The Psychiatric Social Worker in the Psychiatric Hospital

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Summary

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I. Introduction

In preparing for this report, the Committee sent questionnaires to 34 psychiatrists over the country, representing psychiatric hospitals of every kind, state, veterans', and private, requesting them to sit down with psychiatric hospital people in their area, superintendents and staff, medical and social work, and to send the results of their discussions on present practices and desirable changes. Replies were received from 27 of the 34, reporting on the current status of social work in well over 100 psychiatric hospitals and presenting a great many fruitful and challenging ideas for the fuller utilization of social work skills in psychiatric hospital practice. As the replies came in, a series of meetings, 14 in all, were held by Committee members and experts in the New York area, abstracting and co-ordinating the large mass of material. The conclusions and recommendations therefore embody the thinking not only of the Committee and its staff of experts, but also of more than 300 psychiatrists and psychiatric social workers with extensive experience in psychiatric hospitals in all parts of the country.

It is of interest to note that the profession of psychiatric social work had its origin in the psychiatric hospital. The earliest provisions for the inclusion of social work as a function of psychiatric hospital service occurred in 1906 in Manhattan State Hospital in New York and in 1910 at the Boston Psychopathic Hospital. The psychiatric social work program at Smith College School of Social Work was not established until 1918, that at the New York School of Social Work not until 1919. While the over-all field of social work has since made enormous strides in the achievement of professional clarification and status, social work in the psychiatric hospital has lagged far behind, stultified in its development by a parallel failure of psychiatric hospital psychiatry to keep pace with progress in its own field.

Discussion of the role which psychiatric social work should assume in the psychiatric hospital rests upon a number of basic concepts concerning the function of the psychiatric hospital itself. In the first place, the Committee considers that the treatment of the mentally ill is primarily a community responsibility, and that the hospital is a treatment facility of the community, rather than its dump-pile for the disposal of human wreckage. The goal of treatment is seen as return to community living, with the fullest
utilization of all medical resources for the personal, social and vocational rehabilitation of the patient. Treatment in the hospital is regarded as a total institutional process, rooted in medical responsibility, but with the psychiatrily oriented participation of every staff member, each contributing to the total process on the basis of clearly established administrative allocations of responsibility and of well-grounded and disciplined professional attitudes.

The social case worker deals with a wide range of social and personal problems. To enumerate them would be to name the whole gamut of human ills, failure and frustration, such as unemployment, poor housing, need for money, need for medical care, need for help in planning care of children, need for help with disturbed inter-personal relationships. In order to help people who at least momentarily are unable to cope with their own affairs, the social case worker must know the tension in their lives. He must know what can be done about them and how they can be changed. He must also understand what the person feels, how he deals with his feelings, and how this way of responding serves him in the light of his present life pressures, past experience and future aspirations. It is only with this understanding of the person and of what his problem means to him in his present life situation that environmental stresses may be effectively modified and the individual's participation engaged in the recovery of self-reliance.

Whether the individual's social problem originates in, or is complicated by, the external situation or his own motivations, the social case worker may be called upon to render services which meet practical reality needs. When these services are rendered in relation to feelings and ways of responding, they may ease anxieties, relieve discouragement, give new confidence, and enable the individual to manage his affairs more competently. Along with or apart from these actual concrete types of services, the case worker may help the person in the following ways:

a) by helping him to clarify his indecision, or to discharge feelings and also to understand feelings which are obstructing constructive action or inducing destructive behavior;
b) by helping him to understand his situation better;
c) by helping other people significant in his life.

The major areas of learning which the social case worker must experience, assimilate and integrate are:

a) knowledge and understanding of normal human behavior;
b) considerable knowledge and understanding of psychopathology;
c) an understanding of the interplay of family life and its import for the individual;
d) an understanding of community life and its impact on the individual and his family.
e) a comprehensive acquaintance with community resources and skill in using them in service to an individual and his family;
f) an understanding of the helping relationship and its management. This implies understanding what accepting help commonly means to people and becoming acquainted with the various ways in which clients need to use the relationship. It implies also considerable self understanding in order that the social case worker may regulate his own feelings and objectify his own emotional need so that the persons dependent upon him for help may derive strength rather than be weakened through the relationship.

All this makes necessary, in addition to certain content of knowledge, an orderly way of thinking which is attained through study and supervised practice. It implies also a way of feeling about people and their problems which is attained through the knowledge imparted and the discipline developed in professional education.

Psychiatric social work is social case work, practiced in a psychiatric setting. Beyond the basic preparation which every social case worker has, the psychiatric worker will have attained through clinical training:

1) More comprehensive knowledge and a deeper understanding of the significant psychopathology; of differential diagnosis; and of treatment appropriately geared to this.

2) An integration of his skills in relation to that of others in the clinical team, hence a greater knowledge of the function and ways of working in related professional groups.

In this setting he will not ordinarily be expected to undertake the resolution of deep psychopathological conflicts. His contribution to therapy will usually primarily lie in his understanding of human interrelationships and the strengthening of the healthy aspects of the patient's personality by helping him adjust to reality problems.

II. Social Work in Hospital Administration

Social work should operate as a specifically designated administrative department with a director of social work responsible to the clinical director, or in hospitals where there is no such position, on an administrative level which provides direct liaison with the superintendent of the hospital. This administrative provision should require the inclusion of the director of social work in administrative staff meetings and participation in discussions of hospital policies which pertain to the treatment and welfare of patients. The responsibility of social service
to administration cannot be fully met if the director of the social service department functions on a less well-defined basis. The practice of social workers being “called on,” developing a “close relationship,” or attending “informal or formal meetings” mentioned in the general summary of findings, reported by the groups who discussed the questions form, does not seem to this committee to promote the most effective kind of administrative relationship. For continuity and effectiveness, especially in the event of changing personnel, a clearly defined administrative structure is considered essential.

The development by the medical staff of a positive attitude towards social work will depend on their knowledge of the content of professional social work training and on their previous experience in professional inter-relationship with social workers in clinics, social agencies and psychiatric hospitals.

Adequate funds are essential to the development and maintenance of professional standards in any social work program. Specifically, items requiring budgetary provision should include sufficient private interviewing space, transportation, communication, secretarial service, clerical service, provisions for social work students, funds for social service exchange, and a social service library.

III. Functions of Psychiatric Social Work in the Psychiatric Hospital

General: Because of inadequate administrative clarification of his function, the utilization of the social worker is often ineffective, inappropriate and economically wasteful. For example, psychiatric social workers are often used for a variety of clerical and messenger details, for which no professional training is actually required, or they are asked to do psychological testing, for which they have had no training. Then again, there is a tendency for social service to be used too much in out-patient activities and insufficiently for services to patients in the hospital.

It is recommended that the utilization of social services be limited to properly defined case work functions, and that case work activities be integrated into the total program of hospital treatment.

