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A study of twenty-five referrals made by
the Social Service Department of the
Massachusetts Memorial Hospitals to
community social agencies

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF TWENTY-FIVE REFERRALS MADE BY THE SOCIAL
SERVICE DEPARTMENT OF THE MASSACHUSETTS MEMORIAL
HOSPITALS TO COMMUNITY SOCIAL AGENCIES

A Thesis

Submitted by

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(B.A., Brooklyn College, 1952)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1954

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CHAPTER I
INTRODUCTION

As a result of the Greater Boston Survey made under the auspices of the United Community Services of Metropolitan Boston, it was indicated that confusion and lack of understanding existed between the field of medical social work and social agencies in the community. Therefore, a Committee on Interagency Relationships in the Council of Social Work in Medical Care was established. One aspect of the Committee's work has concerned the whole process of referral from hospitals to community social agencies. There is need for an established policy in hospital social service departments in order to improve referral methods and cooperative practices with the goal of providing better service to patients. The idea for this study grew out of the investigations of this committee.

Purpose of Study

This is a study to examine referrals made by the social service department of the Massachusetts Memorial Hospitals to community public and private social agencies from which casework service, including financial

assistance and employment counselling, is requested. The purpose is to determine the practices and procedures in relation to referrals and working relationships between the social service department and community social agencies. An attempt will be made to answer the following questions:

(1) What are the types of problems referred and the agencies to which referrals are made?

(2) What are the methods of referral used in the cases studied?

(3) What was the outcome in the referral to a social agency?

(4) How did the procedures of the hospital social worker affect the referral?

Scope of Study

This study includes twenty-five cases active with the social service department of the Massachusetts Memorial Hospitals which were the total number of cases referred during the months February, March, and April of 1953 to community social agencies. There was a total active caseload of 583 cases during this study period. The Committee on Interagency Relationships compiled statistics of referrals for this three month period and made a very brief analysis of the number and source of referrals from eight Boston hospitals, in preparation

for this study. The patients will be classified as to the types of cases suitable for referral and specific methods and procedures of referrals as defined by the Committee.¹

Method of Study

The cases for the study were selected from the monthly statistical sheets of the social workers employed in the social service department at the time of the study. The names of all cases indicating referral to social agencies for casework service were listed and the medical social case records were then analyzed for this study.

The data for this study was obtained from literature, hospital social workers, social case records, and the use of the schedule. The literature provided the information for discussion, which the writer has used in an attempt to evaluate the growth of thinking of referral procedures in the medical casework setting. Books and articles written from the point of view of medical social work, social case work, and consultation and cooperation of the medical team and social agencies were included.

¹Council of Social work in Medical Care, Inter-agency Relationships.

The director of the social service department of the Massachusetts Memorial Hospitals and members of the social service staff contributed material regarding the history of the Massachusetts Memorial Hospitals and the social service department, unwritten policies and referral procedures, and follow-up information on specific cases that may or may not have been recorded.

Limitations of Study

In some case records, the referral methods and procedures were summarized, and in those instances it was necessary for the writer to estimate the referral activity of the social worker. The conclusions from this study are limited because of the lack of evaluative follow-up reports from many of the referral agencies. Since the scope of the study did not include contact with the referral agencies, only follow-up studies can truly determine the value of the referral.

CHAPTER II
AGENCY SETTING

The Massachusetts Memorial Hospitals is an acute general hospital whose inclusive activities are the care of sick people, medical education, medical research, contributing towards the progressive development of medicine and the improvement of the health in Boston.² The Massachusetts Memorial Hospitals consists of a group of five units--for research and ward care, The Evans Memorial; for out-patient care, the Talbot Memorial; for general hospitalization, the Robinson and Collamore Memorials; and for contagious diseases, the Haynes Memorial. It was founded in 1841 and incorporated in 1855 under the name of the Massachusetts Homeopathic Hospitals. The Massachusetts Memorial Hospitals is a Grade A voluntary hospital financed through endowments, individual contributions and Red Feather Funds. Financial assistance is received from the Federal Government for special problems and research,

²Annual Report 1950, Massachusetts Memorial Hospitals, Boston, Massachusetts, p. 5.

such as cancer research and venereal disease services. Admission to the out-patient department is supervised and partly administered by the social service department. The patient's ability to pay is determined by the admitting office, and free care is available for the indigent.

In 1871 the organization became affiliated with the Boston University School of Medicine. The hospital conducts a school of nursing, a course for medical technicians, x-ray technicians, and provides clinical experience for dieticians, social service workers and theologians.

With the cooperation of the Boston University School of Medicine, the Home Medical Service has provided medical care in the homes of the medically needy individuals in a limited area of Boston for over seventy-five years. This service affords an opportunity for fourth year medical students to study practical medical problems under careful supervision.³ Psychosomatic conferences, conducted by a member of

³Beatrice S. Stone and Henry J. Bakst, M.D., Educational Experience in Social Work and Medicine on a Domiciliary Medical Care Service, p. 42.

the Department of Psychiatry guide the medical students in the management of the emotional problems of patients. The psychosomatic clinic is connected with the Boston University School of Medicine and has its own social service staff. There are thirty-five clinics operating in the out-patient department which include cardiac, thoracic, diabetic, genito-infectious, prenatal, tumor, medical, and many others.

The Medical Associates, an association of a group of practicing physicians provide medical care and treatment, as a division of the hospital located on Commonwealth Avenue.

