

**The evolution of social work mental health practice: Patient records research at Selkirk
Mental Health Centre (SMHC), 1947-1980**

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Abstract

Little is known about social work at psychiatric institutions in Canada. This research looks at patient records at Selkirk Mental Health Centre (SMHC) from 1947-1979 at Selkirk, Manitoba. Qualitative descriptive methods are employed to examine patient records (N=132) for the function and form of social work. A random selection of patient records at SMHC was performed where qualitative themes of social work related activities were identified and collected. Additional data included archival records of provincial and federal reports to provide context for the findings. Social work emerged from practice, becoming increasingly sophisticated as SMHC evolved and degreed social workers entered the field. Findings show that social work was an essential profession for SMHC to address a rising patient census as well as manage the transition to community located mental health care. While some social work related activities are performed by other staff, there is a qualitative difference when a social worker performs these. Findings also showed that social work has a relationship with severe and persistent mental illness as a population served at SMHC. Future historical research can benefit from this study as it includes a developed method for future patient record research. Future research could be in various professional disciplines as well as contribute to the growing knowledge around social work practice in Canada. Findings show that social work is a relevant and important role that has a historic connection in the field of mental health. This study contributes to the growing literature on the history of social work in Canada.

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Dedication

This document is dedicated to my family. My wife Wendi and my children Marianne and Lukas have been most patient with me and cheering me on throughout my studies. I am very grateful for their support. I couldn't have done it without them. Also, thank you mom (Margaret) and dad (Walter). You raised me to be curious about the world and to work towards social justice. I haven't forgotten and never will.

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Chapter 1: Introduction

Introduction

The evolution of social work practice for persons receiving in-patient mental health services is poorly documented for Manitoba. By examining the patient records at the Selkirk Mental Institution between 1947 and 1979 inclusive, I will contribute knowledge to the field of Canadian mental health social work practice. The choice of the Selkirk institution is predicated on the major role this facility has played throughout the time frame for this study in the field of institutional mental health (Committee on Mental Health Services, 1960; Clarkson et al., 1973; Johnson, 1980; Refvik, 1991).

This thesis contributes to a better understanding of the role, via its form and function, of social work in mental health. Specifically, this thesis locates social work as a significant member of the mental health treatment team during a crucial period in the evolution of mental health practice at the institutional level. The findings here show how social workers were involved post World War II and continued to evolve as a legitimate discipline as the psychiatric institution grew in patient census. Social workers are found to be essential for an evolving psychiatric facility in the province of Manitoba. These findings not only provide local knowledge but serve to enrich the Canadian understandings of this sector of social work practice. The research for this dissertation is historical in nature. Patient records are the focus of a historical qualitative descriptive methods approach to examine and describe both the actions of social work and the actors of this profession at a psychiatric institution in Selkirk, Manitoba. Hence, for this study, the patient files containing social work related entries for the population at Selkirk that had been admitted as inpatient is of special interest.

Little is known about social work practice of the mental health care field in Canada within such an institutionalized setting (O'Brien & Calderwood, 2010). Moreover, the evolution of social work practice for persons receiving in-patient mental health services is poorly documented in Manitoba (MB). As the literature review will show, there are questions around what constitutes the form or function of social work. Hence, this research is intended to explore the form and function of social work practice at the institutional level in Selkirk, MB. This research will examine the ways in which social work in mental health is described as a profession and when it is something that is performed. So the essential focus is on the form and function of social work in the context of institutional mental health services.

The form and function of social work are related but separate constructs that bear further clarification. Function refers to the social work related activities that are performed by staff at SMHC. Form refers to the characteristics of a specific discipline, in this case social work, which gives it a distinctive shape. It includes both the way that a function may be carried out by this discipline as well as the values, skills and knowledge that such an approach represents.

As an example, one could see finding housing post discharge as a function performed by staff at SMHC. It is reasonable to expect that staff make a number of phone calls to see if there is any housing available in community. As this thesis will show, when a social worker is involved, finding housing includes developing a systematic network of resources for easy reference and developing rapport with informal supports such as the patient's family. This difference in finding housing speaks to the form of social work as it shows how the same function is distinctly applied when this discipline is involved.

While chapter 2 will explore more fully the current definitions of social work practice in mental health, some comments are made briefly here. The social worker is concerned with

helping the individual receiving mental health services manage the transition back into community from institutional care. This is achieved with a focus on the environment, negotiating the complex areas of entitlements, housing, employment and formal as well as informal supports in what is known as a Generalist Practitioner Model (Zastrow & Kirst-Ashman, 2013, pp 49-51). In mental health, this is achieved in the form of strength based case management, building on the assets in the person's own capacities for recovery (Sullivan & Rapp, 2002).

The advantage of this research is that it will lead to a greater clarity in what the role of social work was in the mental health services as they evolved in this province. The patient records reveal understandings and generate insight as to the shape and pacing of changes in the tasks and functions of social work practice at the psychiatric facility in Selkirk, MB.

There are a number of reasons why this contribution to knowledge is important. For instance, while some research has been done in the field of mental health social work in Canada (O'Brien & Calderwood, 2010; Palmer, Maudsley, Turner, McLennan, 1984), there is a dearth of information on the history of mental health care provided by the discipline of social work in Manitoba. Furthermore, there is a lack of historical knowledge about the role of social work in the field of mental health in Canada.

Regehr and Glancy (2010) provide an excellent textbook on the role of social work in mental health in Canada. The highlights of the book involve current practice with various populations receiving psychiatric care. In fact, their book was an invaluable resource for this study to develop its framework for defining social work actions in mental health in Canada. What is notable, however, is how this textbook illustrates the dearth of what is known about the history of Canadian social work in the mental health field. The author's historical review of

social work care in mental health is restricted to early psychiatric social work post World War II (Regehr & Glancy, 2010, pp 2-3). There is a noticeable gap in the history of social work as the next reference to what social workers do in mental health, begins with a Canadian Association of Social Workers (CASW) survey in Ontario in 2001 (Regehr & Glancy, 2010, p 4). In fact, what social workers do (and did) can only be inferred, based on the writings of two social workers (Teichert (1952) and Skelton (1996) as cited in Regehr & Glancy, 2010, pp 2-3). This illustrates that little appears to be known about the actual evolution of social work practice in mental health in the historical context for Canada. Furthermore, what is published as evidence of such practice does not include a Manitoba reference.

If the definition of social work in mental health practice remains contested terrain, there seem to be two alternative assumptions about this field of practice. One view could be that the social worker is essentially without form and function, shifting with what the medical team discards and requires of this professional to provide services. Another alternative as advanced by O'Brien and Calderwood (2010) is to insist on the social worker being viewed as a legitimate medical (i.e. psychiatric) professional, in order to benefit from the status of having a voice and control over the functions of the mental health social worker.

Research Question

The purpose of this dissertation is to explore the ways that social work as an action and as a profession emerged from the psychiatric institution located in Selkirk, Manitoba, based on a historical qualitative descriptive method. Of primary interest is the question: what are the common ways that social work – both as an action and as a profession – was understood and practiced by staff at SMHC? This gets at the purpose of this research, to explore and uncover the ways social work as role emerged as a form and function in institutional mental health from 1947

to 1979. Ultimately, this gets at seeking to discover what role the social worker has in the mental health professions in Canada.

Organization of Thesis

By engaging in archival research, one is looking into history to see what the changing role of practice had been in order to better understand the current context. Patient records research has the potential to unearth these understandings as the preserved correspondence of mental health professionals will show how perceptions of mental health and the role of the social worker become clearer. As McGrath Morris (2008) so aptly demonstrates, historical research can challenge assumptions about what was, offering new understandings about the past and the impact it has on current practice. In effect, knowing more about what social work did at Selkirk will help strengthen the case for this profession having a relevant place in this area of practice. This means that the research proposed here can play a significant role in adding new knowledge to the field of social work practice, identifying its value and legitimacy as an important and distinct profession in the field of mental health.

Chapter 2 provides a review of social work and mental health literature. It is based on what is known about social work in mental health – both in the US and in Canada, also highlighting what is known about social work in Manitoba within the mental health field during the proposed period of time for this study.

Chapter 3 will clarify the way that the data was selected, collected and analyzed. Figure 1.0 is an illustration of the conceptualization of the way the data is examined to get at the purpose of this study. The three intersecting circles (function, form & role) show how this dissertation sees the emerging role of social work at SMHC. The role of the social worker is expressed in both form and function. The circles show that there are social work functions that

do not contribute to understanding the role of social work as these are performed by non-social workers at SMHC. Furthermore, regarding form, there will be aspects of this not discovered in the patient record or relevant to this particular area of social work practice, hence this circle also only overlaps, illustrating this difference.

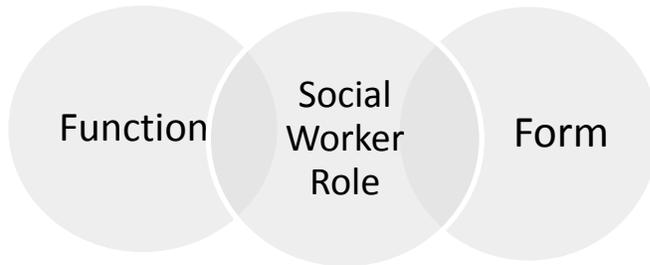
Given the focus on form and function throughout this thesis, further clarification of terms is necessary. Function refers to what action is performed that is of a social work nature. This will be further explicated in chapter 3 as the identification of “social work functional activities” which are then used as a coding scheme to collect patient record entries for further analysis. Essentially, function refers to the actions taken by staff at SMHC that are related to what social work does.