Intake is the studied and differential process of making hospital services available to persons in the community who can benefit by hospital care, and as such it is almost non-existent in present-day psychiatric hospital practice, except in the rare instances where traveling clinics carry out such functions.

It is recommended that intake as defined is an essential aspect of psychiatric hospital practice, and one in which the psychiatric social worker has important responsibilities in relation to the following:

a) To assist in the interpretation of the hospital’s facilities and program to the patient and his family.

b) Assistance to the family with problems arising from the patient’s admission to the hospital, amelioration of the family anxieties in relation to the threat of having a mentally ill relative, interpretation to the family of the hospital’s treatment procedures:

c) Formulation of plans, with the assistance of other community social agencies, which might make admission less urgent or occasionally prevent unnecessary or ill-advised admissions:

d) Establishing a relationship with the family which will encourage them to maintain a positive, non-rejecting attitude throughout the period of care, and ultimately helping them to receive the returning patient with understanding and acceptance.

Reception is the process of helping the patient to accept his hospitalization, of relieving the fears and threats inherent in the experience of compulsion and restraint, of allowing him to respond to the therapeutic potentialities of living experienced under psychiatric supervision and direction.

It is recommended that the social work function in reception should include the following:

a) Participation with other hospital personnel in explanation of routine hospital and medical procedures;

b) Helping the patient to understand that the worker serves as a link between him, his family and the community. Thus, the social worker will assist in maintaining and preserving the patient’s family and community ties.

The Treatment Program. Since the concept of treatment as a total integrated institutional experience should be stressed, the social worker must be concerned with all aspects of the patient’s relationships within the hospital as well as to his family and community. Such activity on the part of the social worker reaffirms the idea that the hospital’s responsibility is limited in time to a period of more specialized treatment, and that treatment carries over into the community. The use of the term “preparing the home” is inappropriate since it implies a previous surrender of family responsibility, and it is the clear-cut function of the social worker to prevent any such disruption in the continuity of the family-patient relationship. For the family, the mentally ill patient often becomes a frightening stranger. The worker
can help the family with this problem of disturbance of familiarity so that they can accept him back as they find him. In such social work activity there is real promise of reducing length of hospital stay as well as avoiding a good deal of unnecessary human suffering.

It is agreed that a treatment plan is shaped by a process of changing formulation of the illness. The psychiatrist may delegate responsibility, and may utilize the skill of the psychiatric social worker both in direct and in indirect work with the patient. Individual professional contributions should be confined to the competence which is derived in the particular professional training. As stated above, the psychiatric social worker’s contribution in the psychiatric hospital, derives especially from his understanding of inter-personal relationships and from his ability to strengthen the healthy aspects of the patient’s personality by helping him deal with reality problems.

Pre-convalescence. Pre-convalescent care should be an integral part of the treatment process within the hospital. The activity of the psychiatric social worker in assuming a professional responsibility under the aegis of psychiatric hospital administration insures that the hospital administration recognizes its continuing responsibility to the community from which it derives its function. This will facilitate the integration of psychiatric hospital services with the general and specific needs of the community in relation to psychiatric problems.

Family Care, which is the placement of patients with families other than their own for care and treatment, is recognized as a major development in the care of psychiatric patients. It is deplorable that this extremely promising procedure has not been more widely employed. It is deplorable that patients who assist in the maintenance of the institution are often denied the benefits of family care.

The responsibility for selection of patients for family care and their medical supervision while under such care belongs entirely to the psychiatrist. The responsibility for finding a suitable home, for interpreting the patient and his needs to the foster family, for maintaining proper standards of care, and for helping the patient in his social readjustment, is primarily a function of the social worker. There is no other professional group qualified by training and experience to assume this responsibility.

Convalescent Care is the re-establishment of the patient in the community. During the period of convalescent care the patient remains a responsibility of hospital authorities. The social worker assists in the discharge of hospital responsibility by exercising continued supervision of the patient and by attempting to make available to the patient all possible community resources which might help in his readjustment, such as, some interpretation to the family regarding the patient’s illness, helping patients to regain their economic security by assisting them in locating work contacts and encouraging the interest and acceptance of former employers wherever possible.

Social History. It is vital that the social history be considered as a constantly reformulated body of information. It consists of material revealed as an outgrowth of a purposeful relationship of the psychiatric social worker with the patient, members of his family, physicians and agencies acquainted with the patient, and other community resources with which the patient may have had some experience, or which may be helpful in future planning. This dynamically developed social history provides the foundation for a continuing relationship of the psychiatric social worker to the patient and his family and community, within the total treatment process, and also makes a very important contribution to total treatment itself.

Education and training. The primary educational responsibility of the social work department is toward students of social work and social work apprentices. The specific content of the educational and training program should be determined by the social service department in conformity with administrative policy. Such training requires adequate personnel to carry on the regular social work duties of providing service to patients as well as the educational program.

Psychiatric social workers should contribute to the education of psychiatric interns and residents in order to broaden their orientation in the following areas: inter-personal relationships of parents and children; social and economic stresses in their impact upon the family life of the patients; the availability of social, health, employment, recreational, educational, vocational, legal and other community resources.

In the education and training program within the hospital for other non-social work personnel, it is the specific responsibility of the social worker to interpret the content of his own professional activities.

The recruiting, screening, training and assignment of all volunteers is the responsibility of the clinical director who may delegate these functions to the heads of the department to which volunteers are assigned. Those assigned to the social service department become the direct responsibility of the chief social worker.

Research. There are two main areas of research which should be of interest to the psychiatric social worker in a psychiatric hospital. The first is the par-
participation in projects developed by the medical staff, related to the total hospital program. Follow-up studies of various groups of patients belong to this type of research, as do studies in social pathology. The second is the evaluation of the effectiveness of the activity of the social work department, such as the refinement of procedures in case work, and exploring trends in community relations affecting mental health.

Community Interpretation. The duties and responsibilities of the social worker, both in the hospital and in the community, place him in a very advantageous position to develop constructive attitudes toward the recognition and treatment of mental illness, and to secure the participation of lay groups in the development of favorable attitudes toward psychiatric hospital care. With psychiatric patients continually returning to the community, there is real and urgent need for an informed public to develop awareness, acceptance and understanding of these patients' problems.

It is therefore recommended that adequate time be allotted to the psychiatric social worker for community interpretation.

IV. Personnel Practices and Standards

Formulated personnel practices. Professionally accepted personnel practices, stating policies relating to classification and salary scales, increments, vacations, educational leave, attendance at professional conferences, insurance and retirement plans, contracts, evaluation and provision for review are basic to a sound relationship between social work staff and hospital administration. There should be a manual in which these personnel practices are specifically stated.

V. Qualifications

The following qualifications are recommended for psychiatric social work positions in psychiatric hospitals:

1. Staff workers

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

Thus this committee strongly affirms that experience is not a substitute for professional training in the field of social case work.

