The development of the Social Service Department of McLean Hospital.

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THE DEVELOPMENT OF THE SOCIAL SERVICE DEPARTMENT
OF MCELAIN HOSPITAL

A thesis

Submitted by
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CHAPTER I
INTRODUCTION

A. Purpose of the Study

The purpose of this study is to trace the establishment and growth of the Social Service Department of McLean Hospital and to consider how it may more effectively be used in the future. The study will be in two phases: an analysis of referrals made to the Department; and an investigation into the understanding of the Department's function by those who make the referrals. In elaborating on these phases the following questions will be considered:

1. For what reasons were referrals made to the Social Service Department during the period under consideration?
2. How did the total number of referrals compare with the total number of cases?
3. Who were the clients: family; patients; other?
4. What were the reasons for referral of clients to the Social Service Department as compared with those at other private mental hospitals?
5. What were the sources of referral?
6. How was the Department seen and used by the hospital psychiatrists as evidenced by: (a) the referrals? (b) answers to the questionnaires? (c) case conferences?
7. How might the Department be better utilized?
B. Scope of the Study and Source of Data

The statistical analysis and discussion will cover all the cases referred to the Social Service Department during the period from its establishment on February 13, 1956 to the end of the first ten months of its operation, November 30, 1956. The data regarding the referrals was obtained by interviewing the social workers (including students) with regard to the following information about their cases:

1. What clients were seen?
2. What were the reasons for referral?
3. What were the sources of referral?
4. When were the referrals made?

To find out how the psychiatrists at the hospital understood the Department and to ascertain the development of their appreciation of its usefulness, questionnaires were sent to all thirty psychiatrists on the hospital staff (with the exception of two honorary staff members), including all residents, and full and part time psychiatrists. This study did not include the private therapists of the patients. Only seventeen of the twenty-eight psychiatrists completed and returned the questionnaire. However, of the eleven doctors who did not respond, six have very little contact with the hospital (some offering only supervision to residents). For the remaining five, a likely reason for their failure to reply is that they did not know enough about the topic to fill in the questionnaire.

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1 For a copy of the questionnaire and accompanying letter, see Appendices A and B.
Another equally important factor would be that the Department does not have the full support of those who did not reply. It was felt necessary to preserve the anonymity of the replies and therefore the psychiatrists were told that there was no need to sign their names to the questionnaires. As only ten of the seventeen psychiatrists who responded signed their names, it is impossible to estimate accurately to what extent or in which way the Director of the Department's and the writer's relationship with the psychiatrists influenced the number and quality of the replies.

C. Value of the Study

It is hoped that this study will prove of use in three directions. In the first place it should aid the Social Service Department to assess its function and development, and in so doing serve as a guide for the future; to assist new social workers and students in their orientation to the hospital; and to serve as a basis for future study by the Social Service Department. Secondly, it should aid the psychiatric staff to better understand social work and its role in this setting. Thirdly, it will provide increasing data for future comparative studies of the potential and actual use of social work in private psychiatric hospitals.
CHAPTER II
DESCRIPTION OF MCLEAN HOSPITAL

The history of McLean Hospital dates from 1811 when its parent institution, the Massachusetts General Hospital, received a charter from the Massachusetts legislature. As the Somerville "Asylum", it received its first patient in October, 1816, and the hospital was in continuous operation at that site until 1895 when it was moved to its present location in Belmont. In June of 1826 the hospital was officially styled The McLean Hospital for the Insane in honour of a wealthy benefactor. In 1892 the name was shortened to McLean Hospital.

McLean Hospital is a private, non-profit institution which is organized and equipped for the intensive study and treatment of patients suffering from mental diseases. Patients are admitted in accordance with the laws of the Commonwealth of Massachusetts on a physician's certificate, by commitment or voluntarily, depending upon the circumstances. Preference is given to those patients in whom a favourable result from treatment may be expected. Patients with doubtful prognosis may be admitted for observation.

A. Accommodation

The hospital is composed of a number of buildings situated on the

1 Tuttle, George T., McLean Hospital: 1811-1914, pamphlet reprinted from The Institutional Care of the Insane in the United States and Canada, Volume II.

top of a large hill. The grounds are spacious and beautiful. There are
approximately 240 private rooms and a few semi-private accommodations
located in eleven buildings. Most of these buildings have two or three
floors or halls. Each hall varies in size and is equipped with its own
dining room, living room, television, and games. The patients are grouped
according to their condition; the total treatment of the patient being
carefully considered in making room assignments and re-assignments.

B. Staff

Under the direction of Dr. Alfred H. Stanton who was appointed Psychiatrist in Chief at McLean in June, 1955, the professional staff increased
by about 100 per cent. At present there are eight full time Permanent
Psychiatrists, six Residents, fourteen part time Psychiatrists; a Director
of Internal Medicine and of Research in Physiology, four Clinical
Assistants in Medicine; a Research Department comprised of a Director of
Scientific Research, and three Neuropathologists; two Assistant Bio-
chemists; a Dental Surgeon; an Anesthetist; a Roentgenologist; two Socio-
logists; two Psychologists; three Psychiatric Social Workers; eighty
full time and thirty part time Nurses; four Occupational Therapists; six
full time and three part time Recreational Therapists; two Instructors in
Physical Therapy; a Director of Music Therapy; and a Librarian.

C. Training and Teaching

Since Dr. Stanton's appointment, the hospital training and teaching

3 For a map of the hospital see Appendix C.
program has also been enlarged. There are now six doctors in the resi-
dency training program; two second year psychiatric social work students,
one from the Boston University School of Social Work and one from the
Simmons School of Social Work; and a number of fourth year medical students
from Harvard Medical School who are placed at McLean for a month's clinical training. The hospital maintains a School of Nursing which has sixty
nursing students. This School is affiliated with the Massachusetts Gen-
eral Hospital, Children's Medical Centre, and the Boston Lying-In Hospital
and sends its students to these hospitals for general nursing training.
There are on the average, thirty-eight students from these hospitals
training at McLean at any one time. There is also an affliating program
with collegiate Schools of Nursing including Radcliffe (whose students
train at the Massachusetts General), Simmons, and the University of Mass-
achusetts, which maintain approximately ten students at any one time at
McLean for psychiatric training. Most of the medical staff hold Harvard
Medical School appointments and the Psychiatrist in Chief is Associate
Professor of Psychiatry.

