nine children. She had had the usual childhood diseases. The patient was a good student during her school career and had completed commercial high school at age 16. She had office experience, but was never permanently employed because she preferred to stay at home.

When the patient was 20, she married a man of her own age. The husband's irresponsibility made the patient very unhappy. He was employed as a delivery man, making his deliveries by motor cycle.

Later, he became a taxi driver and refused to support his wife. The couple had one child. They were divorced two years after their marriage.

When the patient's father died, she did not cry, but sat at home for hours without talking.

The patient was normally a sweet and quiet person who never complained. After the patient's divorce and the death of her father, she refused to cooperate with the family. The family had wanted to do something for the patient for a long time, but none of the members would assume the responsibility.

For a year the patient was possessed with delusions of grandeur and talked of titles and wealth. She refused to help with the housework and spent most of her time knitting and sitting in bed.

The patient was diagnosed as schizophrenia. She was certified to a mental hospital.

Case Number Two

A man, age 63, was referred to Ward R by the family physician. Radios, street cars, and barking dogs made him nervous. The patient refused to eat because he thought his stomach was paralyzed. He told his wife about a vision he had in which he was told not to eat. His family physician stated that he was in good physical health and suggested that he might be mentally ill. He was put on a diet and given medicine, which he refused to take.

The patient was the sixth of twelve children. His parents were farmers who appeared to be normal and happy. The patient was frequently ill during childhood. He was quiet and withdrawn. His siblings frequently teased him until he ran crying to his mother. There was no history of mental illness, epilepsy, or nervous breakdown in the family.

The patient finished grammar school at age 13 and worked on the farm until his marriage. He married a neighbor's daughter and moved to a nearby urban community. The patient worked as a carpenter and was building his home when he attempted suicide. The attempt was attributed to financial difficulties and overwork.

The patient was opposed to smoking and drinking. His wife found it difficult to cook for him because he was particular about his food. The patient always felt that he had stomach trouble and took medicine

for the condition. He was also difficult to live with. He accused his wife when his plans did not materialize.

The patient was certified to a mental hospital for several months. He was diagnosed as having manic-depressive psychosis. Insulin and electric shock therapy improved his condition, and he was discharged from Ward R within two weeks. Five months later, the patient was re-admitted to the ward and given the same treatment. The patient was referred to the psychiatric clinic after his second discharge. During his attendance in the clinic, his condition continued to improve. The patient was dismissed after two months of treatment.

Seven months later, the wife of the patient called the social worker to inform her that the patient was depressed and spent most of his time in bed. His appetite was good, but he ate very little because he feared that his stomach would burst. The patient refused to return to the psychiatric clinic.

Case Number Three

A 40-year-old woman was referred to Ward R by a physician on Ward B. The patient was admitted to Ward B as an emergency case. She refused to talk to anyone but the doctor. The patient had no aches and pains and stated that she felt stupid lying down and sitting up. She suggested taking poison because of her inability to sleep. The patient felt that everything she ate stuck in her throat.

The patient lost her mother in an automobile accident when she was a small child. Her father died when the patient was age 10.

The case was diagnosed as a psychopathic personality. The patient was discharged and referred to the psychiatric clinic. When the patient was seen by the social worker, she was uncooperative.

Case Number Four

A 19-year-old single man was brought to Ward R by the police because of his threatening and belligerent behavior. He was uncooperative during his confinement in the ward.

The patient was the oldest of two children. His birth was normal, although his mother was ill during the entire pregnancy. The patient began

school at age 6. He disliked school and ran away daily. The truancy discontinued when the mother remarried and the family moved to Vancouver. The step-father was an alcoholic who went on two-week drinking sprees. The patient completed grade eight and began a course in mechanics in grade nine. He lost interest and quit school.

The patient's parent secured a position for him with a furniture company. He kept the job one year and quit of his own accord. His mother stated, "He works when he wants to and only when he wants to." The patient obtained several subsequent jobs but refused to work regularly. The longest period of employment after working for the furniture company was driving a truck for six months.