The social service department had its beginnings in the orthopedic clinic, when Dr. Walker realized that although he prescribed medications or appliances, many of his patients were financially unable to carry through his treatment. A social worker began to work with the financial problems and soon realized many other demands, emotional and social, that were worthy of attention. In 1920, the social service department was established. The staff has gradually grown to include the administrator, eleven medical social workers, two case-aids, and several social work students.

The medical social worker is in close collaboration with the doctors, nurses, other staff disciplines,

social agencies, the patients and their families, and may receive referrals from any of these sources. Through the use of casework skills, the social worker attempts to discover and meet the needs of the patients, both medical and social. It is the responsibility of the social worker to refer patients and their families to community social agencies when services are required which are not primarily associated with the medical care provided through the hospital.

The social service department has policies in regard to referrals. A hospital social worker should prepare the patients for the referral and then have telephone contact with the referral agency. A referral letter is indicated in complex situations or when the referral agency requests specific medical-social information regarding the patient. The use of consultation and supervision is suggested on all complex situations or in situations where there is a question of suitability of referral to a particular agency.

CHAPTER III

THE SOCIAL WORKER'S ROLE IN REFERRAL

It is the responsibility of the hospital social worker to relate her function to the medical setting. When problems are first discovered within the hospital which do not have a direct relation to the patient's illness, or when medical treatment is being terminated and the services of a community social agency are clearly needed, a referral should be made. The decision to make an appropriate referral implies clear diagnostic thinking by the medical social worker as to the patient's problem. As indicated in the Report of the Milford Conference on Social Case Work, no social service department is expected to carry all of its cases without the help of outside community agencies but the report presupposes:

- (1) A thorough appreciation of her own function on the part of the hospital social worker.
- (2) An ability to analyze a given situation in order to determine whether to carry it herself, or by whom and at what point it should be carried elsewhere.
- (3) A full familiarity with the functions of other agencies.

(4) An understanding on the part of other case workers as to the medical-social implications of a situation so carried by them whether alone or jointly.

(5) A knowledge on the part of the non-medical case worker of the function of the hospital social worker.⁴

The medical social worker attempts to meet the needs of the sick person in the hospital setting. The problems of financial assistance, employment counselling, child placement, mental illness, family counselling, chronic care and other social problems not related to illness would fall outside the function of the medical case worker. Therefore, referrals to community social agencies would be deemed necessary.

In a careful referral process it would always be necessary to prepare the patient for the referral. "Ideally, the current worker should be able to inform the client of his plans far enough in advance so that time is allowed to work out these feelings."⁵ It is important to clarify the function of the hospital social worker to the patient, and to interpret in general terms, the services that the community agency is able to offer.

⁴Report of Milford Conference on Social Case Work: Generic and Specific, "Some Principles Governing the Division of Labor in Social Case Work," The Family, February 1931, p. 64.

⁵Regina Flesch, Treatment Considerations in the Reassignment of Clients, p. 36.

The patient should understand and accept the reason for referral.

There is not always time during the hospitalization period of the patient to work through his resistance toward referral. It has been established that the worker has a better chance for successful referral of the patient after he has been discharged to his home for a period of time and then returns to the center, especially in situations where there are disturbed family relations. With the cooperation of the medical team and the case-worker's understanding of the patient's problems, the way for proper referrals can be paved.⁶

Another important step in the referral process involves getting the community agency receptive to the referral. The Council of Social Work in Medical Care has formulated definite procedures involved in good referral practice:

- (1) Referrals, when possible, should be made by personal contact between the hospital social service worker and the social worker in the community agency.
- (2) All referrals should be confirmed in writing.
- (3) Letter of referral should state clearly the medical problem, its social implication and whether or not the social service department is continuing social responsibility with the community agency.

⁶Ann M. Powers, and others, "Mother-Child Relationships in Rehabilitation of the Physically Disabled," Social Casework, June, 1951, pp. 264-265.

(4) In cases where both agencies are to share responsibility, division of responsibility should be clarified at the point of referral and at frequent intervals as the situation progresses or changes. Joint conferences on complex situations are indicated if two agencies are working on a cooperative basis.⁷

Cooperation seems to depend on a thorough knowledge of the resources and policies of the other agency. If the hospital and social agency do not know each other's function adequately, each one is apt to demand impossible things of the other with needless friction and loss of time as a result. Leadership responsibility must be vested in one agency with a clear-cut understanding of how the cooperating agency ties in with the delegation of authority.⁸

Eleanor Dodge categorizes the service of the medical social worker in cooperative cases as to the following:

- (1) those cases where the medical condition is a minor phase of the whole problem.
- (2) those problems where the medical problem is major or so involved that any solution demands cooperative planning to determine the wisest plan for placing responsibility for social treatment.⁹

⁷Council of Social Work in Medical Care, Inter-agency Relationships, p. 2.

⁸Josephine G. Taylor, "A Committee on Medical and Family Cooperative Cases," The Family, March, 1936, p. 30.

⁹Eleanor L. Dodge, "Cooperative Service Problems," The Family, November, 1935, p. 216.

In those cases in which the medical condition plays a major role in the problem, so that responsibility for intensive casework treatment falls logically to the medical social worker, it is important to clarify this point with the referral agency.