D. Treatment Facilities

The psychiatric staff at McLean is analytically oriented. Although
the emphasis in treatment is upon psychotherapy, tranquilizing drugs,
electroshock and sub-cutaneous insulin shock therapy are sometimes offered as
adjuncts. The hospital maintains well equipped facilities for x-ray
laboratory studies and medical and surgical procedures. Casework services
are offered by the psychiatric social workers whose role in the treatment
picture is to provide help mainly for families but also for patients, with their social problems and interrelationships.

In addition to the medical, clinical, and social work facilities, the hospital offers extensive occupational and recreational therapy activities. The Occupational Therapy Department provides about seventy-five activities including crafts, painting, ceramics, woodwork and dressmaking. As for recreational facilities, there are two gymnasiums, bowling alleys, table tennis, pool and billiard tables, badminton courts, tennis courts, and a nine hole golf course. In the winter there are sleigh rides and in the summer golf and tennis lessons are given. Movies, teas and dances are sponsored by the hospital, and special trips to museums; points of interest and various entertainments in Boston are frequently arranged. Automobile rides are available. Educational opportunities include music appreciation hours, book reviews, and group discussions. There is a music teacher available, and other courses are arranged as requested by the patients. There is a large and well furnished patients' library containing about six thousand volumes, plus daily papers and various periodicals. There is a non-denominational Chapel on the grounds. In addition, there is a Coffee Shoppe for the patients and their families, a Beauty Shop for women and a Barber Shop for men.

About three years ago, the patients began the Patients' Activities Association to promote social and cultural activities in the hospital.

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4 Much of this information was obtained from an unpublished draft pamphlet for McLean Hospital, written by the Director of the Social Service Department, Miss Golda Edinburg.
They sponsor dances, music appreciation evenings, a drama group and other classes in the fine arts, and publish a weekly bulletin listing the time and place of the scheduled events. In December, 1955, the Patient-Personnel Conferences were started to promote closer relationships between the patients and the personnel. Through practical collaborations, many improvements in regard to the hospital and patient care have been effected.
CHAPTER III

THE SOCIAL SERVICE DEPARTMENT

Social work received its introduction to McLean Hospital in 1935 when the psychiatric social work supervisor at the Massachusetts General Hospital (of which McLean is a division) was appointed as a part-time worker. However, so little use was made of the worker that after a few years this service was discontinued.

Shortly after Dr. Stanton's appointment in June, 1955, to head McLean Hospital, Miss Golda Edinburg, then a supervisor at Chelsea Naval Hospital, discussed with Dr. Stanton the possibilities regarding a psychiatric social work program at McLean. In January, 1956 after further conferences, she was asked to develop a Social Service Department and was appointed as its Director. The Department was established on February 13, 1956.

As is to be expected, Miss Edinburg's first duties centered primarily in the administrative area and in the difficult task of integrating a social work program into the hospital's treatment scheme. Early in her work she wrote, in collaboration with patients and other personnel, an information pamphlet for the use of patients, and thereby closely acquainted herself with the nature of things at the hospital. Since the establishment of the Department, Miss Edinburg has compiled a daily record from which it is hoped she will prepare, when the material is sufficiently well developed, a paper on the special problems encountered in establishing a Social Service Department at a private mental hospital.

By April, 1956, Miss Edinburg found it impossible to handle increasing
duties, and two psychiatric social workers were authorized for the Department, one of whom started at McLean in July and the other in September. An illustration of support of the social workers by the psychiatrists at the hospital may be presented at this point. At this time in the development of the hospital, funds were short and additions to both the psychiatric and social service staffs were needed. The problem of which staff to enlarge was weighed and it was decided that two new social workers be appointed. While Miss Edinburg was alone in the Department, the psychiatrists screened the Social Service referrals in order to provide maximum treatment of a limited number. However, as will be illustrated in Chapter IV, with the additional Social Service staff and the two students who arrived late in September, referrals steadily increased with the Department's ability to handle them.

Gradually too, new duties were taken on. Early in October, 1956, the Department began taking part in the admission process, and early in December, the Department took the responsibility for finding hospital jobs for those patients who were interested in voluntary projects. The social workers at McLean have also been active in various patients' organizations and committees including those of the Patient and Personnel Conference, the Patient Activities Association, and the Discharge Planning Committee. Miss Edinburg, in addition to casework, supervision of workers and students, teaching student nurses, medical students, and residents, participating in conferences, community interpretation and liaison, administrating and planning policy, is also a member of various hospital committees which deal with administrative and professional issues.
As evidence of the continued growth of the Social Service Department at McLean openings have recently been created for a supervisor and two psychiatric social workers. Arrangements are also being made for a psychanalyst as consultant for the Department. For the future, a family care program and a research program are being planned, as well as a greater degree of interpretation to the community. In the year since the Social Service Department was started it has blossomed into a significant feature of the overall program at McLean Hospital and it is to be expected that the future will disclose the realization of present plans for its development and an ever widening scope.
CHAPTER IV
ANALYSIS OF REFERRALS TO THE SOCIAL SERVICE DEPARTMENT

In this chapter, an analysis of the referrals to the Social Service Department will be made in order to determine how it is being used by the hospital staff. The referrals will be analyzed in terms of the reasons for referral, and who was referred to the Department. A comparison will also be made between the clients at McLean and those at three other private mental hospitals.

During the period from February 13 to November 30, 1956, 122 cases were referred to the Social Service Department of McLean Hospital. In this study, one "case" refers to any number of people seen by one worker in connection with one patient. However, if two workers are working with different members of one family, it will be recorded as two cases. For the purposes of this study, a case is included only if the referral is carried through to the extent that one interview is held. Each case was referred to the Department for one or a number of the ten reasons listed in Table I, these reasons for referral totalling 186. It must be emphasized that this is a study of the reasons for which the cases were referred to the Department, and that during treatment, additional services may have been offered by the social worker.