The patient became involved with a girl friend who was one year older than he. The girl friend was too sophisticated for her years. She dressed expensively, wore expensive jewelry, and frequently went on trips. The patient tried to fulfill the demands made by the girl friend who became intolerant and left the patient with a \$300 debt.

No diagnosis was given the patient. His case was referred to a social agency for service.

Case Number Five

A 28-year-old single man was referred to Ward R by the police for mental observation. He had been arrested for vagrancy. The patient was quiet and cooperative when he entered the ward, but later became restless and destructive. He was transferred to a room without a bed.

The patient's initial examination revealed him to be schizophrenic. He claimed to have served time in prison. A clearance with the John Howard Society revealed that the statement was false. The patient became overactive and talkative. He heard voices telling him he was a murderer. He claimed sex maniacs were threatening him. The numerous voices bothered him, and he was unable to sleep.

The patient served in the armed forces. After his discharge, he began drinking heavily. His brother was regarded as a chronic alcoholic and his mother spent two years in a mental hospital because of a nervous breakdown.

The patient was certified to a mental hospital.

Case Number Six

A 76-year-old widower was referred to the out-patient department after he was admitted to the hospital on an emergency basis. The patient complained of bad nerves and inability to walk because his right hip "was gone." He had collapsed on the street while intoxicated and injured his hip. During his examination, the patient denied that he had been drinking. His injury was regarded as minor by the physician.

When the patient was seen in the clinic, he appeared depressed. He lived with a married sister who was nervous and nagged him constantly. The patient had been a resident of the city for 26 years and at one time was a patient in the Provincial Mental Hospital.

Prior to moving to the west coast, the patient had been in and out of mental hospitals in the east. He was first certified shortly after the death of his wife. The patient was 46 years of age at that time.

The patient was one of five children. He was educated as a pharmacist and at one time was regarded as an excellent one. He never had a business of his own, but worked for various drug companies. After moving to the west coast, he worked at odd jobs as a laborer until he became unemployable.

The patient had drunk intoxicants most of his life. He had no children and lived alone after the death of his wife until a year ago. He lost interest in people and things around him, except the radio. The patient sat for long periods without moving. Although he never spoke of suicide, his brother-in-law found a butcher knife in his pocket.

The patient was examined by the psychiatrist, who diagnosed his case as anxiety neurosis. The patient did not require hospitalization. Psychotherapy was not recommended; therefore, the patient was dismissed to return to his home.

Case Number Seven

A 12-year-old male was referred to the pediatric clinic by a social agency for a physical examination. The patient was unable to assimilate many foods and could not control his bowels. He was also enuretic. The pediatric clinic referred the patient to the child guidance clinic for testing because his physical examination was negative. The clinic found the

patient to be emotionally insecure because of marital discord and recommended intensive case work with the parents in the psychiatric clinic.

When the boy was seen in the psychiatric clinic, he was friendly and demonstrated ability to meet strangers. He volunteered information regarding his schooling without help and interference from his mother. He did not like school very much because he had spent two years in the first grade and was on trial in the second grade. His mother felt that a great deal of the boy's slowness was due to treatment received by him in school. His teachers objected to his pompadour hair cut. The teachers tied his hair in ribbons and placed him in front of the class as an object of ridicule. He was active and played well with children in the neighborhood under supervision of his four siblings.

Early development of the boy was retarded. He sat at 9 months, stood at 14 months, and walked at 2 years. His birth was normal after a full-term pregnancy; however, poor feeding habits developed early. The mother could not recall the age at which the patient began to talk, but stated that it was late. The boy was regarded as "delicate" although he had not been ill. He had a tonsillectomy at age 7.

At the time the boy and his mother were seen in the psychiatric clinic, the family was receiving social assistance due to the unemployment of the father. The father had begun studies to become a priest, but became indifferent after treatment for lumbago. He had been employed at various trades, welding, riveting, truck driving, and as a mechanic. For 18 months he was part-owner of a doughnut shop, which later failed. The family lived on savings until they were depleted.

The father was a friendly person who appeared to understand the patient's disability. He did not scold or allow the brothers and sisters to ridicule the patient when he had an accident. The father assisted the mother with the housework and care of the children. He opened a workshop in an effort to carry on part time work, but lost interest and spent a great deal of time in bed.