Form refers to the nature of social work itself. This has to do with the ideology, the values and knowledge base which guide the profession of social work. As an example, one illustration which will be examined more fully in both chapter five and six is “Working with Families”. This is a social work functional activity that was performed by both social workers and other staff, such as physicians or superintendents. While this functional activity may have been the same, its approach was qualitatively different. When a social worker was performing this function, there was a tendency to be less directive and more collaborative. This is an illustration of form – where there is a reflection of the values and method of approach that is different from other professionals at SMHC.

There will be other terms used throughout this thesis that are intended to relate to these two terms. Action will always refer to function while actor or professional refers to form.

Another way this may be conceptualized is as verb and noun. In such cases, verb refers to the idea of function and noun to form.

Figure 1.0 Conceptual Illustration of Research Focus



The logic underlying the order of the results chapters is to show first the function of social work at SMHC. As the purpose of this study is to uncover the evolution of the role of social work, this is followed by the second results chapter that shows the emerging form of the social worker at SMHC. This is based on the idea that in social work, the function preceded the form.

Chapters 4 and 5, then, present the results of data collection. Chapter 4 will begin with the actions, illustrating the function of social work. What is done that is social work. This chapter serves primarily to establish the function of social work at SMHC. Actions inform function therefore also speaks to role. Chapter 5 will focus on what the role of social work is, as informed by the social work actions identified in the patient record. Here there is a shift away from what is done as social work action, to how it is being done. The point is for the analysis to examine what the patient record entries can speak to in regards to the role and form of social work at SMHC. With additional material from government reports, the social work role becomes the focus. The expectations of what can be called social worker as a profession renders visible the role social work played at SMHC during this period of time. Finally, the form of

social work in this area of practice can be examined, comparing what is now known about the social work role with what can be discovered about the orientation or values of social work in mental health. This is both based on what can be gleaned from the patient record as well as the academic literature on this subject.

Chapter 6 is a broader reflection on the findings and their implications. It will examine the findings in light of how this helps explain and show how the form and function of social work emerged at this particular institution. This includes returning to the literature to establish how findings coincide or differ from what is already known about mental health social work.

In order to locate the dynamic context of this research, as well as to study the evolving role of social work in mental health, a review of the literature is necessary. The following chapter will review what is known regarding the evolving role of the social worker in the mental health field in North America. This will serve to illustrate the context within which I study the evolving role of mental health social work practice. Social workers are ethically compelled to work with those identified as disenfranchised, oppressed or marginalized in any other way (Walsh, 2002, p273). People with mental illness, as the literature will show have a history of experiencing the worst of institutional life and the consequences of deinstitutionalization, (Linhorst, 2006; Grob, 1991) and therefore would qualify for social work intervention.

Chapter 2: Role of Social Work in Mental Health - Literature Review

The following review of relevant scholarship seeks to provide the necessary context for understanding the evolving role of social work in the field of mental health. It is intended to provide guidance on what is meant with social work roles and tasks or functions.

Social Work & Mental Illness

The literature shows that social work has had a long standing relationship to the field of mental health. Julia Lathrop, the founder of the National Committee for Mental Hygiene in the US at the beginning of the 20th century is referred to as a social work reformer by Sands (2001, p. 33). Lathrop endorsed a vision of a national organization dedicated to the study of mental illness that examines both the medical and the social perspectives. Southard and Jarrett (1922 as cited in Sands, 2001, p. 34) are credited as first using the term psychiatric social work. Social workers had already been hired at a number of major psychiatric institutions as early as 1904 (Deutsch, 1949 as cited in Sands, 2001, p. 34). It was Southland and Jarrett (1922 as cited in Sands, 2001, p. 34) that first wrote about the functions of social work in psychiatric settings. The tasks were outlined as having to do with something called “social investigation”. This form of work involved fact finding that would include the medical as well as social histories of both the client and the community, in order to improve the diagnostic impression (Sands, 2001, p. 34). Another aspect of social work in psychiatry included individual case work and a focus primarily on economic and sociological explanations of human behaviour (Robinson, 1930 as cited in Sands, 2001, p. 35). In fact, while Mary Richmond (1917, as cited in Sands, 2001, p. 35) introduced a person in relation to their environment, it was Mary Jarrett (1919, as cited in Sands, 2001, p. 35) who declared that “...the mastery of psychiatric knowledge be required of all social workers, not only those who specialize in psychiatric social work.” (Sands, 2001, p. 35).

Eack (2012, p. 235), in writing about cognitive remediation and psychosocial approaches for people diagnosed with schizophrenia, makes the claim that there is a shared history between social work and schizophrenia. First, he refers to the American Substance Abuse and Mental Health Services Administration (SAMHSA) data from 2001 that shows that “Social workers are the primary providers of psychosocial treatments for people with schizophrenia” (Eack, 2012, p. 235). There is a lack of a clear description of what the social worker did historically, in mental health institutions. Even in the articles cited by Eack (2012, p. 235), they tend to involve social workers actively participating in research, but a specific provision of services remains unclear. Furthermore, the locus of intervention is community, not institution. For example, the work by Stein and Test (1980, as cited in Eack, 2012, p. 235) refers to early research on the impact of Training in Community Living (TLC) for people with Serious Mental Illness (SMI) in the community (Stein & Test, 1980). Hence the focus remains on what social workers contribute to community mental health, versus the institution.

From the literature, one could infer that the patients encountered by the social worker at the institutional level would most likely have been people with chronic mental illnesses such as schizophrenia. Since schizophrenia has been understood to be a profoundly disabling condition it would stand to reason that psychiatric institutions would have a significant population of individuals diagnosed as such. In fact, Geoffrey Reaume (2000), in his detailed examination of medical records at the Toronto Hospital for the Insane found that the prevailing diagnosis for all patients treated there tended to be “Dementia Praecox”, which after 1930 was referred to in provincial records as the diagnosis of schizophrenia (p.17). In fact, when referring to the seriously mentally ill as a category, Bond and Campbell (2008, p. 33) state that the majority of these individuals would indeed have a diagnosis related to schizophrenia. Hence, while an

explicit reference to the profession of social work and schizophrenia may not be possible, it can be assumed that it is highly likely that such interactions did indeed occur. This is based on the rationale that if social work was present at the institutional level, contact would have likely occurred between clients that remained longer at these facilities.

In terms of a theory of practice, social work reached a crossroads post World War II when the Freudian scientist was competing with the pragmatic functionalist (Hick, 2002, p. 51; Payne, 2005, p. 80). Robinson (1942) captures the essence of a functional perspective in social work, by arguing that the main purpose of intervention is to restore the individual to a prior form of ideal function. The absence of a concern for the cause, and an emphasis on present issues of dysfunction (Fischer, 1973), marked a significant departure from Freudian, past trauma focused models of care.

Mental Health and Social Work in Manitoba

According to Johnson (1980), Manitoban psychiatric hospitalization rates had already shown a decline in inpatient stays as early as the 1940's. Its relevance for social work must be inferred based on material available from other provinces. During this time, according to Teicher (1952), social work activities at the mental health institutions in Canada involved performing evaluations, providing supportive counselling, and assisting in linking to community upon discharge.

While recorded documents show that in Ontario social workers were given the freedom to provide supportive counselling and to provide group therapy with patients (Skelton, 1996), it does not appear to have been as common in Manitoba. Since treatment in Manitoba during the 1940's and 50's was primarily institutional (Refvik, 1991), mental health social work involved helping the individual throughout the intake process within the institution, and secondly,

ensuring transition to the community with the least risk of recidivism possible (Regehr & Glancy, 2010).

In 1973, a complete review of Manitoba's mental health system was performed by the Clarkson group, an external non-government consultant (Refvik, 1991). This scathing report about the status of mental health services in Manitoba in the 1970's found that social workers still did not have such freedom for counselling and group therapy (Clarkson & M.D.T. Associates, 1973).

The powerful dominance of the psychiatrist in the present service will have to change so that the full exploitation of the services of other professionals can be achieved. In more progressive programs, social workers and psychologists are being used to a greater extent as therapists, and not simply as home finders and psychometric testers. (p. 78)

There is a reference to services provided by social workers at the Brandon Mental Health Centre (Refvik, 1991). Services there appeared to have to do primarily with the planning of discharge and aftercare of patients via these social workers contacting community resources, both family and agency. Clearly the focus here is on ensuring that the social supports are in place.

In 1947, the annual report by the Manitoba Department of Health (Department of Health, 1947) refers to challenges with staff shortages at all psychiatric institutions. While there is acknowledgment of the need for social work, the function appears to be given recognition, not the profession.

We are very fortunate in having secured the services of [Name], RN as Psychiatric Social Service Worker. [Name of social worker] has had extensive experience in the work of hospitals for treatment of mental diseases. She was appointed on November 1st...(p. 256)

While the same report noted that at the Winnipeg Psychopathic Hospital there are two psychiatric social workers on staff that conduct family interviews, this SMHC based social worker's main task appears to be the making of phone calls to community supports. This was confirmed in the following year when the Manitoba Department of Health annual report refers to this social worker as having conducted over 600 phone calls, noting that this has made the staff person indispensable. From this, one can infer that the institution recognized the need for social work as a function, if not a vocation, in the mental health system.

The emergence of academic qualifications in social work mental health practice

In terms of the changing theory of social work practice, in the US during the 1960's there was an interest in a reform approach to practice (Zastrow, 1989). Environmental factors were seen as at least as important as personal factors, such an approach was geared towards changing systems to benefit the individual.