A. Explanation of Reasons for Referral--Table I

1. Admission: At the time of admission, the relatives and/or friends accompanying the patient are seen by the social worker for the purpose of relieving their tensions and anxieties, providing them with some cri-
# Reasons for Referral — February 13 to November 30, 1956

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* There were no referrals during the month of May because the one social worker was unable to be at the hospital for a week in the middle of the month. During the first part of the month she did not accept referrals, knowing she would be leaving and during the latter part of the month she was busy taking care of the cases she already had.
entation to the hospital, obtaining information about the patient, making a social evaluation, and establishing a relationship with them through which further help may be given as necessary. If the patient is brought to the hospital in the evening or at night, the social worker contacts the family the next day and arranges to see them. If the patient arrives at the hospital alone, he may or may not be seen by the social worker, depending on the doctor's decision. In any case, the social worker would contact the relatives.

Illustration:

Mrs. V., a twenty-four year old college graduate was voluntarily admitted to McLean. The diagnosis was borderline schizophrenia. Mr. V., the patient's husband, was seen by a social worker as part of the admission process. Mr. V. was very anxious about his wife's hospitalization and asked a great many questions about her illness, about the hospital, and about treatment. He also brought out financial concerns. The social worker and Dr. X., Mrs. V.'s ward administrator conferred and it was decided that the social worker continue to see Mr. V. about his financial worries and to help him work out a better relationship with his wife.

2. Support: Although there is an element of support in the casework relationship the social worker has with most families, it is recorded in Table I only if this is one of the major reasons for referral. Only three patients were referred for this reason. Margene M. Shea describes the type of work carried on with these patients.

They are finding they can assist the psychotic patient in holding on to external realities, can relieve his immediate situational anxieties, and by the very nature of their relationship, enable him to keep in touch with his social environment. The worker who is secure with the mentally ill patient can offer him empathy,

1 Identifying data of all illustrations have been disguised to eliminate possible recognition.
interest, and friendliness; and as the patient becomes comfortable
in this relationship he is better able to relate to other people.  

Illustration:

Mrs. C., a thirty-seven year old housewife and mother of a fourteen
year old daughter was referred to Social Service a month after
admission by Dr. T. (Her diagnosis was schizophrenic reaction,
schizo-affective type). Mrs. C. had felt left out and felt that
her husband and adolescent son were ganging up on her and making
signals and talking about her, and it was felt that the reality
situation might be contributing to this. Dr. T. also felt that the
husband needed support while plans were being made to get Mrs. C.
into therapy. The husband had also said that he worried over his
wife's behaviour on weekends (at which time she makes home visits),
when she sometimes became rather upset and lost control of herself,
which was especially disturbing to Mr. C. History material was
also requested.

3. Discharge Planning: Included in this category is helping the patient
make the transition from the hospital to the community; by helping to
allay his fears or concerns about leaving the hospital, discussing with
him and helping him make living arrangements, helping him find employment
or to return to his former employment, and so on. The family may be pre-
pared as well, for the job of dealing with problems inherent in the pa-
tient's return to the community. Post-hospital follow-up is also carried
on when indicated.

Illustration:

Mrs. N. is a sixty-four year old, twice widowed woman with three
children by her first marriage, and is a college graduate. She
has been hospitalized at two other mental hospitals for periods
of one week and eleven months respectively. This is her third
stay at Mailean in the past year. Her diagnosis is manic depres-
sive psychosis. Dr. Z. referred Mrs. N. to the Social Service
Department for the purpose of discussing discharge plans. He
pointed out that Mrs. N. has been living alone and has travelled

2 Shea, Margene M., "Planning for Psychotic Patients", Social
a great deal since her second husband died in 1952. It was explained that she would be unable to live with her mother as she is too old and infirm to care for her and for various reasons she was unable to live with her children.

4. Family Relationships: The social worker aids in the development of a better and more understanding relationship between the relatives and patient. Dr. Bobbins amplifies this,

...helping the relative to understand how his own behavior affects the treatment of the patient and, in accordance with the relative's needs and abilities, helping him to modify his behavior if some change is necessary for his and his sick relative's ultimate advantage...2

For this purpose, four husbands of patients at McLean were helped into psychotherapy.

Illustration: Please see illustration under "Admission".

5. Interpretation: This involves helping relatives understand the patient's illness; discussing with them the changes occurring in the treatment program and in the patient's progress and behavior as these affect the family; and helping relatives and/or the patient accept the recommended treatment plans for the patient.

Illustration: Please see illustration under "Support".

6. History and Social Evaluation: A social history is taken by the social worker only at the request of the psychiatrist. Since October, 1956, when the Social Service Department began seeing the relatives as part of the admission process, a social evaluation is recorded on the patient's chart in every case. However, before that time, families were sometimes

referred to the social worker by the doctor for the purpose of obtaining a social evaluation. Therefore, social evaluations are recorded in the table only if they were taken before October. After October, they were recorded in the table under "Admissions". The history includes the background and the present situation of the patient in great detail whereas the social evaluation contains only the present situation. The evaluation includes such things as the personalities of the relatives interviewed, family constellation including members living at home and those living away from home, relatives' and patient's employment situation, financial situation, and problems arising from the hospitalization.

Illustration: Please see illustration under "Support".

7. Financial: This involves the discussion of financial problems with the family or, as in one case where there were no relatives in the picture, with the patient. When indicated, these cases are presented to the Rates Committee where, depending upon the financial situation of the family and the prognosis of the illness of the patient, recommendations may be made to Dr. Stanton for reduction.

Illustration: Please see illustration under "Admission".

8. Patient's Adjustment to Hospital: The social worker helps the patient make a better hospital adjustment by better utilizing hospital facilities, by aiding him in getting a voluntary job in the hospital, aiding him in starting special courses either within or outside of the hospital, e.g. art or piano lessons, or in carrying out special requests of the patient.