2. Case Work Supervisors

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

3. Chief Social Worker or Director of Social Service

In addition to graduate professional training with major emphasis in psychiatric social case work, the chief social worker or director of social service should have had a minimum of five years' experience, at least three years of which shall be subsequent to professional training, during which he has demonstrated leadership ability as well as case work skill. At least two years of the five should have been in a supervisory capacity, and at least three years in a psychiatric setting.

VI. Training of Students of Social Work

Where the social work staff is sufficiently large, is not subjected to the pressure of excessive case loads, and has personnel of supervisory calibre, the Committee recommends affiliation with accredited graduate schools of social work. Students should not be accepted for field work placement in a psychiatric hospital until they have completed six months, or two quarters of field placement in basic case work.

It is recommended that field placement in a psychiatric hospital shall not be less than nine months or three quarters.

VII. Social Work Staff Needs in Relation to Patient Population

There are no present criteria to determine the number of social workers who would be needed to carry out the practical job of providing patients with adequate case work services. Nevertheless, some attempt should be made to establish reasonable ratios to guide hospital administrators in determining the size of the social work department. The ratio of one psychiatric social worker to every 100 annual admissions suggested by the American Psychiatric Association is inadequate.

It is therefore recommended, on the basis of careful consideration, that there be at least one psychiatric social worker to every eighty new admissions per year; and in addition at least one psychiatric social worker for each sixty patients on convalescent status or in family care. Administrative and supervisory psychiatric social workers should be added in the ratio of one
supervisor to every five staff case workers.
In conclusion, it is this committee's conviction
that the establishment of the minimum psychiatric
social work program herein recommended will result
in better care for patients, decrease in length of pa-

tient stay, reduction in number of re-admissions and
improved public relations.

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Summary of Questionnaire Findings of Study of the Function of Psychiatric Social Workers in Psychiatric Hospitals

The Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry has, since November 1946, occupied itself with the study of the role of the Psychiatric Social Worker in Psychiatric Hospitals.

The following discussion outline was formulated in an effort to determine the maximum use of psychiatric social work skills as they are now being utilized in Psychiatric Hospitals.

PART ONE
I. The Place of Social Work in Hospital Administration.
   A. What should the relationship of social work be in the over-all hospital administration?
   1. What are the essentials needed in hospital organization and administration for the most effective development of the social work program?
   2. How should the social work department contribute to the hospital policies on the over-all program of care of patients?
   B. What are the essentials for social work in relation to: office space, facilities (telephones, transportation, Social Service Exchange, literature, secretarial service, etc.)

II. What is the optimal contribution of psychiatric social work in the following services?:
   A. Intake.
   B. Reception.
   C. Special treatment programs, e.g., shock therapy.
   D. Continuous case work treatment with patient and family.
   E. Convalescent care.
   F. Family care.
   G. After care services (parole and discharge).
   H. Social history, when taken, how extensive, for what purpose. Interpretation to patient’s family of patient’s illness, hospital program, financial responsibility of family for patient’s care.
   I. How should social workers participate in diagnosis and treatment plan?
   J. Does the social worker participate in treatment of patients directly? (Discuss)

III. The social worker in the Educational and Training Program within the Hospital.
   A. What is or should be the social worker’s responsibility in the education of:
      Attendants
      Nurses
      Social workers (students)
      Medical personnel
      Volunteers (lay)
   B. How can social work participate in research in the hospital?

IV. Social worker’s responsibility for interpreting the hospital to the community.

PART TWO
Professional Standards and Practices.
I. Personnel standards.
   A. How are training and experience standards for psychiatric social workers established?

   B. How much choice of social work personnel does the director of the department have?
   C. What are the standards for supervision of the social work staff—(including students)?

II. Discuss assignment of responsibilities of the social work staff in relation to:
   A. Training and experience.
   B. Rotation of services.

III. How can more training opportunities be made available for student social workers in psychiatric hospitals?

PART THREE
I. What are the current ratios of social workers to patients and what should they be in:
   A. Hospital census?
   B. Family care?
   C. Patients on convalescent status in the community?

II. Social work salary scales—what should these be?

III. What factors are there in the hospital setting at present that attract or repel psychiatric social workers?

PART FOUR
I. In what areas of the hospital can psychiatric social work time be most effectively utilized?

II. What ideas for experimentation in hospital assignments have psychiatric social workers had?

III. What are the methods of therapy utilized by psychiatric social workers i.e., individual treatment, group psychotherapy, psycho-drama?

IV. What use of voluntary services is made in the current practice of the hospitals for the mentally ill? How much supervision by psychiatric social workers is there, of this volunteer personnel?

V. What are the values for psychiatric social work students of the State Hospital training as a center for orientation in psychopathology?

VI. What are the most satisfactory conditions that one can visualize for effective use of psychiactric social workers in the hospitals for the mentally ill?

It was recognized from the outset that a period of nine months assigned to this study, made the study of the functional use of social workers in all of the Psychiatric Hospitals in the United States and Canada, an impossible assignment.

To obtain a fair sampling of current practice and philosophy, thirty-four question forms were sent to psychiatrists in many parts of the country.

The psychiatrist to whom the original Discussion Outline was sent, was asked to form discussion groups of psychiatrists and psychiatric social workers in this area.

The response to these requests was more than gratifying. In some places the groups formed, included psychiatrists and social workers from many private, state and veterans hospitals in the area. The letters which accompanied the replies indicate that these professional people spent many evenings in discussion and formulation of their replies.

The thoughtful preparation and the dynamic philosophy expressed by the various groups in the volume of material sent to the Committee have made this report possible. Such enthusi-
astic cooperation and whole-hearted assistance indicates a vital interest in the subject as a whole.

This effort at joint thinking has resulted in the expressed determination to continue monthly discussion meetings during the coming year by many of the participating groups.

The Committee members and consultants in the New York City region assumed the task of studying and reporting the material received.

The richness of content of the replies can be only partially reflected in the Committee's efforts to summarize the opinions expressed. This is particularly true of the material formulated in answers to PARTS ONE AND TWO.

The following summary represents the consensus of opinions reflected in the twenty-seven replies which were received.

PART ONE

I. The Place of Social Work in Hospital Administration.

A. What should the relationship of social work be to the over-all hospital administration?

The relationship of social work to the over-all hospital administration to be effective should be formulated. Social work should not operate under a specifically designated administrative department with a director of social work on an administrative level which would make him responsible to the clinical director, where such medical authority is available; or on an administrative level, where admits of direct liaison with the superintendent of the hospital. This administrative relationship should be on a level sufficiently high to insure the inclusion of social workers in the attendance at administrative staff meetings and participation in discussions of the formulation of hospital policies which pertain to the treatment and welfare of patients. It was felt that basic responsibility for the social services to over-all administration could not be fully met if the director of the social service department was related to the over-all administration on a less defined basis. The practice of social workers being "called on," developing a "close relationship," or attendance at "informal or formal meetings" was reported by some hospitals. For continuity and effectiveness, especially in the event of changing personnel, a clearly defined administrative structure was considered essential.