During the 1960's at the national level, the Canadian Mental Health Association (CMHA) defined national expectations for the level of academic degree needed for psychiatric social work (Tyhurst et al., 1963). In effect, the recommendation was for the MSW to be the national standard. The first social worker hired at Selkirk was a Registered Nurse (RN) who was to perform tasks identified as "social work". Now the CMHA had identified a particular academic degree as being required for a social worker in mental health service provision. In effect, one can infer that a shift from the function of social work as an action performed by any

staff at the hospital to a form of an identified degreed actor of social work practice was emerging.

Social workers as actors in mental health

Later the CMHA organization provided another clue regarding the emerging role of social work in mental health. In 1971, the CMHA found itself for the first time without a medical professional in the leadership position. According to Griffin (1989) a psychiatric social worker was in charge. During this time, the organization was supportive to ex-patients as they sought to criticise the status quo mental health system that continued to engage in ongoing involuntary commitment and Electro-Convulsive Therapy (ECT) use. This gets at the emerging values of the social work profession as its form becomes more visible in this field of practice.

That still left the question what is the function that psychiatric social workers serve in practice. The CMHA report does provide insight into what was understood as social work activity during the 1960's. The CMHA report refers to social workers as skilful at improvising in the absence of comprehensive community mental health services (Tyhurst et al., 1963). This reference to social work by the CMHA report would make for the logical conclusion that the case management model as described by Solomon (1998) in the US was performed by this profession in Canada. In the US, case management emerged as a result of the disorganized and ill equipped deinstitutionalization project. The CMHA report refers to the functions of social work more explicitly in terms of being the experts in a clinical team, in the area of the social environment (Tyhurst et al., 1963). Little else was said about what the social worker actually does in this report. In order to gain a fuller understanding of what it was that the psychiatric social worker did, one would have to rely on what Mort Teicher said back in 1952. In terms of form, the social worker is to be a link between institution and community, working to address

community resources and to network with these. The idea was that the social worker be the one to network with the social environment to ensure that recidivism is reduced, by adequately connecting the discharging patient to necessary and needed community supports (Teicher, 1952). It is of note that the CMHA report describes the form of the social worker as a consultant to the inpatient team to ensure the correct simulation of a social environment congruent with the environment the patient would be returning to in community (Tyhurst et al., 1963).

In the 1970's, a more interactional model emerged in North America for social work practice, focussed on seeking to change, or to mediate the relationships between the person and the environment. During this time, theories about the family as a microcosm of social systems and hence the target for intervention emerged (Freeman & Trute, 1983). Based on ecosystems theory (Zastrow & Kirst-Ashman, 2007), the meso-system of the family was understood to be formative in the development of the individual.

Solomon (1998) later made the case that the debacles around deinstitutionalization are what brought about the case manager role. As patients were released to the community, a community mental health system in its early development was unable to meet the multiple demands and challenges of this population (Smrtic, 2010, p. 536; Sullivan & Rapp, 2002, p.181). By the end of the 1970's, case management had become a mainstay of community mental health programs.

In the US during the 1970s, the term "clinical social worker" became the accepted way to refer to a variety of disciplines in the profession, including psychiatric social work (Frank, 1979). It was during this time that social workers outnumbered their colleagues in psychiatry and psychology at the local community mental health centres throughout the US (Lecca, 1983, p. 37).

A Marxist critique of social work practice at this time meant a rejection of what now was perceived as being handmaidens of a corrupt state (Martin, 2003). Structural critiques supported social work practice that rejected traditional roles, since they were understood to be supporting an unjust status quo in society (Mullaly, 2007). However, while the socially radical social worker was seeking to challenge the psychodynamic schools of social work as supporting oppressive capitalist regimes (Martin, 2003), it was the clinical social worker that was able to get employed in the US when government regulation called for objective standards of practice (Lurie, 1979).

Following further changes to the community mental health model - the cutting of funding, the restricting of treatment to short term and less ego based - the clinical social worker left the public sphere and entered into private practice (Frank, 1979). In effect, it was a move of liberation from the control exerted by the agency and the psychiatrist (Germain, 1979), but it did mean a shift to now providing therapy to those less ill and more affluent (Frank, 1979).

There are of course other theories why it was that the more educated and experienced clinical social workers abandoned the public mental health arena. The Council on Social Work Education (1987, pp. 187-188) noted that there are a number of factors that have impacted social work's departure from community mental health. Among them were the failure by the state to insist on trained professionals, psychodynamic models failing to translate into working with the chronically mentally ill, and an apparent apathy by schools of social work to take a leadership position in curriculum changes, in order to address the realities of community mental health care. Further comments in this 1987 document included concerns over the ethics of having the least trained providing the bulk of care for the seriously mentally ill, as well as lamenting the interests of graduates for better salaries, as reasons to opt out of public mental health work.

Callicutt (1983, p. 37), however, claims that the presence of social workers was not just at the clinical level. Social workers were included in all forms of management and clinical supervision, education, training and program evaluation at community mental health centres during this time in the US.

For developments in Canada, an article from Ontario regarding the role and function of social work in mental health sheds some light on the subject (Palmer et al., 1984). It appears that social workers inside psychiatric institutions tended to perform social histories, assessments and individual therapy. More than half of the respondents reported having an MSW while another 22% had BSW degrees (Palmer et al., 1984). It is unclear what education or training the remaining percentage of social workers had, but it would stand to reason that they had less than a BSW education. Despite deinstitutionalization being in full swing, it is likely that these social workers spent little time with community supports (Palmer et al., 1984).

The outmigration of Canadian social workers towards the private sector mirrors that of the US, due to an increasing trend towards government cutbacks in social and health sectors (Hick, 2006). Certainly, a national study in the 1980's (Mental Health Division, 1985) found the profession of social work listed as a service provider throughout the provinces in the field of mental health. In effect, this study showed the profession as being primarily known for their function of completing and reporting on evaluations and assessments.

Social work in Manitoba Mental Health

At the local level, the role of the social worker appeared to become more essential due to community located mental health care receiving increasing attention (Refvik, 1991). When the Clarkson group had evaluated Manitoba mental health services in the early 1970's, they had raised the concern that the social worker is under-utilized, resulting in using social workers primarily to be "home finders" (Clarkson et al., 1973 p78).

When writing about the Brandon based psychiatric institution, Refvik (1991) noted that social work was done by the psychiatric nurse during this time. The former Director of Social Work at Selkirk Mental Health Centre (SMHC) (T. Hryniuk personal communication September 1, 2011), noted that there were incentives at the end of the 1960s into mid 1970's for staff to get MSW degrees.

It is apparent that the province of Manitoba had a clear expectation that social workers at the psychiatric institutions have academic credentials that matched their job function. Two government reports during the 1970s refer to the expectation of an influx in graduates with BSW degrees from the University of Manitoba that is clearly linked to the domain of mental health service provision (Division of Research, 1972; Manitoba Department of Health and Social Development, 1975). This would lend credence to the idea that the social worker- as a degreed individual- was perceived to be part of the mental health sector. In light of the literature from the CMHA (Tyhurst et al., 1963) as well as the former Director of Social Work comments about the MSW expectation at SMHC, it is odd that this was not mentioned as the standard in the aforementioned government reports.

In terms of intervention, according to the former Director of Social Work at SMHC (T. Hryniuk personal communication September 1, 2011), the Selkirk facility promoted family therapy via the social work staff in addressing mental health care. This approach to treatment was embraced by the psychiatric nursing staff within the institution. By the 1980's, the community mental health program staff were also able to provide family therapy, which was in part provided by social workers (T. Hryniuk, personal communication, September 1, 2011).

In 1996, a study of the sectors wherein social work practice is located was launched. The purpose of this report was to provide the directors of the schools of social work a sense of where and in which sectors of practice these professionals were presently located (Westhues, 2001). The report noted that one of the domains of practice continues to be mental health (Westhues, 2005). It remains unclear, given the available literature, to identify precisely where the social worker was active in mental health, especially in Manitoba. Given that reports in the 90's make reference to the presence of social workers as experts during surveys and evaluations of the mental health system in the province (Winnipeg Regional Mental Health Council, 1991; Partners for Health, 1992), it is reasonable to assume that the profession continued to have status in this area of practice. It remains unclear whether the form or function defined practice. According to former Manitoban social workers in mental health, when community based care replaced institutional practice, the psychiatric nurse tended to transition out of the facility into the field, while the social worker changed to another vocational sector (A. Hajes, personal communication, August 11, 2010; T. Hryniuk, personal communication September 1, 2011). Hence it can be assumed that social work had a greater role in the mental health sector at the institutional level, prior to the era of deinstitutionalization and subsequent community mental health.

Current views of Social Work in Mental Health in North America

Recent national reports have called for a primary care team that includes the social worker as a core member, along with psychiatric nursing, psychiatry, psychology and occupational therapy (Government of Canada, 2006). Regehr and Glancy (2010) are able to comment on the form of social work in current models of care.

Social workers practising within the recovery model apply the principles of hope and self-determination at all levels of practice...At the direct-service level, they help

individuals build positive relationships with others, develop meaningful daily activities, find a sense of purpose and seek to attain personal growth. (CMHA, 2008 as cited by Regehr & Glancy, 2010, pp.132-133)

Kerson (2004) makes the case that the perspective of a boundary between physical and mental health is illusory, given new research that a holistic approach makes sense, and that social workers are able to provide this perspective given their orientation. Yet Davis-Berman and Pestello (2005) offer the opposite view when they assert that the 1990's focus on the brain must be seen as a regression back to a strictly medical model for mental illness. They make the case that it is the social worker's role to challenge self-stigma and to empower clients to assert their basic human rights as they are infringed upon by significant side effects of psychotropics. In fact, social workers are able to challenge assumptions of a biomedical approach as too limited to address the multiple and complex issues and problems that contribute to mental health for those who use services in this sector of practice (Heinonen & Metteri, 2005 as cited in Schwartz & O'Brien, 2010, pp. 107).