It is the responsibility of the social worker in a medical setting to keep the social agency informed of medical progress in a case where both agencies are active. The referring agency should request an evaluative follow-up report from the referral agency. It is the goal of the hospital social worker to offer the best service in order to help the patient with his problems. A well-planned referral can often have a significant role in achieving this goal.

CHAPTER IV
ANALYSIS OF DATA

The purpose of this chapter is to present the data obtained from twenty-five cases which form the basis of this study. The material will give a picture of the types of problems referred, the community agencies to which referrals were made, and the methods and procedures by which these were made.

TABLE 1
DISEASE GROUPS OF PATIENTS STUDIED

<u>Principal Medical Problem</u>	<u>Number of Patients</u>
Infectious Diseases	5
Gynecological Conditions	5
Psychoneurotic Reactions	4
Diseases of Brain Damage	4
Cardiac Diseases	2
Diseases of Allergy	1
Gastro-Intestinal Disorders	<u>1</u>
No Medical Problem	<u>3</u>
Total	25

The two largest groups of the principal medical problems of the patients studied are the infectious diseases and the gynecological conditions, including

pregnancy. The third largest group (four), the psychoneurotic illnesses, were medical problems without an organic disease. What might be considered in the extreme opposite group were the four patients with the diseases of brain damage, including epilepsy and senility. The three patients presenting no medical problem had personality and behavior maladjustments.

TABLE 2
TYPES OF PROBLEMS REFERRED TO COMMUNITY AGENCIES

<u>Principal Social Problem</u>	<u>Financial Need</u>	<u>Number of Patients</u>
Disturbed Social Relations	3	11
Vocational Training	2	6
Child Placement	1	3
General Hospital Care	1	3
Chronic Care	0	1
Other	<u>0</u>	<u>1</u>
Total	7	25

Table 2 reveals that disturbed social relations was the principal problem referred to an outside community social agency. Three of those patients were also referred to a public assistance agency for financial assistance. The second largest group, which is six, consisted of those patients who were referred for vocational training, of whom two were also referred for financial assistance. One-fourth of the total group of patients referred to a community agency for casework service were also referred to a public assistance agency for financial assistance.

In the third largest group, which is three, two of the patients were placed for adoption, and one patient was placed in the children's institution with special medical services. Of the three patients

referred for general hospital care, two were illegitimately pregnant women who needed confinement arrangements and casework help with their emotional problems. One patient was referred to a city hospital, the other to a state hospital. One patient was referred for outpatient psychiatric treatment at a city hospital.

The hospital social worker helped the patient understand the value of placing the patient's senile sister in a chronic nursing home. Under the heading "other", the patient was referred to a national emergency agency to work through plans to secure an army discharge for her son.

TABLE 3
METHOD OF REFERRAL TO COMMUNITY AGENCY

Type of Agency	Agency Conference*	Telephone call(s)	Letter(s)	All
Family agency	0	8	0	0
Vocational service	0	6	5	5
General hospital	0	4	0	0
Child placing	1	3	1	1
Nursing home	0	1	0	0
Detention center	2	2	2	2
Other	<u>0</u>	<u>1</u>	<u>0</u>	<u>0</u>
Total	3	25	8	8

*This refers to joint conferences when two agencies are working on a cooperative basis.

The largest group of referrals, of which there were eight, were to a family agency. In all of these, the worker had telephone contact(s) with the referral agency but there were no letters of referral written. In one situation, the patient was referred for casework service and temporary financial assistance, and the hospital social worker was responsible for informing the agency of the patient's medical progress. In another referral which involved casework with a pregnant mother, the hospital social worker was responsible for relating the medical progress regularly to the referral agency.¹⁰

¹⁰This refers to a community social agency to which the hospital social worker initiates a referral.

In all instances, the family agency was to assume full casework responsibility. An evaluative follow-up was received from the family agency on five patients, which represents more than one-half of the patients of this group.

There were six referrals to the vocational service agencies. In all instances the hospital social worker had telephone contacts with the referral agencies. In five situations, a referral letter, including a social-medical diagnosis, was written. The hospital social worker was to assume casework responsibility of the patient and the vocational service agency was to provide training for three patients. In the other three situations the referral agency was to provide vocational training and the hospital social worker was to keep the agency informed of the patient's medical progress. An evaluative follow-up was received from the vocational service agencies in five out of six cases.

The referrals to a general hospital included four. All referrals were confirmed by telephone contact(s) and there were no letters of referral written. One patient referred to a state hospital was told about the agency, but did not participate in making the necessary arrangements. The other patients in this group did participate in the referral process. The hospital social worker at

the general hospital assumed the medical responsibility of reporting on the patient's progress to the worker of the referring agency, however, there was no clear division of casework services with this patient who had social and emotional problems. In the remaining two situations, the general hospital assumed full medical and casework services to the patients. An evaluative follow-up was received from the general hospital on two patients.

There were three referrals made to child placing agencies. In all of these, the worker had telephone contact(s) with the referral agency. A referral letter including a medical-social diagnosis was written in reference to one patient, and the referral agency was to assume full responsibility for medical care and casework services. The hospital social worker would continue to visit the patient on a sporadic basis for the purpose of observing the patient's follow-up progress. There were several joint conferences between the hospital social worker and the child placing worker to evaluate and discuss plans for the patient's casework treatment. An evaluative follow-up was received from this referral agency. In the other two situations, the referral agency assumed

full casework responsibility, and the hospital social worker reported the patient's medical progress. There was no evaluative follow-up on these patients.