A determining factor in hospital organizations for the most effective development of a social work program was seen to be reflected in the attitude of the superintendent or responsible head of the hospital. A favorable attitude could be fostered in a clear understanding of the potential role of social work in relation to the care and treatment of the mentally ill. This would imply a responsibility of the director of social service to interpret the contribution and needs of his department in effective representation of social work, while participating in policy-making councils such as those which consider their social service budget, treatment program, personnel, etc. The development of a positive attitude towards social work has its roots in a knowledge of the content of professional social work training and in the experience of psychiatrists who have worked together with social workers in a professional inter-relationship in clinics, agencies and psychiatric hospitals.

The social work department can best contribute to hospital policies in an over-all program for the care and treatment of patients by participating in the planning of general policies, particularly as they affect the social service aspects of the treatment program. One response to the questionnaire noted that by reason of the social worker's relationship to the patient and his family, wherein reactions to the treatment and the program became available, he was placed in a favorable position to contribute to the understanding of administrative problems. It was also noted that social service would be better able to give effective service to patients and families if it were fully acquainted with administrative needs and decisions. In this way social service, out of a more focused awareness of its professional standards and practice, can contribute to the development of confidence in a program whose community ties are reflected in an interchange of hospital and community requirements.

The tendency to use social workers for certain assignments such as non-professional clerical details was not considered effective use of personnel. Such medical assignments as consents for autopsies are seen as essential medical responsibility, but in cases where the medical authority considers that the social worker has a better relationship with the family members, this responsibility may be delegated occasionally to a social worker by the doctor.

B. What are the essentials for social work in relation to: office space, facilities (telephones, transportation, Social Service Exchange, literature, secretarial service, etc.)

It was generally agreed that adequate funds are essential for the development and maintenance of professional standards in any social work program. Specifically, items requiring budgetary provision included sufficient interviewing space, transportation, communication, secretarial service, clerical service, provision for social work students, funds for attendance at meetings, for social service exchange, and the requirements of a social service library providing current and contemporary books, periodicals and literature necessary for the continued growth and development of the staff.

II. What are the major contributions of psychiatric social work in the following services?

A. Intake.

Regarding this point the consensus of opinion indicated that, while the intake function usually includes an orientation of the patient to the services offered and his response to them, it was recognized that the patient who is mentally ill and for whom hospitalization is considered, is not always able to participate in the intake process on this basis. Depending upon the specific administrative relationship of the hospital to the community, the point of intake was seen as an extremely valuable opportunity for the interpretation of the hospital facilities and program to the patient. In some instances help could be offered by the social worker to the family with problems relative to leaving the patient in the hospital. One mental hygiene department felt that at intake the social service department would be of great assistance in the screening process of patients awaiting admission. This group indicated that often times the social services department with the assistance of other social agencies, could work out plans which would make admission less urgent and occasionally unnecessary.

Where patients were seen by a clinical team prior to commitment, it was recognized that the social worker would participate in the decision which might be made to determine the degree of urgency for hospitalization. In many instances the social worker's intake function was seen to include the opportunity for interpretation of aims, methods and procedures related to the hospital's plan of treatment. When feasible, it was indicated that the social worker, at intake, could reduce anxiety by pointing out the need for the continued interest in the patient to his family and act as a source of information concerning visiting privileges, hospital procedures, etc. In addition, the point was stressed that social work effort in securing the cooperation of the family and working with attitudes that might interfere with the course of treatment was seen to have far reaching effects on the period of hospitalization.

B. Reception.

Consensus of opinion indicated that the social work function in reception should be integrated with that of the admitting physician. In some settings social work content might conceivably be the foundation for the basis of selection of patients. In other situations, depending upon the conception of the reception function, an initial interview by the social worker might include an orientation of the patient to his next steps in treatment, or simply a recount of procedural data, such as what
happens to his clothing and other personal effects. Opinion was expressed that the role of the social worker during the reception period must be related to the specific hospital and integrated with the other professional and sub-professional categories of personnel who discharge responsibilities at this point of hospital administration relating to the total treatment program. One example cited the contact which the social worker has with the transportation officer as the first step in the patient's treatment. This can be developed to the extent that the transition from the community to the hospital can be effected without the trauma of isolation which often negatively conditions the eventual course of treatment. The assistance of the social worker during the early days in the hospital was also seen as having inestimable value in the orientation of the patient, individually or in the group to hospital living. It was frequently stated that social work activity tended to minimize some of the anxieties which the hospitalization may have aroused within the patient.

C. Special Treatment Program.

The interpretation and explanation of special treatment programs, such as shock or insulin therapy, was seen to be primarily a medical responsibility. A discussion of the risks involved, safeguards to be taken and the general medical concern for the welfare of the patient was viewed as a responsibility requiring the authority of a physician in order to allay anxiety, or to clarify reasons for not utilizing a specific therapy requested by the family which would not be advisable in the given instance. However, in some instances such as when a patient's family resides in a locale which would make the hospital inaccessible, or when it is the social worker who has developed the closer relationships with the family, it was felt that this responsibility might be delegated to the social work department by the responsible medical authorities.

D. Continued Case Work Treatment with the Patient and his Family.

In all of the replies the psychiatric social worker was recognized as the most effective person for maintaining a continuous contact between the patient and his family. In this relationship, an effective liaison could be maintained, and adequate consideration could be given to emotional problems arising, either in the family or with the patient himself. This would insure a continued dynamic relationship with the community. In this manner, it would be possible to evaluate the home situation with regard to prescribed or contemplated visits or preparing the family for the re-admission of the patient. This role for the social worker makes it possible for the hospital to assume and reaffirm a temporary responsibility, with the continuing responsibility remaining with the family and the community, as after-care planning becomes part of the total treatment process.

It was seen that the relationship of the social worker with the patient and the physicians as well as other hospital personnel. The social worker's awareness of the patient's program and progress will be reflected in the pace of the preparation of the family for the patient's discharge. The degree of readiness of the home to receive the patient will be invaluable to the physician in his planning and treatment. The liaison between the social worker and the attendants was seen to facilitate referral of patients' problems, and to stimulate interest in an extension of the patient as a member of a family group within the community.

E. Pre-convalescence.
F. Family-care.
G. After-care.

It was generally felt that the considerations of pre-convalescence, family-care and after-care services could best be discussed as directly related to the concept of continued treatment. It was frequently stated that family-care might also be considered as related to special treatment programs. (II G.) since the patient usually continues on the active census of the hospital administration. Consensus of opinion recognized that basic to the philosophy of the contribution of the psychiatric social worker to the treatment program of the psychiatric hospital is his orientation to the needs of the community, and the origins of the patient as an individual deeply rooted within the community. It was agreed that the use of the skill of the psychiatric social worker, which gains its dynamic stimulus in a sensitivity to inter-personal and inter-agency relationships, furnishes further opportunities for the psychiatric hospital to function as a resource of the community for the care and treatment of members within the group who are mentally ill. This position of the psychiatric social worker in assuming a professional responsibility under the aegis of psychiatric hospital administration insures that the hospital administration recognizes its continuing responsibility to the community from which it derives its function, and results in providing the means of integrating psychiatric hospital services with the general and specific needs of the community.