Review of History of Social Work in Mental Health

In summary, the profession of social work appears to have been present throughout the period of mental health reform from the turn of the century until present day. As early records show, the psychiatric system had identified a need for social work practice as early as the beginning of the 20th century (Sands, 2001, p. 34). In Manitoba, the Selkirk psychiatric institution reported hiring its first social worker after World War II (Department of Health, 1947, p. 256).

The literature is rife with changing roles and functions of the profession in this area of practice (Frank, 1979; Lurie, 1979). Changing paradigms of care as well as funding structures

have influenced the prevalence of this profession in the field of psychiatry in the US (The Council on Social Work Education, 1987, pp. 187-188).

In Canada, the presence of the social worker in psychiatry seems to be a given (Tyhurst et al., 1963; Mental Health Division, 1985; Westhues, 2005; Government of Canada, 2006; Regehr & Glancy, 2010). In Manitoba concerns about the academic qualifications (Division of Research, 1972; Manitoba Department of Health and Social Development, 1975) as well as the appropriate range of functions of social work have been expressed during the course of mental health reform (Clarkson et al., 1973).

While some records indicate the need for a social worker at Selkirk, even going so far as describing the individual's specific activity of making phone calls to community supports (Manitoba Department of Health, 1948, p. 221), little is known about the functions performed by such social workers at Selkirk, particularly the role they played in the treatment for those admitted inpatient at this facility. As can be seen from the prior literature reviewed, little reference to inpatient social work is available to draw from, as invariably the radical changes brought about by de-institutionalization have shifted the focus to community located social work practice.

In order to frame this research more clearly, it is important to define what it is that social work does in mental health. This is predicated on the fact that this study will identify social work practice, both when performed by identified social workers or other members of the treatment team. In order to be able to locate evidence of such activity, it will need to become apparent how such practice has been defined in the literature beyond what has already been established above.

Definition of social work practice in mental health

Fook (2001, p. 119) makes note in a qualitative study how difficult it is to locate expert social work practice. She makes the case that it is difficult to pin down what this is, given the variety of locations where the discipline operates, but that it is important for the discipline to engage in this form of research. O'Brien and Calderwood (2010, p. 321) echo this notion as they write about how little information is available about what social workers do in the field of mental health, especially at the institutional level, leading to a devaluing of status and their contribution to this field. In effect, little is known about social work practice in psychiatric institutions, hence the stated objective for this dissertation. Despite these concerns, a number of commonalities emerged from the literature by which to develop a framework for identifying social work tasks or functions in the historical records at the Selkirk psychiatric institution.

Zastrow and Kirst-Ashman (2013, pp. 49-51) describe in detail the tasks of a Generalist Practitioner that illustrates well what is meant by the roles of social work practice. As an *Enabler*, the social worker intends to help clients cope with various stresses and crises. What this means is that the social worker helps the client to focus on strengths and assets in themselves, and in their environment, to engage in problem solving via breaking overwhelming goals into manageable steps, in an effort to restore coping and self-sufficiency. This fits with what Sullivan and Rapp (2002, p. 184) identify as a hallmark mental health social work orientation called the strengths- based case management approach. This approach borrows from earlier ecological models in social work and adds the radical notion of “...accenting and capitalizing on the inherent strengths in people and the social environment... [In order to]...activate the process of recovery” (p. 184).

The *mediator* role is one that has to do with helping resolve conflict or disagreements between the various systems, from the individual to the larger, or macro environment or system (Zastrow & Kirst-Ashman, 2013, p. 49). What the authors identify as tasks are those indicative of where the social worker seeks to improve communication among these different levels or groups. In mental health social work practice, this can be seen when the social worker seeks to mediate between the agency and the client or the informal support system to find a compromise that will satisfy all parties involved (Corcoran & Dearborn, 2002, p.109).

Another role that has been identified is that of *integration or coordination* (Zastrow & Kirst-Ashman, 2013, p. 49). This can be understood as the social worker taking on the task of seeking to coordinate or organize from various sources, of developing linkage to sources in the client's environment. In mental health, this can be understood as the role of the social worker on a multidisciplinary team in coordinating service provision that addresses a holistic aspect of needs for the client (Sands & Angell, 2002, pp. 266-269). This includes the development, maintenance, and monitoring of an integrated treatment plan with the treatment team.

In terms of form, current models of social work practice tend to focus on a *bio-psycho-social* or an *ecological perspective* to identify service needs (Zastrow & Kirst-Ashman, 2013). This has been identified as a key ingredient in what the social worker can contribute to a mental health treatment team (Haight & Taylor, 2007, p. 172). What this means is that the mental health social worker is concerned with, among other things, the living conditions that the client will return to and will hence focus on housing and the relationships with informal supports upon discharge. Given what Fuchs (2002) gives as a rationale for a professional to assist in navigating and coordinating a disorientating social service system, this appears to be a relevant function for the Canadian social worker to perform as well.

Another role the social worker adopts is that of a *manager* who oversees via administration and evaluation, the services of a given agency or organization (Zastrow & Kirst-Ashman, 2013). The tasks here include streamlining programs or implementing new ones that address identified needs in a given context of practice.

The role of an *educator* is one where the tasks include providing information and teaching skills to empower the client and possibly their informal support system (Zastrow & Kirst-Ashman, 2013). In terms of mental health, the case has been made that the task of providing psycho-social education is hence a function of the mental health social worker (Lukens & Prchal, 2002, pp. 132-134).

According to Sullivan and Rapp (2002, p. 191), *case management* is a good fit for social work practice. Certainly, Zastrow and Kirst-Ashman (2013, p. 50) effectively make this case when they describe the role of the broker for social work. Sullivan and Rapp (2002, p. 184) would argue that in mental health, the strength-based case management model is a response to the broker model and its failures to respond to the needs and realities of those with significant mental health issues and is affiliated with the social worker orientation to practice. The broker model was seen as too impersonal in how it defined services to those with SMI and that the quality of the relationship between worker and client was paramount (Sullivan & Rapp, 2002, p. 183). The idea of case management, then, is that there is one professional who is responsible for all aspects of care and service provision. This accountability ensures that there is someone who will monitor extant services and modify or link to further resources as necessary (Sullivan & Rapp, 2002, p. 183). Fuchs (2002) makes the case that this means that the Canadian social worker needs to effectively link clients to both formal and informal supports based on a detailed knowledge of said resources and advocacy skills. Furthermore, it ought to be a blending or

“meshing” of informal and formal supports that the social worker should strive for (Fuchs, 2002, p. 360). In effect, the environment that clients are involved in is a blend of both professional assistance such as entitlements and the friends and family that surround them. Social workers need to work to coordinate and integrate these aspects of community living for the individual to function optimally in their environment.

Further roles include the *facilitator* who ensures communities or groups engage in discourse towards a common goal or outcome (Zastrow & Kirst-Ashman, 2013, p. 50). In regards to mental health services, it has been identified that the social worker is active in facilitating groups at various levels, including psychotherapeutic interventions such as family therapy (Walsh, 2002, pp. 77-79).

When taking on the role of the *initiator*, this can be understood as one who ensures that there is momentum to address an issue that is perhaps not identified as a priority by others (Zastrow & Kirst-Ashman, 2013, p. 50). Essentially, in this role, the social worker is engaging in tasks that involve follow up to ensure that identified priorities or goals are actually being addressed.

Finally, it is the role of being an *advocate* that is identified by Zastrow and Kirst-Ashman (2013, pp. 50-51) as a role of the social work professional. This can be direct or indirect but involves the confrontation of areas where barriers are present that prevent the client from attaining their goals. Fuchs (2002, p. 357) makes the point that advocacy is an essential ingredient in addressing the needs of clients as they attempt to negotiate social service systems that are fraught with gaps. O’Brien and Calderwood (2010, p. 330) note that advocacy in mental health social work in Canada is actually more prevalent than for American counterparts. Essentially, the identified tasks in advocacy are speaking out via getting the word out about a

given law, policy or other institutional barrier on behalf of another group in order to bring about change (Chappell, 2006, p. 116). The way O'Brien and Calderwood (2010) define this is the addressing of "social inequities that contribute to mental illness" (p. 330).

In summary, social workers act in many roles when performing their tasks. This spans the range of mediating, coordinating and facilitating diverse aspects of a complex social environment according to a Generalist Practitioner Model (Zastrow & Kirst-Ashman, 2013, pp. 49-51). This includes taking the lead to advance an agenda in the best interest of the client (whether a person, a group or an organization) or providing the education needed to promote agency on the part of the client. While present in both countries, it is in Canada where there is a stronger focus on the advocate as a role the social worker adopts in the field of mental health (O'Brien & Calderwood, 2010, p. 330).

As it has become apparent, the role of the mental health social worker is similar to other areas of social work practice. Social work aims to address the social aspects of care, from the point of intake to discharge and aftercare. Current models include a focus on the environment that is seen as an asset or detriment to the individual's mental health. Treatment is seen as consisting of early assessment to facilitate effective interventions and treatment (Regehr & Glancy, 2010, p. 3).

Regehr and Glancy (2010, p. 4) identify a number of core functions of social work practice in mental health. First, it is understood that social workers perform a *comprehensive psychosocial assessment* that looks at all aspects of life. This includes looking at informal supports, identifying the needs, strengths and the coping skills of both the individual and said resources in

their environment. They note that *counseling and psychotherapy* are aspects of social work service provision with a proviso that the orientation be a bio-psycho-social, environmental one.