In connection with the last mentioned item, relatives of the patient were also seen by the social worker.
Illustration:

Mrs. B., a sixty year old, widow and mother of two married children, was lobotomized in 1945 and is paranoid schizophrenia. She has been at McLean for seven years, being unable to care for herself outside of an institution. Mrs. B. has made a fairly good hospital adjustment being active in patient organisations, spending much of her time in occupational therapy, and has been working part time in the hospital library. However, prior to referral to the Social Service Department, she stopped work at the library because she felt everyone was talking about the poor clothes she was wearing, and began to complain about how shabbily she was dressed. In reality, she did not have many clothes but her feeling that others were talking about it was probably due in large part to her illness. Dr. S. referred the case to the Social Service Department, suggesting we encourage Mrs. B.'s daughter to take her mother shopping.

9. Transfer to Another Hospital: This involves helping the relatives with their feelings around the move and making plans for the transfer of the patient.

Illustration:

Mrs. M., is a sixty-three year old housewife who was admitted to McLean November, 1956. She was diagnosed, agitated depression. Her illness dated to a heart attack a month before admission at which time she was hospitalized for a week. When she returned home, she trembled and became fearful of any activity which might precipitate another heart attack; of going outside, seeing friends, doing housework. She became progressively more depressed and was referred to McLean. The initial plan was that she would be admitted only until there was an available bed at the Boston Psychopathic, as they were unable to afford Mrs. M.'s hospitalization here for any length of time. It later turned out however, that against the advice of the hospital, Mr. M. took out a loan, and therefore the transfer was not carried through.

10. Pre-admission: In this case, the social worker worked out the admission with the family before it took place.

Illustration:

Mrs. N., a fifty-one year old, married, separated, mother of two adult daughters was referred to this hospital by Dr. K. because of alcoholism. Dr. K. originally phoned on June 20, 1956, in
order to arrange admission but as no bed was available, admission was delayed. Again, on July 1, 1956 Dr. K. telephoned that Mrs. H. was in bed and drinking all day. When a bed became available the middle of July, the case was referred to the social worker so that various family and legal problems around the commitment could be worked out.

Table I

As illustrated in this table, the largest number (37) was seen as part of the admission process. As the Department in October, began taking on the duty of interviewing the closer relatives of each patient admitted to the hospital, the number of referrals in this category were understandably heaviest during the months of October and November. The Department dealt with the following four categories of reasons in nearly equal numbers: support (27); discharge planning (26); family relationships (26); and interpretation (23). History (20) and financial (17) comprise the next largest number of referrals. The Social Service Department has had only a few referrals for purposes of helping the patient adjust to the hospital (6); transfer to another hospital (2); and pre-admission (1).

B. Total Reasons for Referral as Compared with Total Cases

As seen in Table II, the psychiatrists and others during the first five months (except in April) made referrals for one reason per case only, whereas in the latter five months, cases were referred for a number of reasons. For example, in February, three cases were referred for three reasons, whereas in July fifteen cases were referred for twenty-two reasons. This would seem to indicate that those making referrals were becoming more aware of the functions and scope of the Department.
TABLE II

TOTAL REASONS FOR REFERRAL AS COMPARED WITH TOTAL CASES

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Reasons For Referral</th>
<th>Total Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mar.</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Apr.</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>July</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Aug.</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Sept.</td>
<td>36</td>
<td>19</td>
</tr>
<tr>
<td>Oct.</td>
<td>43</td>
<td>27</td>
</tr>
<tr>
<td>Nov.</td>
<td>45</td>
<td>25</td>
</tr>
</tbody>
</table>

Total 186 122

Also illustrated by both Tables I and II, in July, with the addition of a new social worker to the staff, referrals to the Department increased. Again in September and October, when another worker was employed and two students began fieldwork, there was a decided increase in the referrals. This steady increase of referrals to the Department during the first ten months of existence may be attributed to two factors: the taking on of new duties (partly because of the increase in staff) by the Department, e.g. taking part in the admission process, and interviewing all patients requesting jobs in the hospital, and the increase in psychiatric staff.

C. Clients Referred to the Department

1. Family: Included in this category are forty-three parents, siblings, children, and in-laws; thirty-five husbands; and nine wives. Also included in this group (but not tallied), are five patients who were seen as well
as the families by one worker (most of the contact being with the family).
This follows from the definition on page twelve, "one 'case' refers to
any number of people seen by one worker in connection with one patient."

2. Patient: Of the twenty-eight patients seen; seventeen were female,
and eleven male.

3. Others: Included here are two best friends; two hospital employees;
an ex-husband; a lawyer; and a guardian.

TABLE III

CLIENTS REFERRED TO THE DEPARTMENT

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Family</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>13</td>
<td>4</td>
<td>15</td>
<td>20</td>
<td>20</td>
<td></td>
<td></td>
<td>82</td>
</tr>
<tr>
<td>Patient</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td>15</td>
<td>8</td>
<td>19</td>
<td>27</td>
<td>25</td>
<td></td>
<td>122</td>
</tr>
</tbody>
</table>

D. Reasons for Referral of Families and Patients to the Department

As seen in Table IV below, families were seen mainly for the follow-
ing reasons: admission, family relations, support, and interpretation. By far the largest number of patients was seen for discharge planning, and the next largest group was seen in order to better their adjustment to the hospital. Clients other than families and patients, were seen mainly on admission.
TABLE IV

REASONS FOR REFERRAL OF FAMILIES AND PATIENTS TO THE DEPARTMENT

<table>
<thead>
<tr>
<th>Reasons for Referral</th>
<th>Family</th>
<th>Patient</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>30</td>
<td>2</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>Support</td>
<td>23</td>
<td>3</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>6</td>
<td>18</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Family Relations</td>
<td>24</td>
<td>1</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Interpretation</td>
<td>21</td>
<td>2</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>History</td>
<td>17</td>
<td>1</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Financial</td>
<td>16</td>
<td>1</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Pt.'s Adjustment to H.</td>
<td>1</td>
<td>5</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Transfer</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Pre-admission</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>144</strong></td>
<td><strong>33</strong></td>
<td><strong>9</strong></td>
<td><strong>186</strong></td>
</tr>
</tbody>
</table>

E. Clients at McLean and Other Private Mental Hospitals: A Comparison

At both the Menninger (Topeka, Kansas) and Yale (New Haven, Connecticut) Clinics, by far the greatest emphasis is placed on working with the families. On the other hand, Hillside Hospital (Glen Oaks, New York, New York), in a study over a three month period, found that over twice as many interviews were held with patients than relatives. As a result of this study, however, the social service staff of that hospital arrived at the conclusion that the emphasis on work with patients was not good.