It was generally accepted that in each of his services the contribution of the social worker must be related to the primary medical responsibility. As plans are formulated for pre-convalescence, family-care and after-care services, the psychiatric social worker will be in a position to both supplement and complement the formulation of the treatment plan by his relationship with the patient's family and the community resources which meet the patient's needs. Opinion was expressed that the primary responsibility for direct treatment rests with the psychiatrist, but where the competence of the social worker and the situation warrants it, at times this responsibility may be delegated to the social worker. This treatment responsibility is differentiated from the social services administered by social work personnel. To be effective all services of social work personnel should be planned on a specific and selective basis, designed to meet the needs of the individual patient. An example given in the responses describes the practice of family-care where a patient has received maximum benefit from hospitalization. In this instance, the social worker is responsible for assisting the hospital in locating foster families. He should make studies of the home to insure meeting the patient's need for care. He should select the home for the patient after consultation with the psychiatrist and be responsible for arranging the placement of the patient. This would involve working with the patient in his preparation for the placement, as well as with the foster family, and if such exists with members of the patient's own family. The social worker would maintain continuous contact with the foster home and the patient. This is necessary to assist the foster family with the problems they encounter in living with the patient. The objective is to assure stability to the patient in a home that is satisfactory for his care. At the same time, this continuous contact helps the hospital to continue its responsibility, and remain aware of progress or lack of progress through social work reports. Thus, additional out-patient treatment or re-hospitalization can be expedited as required. The social worker representing the psychiatric hospital to the foster home through effective liaison, represents a stabilizing influence to the foster home, and assures coordinated effort in the continued treatment of the patient.

It was stated that during periods of convalescence, the social worker materially assists in the discharge of hospital responsibility by exercising continued supervision of the patient. He may assist with readjustment problems as they arise within the patient's family, or in solving the patient's difficulties in his efforts to take his place back in the life of the community. Through the use of hospital out-patient facilities of which social case work should be an integral part, and through the cooperation with social agencies in the community, the avoidance of relapse or delay of the return of the patient to the hospital may often be possible. Conversely, the social worker's awareness of inter-personal relationships can prevent the endangering
of the mental health of others within the family group.

H. Social History

The psychiatric social worker's contribution of the social history has long been seen as one of his major services to psychiatry. For this service to be most highly effective, the full technical skill of the psychiatric social worker must be used. Viewing the major function of the social history as a contribution both to differential diagnosis and treatment, including possibilities for return of the patient to the community, it is vital that the history be considered as a constantly reformulated body of information. This material should be compiled from the information revealed as an out-growth of a purposeful relationship of the psychiatric social worker with the patient, members of his family, physicians and agencies acquainted with the patient and other community resources with which the patient may have had experience or which may be helpful in future planning. In this way the social history is seen as a dynamic service which increases the total understanding of the patient's difficulty, and facilitates the development of changing plans in both the hospital and after-care treatment programs. This concept of the social history affords the opportunity to the psychiatric social worker for a continuing contribution in relationship with the patient, his family and the community, and in turn with their relationship with the psychiatric hospital.

Recognizing the need for certain statistical data, it was noted that the significance of the contribution of the social history could easily be lost if it were merely considered as a routine service. The danger of sterile, stereotyped content can be avoided if there is a continuing selective process involved in the development of the social history which is directly related to the dynamics involved in the approach to differential diagnosis. An illustration of such an approach was seen in the value of the social history in relation to the senile patient as contrasted with that of a child suffering from a severe behavior disorder. The content and selective emphasis, it was seen, would be directly geared to the specific problems involved in the diagnosis and treatment aims and goals for the patient. In considering this topic, it was recognized that the psychiatrist in his examination of the patient will bring out material of a historical nature which will be complemented by the social history. The combined material contributes to the total understanding of the patient and furnishes the background for the therapeutic approach.

I. How Should Social Workers Participate in Treatment Plans?

J. Does the Social Worker Participate in Treatment of Patients Directly?

The consensus of opinion indicated that the psychiatric social workers' contribution to treatment is variously seen as being both direct and indirect in nature. In some programs, especially while the patient is within the hospital, treatment is conceived as being totally within the "function" of the psychiatrist. Even in these cases, it was recognized that in the course of an admission interview the psychiatric social worker may have "an indirect part in treatment through relieving anxiety about practical matters at home." However, during the after-care period, it was generally accepted that the psychiatric social worker is able, under the supervision of the psychiatrist, to "carry out psychotherapy with the patient." Another point of view expressed includes the psychiatric social worker as a participant in treatment, "directly, if desired by the doctor, either under his supervision or in consultation with him."

Reconciliation of the varying points of view expressed in the twenty-seven replies is possible, if it is agreed that the primary responsibility for integration of treatment rests with the psychiatrist. (This committee's definition of psychotherapy in Circular Letter No. 21, Group for the Advancement of Psychiatry follows). "Psychotherapy consists of any considered and competent medical endeavor, directed towards the improvement of the emotional health of the individual, based upon the understanding of the psychodynamics involved and of the needs of the individual under treatment. Psychotherapeutic endeavor may include adjunctive professional services under the supervision of the psychiatrist. An essential in psychotherapy is found in the interpersonal relationship existing between two people, one asking for help, and the other assuming the authority and having the competence to give help in an area involving a personal problem which is handled through a psychological process." It was further indicated that when it is agreed that a treatment plan is shaped by the process of a changing formulation of the illness, it is possible for the psychiatrist to delegate treatment responsibility and to utilize the skill of the psychiatric social worker in both direct and indirect relationship with the patients. Implied in this professional inter-relationship is a differentiation of the techniques of psychotherapy from those of psychiatric social case work. This position rests on the assumption that diagnosis and treatment of emotionally compounded conditions requires an integrated, inter-professional approach with the participants all contributing. The replies indicated that the individual professional contribution should, of course, be confined to the competence which originates in the different professional training. The training of the social worker, while including a familiarity with psychopathology and a working knowledge of therapeutic techniques, does not usually qualify him to undertake the resolution of deep psychopathological conflicts. His contribution to therapy in work with the mentally ill, will lie primarily in his understanding of human inter-relationships and the strengthening of the healthy aspects of the patient's personality by helping him adjust to reality problems with increasing emotional satisfaction.