Psycho-education is also identified as a core function of mental health social work practice (Regeh, & Glancy, 2010, p. 4; Lukens & Prchal, 2002, p. 125). This includes education for both the individual and informal supports on the nature of mental illness as well as ways of coping.

As is the case in the Generalist Practitioner Model (Zastrow & Kirst-Ashman, 2013, p. 690), *case management* is a core function of the discipline's function in the mental health setting (Fellin, 1996, p. 3; Glancy & Regehr, 2010, p. 4). Participation in *consultation* among the disciplines providing mental health is also seen as a function the social worker provides (O'Brien & Calderwood, 2010, p. 331; Regehr & Glancy, 2010, p. 4). In effect, it is the provision of a discipline specific perspective within the treatment team. Sullivan and Rapp (2002, p. 188) note that even in the days of deficit oriented models of care, the social worker's views shaped the formation of environments to act as "social prosthesis" for those identified as being unable to adapt to community life.

As in other fields of practice, the role of *supervisor* is seen as an aspect of social work practice in mental health (Regehr & Glancy, 2010, p. 4). This includes the social worker providing field supervision to students and paraprofessionals. Advocacy is identified in the areas of board memberships, enacting or strengthening community connections and specifically pushing for the addressing of gaps in the system that would harm the client (Regehr & Glancy, 2010, p. 4). *Teaching* is identified more broadly as giving presentations or running workshops. Gioia-Hasick and Brekke (2002, pp. 146-153) would add that, in mental health related social

work, teaching takes the shape of teaching global skills that include communication, problem solving, social and emotion regulation skills for the individual struggling with mental illness.

Finally, the question may arise as to the ways in which the form and function changes depending on the academic degree of the social worker. Put another way, one may expect that there are differences in what a MSW and a BSW do in mental health practice. Sullivan and Rapp (2002, pp. 183-184) would argue that it was the broker model's lack of addressing the reality of personally encountering clients in care that brought about the emergence of a therapist-case manager model where the advanced degree is expected. However, the tasks of case management can be a full time job. "...it can be argued that case management has emerged as a specialty role precisely because existing professionals are reluctant and/or unable to assimilate these duties in daily practice." (Sullivan & Rapp, 2002, p. 184). Hence the case manager tends to be a role performed by the BSW.

O'Brien and Calderwood (2010, p. 330) write how it is apparent that in the US, the mental health social worker is more clinically focussed, while the Canadian cohort is more balanced to engage in critical practice that includes advocacy. This is identified as due to the fact that Canadian social workers are "...challenged to be both clinically relevant and critical" (O'Brien & Calderwood, 2010, p. 330). Nevertheless, therapy and supportive counselling are identified as some of the activities that Canadian social workers perform in mental health practice (O'Brien & Calderwood, 2010, p. 330; Regehr & Glancy, 2010, p. 4).

In summary, it is possible to describe social work activity in the field of mental health, but it is important to note the nature of the literature consulted. First, much of the source material is from an American context. Second, much of the literature focusses on what it is that

social work does in community mental health. While it may be possible to draw inferences to the inpatient context, this reality needs to be considered. Finally, the literature tends to focus on current areas of social work activity, leaving the historical aspects largely unanswered. The last two caveats to the literature findings are, however, also the reasons why this dissertation will contribute new knowledge to the field of social work practice.

Conclusion

This chapter has shown how social work is located in mental health in Canada. The literature on historical research makes it clear that there is no firm or fixed standard for research design or implementation (Tosh, 2006). Patient record research comes with its own challenges but opportunities as well – to challenge popular assumptions of history. In this case, it is the opportunity to challenge assumptions around the practice of social work at the psychiatric institution at Selkirk, MB.

This chapter sought to expound on what is known for the practice of social work, both in form and function in the area of mental health. Furthermore, the literature consulted informs the methodology for this study as it guides the identification of social work actions performed in the mental health service sector. While much is known about social work in community mental health, little is known about what this profession did at the institutional level, lending further support to the purpose of this study.

Chapter 3: Research Methods

Research Design and Methods

This is a form of historical research that employs a qualitative descriptive approach (Lambert & Lambert, 2012). Sources on historical research have made the case that inquiry into the past is fraught with challenges that involve the ontological blinders of the present day historian (Howell & Prevenier 2001; Tosh, 2006). Qualitative descriptive research tends to remain close to the data in describing what is present as thoroughly as possible versus more inductive qualitative approaches that seek to generate theory about what is found. This fits with how I think about historical research in that I am looking to capture what was actually reported in the patient record. In fact, qualitative descriptive research can be seen as "...concerned with explanations, descriptions and perspectives, relating to a particular population...." (Terry, 2010, p. 596). Many methodologies can fit under qualitative descriptive, provided the main focus is on seeking to describe as close to the "facts" of the phenomena rather than inductively generate theory (Sandelowski, 2000; Kuluski, Gill, Naganathan, Upshur, Jaakkimainen, Wodchis, 2013; Vaismoradi, Turunen, Bondas, 2013).

Qualitative descriptive research has included the use of medical records (Vandyk & Baker, 2012). In effect, qualitative descriptive research is "... valuable when straight descriptions are required to provide answers to questions of special relevance to practitioners and policy makers" (Sprague, Swinton, Madden, Swaleh, Goslings, Petrisor, B. et al., 2013, p. 2). In terms of methodology, then, a qualitative descriptive approach can include the use of preconceived coding schemes, which can be refined via aspects of grounded theories' approach of constant comparison - of going back to the data and comparing or even combining codes into a larger aggregate (Gutierrez, Brenner, Rings, Devore, Kelly, Staves, Kaplan, (2013) as well as descriptive statistics (Kuluski, Gill, Naganathan, Upshur, Jaakkimainen, Wodchis, 2013). The

current chapter will illustrate how this approach towards patient record research is conceived and developed in order to address the main purpose of this thesis.

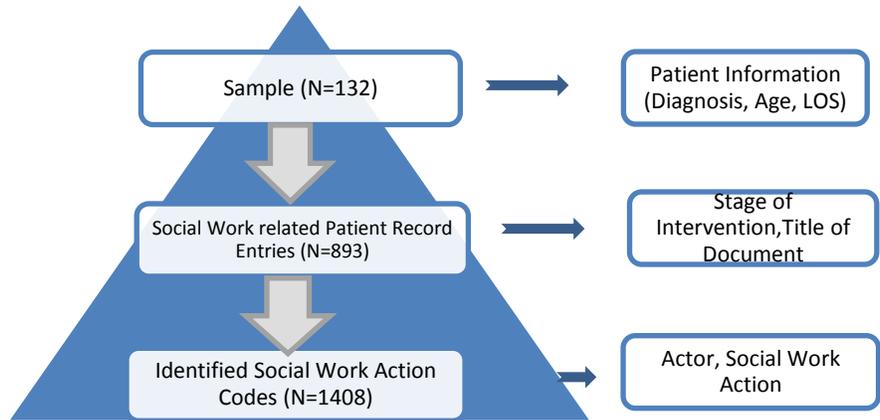
The initial research action was to select an equal sample of patient files per year from the Selkirk Mental Health Centre Archives (SMHC) archives, for the years 1947 to 1979 inclusive. Since the intention is to uncover what the social worker did at the psychiatric institution – as well as who actually performed social work activity – there needs to be a conceptual formulation for what can be identified as “social work activity”. The design involves a qualitative descriptive approach utilizing descriptive statistics to inform qualitative findings because of the nature of the data available and the purpose of this research.

Qualitative approaches lend themselves to the formulation of concepts and themes that originate from the data (Creswell, 2007). It is this inductive element that is ideal in the formulation of a conceptual framework around “social work activity” for the purpose of this study. Lambert and Lambert (2012) note that elements from grounded theory can be found in descriptive qualitative approaches via the act of constant comparative analysis but differ in that this does not lead to the emergence of a theory. Qualitative descriptive approaches tend to remain close to the data in describing what is present as thoroughly as possible versus more inductive qualitative approaches. Descriptive statistics serve the qualitative data in that they extend or even provide new insights into the findings. The data was collected from a large volume of archival material. Hence, by performing frequency counts engaging in descriptive statistics, it is possible to explore trends and relationships in the data. Qualitative descriptive method allows for both a conceptual development narrative and an effective analysis of relationships of the data encountered in the patient files.

The patient records were explored guided by an informed understanding of social work. This understanding was derived from both the writer's mental health social work experience in Indiana, USA as well as review of the social work literature. The primary source of data for this study is from the Selkirk Mental Health Centre Archives, additional sources are identified below.

Figure 3.1 is a visual representation of the data collection process employed for this study. The triangle represents the visual display of the increase in data generated from the collection process. The base of the triangle then is the number of times a given social work activity was identified in the patient record. The following sections on collection and analysis will elaborate on the steps in detail but it is important to note here that the selection of social work related patient record entries via an initial coding scheme of social work actions and subsequent development of final social work function codes are both a collection process, and an analysis of the data. In order to identify relevant patient record entries, they are in effect analyzed for content that reflects social work functional activity. By identifying these entries for the content they provide, their collection is performed for further analysis.

Figure 3.1 Illustration of Data Collection Process



Location of the Data

SMHC has microfiche records of patient files dating back to the founding of the Selkirk facility. It is in the Selkirk facilities' medical records office that an archive of microfiche files are kept up to 1980, and thereafter continue as hard copy patient records stored in the same location until 1997. However, according to staff at the SMHC Archives, some patient records have been converted to microfiche after this date up to 1996 but the majority of files have not (Manager, Health Information Services & Technology, Personal Communication, March 1, 2012).