The mother had a child who was born out of wedlock prior to her marriage to the father. She had many somatic pains and believed she had cancer, tuberculosis, heart trouble, etc. She accused the father of having an affair with another woman and claimed that the woman had stopped associating with

him after the family began receiving social assistance. The mother would not consider leaving the father because she felt he was not well. She recognized the good relationship between the children and the father and felt that the welfare of the children was more important than her feeling toward the father.

The physical standards of the family were good. The family occupied an eight room house which contained a play room for the children. Housekeeping standards were high and the children were always clean.

The psychiatric clinic referred the case to the social service agency for intensive case work with the parents.

Case Number Eight

A 65-year-old widow referred herself to the clinic. She told the social worker that she had been given injections by an invisible agent. While sitting alone in her living room, she felt pricks in the calves of her legs which moved up her back, neck, and to the brain. Following the injections, she became sleepy and had to go to bed. Prior to this, she claimed her children stole into the room and injected her when she was asleep. Another time she believed that gas escaped into her living room and choked her.

The patient had become desperate and informed the social worker, "I will do anything to cooperate-- even let them lock me up if they think I will do harm to someone."

The patient was born and reared in a farming community. She was the ninth of ten children. Her mother died from childbirth when the patient was age $4\frac{1}{2}$. The patient remembered seeing the mother in a coffin and was told that she reacted with anxiety. The patient's father married two years after the death of the mother. The step-mother died when the patient was age $13\frac{1}{2}$. The patient's father married again and the second step-mother was abusive. She favored her children more than her step-children. The patient claimed that the step-mother was dishonest and that her father was fearful of her.

The patient enjoyed school and made high grades. Her parents forced her to discontinue her schooling in the sixth grade. The patient felt keenly about the lack of education and read everything she could get.

At age 17, the patient fell in love with a boy in the neighborhood. The couple planned to elope, but the step-mother intervened and the patient was

forbidden to see the boy again. The patient's father died suddenly when she was 25. Her home was broken and the patient married the guardian of her deaf and dumb sister. The husband was 18 years her senior.

The patient had an unhappy marriage because she and her husband had very little in common. They addressed each other as Mr. and Mrs. because of their poor relationship. Because he was the inspector of schools, he frequently reminded his wife of her lack of education. The husband was the father of seven children by a previous marriage. Every time the patient became pregnant, her husband made it clear that he despised her.

After the husband died, the patient cared for her four children and her step-children until they grew up and became self-supporting. For two years the patient had lived alone and supported herself by sewing and alterations.

The psychiatrist diagnosed the patient as schizophrenia with deep seated paranoid delusions. Her attitude was cooperative and after three interviews with the social worker, she was certified to a mental hospital.

Case Number Nine

A 25-year-old single man came to the clinic requesting help. Three years previously, the man had been a patient in Ward R and had received electric shock treatment. He refused further treatment because he felt the treatment did not improve his condition. Nothing was heard from the patient until he came to the clinic.

The patient complained of headaches, blinding spells, visions of light, indigestion, burning in the throat, pains in the chest, and a feeling of numbness over his body. His physical examination, x-rays, and tests were negative.

Prior to the patient's admission to Ward R, he was walking with friends when he "suddenly got a funny feeling". He did not fall or lose consciousness nor did he notice a twitching of his muscles. He did not bite his tongue nor was there frothing at the mouth. The queer feeling lasted for 15 minutes.

The patient's friends took him to a coffee shop, where he rested before going home. The attacks occurred three or four times while the patient was in bed. He had considerable palpitation, twitching of the muscles, hot flashes, and blankness of the head.

The patient was seen in the psychiatric clinic by the psychiatrist. He was diagnosed as psychoneurotic,

anxiety state with mild reactive depression. Electric shock treatment was prescribed, but the patient refused to undergo treatment.

The patient returned to the clinic three times for psycho-therapy by the psychiatrist and the social worker. The patient was discharged from the clinic because he had insight into his condition and had found employment.