III. The Social Worker in the Educational Training Program within the Hospital.

A. Responsibility for Education.

Opinion was expressed in regard to the social worker's contribution to the education and training programs within the hospital. The replies indicated a clear understanding, namely that the specific responsibility of the social worker will be confined to the content of his profession. This limitation holds for purposes of working relationship with attendants, nurses, medical personnel and lay volunteers, except where these volunteers are specifically assigned to the social work department. As a necessary orientation to the structure and function of the social work department, there must be effort made to acquaint the aforementioned personnel with the psychiatric social worker's job responsibility and content, both didactically and in discussion with groups. In individual situations the orientation is conceived as a continuing process related to specific discussion of patient's problems while in the hospital. Attendants may also occasionally be interested in the after-care progress of patients. The potential contribution to in-service training is beginning to be realized in some hospital settings through the increased use of psychiatric social workers as instructors in the training programs of psychiatric interns and residents.

The responses indicated the assumption that the assignment of all volunteers, such as supplementary recreational personnel, nurses' aides, etc., is the responsibility of the clinical director. In working out educational and training programs for this category of volunteers for supplementary personnel, the responsibility of the social service department is recognized as being confined to the participation of the director of the social service department in the administrative conferences which formulate policy and program. In regard to students of social work and social work apprentices, where there is direct administrative responsibility exercised by the social service department, the specific content of the educational and training program will be determined by the social service department in conformity with over-all administrative policy.
B. Research.

It was generally recognized that the opportunity for research gives impetus to the growth of a hospital treatment plan. Research activities, while following an integrated pattern with over-all hospital needs, should be divided into segments which delineate responsibility to the specific areas of professional competence. The social work department can be most helpful in projects related to intake, the specific contribution of the social worker during the hospitalization period and in matters relating to the integration of the hospital program with the community in so far as pre-convalescence, family-care and after-care are concerned. Social workers can also contribute to research on treatment results by providing data derived from their follow-up with discharged patients and their families. Although the social work department's primary responsibility in research should aim toward a review of its own effectiveness, it was also emphasized that real interest should be developed towards the study of questions pertaining to social pathology. In meeting this objective, it was suggested that attempts be made to establish criteria for adequate staff related to case load; to evaluate social work techniques as they relate to in-patient treatment and convalescence; and to refine procedures necessary for increasing the efficiency of the department; and to explore trends in community relations affecting mental health. Research activities should make provision for the inclusion of the social sciences from which social work draws much of its vitality.

IV. The Social Worker's Responsibility for Interpreting the Hospital to the Community.

The consensus of opinion expressed the concept that the duties and responsibilities of the social worker, both within the hospital and the community, place him in a very advantageous position to develop constructive attitudes toward the recognition and treatment of mental illness, and insure the participation of groups in the development of constructive attitudes toward psychiatric hospital care. It was seen that the social worker can contribute much as the official representative of the hospital superintendent in organizing lay discussion groups, addressing and making contacts with social agencies and organizations representing citizen groups. It was stressed that the after-care program in particular will offer opportunities to secure the cooperation of protective and rehabilitative agencies, both public and private, which can be of assistance in helping to hold the gains made through hospitalization. With the continual addition of mental patients returning to the community, it was recognized that there is need for recognition by an informed public of the problems which are attendant upon this increase of discharges from the hospital population. Emphasis was placed upon the fact that the social worker's responsibility and training place him in a key position to materially contribute to an ever-expanding program for psychiatric hospital public relations.

PART TWO

Professional Standards and Practices.

I. Personnel Standards.

Recognition was given the fact that the present supply plus the number of graduates of schools of social work who can be trained in the near future, fails to meet the demand for social work personnel. It was recognized that "sub-professional" personnel can make a contribution, and that in-service training programs can be utilized to meet the needs of a specific program by training individuals in the discharge of specific psychiatric hospital responsibility. Nevertheless, the consensus of the responses from the twenty-seven groups adhered to and reaffirmed the belief in the need of maintaining the professional standards for psychiatric social workers as set forth by the American Association of Psychiatric Social Workers and reported to the Group for the Advancement of Psychiatry in Circular Letter No. 21, dated February 21, 1947, carrying the approved report of the Committee on Psychiatric Social Work.

The reports indicated that the current practices in various public psychiatric hospitals require the employment of social work personnel as set forth by various civil service standards. It was generally accepted that individuals with professional social work training were preferred in the selections from civil service lists. Examinations and requirements for social work positions were usually developed by civil service authorities in consultation with professionally recognized authorities in social work. The consensus of opinion obtained was that a minimum basic requirement for any individual to be considered for employment in a position of social work responsibility is that he be a college graduate. This minimum would permit the possibility for the applicant to obtain graduate professional training if he so desired. It was repeatedly mentioned that a program of educational leave be specifically provided for, where it is not possible to secure a fully professionally trained social work staff. This practice would serve to encourage staff members to complete their professional education and to stimulate their professional growth through attendance at conferences, seminars and institutes related to social work.

It was agreed that in order to secure a professional level of practice in any social work program, the director or responsible head of the social work program must meet the professional requirements as established by the A.A.P.S.W. Supervising social workers, to be effective, must also be of professional caliper. In regard to the use of sub-professional standards of personnel, categories of positions with a defined grading of responsibility should be set forth as an essential requirement of sound and administration. Licensing of psychiatric social workers was recognized as being desirable, but would have to be met by state legislation, with the ultimate establishment of national standards and inter-state reciprocity.

It was agreed that the director of the social work department, with the concurrence of the hospital superintendent, would have final responsibility for the selection of social work personnel. This was seen to be essential if he was to be held responsible for the operation of his department. Employment interviews with psychiatric participation, were deemed advisable in the selection of suitable personnel. The development of a classification plan defining the kind and degree of responsibility expected of various social work grades was considered as a necessary foundation for setting personnel standards.

The concept of supervision in social case work was recognized as being of elemental significance in both the training and practice of social case work. It was specifically stated that through effective supervision the methods of social case work are learned, the skill of the practitioner is developed. It is sound and important for psychiatric hospital administration to be aware that the services of the social work department and the translation of the policies of the hospital into case work practice will be secured through the effectiveness of supervisory social work personnel.

The opinion of the groups reporting, stressed the fact that a supervising social worker should be one who has demonstrated more than the ability to capably discharge the responsibilities of a social worker. It was specifically stated that, essential to good social work supervision is the quality of stimulation derived through the growth of professional competence made possible by constructive administrative and teaching capacities of the personnel involved. It is, therefore recognized that beyond graduate professional training a minimum of two years' of social case work experience is essential as a basis for the selection of supervising social workers. The practice as reported is to equate successful experience with training, and substitute experience for training and vice versa. While this was recognized as being expedient, the opinions expressed made amply clear that the nature of professional training is such that experience cannot be made its equivalent. While recognizing that experience can develop an individual to the point where he can successfully
administer the social services of a specific agency, total orientation to the profession of social case work, with its values of broader vision and imaginative scope, was seen as best achieved thru graduate education.