The files are indexed via patient numbers given at the point of admission to the facility. Sometime in the 1970s there appears to have been a period where patient numbers were given, regardless of whether this was a new admission or not. In other words, some files have two numbers – the one that was assigned at first admission, and the one that was assigned the first time they were admitted in the 1970's.

In terms of contents, a file number may include a number of forms – admission, assessment, program notes, supplemental progress notes, medical forms and social history. First, there are admission forms. These take the shape of mental health committal documents and direct admission or transfer from alternate facilities forms. There are assessment forms which may vary given the time period of study, as earlier documents appear to have a more physiological frame of reference while later files include social or collateral information and even assessments for suitability for vocational or foster home placements.

Generally there is some documentation indicative of progress notes or reports, sometimes listed as case conferences or a summary of progress. Frequently there are documents that appear to be continuous in nature. For the purpose of this study, they are referred to as “Supplemental Progress Notes”. There are medical forms, including lab work and summaries of medical conditions as well as the treatment of these. Depending on the file, there are differing volumes of correspondence between staff and family as well as at times the patient. In the final decade of study the social history as a form appears to be included in the patient file.

Other documentation includes correspondence between staff at SMHC and external agencies such as departments of welfare, Veteran’s Administration and vocational rehabilitation services. The documents that are in the patient record are either authored by SMHC staff or by said agencies. Both are included in this study if they provide evidence of social work activity by SMHC staff. This includes any letters written by SMHC staff to local employers seeking to get a patient a job.

Unit of Analysis

The unit of analysis for this study is the patient record entries about social work activity in the patient file (1947-1979) at SMHC. In order to avoid confusion, I am making the

distinction that it is not the outcome of treatment that is of interest for this study. The focus of this dissertation is to seek to understand the role of social work – both via form and function - in the treatment for people admitted as in-patient to the Selkirk facility.

Time Frame of Study

The time frame for data gathered for this study is from 1947 to 1979 inclusive. There are a number of reasons for the selection of this time period. First, there is a concern that the immediate influence of World War II would confound the study. In 1940 it was reported that many personnel were leaving psychiatric institutions in Manitoba to serve in the military (Department of Health, 1940). This means that the patient records would not likely be as reflective of the actual staff serving at SMHC. Until the end of WWII, positions at SMHC are held by conscientious objectors. The year 1947 would be a reasonable time frame to begin this study. This is confirmed by documents retrieved from the Manitoba Legislative Library. An annual report by the Provincial Psychiatrist that year refers to 1947 being the year that all staff that intends to return from serving in military have either returned or resigned (Department of Health, 1947). What this means is that as of 1947, SMHC had returned to a prewar status quo. It is more likely that a sample during this time frame captures patient record entries that are an accurate portrayal of the staff at SMHC.

The second reason for this year being significant has to do with reference to social work. Regehr and Glancy (2010) note that this is the year the first psychiatric social worker was hired in Toronto (p 3). As noted in the literature review, the first psychiatric social worker was hired at Selkirk Mental Hospital on November 1st of that very same year as well (Department of Health, 1948). As the literature review has shown, this period of time was also one where

significant changes in the understanding of the causes of mental illness and its treatment had occurred.

This study concludes with 1980, given the literature around the evolution of social psychiatry as well as the emergence of community mental health models (Johnson, 1980; Lecca, 1983; Grob, 1991; Fellin, 1996). While the 1970s have been viewed as a time when community models failed to fulfill their promise in North America (Gutman, 1991 as cited in Smrtic, 2010, p. 564) as well as within Manitoba (Toews, 1979; Working Group on Mental Health, 1983), it is in the last decade of this study, that Evidence Based Practice (EBP) emerged (Fellin, 1996). A shift in thinking regarding clinical practice resulted in a focus on providing services that are scientifically evaluated for evidence of effectiveness (Gambriel, 2005). The Program for Assertive Community Treatment (PACT) is an example of evidence based practice in community mental health services (Allness & Knoedler, 1998).

An inter-office memo dated 1973 by the Social Work Student Unit at Selkirk Mental Health Centre urges the Manitoba provincial government to consider using the Manitoba Association of Social Workers (MASW) to spearhead innovation around community mental health implementation for the province (Social Work Student Unit, Inter-Office Memorandum, April 26, 1971). From this document, it is clear that the province was gearing up for deinstitutionalization and hence community mental health models of care. In other words, given the historical changes due to the impact of de-institutionalization, it is reasonable to suppose that by 1980, treatment would have shifted more towards out-patient models of care at SMHC and hence no longer as relevant to this study.

Purpose and Scope of Study

By examining the patient record at SMHC, I seek to uncover the way social work was practiced and by whom during the time period (1947-1979). What is important to note is that data collection encompassed all stages of treatment. In other words, if patients are admitted, treated and then discharged, one would want to know what social workers were doing at each of these 3 stages. The point here is not to assume it is known within which stage(s) of “treatment” the majority of social work service provision was provided.

Permissions & Privacy

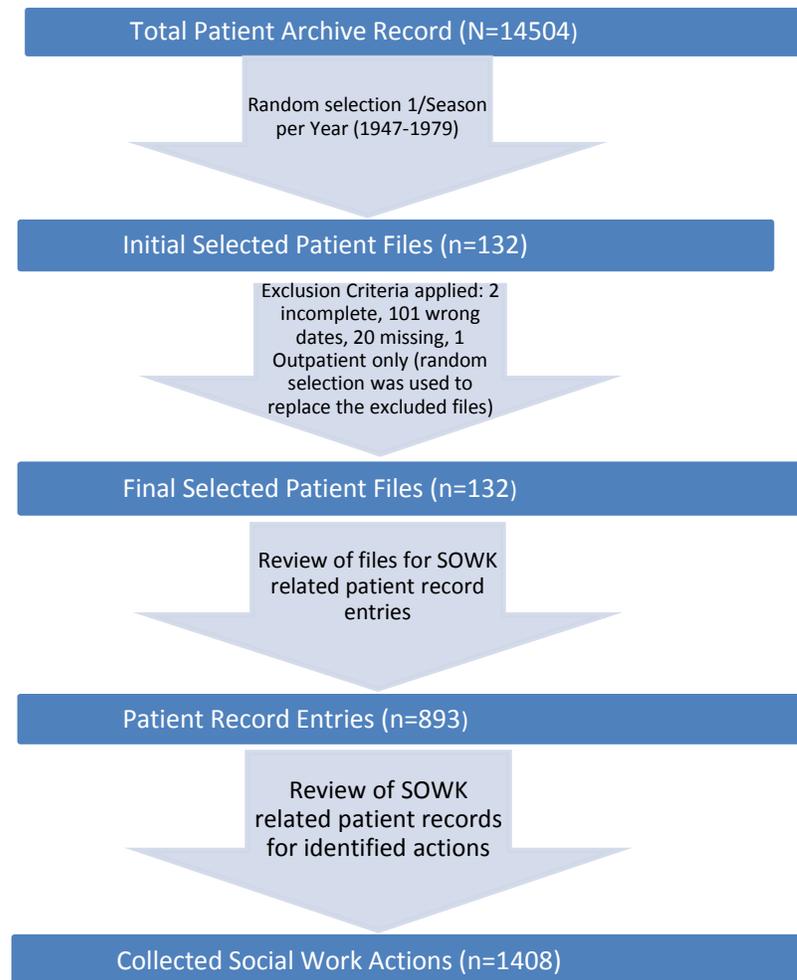
The sampling frame includes all the patient files admitted to SMHC during the time period of study. The data collection form in Appendix A is the template for the initial collection. Access to this data was approved by the SMHC Research Ethics Board and confidentiality agreements were signed in accordance with the Personal Health and Information Act or PHIA (C.C.S.M. c. P33.5, 2012). See Appendix D for a copy of the signed confidentiality agreement and letter of permission from SMHC.

I have spoken with the chair of the Psychology and Sociology Research Ethics Board (PSREB) at the University of Manitoba. It is his view that I would not need to go through a formal application for ethics approval through the University of Manitoba’s PSREB (B. Barth, personal communication, October 11, 2012), given the nature of the data that I planned on using. Furthermore a master list that has the original patient number linking to the new identifier or recoded patient number is located on a password protected computer in an Excel spreadsheet document that is separately password protected.

Data Collection

Figure 3.2 is an illustration of the data retrieval process. Note that this process follows a number of stages which will be discussed in greater detail below. Specifically stages involving random sampling, exclusion criteria and the coding process.

Figure 3.2 Illustration of Data Retrieval Process



Microfiche was reviewed via consecutive examination of the film. Each film was examined for evidence of forms and or entries on forms illustrative of social work related actions and or the professional designations of the social worker. The same approach was used in the case of hard copy patient files. While some forms may be labeled in ways that indicate social work activity (e.g. Social Assessment, Social History etc.), with the exception of sections of the patient record irrelevant to social work, such as blood pressure checks, possessions inventories and physical examinations or laboratory tests, all documents went through my data collection review process. All documented entries in the patient record are hence reviewed for inclusion in the data collection process.

Patient information by date of admission is available in an organized fashion. First, I was given an electronic copy of the Excel spreadsheet for the patient records already entered by the SMHC archive staff. I requested and received an electronic copy of said spreadsheet with names removed. For this master list, the only identifier is the original patient number and date of admission to SMHC. For the remaining 11 years (1969-1979 inclusive), I manually entered into this existing master spreadsheet the patient numbers, along with dates of admission. This was done using the ledgers at the SMHC archives where hard copy records of this data are located. The data available in the ledger is the name, dates of admission and discharge, along with a patient number in handwritten format.