One referral to a nursing home was made in which the hospital social worker had telephone contact with the referral agency who was to assume full responsibility for the patient's sister. The hospital had no medical contact with this referred patient. There was an evaluative follow-up from the nursing home.

There were two referrals to a detention center. Both referrals were made by several telephone contacts and a referral letter stating the medical-social diagnosis. In the referral to one detention center, the adolescent patient was receptive to the referral, but her parents were not ready for this step. The hospital social worker was to continue casework service with the patient's parents and work toward a goal of the patient's referral. In the other case, the detention center was to be a temporary placement. The hospital social worker was to continue casework service with the patient's parents and continue to formulate placement plans for the patient. In both instances there were several cooperative agency conferences.

The "other" patient was a referral to a national emergency agency, in which the worker had several telephone contacts, but there was no referral letter. The referral worker was to assume responsibility for the patient's son, and the hospital social worker would share the patient's medical progress with the referral agency. There was no evaluative follow-up from the national emergency agency.

TABLE 4
PARTICIPANTS IN THE REFERRAL PROCESS

Source	Number of Patients
Physician	12
Social Work Supervisor	1
Conference	2
Non-Medical Staff	1
None	5
Combination*	<u>4</u>
Total	25

*This refers to two or more of the listed sources used in the referral process.

This table shows that the medical social worker had consultations with the physicians on twelve patients. This would indicate that the physicians recognized the importance of the psycho-social component in medical care. In addition to the physicians participating in referrals for help with disturbed social relations, of which there were five, the problems were as follows: five for vocational training and counselling, one for child placing, one for general hospital care, and one for help in arranging an army discharge for a member of a patient's family.

The second largest group (five) had not used supervision and/or consultation in the referral

process. The social worker made the following referrals: one to a chronic nursing home, one to a child placing agency, one to a family agency, one to a vocational training center, and one to a general hospital.

The third largest group used a combination of consultation and supervision for four of the patients with disturbed social relations. On two of these patients, one referred to a detention center and the other, a referral to a family agency, there was also a conference of the social workers and the medical team. In two of the referrals, there were individual conferences with the psychiatrist.

The hospital social worker was requested to make a referral in two cases that were discussed at an intake conference, where the patients had disturbed social relations and were referred to a family agency.

In another situation, the hospital social worker consulted with her casework supervisor for a patient who needed family counselling. The worker consulted with the clinic executive in a situation where the patient needed hospital care.

TABLE 5
STEPS IN THE REFERRAL PROCESS

Steps	Number of Patients
Patient prepared*	20
Agency prepared**	25
Follow-up requested by medical social worker	20

*This refers to discussion and acceptance of the referral as worked through with the medical social worker.

**This refers to the medical social worker contacting the referral agency and getting the referral understood.

This table shows that twenty patients of the total group were prepared for the referral. The total group of referral agencies were prepared for the referred patients. In twenty instances, the medical social worker requested follow-up information from the referral agency. These reports indicated that seventeen patients did get to the referral agency, three did not (these patients had not accepted the referral), and there is no information on the remaining five patients of the total group. Of the seventeen patients that did get to the referral agency, eleven

patients accepted service from the agency, and six did not.

TABLE 6
CLASSIFICATIONS* OF TYPES OF PROBLEMS REFERRED

<u>Classification</u>	<u>Number of Patients</u>
(1) Psycho-social problem without a medical problem	3
(2) Major social problem with a minor medical problem	4
(3) Medical problem and social problem in the same situation without significant relationship between the two.	3
(4) Major medical and major social problem in the same situation which may or may not be significantly related.	<u>15</u>
Total	25

*As suggested by the Council of Social Work in Medical Care.

Group (4) has the largest number of patients, of which there are fifteen. Eleven of these patients got to the referral agency, two did not, and there is no information on the remaining two. Of the four patients referred who had a major social problem with a minor medical problem, three of the patients got to the referral agency, and there is no follow-up on the other patient. In group (1), one patient got

to the referral agency, one did not, and there is no information on the other patient. Of the three patients in group (3), two patients got to the referral agency and there is no follow-up on the remaining patient.

TABLE 7
SOCIAL SERVICE SOURCE OF REFERRALS

<u>Source</u>	<u>Number of Patients</u>
Psychosomatic Clinic	10
Pre-Natal Clinic	5
Home Medical Service	5
Haynes Infectious Disease Hospital	3
Genito-Infectious Disease Clinic	1
In-Patient (House)	<u>1</u>
Total	25

The largest source of referrals made by the hospital social worker were from the Psychosomatic Clinic. This comprised ten of the referrals studied. The next two largest groups were the Pre-Natal Clinic and the Home Medical Service, with five referrals each. The remaining referrals were distributed, representing one-fifth of the twenty-five patients. This table shows that the main source of referrals are from the out-patient department clinics.

CHAPTER V
CASE PRESENTATIONS

A limited number of cases, nine in all, has been selected to demonstrate the types of cases that are suitable for referral to community social agencies. The selection has been based on the criteria for cases suitable for referral as defined by the Council of Social Work in Medical Care. An attempt will be made to determine the worker's activity in the referral methods and procedures as influenced by the types of problems. The classification of cases will be presented as follows:¹¹

- (1) A psycho-social problem which exists without a medical problem - two cases.
- (2) A major social problem with a minor medical problem - two cases.
- (3) A medical problem and a social problem in the same situation, without significant relationship between the two - two cases.
- (4) A major medical and major social problem in the same situation, which may or may not be significantly related - three cases.