In regard to the supervision of social workers, it was reported that specific time was allotted for one individual supervisory conference per week, usually of an hour's duration. The ratio of workers per supervisor varied from one supervisor to six workers, to one supervisor to four workers. It was clear that variables of this nature are inevitable, since factors to be considered are the quality and experience of the supervisor, the extent of the administrative responsibility in addition to the supervisory responsibility, and the gradations of the duties and responsibilities of the workers. It was generally recognized that where the workers are better trained and more experienced and the supervisory relationship takes on a quality of consultation, more self-direction can be expected from the worker, and consequently, less demands will be made on the supervisor, allowing for an increase in the number of workers per supervisor.

It was agreed that the supervision of students of social work represented a different responsibility of the social work department, since the status of a student connotes either an educational affiliation or an educational purpose. The supervisory process was seen, in the case of students, as being directly related to the educational process. Where the student is placed in field work with a psychiatric hospital, a Graduate School of Social Work, the supervisory objectives will be safe-guarded through the responsibility exercised by the school for that portion of its educational process. It was suggested that where the student status is one established by a psychiatric hospital or department for purposes of supplementing social work personnel through in-service training, a program should be worked out whereby the student status becomes a temporal one with specific training objective. When these objectives are met, it was recognized that positions should be established for sub-professional categories of social work personnel whose responsibilities are clearly defined. Opinions indicated that a classification plan should be organized to establish standards of performance for all positions, describing the quality and quantity of performance expected. Evaluations should be prepared at six month intervals. It was suggested that good personnel administration accepts the need for a written manual of personnel policies and procedures.

II. Discussion for Assignment of Responsibilities of the Social Work Staff in Relation to:

A. Training and experience.

The value of training was emphasized as having direct relation to the assumption of increased responsibilities for social work duties. Experience was seen as having a value proportionate to the extent of basic professional training for social work. Consensus of opinion regarding the positions of director or chief of the social service department indicated that the individual to be assigned should be a person who has completed graduate training in social work and has shown outstanding ability in carrying out supervisory and administrative responsibilities. In the position of case work supervisor the most skilled workers were considered to be desirable since here they could exert the broadest influence on the quality of social work practice. The social work function at intake was generally considered to be a key assignment requiring a well-trained and experienced person. Where social workers were used in individual "intensive therapy," it was noted that they carried small, selective case loads, but were chosen for their special personality qualifications in addition to their specific professional equipment. Comments also referred to social work assignments in which there was the need for mature, responsible judgment, such as in family-care and after-care programs, which would require highly skilled individuals of professional caliber.

B. Rotation of services.

Generally speaking, there was little evidence offered of programs in which social workers rotated in the different services. This practice was considered desirable, but the problems of administration, and the paucity of trained personnel did not make rotation of services feasible. The practice as reported was to assign those best suited to different levels of responsibility. The desirability of familiarization with the routine throughout the hospital was emphasized. Rotation of services was acknowledged as an objective for increasing the effectiveness of the social worker within the psychiatric hospital setting.

III. How Can More Training Opportunities be Made Available for Student Social Workers in Psychiatric Hospitals?

With the repeated expression of need for additional personnel, the need for training opportunities was emphasized as a means whereby available personnel might eventually be augmented. The point was made, however, that training opportunities should remain an educational process, and should not, per se, be considered as a means whereby staff will be immediately augmented. To guard against this possibility, the comments referred to in Part II, 1, regarding personnel standards was reviewed, and in some instances, restated. The primary need in training was seen to be methods of securing adequately trained and experienced supervisors of social work, since this category of personnel is considered to be the backbone of a training program for social case work. Most desirable was considered to be an affiliation with a graduate school of social work which would facilitate maintaining the primary teaching quality of field work instruction. The establishment of a social work department with acceptable personnel standards was recognized as being a foundation on which training opportunities could be built. The encouragement of individuals to seek experience in psychiatric hospitals was suggested through making available fellowship and other funds for training purposes. An increase in the availability of psychiatric time to conduct seminars and conferences with students was suggested from several sources as a concrete method which psychiatric hospital administration could immediately employ to enrich training opportunities.

PART THREE

I. What are the Current Ratios of Social Workers to Patients. And What Should They be in:

A. Hospital Census?

The ratio of social workers to patients was reported in a number of ways. These ratios in some instances are indicative of the various conceptions of the assignment of social workers; in others they served as a practical basis for the securing of budgetary appropriations for the professional category.

The spread between the actual ratio and the desired ratio was quite marked. The operating ratios in a few responses included the consideration of both student and apprentice social workers, although there was a lack of clarity in the differentiation of responsibility and case load. By and large, there was an attempt to relate the A.P.A. standards of one social worker per 100 annual patient admissions. The general range, however, covered from one social worker per 100 patients to one social worker per 150 patients. One statewide response reported an over-all ratio of one social worker to 400 patients, which included family-care as well as in-patient and out-patient services. Two reports, where a concentrated teaching and treatment program was in operation, gave an in-patient ratio of one social worker per 30 patients, and one social worker per 50 patients. These responses indicated qualifying and qualitative statements as to the social work responsibility.

There was some discussion in the responses of apportioning ratios of social workers to the annual rate of admission. It was not clear whether this would be related to the specific intake function of social workers in relation to admission, or just how these social workers would be allocated. The ratios in those instances reporting on the basis of annual admission was from 1 psychiatric social worker per 50 patients admitted annually,
to 1 psychiatric social worker per 300 patients. In one mental hygiene department the factor of age of the patients admitted was noted as important in determining the grading of the functional responsibility.

Those responses including consideration of the allocation of supervisory social workers were in a small minority.

B. Family-care.

A very few responses reported active family-care programs, although interest in establishing such a program was expressed by all. A strong social service department was considered vital in the planning and operating of this program. The general range of psychiatric social workers to patients in family-care fell between 1 psychiatric social worker per 25 patients to 1 psychiatric social worker per 75 patients.

C. Convalescent-care.

Here again there was unclear expression of the assignment and differentiation of psychiatric social work responsibility. Some responses showed separation of assignments to in-patient; most others did not. However, the range within which the overwhelming number of the responses was distributed was from 1 psychiatric social worker per 30 patients in convalescent status to 1 psychiatric social worker per 90 patients. One response which reported a present ratio of 1 psychiatric social worker per 200 patients hoped for a reduction to 1 psychiatric social worker per 80 patients.

II. Social Work Salary Scales.

Social work salary scales were considered in relation to varying degrees of training, experience, competence and responsibility. One response in which the use of "apprentices" was reported offered a salary scale to this category of personnel of $1600 to $2100. The beginning case work in most of the instances reported assumed professional training as a basis for qualification to be termed a beginning practitioner, the stipends paid ranged from an initial salary of $1530 plus maintenance to $2400 without maintenance. These entrance salaries generally provided for regular annual increments, although the basis on which these increments were granted was not clearly defined. The salary range of the worker in this category extended to the upper limits at $3120 per annum. However, in two instances there was special mention made of the need to encourage skilled practitioners to remain in the practice of psychiatric social case work. In these instances the recognition of superior experience and skill provided for a salary ranging up to $4200 per annum. It is worthy of note that this category of specifically qualified individuals fell into a salary range which was overlapping with almost all reported salary scales in the supervisory range. Where this group of experienced and skilled personnel was singled out, the contribution of psychiatric social workers to psychotherapy was recognized and encouraged.