When entering the remaining 11 years into the Excel spreadsheet, I would review patient numbers for duplication or readmission and omit these from data entry. Names were not entered into the master list in order to match the existing format and address confidentiality considerations. SMHC at various times admitted prior patients under new patient numbers. Given this practice, the ledgers were carefully reviewed to see if the patient number is a new

number for a prior patient or a new patient. The ledgers are a source of data as to who was admitted at SMHC on a given date. In other words, readmissions are logged in as well as new admissions. Hence, all admissions required thorough screening to ensure that only new admissions are actually entered into the master Excel spreadsheet for the purpose of this study.

Coding and Randomizing

The original patient numbers in the Excel Master spreadsheet were consecutively recoded with numbers based on a random starting number. Then an Excel Function was used to select a random recoded number per unit (January-March, April-June, July-August, September-December) per year of study. This took the form of using the “=randbetween (x,y)” command where x and y include the recoded numbers range per unit. Exclusion criteria for this study were if the file would be any patient file initiated as out-patient in status, was exclusively outpatient, or a readmission (prior first admission in another year). In the event that a chart met exclusion criteria, the F9 command was initiated in the Excel spreadsheet to select another random number from the time frame (January–March; April-June etc.).

In the event that a file was missing, archive staff was asked to investigate. Frequently a chart would have been given a new patient number in future admissions and all prior patient file data would be relocated to the new number. If such a new patient number existed, this would be noted in the Excel spreadsheet to exclude the future number from future sampling frames. The way this was done is by removing the recoded number and simply placing “XXXX” in that column to prevent it being selected again, plus changing the range of files in the quarterly year (January-March, April-June etc.)“randbetween” command in Excel as one less file will be in this range. To flag this procedure for ease of follow up, comments were inserted in the Excel spreadsheet for both the original patient number and the new one. While many of the files were

located initially, there were numbers that did not reoccur in the year during which the new number had been assigned. One can speculate on why some numbers were absent in the ledgers and or the spreadsheet but their absence serves the same function of omission from study. Suffice it to say, measures were taken to search for them and to actively exclude them if located. Using the Excel search function addressed those that did and were treated as ineligible for the given year.

If selected and included in the study, the recoded number for the original patient file number is used so I can locate it this way in the master file of the Excel spreadsheet. Missing files are handled as eligible files but not available so a reselection of files is initiated. However, since eligibility in inclusion criteria remains unknown, their absence from the sample frame is not warranted. The file is flagged with a comment in Excel to note said record's absence. The reader is advised to see the results section for a more thorough analysis of missing and excluded files from this study.

Reviewing Selected Files

Next, the patient file was reviewed either on microfiche or in hard copy to see if it is eligible for data collection. If no exclusion criteria are met, it was carefully reviewed for content related to social work (form and/or function). This is based on the identified tasks performed by social workers as found in the literature (see Appendix F). Identifying samples for collection is informed by literature as well as my own experience in the field. Identified samples, when located, are given initial coding to indicate the rationale for sample selection and collected via the Raw Data Collection Form (see Appendix A).

Creswell, (2007, p. 130) advises to take notes while transcribing recordings of participant interviews to ensure insights generated by this process are not lost. A case can also be made that

archival records are a form of transcript available for review. Hence, I wrote research notes throughout the process of data collection and analysis in order to capture qualitative data.

Operational Definitions

Operational definitions for social worker and social work related tasks or functions are employed throughout the study. A social worker was identified as anyone working at social services in the capacity of performing services to or on behalf of a patient and or their families, who has the title of social worker or has the academic credentials (i.e. BSW or MSW). Social work tasks were understood as anything identified as being performed by a social worker (e.g. counselling, teaching, psycho-education, field supervision of social work students and paraprofessionals, completing social histories, discharge planning). Furthermore, anything as defined by the Generalist Practitioner Model (Zastrow & Kirst-Ashman, 2013, pp. 49-51) and/or the core tasks of social work in mental health as stated by Regehr and Glancy (2010, p. 4) were considered appropriate definitions of social work related tasks or functions (see Appendix F). These include performing comprehensive psychosocial assessments, case management, facilitating and engaging in interdisciplinary consultation (where social functioning and supports are stressed), as well as advocacy efforts (on behalf of patient and/or patient family, community board participation etc.) and family related aspects of care (therapy, collaterals, etc.). In any case, the aforementioned tasks are treated as codes of social work function (i.e. social work functional activities) by which I review the patient file contents and will be remarked upon more thoroughly in the section on data analysis.

Quotations from the Patient Record

Patient record quotes were taken whenever such an identified content was found. These social work related patient record entries were at times extensive quotations – in order to see what is found clearly and to allow for greater analysis of the content during the analysis stage of

research. All patient names (including family members) during this stage of collection are hidden via “XXXX” during the quote collection process to protect confidentiality. Each patient record entry includes a reference to what type of patient record was found. This frequently comes from the document’s own heading or title. I use the term “supplemental progress note” to connote when there is no heading and it is one of the most common ways the chart is set up – a running commentary by various disciplines. I took memos and notes throughout the data collection process.

While data collection was uniform, if the data was not from SMHC staff (i.e. a letter to the staff at SMHC), the information as to author was disregarded and the addressee, added to the name of the document usually, became the focus. I am only noting the documents generated by SMHC in order to capture what was done at the institution. When such data addresses SMHC staff, it illustrates what was expected of said staff to perform at the institutional level. Hence it is included and coded thus. When there is data in a patient record from Winnipeg Psychiatric Hospital (WPH), this is ignored as this meets exclusion criteria of data not pertaining to SMHC staff. In other words, data was collected whenever the focus involved SMHC staff. This could be authored by SMHC staff or be related to what an external author is expecting of SMHC staff to perform as part of their duties.

Dating Methodology for Demographic Purposes

Demographic data was largely gathered off the face sheet that most commonly would take the shape of a full page form called “Register Data Sheet” invariably available for each file. Unless admission and discharge were in the same month, I would treat each month as a separate unit – as my analysis will not go further than year or month. Days in treatment at SMHC are not a unit of measurement for this study. If an admission was less than a month, I would enter the

number of days into the spreadsheet. In creating categories for analysis, such entries are later included in the code of 1 month. For example, if a patient has a length of stay (LOS) of 1 year, 5 months and 12 days, the 12 days are considered part of an additional month. For the purpose of this study, the patient has a LOS of 1 year and 6 months.

Anyone that is readmitted within the 6 months' probation is not considered a readmission as they have never been formally discharged. This is based on the policy at SMHC of discharging from hospital on 6 months of probation. Hence, all activity during this time period is still the responsibility and domain of hospital staff. Therefore, the intervention stages for the samples collected include anything related to probation. However, if the record clearly shows that a discharge occurred prior to 6 months, this would be treated accordingly and collection would cease at the point of the discharge date as in such instances the institution is clearly no longer involved in the care of the patient.

If patients were readmitted within the 6 months, they were not counted as a new admission for demographic purposes, but the workup on day one (of the readmit) would be treated as admission related as this is the focus at that point of time and lends itself to proper qualitative analysis of such an activity. To clarify, for data collection, this will not mean that another admission has occurred.

Usually, discharge is when probation occurs, so there may be up to 6 months of qualitative patient record entries illustrating what is done (i.e. function) during this stage by the social worker or alternate staff performing social work. This was also done in the hope that patient record entries in the admission and ongoing treatment categories would more accurately cover the inpatient activities done by social work, the argument being that the nature of social

work activity as located at the institution is of interest. Anything beyond full discharge (from probation) falls beyond the scope of the inpatient social work function. The way I ascertain this is a combination of data sheets indicating admission and discharge as well as (when possible) the letter of probation and summary of discharge (as well as notice to family of said probation/discharge status). What this means is that in some cases the discharge summary is less than 6 months and will be treated as such rather than the default 6 month if the patient record has documents stating this. As an illustration file 12859 (recoded) had multiple admissions within a 6 month window which are treated as separate and distinct (not readmission) because the discharge from SMHC had been Against Medical Advice (AMA) hence no probationary period was provided.

For each file, each year of treatment was examined in detail and demographic data was collected (See Appendix A) and then entered via Excel. The demographic data concern such items as the kind of diagnosis made, the gender of the patient, and the age at which they were admitted. Further demographic information includes the number of admissions and LOS. Authors of patient record entries for a patient file were entered in the spreadsheet in a number of ways. Their degree, their professional designation, and the frequency that they appear in a particular patient file were all included in the spreadsheet.

Data Collection Phases

The procedure for data collection took a number of phases. In phase one, the patient file is scanned in order to locate where documentation relevant to the study is located. In other words, sections of the chart that relate to physical care are noted and then omitted from further review.

Data cleaning took the form of synchronous activity during the collection process, as duplicate files were removed from future sampling frames as soon as they were discovered. Given the size of the patient records in the SMHC archives and the time limitations of this study, it is likely that not all duplication in the sampling frame were discovered. One would need to review every file in the collection for faulty admission data which would exceed the capacity of this researcher to complete the study within the time lines of a dissertation. It was therefore handled as I proceeded with the study in random selection. In effect, each time I randomly selected a file, it was reviewed to see if the admission data on the Excel master spreadsheet matched the contents of the actual patient file. If prior admissions or any other exclusion criteria were found, it was omitted from study. There were occurrences where a patient file was already filed under a new number that had been assigned in a later admission. In such an instance, I would note this location and remove the later number from the year in which it had been assigned, as it would be a duplication of the file – available in both the actual year of first admission and in the future year of admission wherein the new number had been assigned. In all likelihood, I would have identified this file as ineligible in the future year of admission, but this procedure is a way in which I was able to address this challenge proactively.