¹¹Council of Social Work in Medical Care, op. cit.

(1) Two cases are presented in which the hospital social worker referred the patients to community agencies because there was a psycho-social problem which existed without a medical problem.

Case 1

Mrs. B. was a twenty-seven year old attractive, Negro, married woman with two children, who requested help regarding a marital problem. The patient was contemplating divorce as she felt that her husband's serious approach to life was incompatible with her desire for a more relaxed, freer way of living. Mr. B. was an art student with a history of two years hospitalization in a mental institution.

The patient's complaints were of a sharp pain over the left side of her chest and dizziness. Mrs. B. was admitted to the hospital and discharged with a diagnosis of "no organic disease". The patient had been followed in Medical Clinic for current complaints.

The social worker discussed referral with a family agency worker for help in marital counselling. Mrs. B. showed resistance, at first, because she was fearful that her husband would describe her as an unfit mother. The patient liked to drink, smoke and visit friends occasionally. After the worker explained the policies of the family agency, assured Mrs. B. that she and her husband would be seen by different workers, and pointed out the positive aspects of the parent-child relationship, the patient was able to accept the referral.

Comment:

This was a psycho-social problem which existed without an organic medical problem. Marital counselling

is a problem that falls outside the function of the medical social worker and is suitable for referral. With continued reassurance and support from the worker, the patient was able to express her fears about discussing her marital problems at a family agency. Clarification of the function and policies of the family agency by the worker, was important in preparing the patient for the referral.

The hospital social worker consulted with Mrs. B.'s doctor, who had recognized the psychogenic components in the patient's symptoms and had referred the situation to social service. The worker had several telephone contacts with the referral agency, and they were to assume full casework responsibility. When the patient did not keep her first appointment at the family agency, it was agreed by both agencies that the medical social worker should work through the patient's resistance for help.

Clear diagnostic thinking as to the patient's problem, supportive casework help, the readiness of the patient, and the agency's receptiveness were important factors in getting the patient to the referral agency. There is no follow-up information to indicate whether the patient actually got to the agency or

accepted service from the family agency.

Case 2

Laura B. was a fourteen year old girl whose psychoneurotic behavior manifested itself in fire-setting and truancy. The psychiatrist was working with the patient and evidences of strong self-destructive tendencies initiated the recommendation for institutionalization. The patient was frightened of her own actions and was willing to be committed.

The hospital social worker attempted to work with the parents to accept the psychiatrist's recommendation. Mr. and Mrs. B. presented many guilt feelings about institutionalizing the patient. They feared that the patient might kill them or their other children when she was released. Mr. and Mrs. B. were beset by feelings of guilt and inadequacy as parents. The worker helped the parents release some of their guilt feelings, pointing out that institutionalization provided the only answer to the patient's problems, and this was strongly recommended by the medical staff. Arrangements were made by the worker to have a public assistance agency financially support the patient in placement, since the family was unable to assume this responsibility.

The detention center was to provide full casework responsibility for the patient. Laura's parents would continue to receive casework service from the hospital social worker. Mrs. B.'s lack of readiness to accept this solution interfered with the patient's being insitutionalized at this time.

Comment:

In this case the patient had a serious psycho-social problem without a medical problem. The worker had several telephone contacts with the referral agencies. There was

a conference and several consultations with the psychiatrist, casework supervisor and the referral agency. In the referral letter there was a social diagnosis of the patient and a clear definition of responsibility for service to the patient and her family. The worker continued further casework service with Laura's parents, as this was the medical staff's recommendation to help them resolve their guilt feelings and eventually accept the referral.

(2) Two cases are presented in which there is a major social problem with a minor medical problem, and referrals were made by the hospital social worker to community agencies.

Case 3

Mrs. S. was a twenty-eight year old attractive woman who was pregnant and wanted to place her expected child for adoption. The patient was being seen in the Prenatal Clinic. Mrs. S. described her husband as a kleptomaniac, who stole small sums of money. The patient was on the verge of separating from her husband when she discovered that she was pregnant.

After the worker had a conference with the psychiatrist, it was decided that adoption would not solve the patient's problems and that Mr. S. should be seen for casework help. The patient's husband felt that he could not afford another child at this time and his strongest reason for wanting the adoption was that he feared that his wife's irritability with the new baby would increase their marital problems. Both Mr. and Mrs. S.

have described their childhood as one of emotional deprivation and they did not want to take on the responsibility of another child. The patient and her husband were seen by different workers.

A referral was made by the worker to a child placing agency, who agreed to assume full casework responsibility for the patient and her baby. Mrs. S. needed supportive help from the hospital social worker in accepting the child placing agency's requirements that she must supply the layette and pay board until the baby is adopted. The hospital social worker helped the patient to work through some of her guilt feelings about having the baby adopted. Mrs. S. did get to the referral agency and received service from them.

Comment:

In this situation the major social problem was the patient's request to have her expected child adopted and the minor medical problem was the patient's pregnancy. Mrs. S. was very receptive to the referral, although the worker did not expect the adoption of the child to solve the patient's social and emotional problems.