The category of supervisors was generally reported as falling under the heading of Senior psychiatric social worker, Assistant Supervisor and Supervisor, depending upon the administrative organization and nomenclature. Frequently the term Supervisor of Social Work was used interchangeably with Director and Chief of Social Work. There were comments and allowances made for the varying degrees of responsibility and the community in which the hospitals were reported. The range extended from $2400 with maintenance to $5000 without maintenance.

III. What Factors Are there in the Hospital Setting at Present which Attract or Repel Psychiatric Social Workers?

The responses were almost unanimous in stating that psychiatric hospitals today offer the least attractive opportunity in the entire field of psychiatric social work. Comments included: "The lack of dignity of person," "isolation," "pessimism and cynicism," "sense of subordination," "low pay" on the personal side. In regard to professional practice, comments included: "lack of recognition of the function of a social service department within the hospital, as well as lack of a defined program and responsibilities," "frequently social workers are not recognized as professional people," "poor calibre of medical staff," "ineffective administrative integration," "no opportunity for study," "high case loads, long hours," et cetera.

In order of frequency the lack of professional recognition and status was reported most frequently as a repelling factor. The absence of formalized personnel practice standards was mentioned almost as frequently. Coming next in rather close order was the poorly defined relationship of social work to medicine and medical faculties, as well as the more personal considerations of the isolation of institutions and the often unnecessary hardships of institutional living. Also mentioned were the quality of supervision or absence of it and the heavy pressure of the caseloads.

The one outstanding attraction which was overwhelmingly mentioned as most important falls under the broad heading of educational opportunities for professional growth. A second factor which was thought to attract good social workers was the establishment and development of a dynamic treatment program in which they could participate. There was some mention of the security factor offered by employment in a psychiatric hospital and the emotional satisfaction which could be derived in helping individuals suffering from emotional illness.

PART FOUR

I. In What Areas of the Hospital Can Psychiatric Social Work Time be Most Effectively Utilized?

Although the responses covered a wide range of psychiatric social work function, they were quite consistent in seeing psychiatric social work as extremely valuable in developing and assisting the psychiatric hospital treatment program as well as in relating psychiatric hospitals to the community. Often there were valid statements of function which social workers could perform in hospital and at the same time improve and extend the quality of supervision, the general status of social work in the hospital administration and acceptable personnel practices. As one might expect, the second factor which was thought to attract good social workers was the establishment and development of a dynamic treatment program in which they could participate. There was some mention of the security factor offered by employment in a psychiatric hospital and the emotional satisfaction which could be derived in helping individuals suffering from emotional illness.

II. What ideas for Experimentation in Hospital Assignment have Psychiatric social workers had?

Very few ideas for experimentation were offered. Among those mentioned were experimentation with interview techniques,
individual and group therapy, a plan for continuous assignment to patients from the point of admission through discharge. psycho-drama and a suggested evaluation of types of case work services.

III. What are the Methods of Therapy Utilized by Psychiatric Social Workers, i.e., Individual Treatment, Group Psychotherapy, Psycho-drama?

In this discussion of therapy there was recognition of the primary responsibility of the physician for treatment. In one response concern was expressed about the participation of psychiatric social workers in psychotherapy or psycho-drama. In this connection attention is called to this committee's definition of psychotherapy which appeared in G.A.P. Circular Letter No. 21* (See Footnote.)

Most frequently mentioned was the psychiatric social worker's activity in relation to the individual patient. Individual treatment was variously described as case work treatment, supportive treatment or psychotherapy. Group therapy was recorded as being used infrequently. It was noted that the degree that psychiatric social workers could be used in various types of direct psychotherapy is dependent upon the amount and quality of available psychiatric supervision.

IV. What Use of Voluntary Services is made in the Current Practice of the Hospitals for the Mentally Ill? How much supervision by Psychiatric Social Workers is there of this Volunteer Personnel?

The use of lay volunteer services has not been thoroughly explored. The future development of a lay volunteer program would seem to be directly related to the availability of staff for training and supervision of such lay volunteers. A majority of the responses showed no use of lay volunteers, although interest in utilizing them was expressed, especially in activities related to entertainment, recreation, and general visiting.

In those instances reporting the use of lay volunteer services supervision by psychiatric social workers was most often mentioned. In-Service training by psychiatric social workers was noted twice. Delegation of the responsibility for supervision of lay volunteers was mentioned in one instance as being exercised by the occupational therapy staff and the recreation department.

V. What are the Values of the State Hospital Training as a Center for Orientation for Psychiatric Social Work Students in training background in Psychopathology?

There was unanimity in the opinion that psychiatric hospitals offer rich resources in training for psychiatric social work students. Particular emphasis was placed on the opportunity for developing constructive attitudes toward mental illness and familiarity with the extremes of human behavior. The relationship with the mentally ill was seen to provide an opportunity for developing a "feeling" for these people which goes far beyond "an intellectualized appreciation of mental ill health." "It helps the student to a deeper understanding of all human behavior." A special point was made that for a psychiatric hospital to be used as a training center, its medical program must be treatment oriented, and adequate case records must be maintained.

VI. What Are the most Satisfactory Conditions that one can visualize for effective use of Psychiatric Social Workers in the Hospitals for the Mentally Ill?

Medical acceptance of psychiatric social work and the integration of such acceptance in the administrative structure were considered to be the most important requirements for their effective use. Next in importance was the need for a ratio between psychiatric social workers and patients which would permit good case work. The third most important requirement was the need for competent psychiatric leadership. The need for adequate staff in other departments was mentioned. Fourth was the formulation of good personnel practices, including the basic requirement of graduate training; adequacy of salary scales and other standards pertaining to working and living facilities. There were a number of comments on the desirability of training programs for staff development research opportunities, and better selection of patients for after-care service. The development of facilities for the community care of patients and a closer relationship between hospital administration and the community were also stressed.

Through the mass of material in our study ran the continuous thread of promise of more mature opportunities for social work to participate in the better care of the mentally ill.

*Note the definition to be found on page 10.
GROUP FOR THE ADVANCEMENT OF PSYCHIATRY

The Group for the Advancement of Psychiatry is an active group of approximately 150 American and Canadian psychiatrists, all of whom are members of the American Psychiatric Association. The Group neither supplants nor substitutes for any existing organization. It was formed in May, 1946 for the purpose of surveying and studying various fields of knowledge and interest within and related to psychiatry, with the intention of stimulating progressive action, research or further study in those spheres where such may be needed. GAP Committees:

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