3 Ibid.


The accessibility of the caseworker has led to confusion for the patient, frequently resulting in a dilution of the psychotherapeutic relationship and a channeling or deflection of anxiety away from the therapeutic hour.6

They concluded that

"...the greatest benefit...may be achieved through the concentration of casework effort with the relatives of patients who often represent the complex and pathological life structure from which the patients' disorders emerge."7

From the writer's limited experience, she would tend to agree with this argument that the emphasis of the social worker's responsibility should be with the family. However, successful and valuable work with patients may be carried on by the social worker in conjunction with psychotherapy in selected cases. There were three of these cases referred to the Department during the period studied at McLean. As seen in Table III, a ratio of approximately three families to every patient was seen by the Social Service Department at McLean. It appears, therefore, that McLean falls between these two extremes, tending to lean more towards the former two Clinics mentioned.

Although all three hospitals interview relatives for the same purpose as does McLean (see Table I), there is some disagreement as to the role of the social worker with the patient. The social workers at Hillside Hospital see their major activity with the patient centering on problems occurring before hospitalization and before discharge. Both Yale Clinic and

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7 Ibid, p. 60.
8 Ibid, p. 60.
9 Tennant, op. cit., p. 240.
McLean (as seen by the referrals in Table IV) agree with the latter. However, McLean has had only one referral for pre-admission. The practice at Menninger, though, is quite different. There, as a rule, the psychiatric social worker has very little responsibility directly with the patient who is being discharged.

Not mentioned in the articles regarding the three hospitals discussed, is the category "Patient's Adjustment to Hospital" which is found in Table IV of this study. Five out of thirty-three referrals of patients at McLean were made for the purpose of helping the patient make a better hospital adjustment. Even more emphasis will be placed in the future on helping the patient in this respect, as the Social Service Department, beginning early in December, 1956, has taken the responsibility of interviewing all patients requesting jobs in the hospital.
CHAPTER V

HOW THE PSYCHIATRISTS SEE AND USE THE SOCIAL SERVICE DEPARTMENT

In this chapter, a study will be made of the way in which the psychiatrists at the hospital see and use the Department. This will be assessed by an analysis of the source of referrals to the Department, the answers to the questionnaires, and the role of the social worker in the conferences.

A. Source of Referrals

As Table V below discloses, the vast majority of referrals to the Social Service Department were made by psychiatrists and a detailed description of these follows. The remaining sources of referrals fall into two categories, "Admission Office" and "Others", and these will be considered and explained as well.

<table>
<thead>
<tr>
<th>TABLE V</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE OF REFERRALS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for Referral</th>
<th>(6)</th>
<th>(8)</th>
<th>(14)</th>
<th>SUB</th>
<th>TOTAL</th>
<th>AO</th>
<th>0</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>12</td>
<td>7</td>
<td>3</td>
<td>22</td>
<td>37</td>
<td>5</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>10</td>
<td>11</td>
<td>2</td>
<td>23</td>
<td>26</td>
<td>3</td>
<td>26</td>
<td></td>
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<tr>
<td>Family Relations</td>
<td>11</td>
<td>9</td>
<td>3</td>
<td>23</td>
<td>23</td>
<td>3</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Interpretation</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>20</td>
<td>16</td>
<td>3</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>History</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>18</td>
<td>16</td>
<td>2</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>8</td>
<td>8</td>
<td></td>
<td>16</td>
<td>16</td>
<td>1</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Pt.'s Adjustment to H.</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Pre-admission</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total Reasons</td>
<td>64</td>
<td>50</td>
<td>15</td>
<td>129</td>
<td>37</td>
<td>20</td>
<td>186</td>
<td></td>
</tr>
<tr>
<td>Total Cases</td>
<td>39</td>
<td>37</td>
<td>10</td>
<td>86</td>
<td>21</td>
<td>15</td>
<td>122</td>
<td></td>
</tr>
</tbody>
</table>
KEY:
RP--Resident Psychiatrists (full time)
PS--Permanent Staff (full time)
PPT--Part Time Psychiatrists (including one Resident)
AO--Admission Office
O--Others
The numbers in brackets refer to the number of psychiatrists in that category.

1. Psychiatric Referrals: Before an analysis of Table V is made, it must be explained that not all the psychiatrists have been at McLean since the Social Service Department was established. Four of the six residents were taken on July 1, 1956 and one resident who was also taken on at the hospital July 1, 1956, left early in September. One permanent psychiatrist was employed two weeks after the opening of the Department.

Thirteen of the fourteen part time psychiatrists were employed since February 13, 1956, the median date of employment for the group being July 25, 1956. However, until July when an additional social worker was employed, the psychiatrists carefully screened referrals to the Department, realizing that one worker could cope with only a certain number.

From Table V it may be seen that eighty-six cases were referred by twenty-eight psychiatrists; the referrals being distributed far from evenly amongst them. Two permanent psychiatrists and two residents made forty-three referrals. In other words, 14 per cent of the psychiatrists made 50 per cent of the referrals. The two residents who made the most resident referrals had been at the hospital since the time of the establishment of the Department. There was a very wide range of referrals amongst the four residents who started July 1st. The one permanent psychiatrist who was employed March 1st, will for the purposes of this
study, be grouped with the other seven permanent psychiatrists. Two of this group made twenty-two of the thirty-seven permanent psychiatrist referrals. That is, 25 per cent of the permanent psychiatrists made 60 per cent of the referrals for their group.

Although it may appear that the residents as a group are using the Department to a greater degree than the permanent psychiatrists because six residents made approximately the same number of referrals as eight permanent psychiatrists, it must be noted that two of the permanent psychiatrists have almost completely administrative positions and the other six have partly administrative positions.