The medical social worker had frequent telephone contact with the child placing agency, discussing the patient's social diagnosis and medical progress. The worker made use of supervision and consultation with the psychiatrist on the suitability of the referral.

Case 4

Miss B. was a twenty-three year old, illegitimately pregnant woman who requested help in the Prenatal Clinic with confinement arrangements and after-care for her baby. The patient was unable to pay for this maternity care. The father of her unborn child was a married man, but the patient did not know that he was married until after her pregnancy. The patient's family are in the South, with the exception of a married sister, whom Miss B. has been living with in Boston.

The patient was receptive to making arrangements at a state hospital for her confinement. Miss B. participated in the referral by filing an application at a public assistance agency. The state hospital agreed to handle all plans for adoption of the baby. When the patient realized that it would be necessary to divulge the name of the father of her baby, Miss B. withdrew her application. The hospital social worker then suggested that the patient apply at a city hospital for care. Miss B. preferred to make her own arrangements. The hospital social worker encouraged the patient to contact the social worker at the city hospital in regard to plans for the baby. The referral agency assumed the full medical care and casework services.

Comment:

In this case the major social problem was the illegitimate pregnancy and the needed hospital care for the patient; the minor problem was the pregnancy. Although the patient was receptive to the referral to a state hospital, she was unwilling to institute

legal proceedings against the father of the baby. The hospital social worker cancelled the patient's application with the public assistance agency and accepted the readiness of the patient for the referral to the city hospital. The worker had telephone contact with the referral agency, and a social diagnosis of the patient was given. It was clearly understood that the city hospital worker would assume the casework services.

(3) Two cases are presented in which the hospital social worker referred the patient to community social agencies because there was a medical problem and a social problem in the same situation, without significant relationship between the two.

Case 5

Miss M. was a twenty-six year old single, emaciated-looking girl who was living away from home in a dilapidated boarding house. The patient was known to the Home Medical Service and had current complaints of coughing and vomiting, indicating a tentative diagnosis of pneumonia and a question of tuberculosis.

The patient had had a nervous breakdown in the eighth grade, at which time she left school. Miss M. describes her family relationships as "very poor". The patient was employed by a laundry in Boston, but had been feeling so ill that she was out of work for a few weeks and had no money for rent or food.

The hospital social worker explained the public assistance relief program to

the patient, and although the patient was hesitant about receiving relief, the worker assured her that this was the best temporary plan. The worker had telephone contact with the public assistance agency and the welfare worker was sent out to visit the patient.

The extern on the Home Medical Service and the hospital social worker discussed hospitalization at the city hospital with Miss M. and the patient was admitted for a diagnostic evaluation. The tentative diagnosis of tuberculosis was ruled out and the patient was discharged. The case was closed.

Comment:

In this situation, the medical problem was the question of tuberculosis and the social problems were need for hospitalization, financial assistance, and personality adjustment. Miss M. was receptive to the referral to the public assistance agency, after the worker assured the patient of the value of this plan. There was no indication as to whether financial assistance was secured, since the case was closed at the point of referral. The social worker and the doctor had a consultation on the hospital referral, and Miss M. was able to accept this. The city hospital assumed the medical responsibility and the hospital social worker followed the patient's medical progress. Although the diagnostic thinking about the patient indicated social and emotional problems, there was no clear division of responsibility in regard to casework

services for the patient with the referral agencies and no attempt on the part of the hospital social worker to resume follow-up contact with the patient. The worker had telephone contacts with the referral agency and there is a question as to whether any social diagnosis of the patient was shared.

Case 6

Mrs. C. was a thirty-one year old, married, obese, pregnant woman who was being seen at the Prenatal Clinic. The patient had two children of her own and two step-children. The patient's husband was a shipyard worker whose job depended upon the weather. During the winter months the family was provided for by the local public assistance agency. The family had outstanding debts, amounting to several hundred dollars.

The doctor's recommendations were that the patient be on a prenatal diet because she had gained too much weight. Mrs. C. could not afford to do this financially. The patient was also having difficulty managing one of her step-children and questioned the hospital social worker about a referral to a family agency. The worker had contact with a family agency, who agreed to assist the patient financially for one month and then to re-evaluate the situation if further aid was needed. The hospital social worker was to inform the referral agency of the medical progress of the patient.

Comment:

In this situation, the patient's medical problem was pregnancy, complicated by obesity, and her social

problems were disturbed family relations and financial need to meet the doctor's recommendations, which may be parallel problems but without significant relationship between the two. Since Mr. C. was working at the time, the family was not eligible for public assistance, and the family agency did provide financial assistance for one month. The hospital social worker had several telephone contacts with the referral agency, but there was no letter of referral. In the telephone contacts, it was decided that the referral agency would assume casework responsibility, but the only service provided was financial assistance. Neither agency handled the family-child relationship problem.

(4) Three cases are presented in which the social worker referred the patients to community social agencies because there was a major medical and major social problem in the same situation which may or may not be significantly related.

Case 7

Mr. F. was a twenty-six year old, single man who was an immigrant from Ireland and had been living with an aunt and sister in New England. The patient's occupation was that of a manual laborer.

The patient had pulmonary active tuberculosis and was hospitalized for one and a half years at the Haynes Infectious Disease Hospital. When the patient was ready for discharge, he was confronted with a financial and occupational problem. The hospital social worker discussed the services offered at a vocational training agency and the patient was receptive to this referral. The worker contacted the referral agency, who was willing to accept the referral.