Case Number Ten

A 32-year-old housewife was referred by the general medical clinic in the Out-Patient Department because no physical basis was found for her complaints. The patient suffered with backaches, pains in the breast, and swelling of the ankles and hands.

The patient was the second of five children born to the parents. Her early childhood development appeared normal. She discontinued school at age 13 to work in a box factory because of inadequate income in the family. Following this job, she was employed as a clerk in several stores. At age 19, the patient married a man $4\frac{1}{2}$ years her senior. She did not love him, but married because her home life was unhappy. Her parents had divorced when the patient was 17. The mother remarried.

The patient's marital life was unhappy. Her husband was co-owner of a business with his brother. Because the business was not successful, the husband began drinking. His brother dissolved the business and the husband became employed as a taxi driver.

The patient liked movies and visiting with friends. She disliked housework, although she felt it was not difficult. After working all day, the patient was tired by evening.

The case was diagnosed as psycho-neurosis with mild anxiety symptoms. The psychiatrist recommended psycho-therapy treatment once a month. Improvement was shown by the patient after three treatments. The patient had good insight in the relationship between her domestic problems and her physical symptoms.

The cases accepted for treatment by the hospital, judged by these examples, reveal that the psychiatric department has made a conscientious effort to give service to the patients and to the community. But the

psychiatric ward and clinic operate within the realm of their function. Both are diagnostic centers treating the patient with minor mental disorders. The psychiatric department recognizes all referrals and accepts all cases for examination. Furthermore, it delegates the responsibility for the patients to the proper authorities.

The ten case examples used in the chapter show a varying degree of information obtained on the patients and the service rendered to them by the social worker. The principal weakness in the case records lies in the fact that they have been poorly recorded. The case examples indicate that the principal function of the social worker is confined to compiling case histories. The case examples fail to show the worker-patient relationship, the treatment, or any of the services performed by the worker for the benefit of the patient.

It would be desirable for the services of the social worker to be utilized to the fullest extent by the psychiatrist in order to render the best service to the patient. All patients admitted to the psychiatric ward should be referred to the social worker, as is done in the psychiatric clinic. This procedure would make the patient comfortable and relieve any anxiety that might exist upon entering the hospital.

The social worker should begin to establish a relationship with the patient shortly after his admittance to the ward in order to pave the way for the psychiatrist's subsequent examination, diagnosis, and treatment. In addition to establishing rapport with the patient, the social worker should obtain and prepare a full social history to be utilized by the psychiatrist prior to examination and during treatment of the patient.

It is desirable that the social worker and the psychiatrist work in complete harmony in planning for the best interest of the patient. Consultations between the social worker and the psychiatrists should be held at convenient intervals. The patient's progress should be discussed and evaluated.

The social worker should also be utilized in any capacity where need is indicated for extensive social service work.

Numerous situations requiring social casework treatment are found among the families of psychiatric patients. Typical situations which may call for casework procedures are those in which measures must be taken to keep the family together when a key member becomes incapacitated, when there is need for temporary or permanent placement of children, when it is necessary to explain to the family the diagnosis and prognosis of illness and to prepare them for the patient's return to the home.¹²

¹² Lawson G. Lowrey, Psychiatry for Social Workers. New York: Columbia University Press, 1950.

The services of the social worker should be used more by the psychiatrist in both the psychiatric ward and clinic for psycho-therapy treatment of the patients. Psycho-therapy treatment by the social worker should be done under close supervision of the psychiatrist. For the patients who are discharged from the hospital to the community, follow-up treatment should be performed by the social worker. This procedure should require as many contacts as deemed necessary to insure the patient's readjustment.

CHAPTER VI

AN ASSESSMENT

Proceeding from a description of the psychiatric program of the Vancouver General Hospital, the aim of this study has been to disclose what Vancouver General Hospital has contributed to psychiatric care for the mentally ill.

Financial responsibilities for the hospital's psychiatric department are shared by the provincial and local governments and by private donations of firms and individuals. Vancouver General Hospital is the first and only general hospital in the Province of British Columbia that provides care for the mentally ill. Administration of the hospital's psychiatric program is shared by the Provincial Government and the hospital.