It is interesting to note that although both the residents and permanent psychiatrists referred approximately the same number of cases to the Department, the residents referred for many more reasons as compared with the number of cases than did the permanent psychiatrists. The residents referred over twice as many cases for History taking, and nearly twice as many for Interpretation and Support. This is probably due to the fact that the residents are responsible for the write-up of the evaluation period and for recommending a treatment program. However, it must be clarified that the administrator has the final responsibility for the treatment program and therefore the resident's recommendations may or may not be implemented. If the resident's recommendation for referral to Social Service is accepted by the administrator, it is considered in this study as a resident referral.

There are two variables in this study; during the period under consideration, both the psychiatric staff and the social service staff
increased. As the concentration of appointments to staffs of both disciplines were made during July, psychiatric referrals have been further broken down into two groups, those cases referred before July and those since July.

TABLE VI

PSYCHIATRIC REFERRALS—BEFORE AND SINCE JULY

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Resident</th>
<th>Permanent</th>
<th>Part Time</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before July</td>
<td>8</td>
<td>14</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Since July</td>
<td>31</td>
<td>23</td>
<td>9</td>
<td>63</td>
</tr>
<tr>
<td><strong>Total Cases</strong></td>
<td>39</td>
<td>37</td>
<td>10</td>
<td><strong>86</strong></td>
</tr>
</tbody>
</table>

Although the permanent psychiatrists limited the number of referrals before July when there was only one social worker, as seen in Table VI, with the addition of two workers and two students, their referrals from July to November 30, 1956 did not even double. Similarly, whereas two residents referred eight cases before July, six residents referred only four times that number after the addition to the social service staff. If the additions in both staffs were taken into account, one would expect a very much higher proportion of referrals. Whether the grand totals were to be compared with the increase in medical service staff or with the increase in psychiatric staff, the total cases referred would not rise proportionately from the first period to the second.
As a group, the part time psychiatrists (who work at McLean on the average of about one-quarter of the time that the permanent people do) in proportion to working hours since July, made only 66 per cent of the referrals the permanent psychiatrists (including residents) did. To explain further, the permanent psychiatrists referred a total of fifty-four cases since July; one-quarter of which is thirteen and a half; nine being two-thirds of thirteen and a half, or roughly 66 per cent. It should also be noted that all ten of the referrals were made by five of the fourteen psychiatrists of this group. A probable explanation for the limited number of referrals by part time psychiatrists is that there is less chance for these psychiatrists to come in contact with the social workers at the hospital, and as a result, less chance for them to receive information about or interpretation of the Social Service Department. Another, and perhaps more significant reason for this would be that the part time psychiatrists mainly supervise the residents or else are called in as therapists after the treatment plan is established and therefore would have less opportunity to make referrals to the Department.

2. Admitting Office Referrals: Under this heading in Table V, "37" is entered under "Total Reasons" and "21" under "Total Cases" referred. Twenty-one of the cases were seen as part of the admission process only, while sixteen were seen, as a result of a conference between the social worker and the admitting resident or ward administrator, on a continued basis for one or more of the other nine reasons for referral. For purposes of this study, these sixteen are considered to be referred by the psychiatrist although in many cases the social worker actually made the
suggestion that the client continue to be seen.

3. Other Referrals: Included in this category in Table V are: three referrals made by the nursing staff; three were self-referred; two were referred by outside therapists; two by their sisters-in-law; two by the admitting officer (before the Department began taking all admissions); one by the Bates Committee; one by the Assistant Director of McLean (not a psychiatrist); and one by the resident who left in September.

B. Psychiatrists! Understanding of the Department as Seen Through the Questionnaires

Of the seventeen responding psychiatrists, seven are permanent psychiatrists, six are part time, and four are residents. The experience of the total group ranges from six months residency to thirty years experience. Only four of the six part-time psychiatrists gave the number of hours they work at McLean. The average time per week of these four people is fourteen. However, as the psychiatrists who have the least contact with the hospital did not respond to the questionnaire the average is likely to be considerably lower than this; possibly eight to ten hours per week.

All seventeen responding psychiatrists have had previous contact with social workers (psychiatric and medical); the contact being mainly that of working with the social worker on a team. Other contacts included: two psychiatrists had experience as consultants for social workers; one worked in collaboration with a social worker in research, and taught social work students in college; another taught a course at the Boston University School of Social Work; and one had a social worker as an
instructor at medical school.

Through questions three and four on the questionnaire, an attempt was made to assess the psychiatrists' understanding of the Department. Responses to these questions were divided into four groups: very good, good, fair, and poor. A response was considered "very good" if the psychiatrist showed considerable knowledge of the social worker's scope, goals, techniques and skills; if he gave a clear picture of the two major types of treatment (environmental and psychological); and if he spelled out the types of treatment which the social worker carries out with the families and patients at McLean. A "good" response is one which covers similar information as that of a "very good" response but does not spell it out so clearly. A response is considered "fair" if the psychiatrist has no framework of understanding but rather sees only a few of the responsibilities of the social worker. A "poor" response is one in which the psychiatrist has no knowledge of the social worker's scope, goals, techniques, or skills—when he knows only that the social worker interviews families and patients. Of the seventeen responses, only one seems to show a "very good" understanding of social work in general and of the Social Service Department at McLean in particular; nine others show a "good" understanding; four show "fair" understanding; and three show "poor" understanding.

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1 See Appendix A.
TABLE VII

PSYCHIATRISTS' UNDERSTANDING OF THE SOCIAL SERVICE DEPARTMENT AS SEEN BY THE QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Psychiatrists</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8) Permanent</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>(14) Part Time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>(6) Resident</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>9</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

The numbers in brackets refer to the number of psychiatrists in that category.

It may be seen from Table VII that, as a group, the permanent psychiatrists have the best understanding of social work in general and of the Social Service Department at McLean in particular; the residents have the next best; and although the part time psychiatrists have a great spread from very good to poor, as a group they understand the Department the least.

Following are examples of answers to these questions from each category.