The worker also made referrals to a local health unit for a continued medical contact for the patient and to a public assistance agency for temporary financial relief. Mr. F. actually got to the vocational training agency and received service from them.

Comment:

In this case, the major medical problem was tuberculosis and the major social problem was the need for vocational retraining. The hospital social worker recognized the patient's lack of confidence due to cultural and medical factors and offered Mr. F. reassurance and support in learning a new vocation. The worker had consulted with the doctor and the medical recommendations were for work involving light to moderate activity. There were frequent telephone contacts between the worker and the vocational service agency and a letter was sent by the worker stating the patient's medical-social diagnosis. The hospital social worker encouraged the casework responsibility

of the vocational center and was able to gradually relinquish casework service with the patient. At the point of referral, there was shared casework responsibility between agencies. After a few months, the hospital social worker reported the medical progress of patient but no longer offered casework service.

Case 8

Miss G. was an attractive twenty year old girl, who had been in Boston only two days, having come from her home town in New Hampshire. The patient presented herself at the hospital as illegitimately pregnant. An examination revealed as follows: ten weeks pregnancy, residual gonorrhoea, and a kidney infection. The patient was to be seen by the Genito-Infectious Clinic and the Prenatal Clinic.

This was the patient's second pregnancy. Miss G.'s baby was living with her mother and the plan was for this child to be adopted by the mother. The patient was unwilling to discuss the paternity of the unborn child, except that the father was not the same man responsible for her first pregnancy. Miss G. did not wish the people of her community to know of her condition and planned to deliver in Boston. The patient had no money and the doctor felt that her acute kidney condition would prevent her from working for at least two months.

The hospital social worker discussed referral to a family agency with Miss G., since she had no satisfactory plans for confinement or placement of the baby. The patient was receptive to the referral. In the referral to the family agency, it was

understood that the referral agency would assume full casework responsibility and arrange plans for the care of the mother and baby in addition to giving emergency financial assistance. The hospital worker would be responsible to inform the referral agency of the patient's medical progress.

The patient followed no rules of clinic procedure and refused to make the required arrangements for admission to the clinic. During her fifth month of pregnancy, she was admitted to the hospital for contractions, stating that she had gotten into a fight. The psychiatrist diagnosed the patient as being "a psychopathic personality, presenting severe character disorders" with much evidence of early deprivation.

The family agency worker provided transportation for the patient to return to her home town, because it was felt that Miss G. was living a precarious existence in Boston. The patient was referred to the local family agency, who in turn referred the patient to the local child placing agency for the adoption of the patient's second child.

Comment:

In this situation, the major medical problems were gonorrhoea, pregnancy, and a kidney condition. The major social problem was the patient's psychopathic personality. These problems were significantly related in that the patient appeared to have done much acting out in the past and present.

The hospital social worker had constant telephone contact with the family agency. Although this was a

complicated situation, there was no written letter with the patient's social diagnosis. There is some question as to the clear diagnostic thinking of the worker in initiating a referral to a family agency. Since the patient stated that she did not want to return to her home town, the writer questions the suitability of these plans, in the referral. There is no evidence that steps were taken to refer the patient to a public assistance agency for temporary financial assistance.

Case 9

Donald P. was a three and a half year old boy who was hospitalized at Haynes for chicken pox. The patient was also suffering from asthma and eczema, which the doctors felt was the result of emotional disturbances.

The patient's mother had died in childbirth of his baby brother. Donald had temporarily been living with a paternal aunt and uncle. Donald's father asked the medical social worker to arrange placement for the patient.

The medical social worker consulted with the psychiatrist concerning the most suitable referral agency to meet Donald's needs. The children's agency was contacted and agreed to assume full casework responsibility for the patient. The hospital social worker was to inform the referral agency of the medical progress, while Donald was still in the hospital, and the children's agency was to be responsible for Donald's medical care after the transfer was made.

The worker also contacted the local public assistance agency to provide financial support for Donald's placement, and this agency was receptive to the referral.

Donald was prepared for the placement by the social worker, who also accompanied him to the referral agency. On follow-up visits, the hospital social worker observed that Donald had made a very good adjustment and that his asthma and eczema conditions had improved.

Comment:

In this case, the major medical problems of asthma and eczema and the major social problem of placement for Donald, are significantly related.

Clear diagnostic thinking of the medical social worker for the type of placement which would meet the needs of Donald was an important factor in the referral. The worker had several telephone contacts with referral agencies and had written letters of referral stating the social and medical diagnosis of the patient. The worker had personal conferences with the psychiatrist and the worker from the child placing agency.

Donald's father participated in the referral process by filing an application and having a personal interview at the public assistance agency. Donald was helped to accept the placement in that he had continued follow-up contact with the hospital social worker.

CHAPTER VI
SUMMARY AND CONCLUSIONS

The purpose of this study was to examine referrals made by the social service department of the Massachusetts Memorial Hospitals to community public and private agencies from which casework service, including financial assistance and employment counselling, was requested, and in which responsibility was shared or completely transferred. A total of twenty-five cases active with the social service department during the specified three month span of time and referred to community social agencies was analyzed to answer the following questions:

(1) What are the types of problems referred and the agencies to which referrals are made?

(2) What are the methods of referral used in the cases studied?

(3) What was the outcome in the referral to a social agency?

(4) How did the procedures of the hospital social worker affect the referral?