The psychiatric department's historical background has revealed the progress made by the hospital toward establishing adequate facilities, better treatment, and improved services for the patient. The establishment of the psychiatric clinic was the result of the psychiatric ward's inability to accommodate the needs of the community.

The psychiatric ward and clinic function as a diagnostic and short-term treatment center. The

psychiatric ward assumes responsibility for the treatment of the patient suffering with mental illness and the psychiatric clinic accepts the patient with minor mental disorders.

The psychiatric ward does not limit its intake. It accepts all mental cases and discharges them to the proper authority. The psychiatric clinic restricts its intake to adults. Children requiring institutional care are examined in the clinic because certification of the patient by the psychiatric department is required by law.

Shock therapy constitutes the largest portion of treatment given in the psychiatric ward and psychotherapy is the only treatment administered in the clinic. The number of patients given treatment and the extent of treatment given by the psychiatric staff are limited. Service of the psychiatric social worker on Ward R is rendered at the request of the psychiatrist. The clinic depends to a great extent on the service of the psychiatric social worker.

The majority of patients discharged by the psychiatric department are returned to their homes. There is an interrelationship between the function of the psychiatric ward and the mental hospitals. The psychiatric clinic tends to function in conjunction

with the social agencies in the community. Despite the limitations of the psychiatric department, conscientious effort has been made to serve the patient and the community.

Conclusions and Recommendations

The study has shown that the need for a psychiatric department at Vancouver General Hospital continues to exist. It was shown in the analysis of the referral sources that the psychiatric ward and clinic were used by a diversified group of social agencies and individuals.

The analysis of the treatment given the patient indicates that the psychiatric department functions primarily as a diagnostic center. A good organization for medical therapy depends upon an adequate number of personnel; and, as the study has shown, the psychiatric department depends upon free services of the staff psychiatrists. The department does not have a resident psychiatrist: it depends upon the service of the intern when a staff psychiatrist is not available. There is no psychologist for testing purposes. Psychometric tests are given by psychology students of the University of British Columbia to supplement the psychiatrist's diagnosis, but these tests are given only at the request of the psychiatrist.

On the basis of the inadequacies disclosed by the study, the writer wishes to offer the following major suggestions with the hope that they may be given consideration for improvement of the Psychiatric Department of Vancouver General Hospital:

1. That the psychiatric staff for the ward should be composed of two resident psychiatrists, a psychologist, two psychiatric social workers, a group worker, and an occupational therapist.

2. That one of the resident psychiatrists should be the administrator of the psychiatric department of the hospital.

3. That the director of the psychiatric ward should be free from political connection and influence.

4. That the bed capacity of the present psychiatric ward should be increased to care for fifty or more patients in order to accommodate the needs in the community.

5. That the ward should be divided into sections to provide for care of the patients according to classification of illness.

6. That comfortable lounges equipped for reading and music should be provided for relaxation of the patients.

7. That the psychiatric department should include the psycho-somatic approach in treatment of ward and clinic patients.

8. That rehabilitation of the patient should begin while the patient is in the hospital.

9. That rooms be provided for occupational and recreational therapy as a part of the treatment.

10. That a greater emphasis should be placed upon the keeping of adequate and accurate records, as through this medium evaluation of the psychiatric department's program can be accomplished.

The writer also offers the following lesser suggestions:

1. That the psychologist should administer psychometric tests to all patients as a part of the initial examination.

2. That the social worker should assume responsibility for obtaining the social history of all patients and for administering some psycho-therapy.

3. That follow-up study should be made of all patients discharged to their homes from the hospital.

4. That the group worker should be responsible for the planning and directing of recreation for the patient.

5. That the occupational therapist should be responsible for the occupational therapy program.

6. That the nursing staff should be appointed according to the need on the ward.

7. That the rehabilitation of the psycho-neurosis group in the clinic should be emphasized.

8. That the psycho-neurosis group should be seen daily as a part of treatment.

9. That the psychiatric clinic should be composed of a full time, paid psychiatrist and two psychiatric social worker.

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