(a) "Very good" understanding,

As I see it the general scope of a psychiatric social worker is comprised partly of doing psychiatric case work therapy and partly helping to carry out certain manipulations of a patient's environment. The casework therapy may involve brief contacts with relatives of hospitalized patients or may involve long term contacts with the spouses or other members of the patient's family. As I see it the psychiatric caseworker should almost always work in conjunction with the psychiatrist and should, in most cases,
limit her work to efforts at helping the patient see how best to
deal with a reality environmental situation. This practically
always involves the caseworker having a more or less clear under-
standing of certain unconscious ramifications in a client’s be-
havior or attitudes. However, I feel that the caseworker’s job
is mainly to help strengthen the patient's defenses so that he
may deal with these more effectively rather than working on an
interpretive level. I also see the caseworker’s activity as a
possible definitive treatment effort for patients who cannot to-
erate a probing psychiatric approach and also as adjunctive in
preparing certain very, sick patients to accept psychotherapy.

In the McLean Hospital I feel that at least for the duration
of the patient’s hospitalization it is very often vital that mem-
ers of the patient’s family, particularly the important relation-
ships, should be seen fairly frequently in order that they may be
advised and guided in the development of attitudes toward the sick
patient. Also, it is important for relatives to have some help in
reconciling certain attitudes toward the hospital so that they can
be more supportive to the patient. An additional service rendered
by the social worker stems from her maintaining a good relationship
with other agencies so that complications to a patient’s treatment
can be circumvented through her use of extra hospital contacts.

(b) "Good" understanding.

Social workers have a greater grasp of community resources
than do psychiatrists. To work with patients when the main problem
is in the area of social adjustment, interpersonal relationship in
the family, or job problem. Working with relatives.

Working with relatives when there is a problem in connection
with hospitalization, clarification to them of what the hospital
is doing, bringing about changes in relatives for therapeutic pur-
poses as far as the patient is concerned, breaking if possible the
vicious circle in which the patient is discharged to the same sit-
uation as before. Working with patients in (i) job and (ii) adjust-
ment in the family or community at the reality level with an under-
standing of dynamics.

(c) "Fair" understanding.

Interviewing for information and therapy.

(i) Contact with difficult relatives.
(ii) Arranging for after hospital disposition and follow-up.
(d) "Poor" understanding.

   (i) Casework.

   (ii) Any function agreed on by the worker, therapist, and administrator to help the patient.

Casework—including work with patients and families.

While it would have been desirable to cross-check the information received with an analysis of whether those who received a higher rating on the questionnaire also were responsible for a proportionately larger number of referrals, this inquiry was prevented because it was felt necessary to preserve the anonymity of the replies in order to encourage as wide a response as possible. It is the writer's feeling however, on the basis of knowing these doctors personally, that many of them know a good deal more than they put down on the questionnaire.

On the questionnaire, the psychiatrists were asked to evaluate whether they have changed or added to their previous ideas about social work since the Department was established at McLean. To this question, nine psychiatrists answered "no" or "not yet". Three "have not been at McLean long enough to know." Three answered that the Social Service Department at McLean reaffirmed their high opinions of social workers and how essential they are. One stated, "Not materially except to deal with a number of problems more concretely". And finally, one seems to see the social worker as a second rate psychiatrist and feels that as McLean is a private hospital with an adequate number of doctors, there is no need for social workers. He feels that, "the private patient paying full rates and his family want to deal directly with the attending physicians."
C. Conferences

At McLean, there are three kinds of formal conferences: the news, the work-up, and the case presentation conferences. An attempt will be made to explain the role of the social worker in these conferences.

Every morning, from 8:30 a.m. until approximately 9:00 a.m., the news conferences are held. During the first twenty to twenty-five minutes, a nurse from each ward and members of other disciplines and departments present brief reports of significant events of the previous twenty-four hours. Announcements concerning hospital policy and administration are also made at this time. The remaining conference time is spent in individual communication between the psychiatrists, social workers, nurses, and other professional staff of the hospital. It is during this period that most of the communication between the social workers and other members of the staff is carried on.

There are two work-up conferences a week. These are teaching conferences in which the residents present their new cases for discussion and evaluation of treatment plans. They are led by a permanent psychiatrist and the Director of Social Service. In this way, direct interpretation of the ways in which the Department may be used, is carried out.

There is one case presentation conference a week. At this conference a case in which a particular problem is involved or one which may illustrate teaching points, is presented either by a resident or a permanent psychiatrist. These conferences are attended by the psychiatrists, psychologists, and social workers, and occasionally by nurses and social scientists. After the initial presentation of the case by the psychiatrist,
the members of the other disciplines who have had contact with the patient or family under discussion, are expected to contribute their findings. However, the social workers and the psychologists are rarely informed before the conference begins, as to the patient who is to be presented. For this reason the social worker perhaps does not contribute as much at these conferences as she might, had she previous notice and time to prepare her presentation. It would appear then, that by this lack of communication, the psychiatrists are not benefiting as well as they might at these conferences, from the social worker's contact with the patient or family.
CHAPTER VI

SUMMARY AND CONCLUSIONS

This study was made for the purpose of tracing the establishment and growth of the Social Service Department of McLean Hospital. It was found that within less than a year of its establishment February 13, 1956, the Department was able to offer a comprehensive service in the areas of casework with families and patients, instruction to medical and nursing students, and play an active role in the administration of the hospital.

The study was in two phases: an analysis of referrals made to the Department; and an investigation into the understanding of the Department's function by those who make the referrals. The statistical analysis and discussion covers all the cases referred to the Department during the period from its establishment on February 13, 1956 to November 30, 1956. The data regarding the referrals were obtained by interviewing the social workers with regard to their cases. To find out how the psychiatrists at the hospital understood the Department and to ascertain the development of their appreciation of its usefulness, questionnaires were sent to the psychiatrists on the hospital staff, including all residents, and full and part time psychiatrists.

Through the study of referrals, it was found that the reasons for referral fall into ten groups, the largest being that of "Admission", and the next four largest categories being those of "Support", "Discharge Planning", "Family Relationships", and "Interpretation". It was also
found after a study of clients, that a ratio of approximately three families to every patient was seen by the Department. This differs from some other private mental hospitals studied where the emphasis has been placed almost entirely upon work with relatives only or with patients only.