Limitations were imposed by the summarized referral methods and procedures in some case records.

This made it necessary for the writer to estimate the referral activity of the worker. The conclusions are of limited value because of the absence of follow-up information in some cases.

The principal medical problems in the group were the infectious diseases and the gynecological conditions, representing ten patients. About one-half of the remaining patients were fairly well-distributed in five disease groups. Three patients of the total group had no medical problem.

The types of social problems referred to community social agencies were primarily for patients with disturbed social relationships, representing eleven patients of the total. The second largest group of six patients were referred for vocational counselling and training. The remaining one-third of the patients were distributed into referrals for child placement, hospital care, chronic care, and an army discharge request. Of the total group, one-fourth of the patients were also referred to public assistance agencies for financial aid.

In the analysis of the methods of referrals to community agencies, eight of the patients were referred to family agencies. In all instances the hospital

social worker had telephone contacts with the referral agency. In one-fourth of the family agency referrals the worker was responsible for reporting the medical progress of the patient and in all cases the family agency agreed to assume full casework responsibility. An evaluative follow-up was received by the hospital social worker on five of the patients referred to a family agency. The hospital social worker assumed the responsibility of extending supportive casework to encourage the patient to accept the referral and in one instance, the patient was resistant to the referral and to any service offered by the hospital social worker.

The second largest number of referrals, which is six, was made to vocational service agencies, comprising one-fourth of the total. The hospital social worker had telephone contact with the referral agencies in all cases. The worker wrote five letters of referral, stating the medical-social diagnosis of the patients. In one-half of the cases the worker informed the referral agency of the patient's medical progress. In one instance, the worker continued to provide casework services to a patient. It is implied from this study that in referring cases for

vocational services, a more detailed report of the patient's medical-social diagnosis is given by the hospital social worker in the form of a referral letter, because the referral agency requests this information.

Four of the total referrals were to general hospitals. In all cases, the worker had telephone contact with the referral agency. In one referral there was no clear division of casework responsibility and neither agency offered the patient this service. In the other referrals, division of service to patient was clarified at the point of referral. An evaluative follow-up was received on one-half of the group.

Three patients of the total group were referred to a child placing agency. The hospital social worker had telephone contacts with the referral agencies on all the patients. In one situation, a referral letter including a medical-social diagnosis of the patient was written and a joint agency conference was held. In the remaining cases, (two), the child placing agency assumed casework responsibility and the hospital social worker provided the patients' medical progress. There was an evaluative follow-up on one-third of the group.

There were two referrals to a detention center. The hospital social worker had telephone contacts, referral letters including the medical-social diagnosis were written, and joint agency conferences took place. In one situation, the patient's parents were not receptive to the referral and additional casework services were to be offered to the family by the hospital social worker. Another patient was placed with the referral agency and it was agreed upon by both agencies that the hospital social worker was to continue casework contact with the patient.

In the remaining two, rather simple referrals, the worker had telephone contact with the nursing home and the national emergency agency, but no further service was to be offered by the hospital social worker. There was no evaluative follow-up.

The medical social worker had consultations on one-half of the total group with the doctors, who participated in the diagnostic evaluation of the patients' problems and the suitable referrals. The two largest groups of social problems were for patients with disturbed social relations and need for vocational training and counselling.

In twenty of the referrals to a community social agency, the worker had consulted with either

a physician, casework supervisor, non-medical staff person, conference, or a combination of these sources. Five of the referrals had no indication of the use of supervision or consultation by the worker.

In the total number of twenty-five referrals in this study, ten were from workers in the Psychosomatic Clinic. The next two largest referring groups were the Prenatal Clinic and the Home Medical Service, together comprising two-fifths of the total. The remaining referrals were distributed, representing one-fifth of the hospital sources.

Seventeen of the patients referred to community social agencies did get to the agencies and eleven of the total referrals actually received service from the agency. Three of the patients did not get to the referral agency and there is no follow-up information on the remaining five patients.

The types of problems referred and the agencies to which referrals are made appear from this study to influence the referral methods and procedures. The more involved medical and social problems of the patients and specific requirements of public and private agencies do tend to work out definite methods of referral with the community agency. In the more simple referral, where the medical and

social problems were of a milder nature, there were more variation and less clearly defined methods and procedures.

It is difficult to make a positive conclusion in view of a lack of follow-up material, but it seems on the whole that if the patient was receptive, the agency was receptive, there was clear diagnostic thinking as to the patient's problem, a suitable referral agency had been selected, there was a clear definition of responsibility at the point of referral, there was then a tendency for a more satisfactory referral.

Approved:

Richard K. Conant
Richard K. ...
Dean

APPENDIX

SCHEDULE

Name of Patient:

Social Service Number:

Medical Problem:

Social Problem:

Method of Referral to Agency:

Agency Conference
Telephone Call(s)
Letter(s)

Major Function of Community Agency:

Consultation and Supervision in Referrals:

by Physician
by Casework Supervisor
by Conference
by Non-Medical Staff
by Combination

Referral Procedures of Referring Worker:

Source of Referrals:

Types of Cases Suitable for Referral:

Referral Intended to Help Patient with:

Disturbed Social Relations
Vocational Training
Child Placement
Chronic Care
Hospital Care
Other (specify)

Patient Prepared for Referral:

Steps in Referral Process:

Follow-up by Referring Worker:

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