As the vast majority of cases were referred to the Department by psychiatrists, a detailed study was made of the way in which the psychiatrists at the hospital saw and used the Department. Towards this end, an analysis was made of the source of referrals to the Department, the answers to the questionnaires, and the role of the social worker in the conferences. It was found that the referrals were distributed far from evenly amongst the psychiatrists; 14 per cent of the psychiatrists making 50 per cent of the referrals. The psychiatrists who answered the questionnaire showed on the average a "fairly good" understanding of social work in general and of the Social Service Department at McLean in particular, and on the average, felt that they have not changed or added to their previous ideas about social work since the Department was established at McLean. In the conferences, although the social workers and psychiatrists have a good working relationship, there is a problem in communication regarding the case presentation conferences where the social workers are rarely informed before the start of the conferences as to the patient who is to be presented. It is clear from the distribution amongst the psychiatrists of psychiatric referrals to the Social Service Department, from the answers to the questionnaire, from the number who did not
respond to the questionnaire, and from the use of the social worker in
the case presentation conferences, that the majority of psychiatrists
do not understand or use the Department as well as they might.
CHAPTER VII
RECOMMENDATIONS

A. Future Development of the Social Service Program

For the future, there are a number of important developments now under active consideration. Among these are the establishment of a family care program, the creation of a community interpretation program and the undertaking of various social work research projects.

It is immediately apparent that a family care program is a much needed feature of a psychiatric hospital and that the administration of such a program is a service which ought to be a normal feature of a social service department. Concerning the usefulness of such a program, Hester B. Crutcher states:

Foster family care as used here is the placing of the mentally ill or defective with families other than their own for care. The majority of patients selected for foster family placement are from the hospital classification of "continuous treatment". The outlook for their recovery is not hopeful.¹

However, family care is also used for some patients who have responded so well to intensive hospital treatment that they are placed in homes as a therapeutic measure with the purpose of hastening their recovery and rehabilitation. Family care is thus an extension of both the custodial and the therapeutic services of the hospital.²

...there is a trend...toward placement in the community and utilization of facilities for living that are as nearly normal as possible, with the idea that the individual should have the

² Ibid, p. 2.
opportunity to grow and develop in an environment in which usual life experiences predominate. 3

While this writer cannot agree with Miss Crutcher's emphasis on the use of the foster homes primarily for "continuous treatment" patients, there is definitely a place in the family care program for both types of patients discussed by her. The family care program should have its greatest usefulness in the rehabilitation of patients who are well enough to attempt the adjustments necessary in a "normal" social group but who are not yet ready, or may not be able, to be returned to their former environment. The Social Service Department in this area can perform a valuable service through the selection of appropriate homes for patient placement and also through the preparation and placement of patients in homes most suited for their treatment. Not to be neglected is the work of the Department in overseeing the developing relationships in the foster environment and acting in assisting the integration of the patient into the foster home and ironing out the normal difficulties which such an integration is bound to cause.

Together with other similar departments, The McLean Social Service Department can assist in widening the community's understanding of problems connected with psychiatric treatment, the nature of mental illness, and the social worker's role in the treatment process. A most logical method of promoting community interpretation is by lectures to small social and educational groups, as Parent Teacher's Associations, church groups, clubs, and school and university associations. It is probably

3 Ibid, p. 9.
trite to add the thought that this interpretation is best done by those with practical experience in the field, but it is an important reminder that social service departments must be prepared to devote a part of their time to this important responsibility.

Research in social work is the function of a highly developed social service department and for this reason it cannot have high priority in the immediate future development at McLean. At the same time, each hospital carries with it features which will make research along certain lines more profitable there than in other places, and useful areas for research should be noted for future consideration as they arise. It is suggested that perhaps studies similar to the present one may be made in the future so that at various stages in its development, the Social Service Department at McLean may be assessed. Another possible area for future research would be a study of the role of the social worker at McLean; of her responsibilities and the actual treatment she carries on.

B. Increasing the Awareness by the Psychiatrists of Social Services

Perhaps by implication in what has gone before, it has been suggested that the fault for inadequate awareness of the role of the Social Service Department lies with the psychiatrists on the staff. Such a suggestion however, was not intended. The purpose of the paper thus far has been to consider the actual use made of the Department by the psychiatric staff and it has been demonstrated that the use is not adequate from the social work point of view. The onus for this must in part lie with the social workers. By this, it is not suggested that in the development
of the Department over the past year the staff have failed to capitalize on opportunities. The creation of a new department raises many demands. However, it is for the Social Service Department to bring an awareness of its usefulness to those who ought to be using it. As far as long range goals are concerned it is submitted that the Social Service Department request and prepare for a conference with the psychiatrists in which members of the Department can present various aspects of the Department's actual and potential program within the hospital and then throw open these matters to a full range of discussion. However, no one conference will be a panacea and the Department's long range success in such an education program will depend on its ability to demonstrate its usefulness in day to day activity, something in which to date it has succeeded in doing very well.

Accepted

David Landy

Thesis Advisor
APPENDIX A

SOCIAL SERVICE DEPARTMENT QUESTIONNAIRE
MCLEAN HOSPITAL

N.B. Please write your answers below using additional paper as necessary.

1. How long have you been in residence or how many years experience have you? Are you working part time or full time? If part time, how many hours a week?

2. Have you had previous contact with social workers? If so, where? What was the nature of the contact?

3. What do you see as the general scope of a social worker?

4. What particular types of problems in this hospital do you see as falling within the social worker's function?

5. Have you found that you have changed or added to your previous ideas about social work since the Social Service Department was established at this hospital? If so, in which ways?
January 11, 1957.

Dear Doctor:

As you know, the Social Service Department of McLean Hospital was established less than a year ago. As a part of Mrs. Austin's master's degree program, she is making a study of the development and use of the Department in order to determine how it may be more effectively used in the future. Your help in this project is essential.

Although I realize that you are terribly busy, I would very much appreciate it if you could find time to answer the attached questionnaire. There is no need to write your name on the questionnaire.

Please leave your reply in the Social Service mail box (in the admitting office) or mail it to:

Mrs. Sheila Austin,
Social Service Dept.,
McLean Hospital,
Waverly 79, Mass.

by January 30, 1957.

My sincere thanks for your co-operation,

Golda Edinburg, Director
Social Service Department
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