Use of the Raw Data Collection Tool

The second phase for review of the chart consisted of a detailed examination of all documentation related to the patient's care. The Raw Data collection tool located in Appendix A is how verbatim social work related patient record entries from the patient file were retrieved. Description of what is found is not part of this initial procedure beyond a brief notation. Data that appears to describe the social work actions used in this dissertation illustrating activities are taken verbatim and located on this form as stated above. The date of entry and author of the data is identified by their occupational as well as academic credentials, when possible. Entries in the

chart are examined to identify who is performing a service, or who the actor is, as the author may not be the focus regarding social work action but simply commenting on what was done and by whom. Actions identified as social work related (i.e. functions) were noted, according to the data collection form (see Appendix A). As an illustration, if an entry in the patient record refers to staff arranging for housing after discharge, this correspondence is noted in the data collection form as a social work function and the author's or actor's occupation/vocation is included as well.

Data Collection Follow-Up

While data collection formally concluded in August of 2013, I went back to SMHC in October of 2013 to review the face sheet for hospitalisation rates to ensure that if the 6 months are observed or not, there is parity. In other words, the return to SMHC to review the patient record was done to safeguard that multiple admissions to SMHC within the 6 months probationary period aren't counted as separate admissions. The files I flagged (13191, 13656, 13841) where this was questionable were resolved in favour of the face sheet as any discrepancy in the observance of the 6 month window was related to a good excuse (leaving area of service or AMA) that would then reflect less than 6 months and increased the likelihood that any other deviations are related to this. Hence the SMHC observed discharge protocol is the same as I have observed throughout the study.

Sources of Demographic Data in the Patient File

In order to track and enter each patient file diagnosis at discharge, the most recent diagnosis off the "Register Data Sheet" was taken. This form was consistently present in the record and would have much of the demographic data collected for this study. Sometimes there was a blank next to "Final Diagnosis" so the provisional diagnosis was selected by default. In such cases it is assumed that the diagnosis had not changed. The content of the file itself was a

way to verify this assumption as any changes in diagnosis would be discussed in a treatment meeting or a documented consultation. Such an event is then noted in the supplemental progress notes, and can be seen as another form of verification.

Admission Dates Collection Design

Data from selected patient files were reviewed and collected across all years of admission. Each admission after this first instance was examined for patient record entries ending always post 6 months or when explicit termination of probation status was indicated in the chart. This process continued until the last admission on record was examined. In other words, raw data was collected beginning with the eligible year of study and concluding 6 months post last discharge date within range of this study. What this means is that a patient admitted in 1979 may continue to have data collected until that admission has expired post probation. Subsequent admissions after 1979 are ignored but noted during collection that they are present in the file.

Data from Government Reports

Another form of data collection is the following materials, whose aim and purpose is to provide a better analysis of the patient file materials collected. Therefore, this additional data are located in the chapter 5, in order to provide greater context and facilitate understanding of the data discovered in the study. This research also entailed a detailed review of annual reports by the provincial psychiatrist to the Manitoba Department of Health (located at the Manitoba Archives). This includes national reports (e.g. CMHA and Federal Government), Provincial NGO and government reports. Findings from oral history with individuals having practiced during the period of study in the mental health sector, focusing on what social work was and who performed it at SMHC, are included there as well but are primarily located in the literature review and discussion chapters. According to archival staff at SMHC, there exists a volume of

reports sent to the federal government from 1953 to 1974 that documents the number of social workers employed at the facility and their academic credentials (personal communication, January 08, 2013). These were consulted as well and will be included in chapter 5. The presentation of the data from the federal and provincial reports along with the patient record entries can be understood as another way that the data is analyzed as well.

Data Analysis Stages

A portion of the analysis procedure involved looking at how frequently a given social work action (i.e. function) occurred and sorting it by a demographic category. For example, social work actions or functions were sorted by year of admission to determine if there was a pattern. If sorting by who is providing services, I looked for how often a given social work task was provided by this provider or actor. This was done to explore what the most common social work function was for the profession (i.e. form) as well as which were more likely performed by other members of the treatment team.

For each patient file the basic demographic data was entered in Excel. Furthermore, data as to provider and frequency of activity by stage of treatment is some of the data included on the Excel spreadsheet in order to perform descriptive statistics. There are a number of ways that this is done. When sorting by the service provision date, I looked for who provided social work services (discipline) and what types of services (function) they provided. This was an attempt to explore if changes in social work services and therefore the discipline providing it followed a temporal course. By examining services documented by year provided, I looked for which discipline provided these most frequently and the nature of the service provided. In looking at themes by the stage of treatment (i.e. by intake/treatment/discharge) this same question is

examined (discipline and function). Organizing by age of patient was done to examine whether this age factor impacts the kind of social work activities and who provided them as well.

Preliminary Summary Comment

In effect, I engaged in a research strategy for data analysis that uses the descriptive data as a way to further identify clinical trends and themes not otherwise readily apparent (Risse & Warner, 1992, p. 193). I remained aware, however, of Reaume's (2000, p. 5) assertion of the utility of statistics in this kind of research really being a kind of guide to broad trends, not of the substantive experience of the clinical story. By compiling an aggregate narrative, I sought to identify common ways that social work – both action and profession - was understood and treated by staff at Selkirk, and how social work commonly emerged there.

As the results section shows, a narrative was constructed seeking to describe the story of how patient care evolved while noting any divergences in the patient records for each of the descriptive statistics employed. In essence, the narrative is the description of the social work functions, along with verbatim samples to illustrate these, along with a discussion of where these functions are most frequently located via the demographic data collected. This is located at the conclusion of the results section.

Quantitative Analysis Detail

Quantitative analysis began with the entry of all demographic data collected with the sample sheets into an Excel spreadsheet. This constituted data such as number of folios (or hardcopy), year of admission, season (quarter of year), recoded patient number, diagnosis, age (during first admission) date of first admission, length of stay (see Appendix B), number of admissions, and gender. Further data included tracking in each patient file if an actual social

worker had been involved. The reader is referred to the prior sections above regarding the operational definitions of the social worker.

Next, a number of frequency counts were calculated for each sampled patient record. These included the number of social work related patient record entries collected per patient record. Further to the main research question, the number of social workers as well as the number of social workers with degrees (both social work and non-social work degrees) and the number of non-degreed social workers were counted. In some cases, a recurring employee name would appear with or without degree. Whenever I found prior evidence of degree within the same time frame (e.g. two different entries in the same year for the same author with one entry showing degree) then I defaulted to this.

In calculating the frequency of social work actions, I counted a social worker when this worker designation is in play, regardless of degree. As an example, one employee frequently emerges by name and has an RN designation. Despite this, the employee is at times given the title of “Social Worker” or “Social Work Supervisor”. Therefore such entries are counted as the actions of a social worker, not a nurse. This is consistent with the operational definition of a social worker for this study. This decision is also based on what is known about the institution in that the first social worker hired in 1947 was a nurse (Department of Health, 1948). The social worker, in this case, is someone who is acting as a social worker with a non-social work degree.

The frequency of the RSW designation found in each chart was entered as well. Other frequency counts included the type of social worker in terms of clinical versus administrative capacities. The frequency in which a professional, that is not designated as a social worker performing social work, was also counted and entered for each patient file. This is based on the

designations given by authors in their own entries of the patient file. These included nurse, doctor, clinical director, superintendent, assistant superintendent, executive assistant to the medical superintendent, and psychologist. I added the category “other” where I include anything that isn’t located under the other categories, this includes when I don’t have authorship (e.g. NA). The only exception to the “other” designation is when the document type indicates a social work related title (e.g. Social Service Report etc.). In such cases, the unknown authorship designation is assumed to be a social worker. In the same vein, a document titled “Nursing Assessment” or “Physician’s Note” is identified with authorship according to each professional designation. See appendix for the full code book referencing how this was entered into Excel.

Next, descriptive statistics were calculated and will be elaborated upon more fully in chapters 4 and 5. Relationships among categories were examined in bivariate analysis such as contingency tables.

Coding Patient Record Entries for Social Work Actions

I am aware that in this kind of research there may be a bit of blurring of the line between data collection and analysis as some themes may become apparent during collection. This is consistent with qualitative approaches to research (Creswell, 2007; Monette, Sullivan & DeJong, 2011) and will thus be incorporated in the collection aspect of archival research. The approach in this study is qualitative descriptive in nature (Sandelowski, 2000) employing what I am referring to as “repeated coding procedures” similar to constant comparison.

Similar to other qualitative approaches, the first steps towards analysis began during the data collection process at the archives in Selkirk. Initial codes were applied, informed by the literature on mental health social work and my own prior experience in this field. Next, each

social work related patient record entry was reviewed independently and exhaustively with multiple codes being applied to it during a second review.

Upon reviewing each and every social work related patient record entry and applying additional codes, the original codes contrived during the data collection procedure were compared to these newly derived codes in the second review for similarities and differences. While engaging in the process of identifying themes, the notes taken during the data collection process were consulted to aid in this process.

Next, all codes were compiled in an exhaustive list during a third review of the samples. These were compared to the list of identified tasks or functions for social work in mental health (see Appendix F). Codes were then assigned into broader codes or categories belonging to this original list of social work tasks or activities as identified in the literature. This was done via comparison and contrast of said literature as well as my own personal experience in the field of mental health social work. These identified social work related functions are treated as codes within which to sort and subsume the exhaustive list in order to manage analysis effectively. Finally, the codes were submitted to two social workers with experience in the field of mental health for review and verification. One is Len Spearman, PhD -a member of the PhD committee involved in this dissertation - while another is Terry Hryniuk -a social worker with lengthy experience as a Rehabilitation Counsellor and finally as Director of Social Work at SMHC. Both are satisfied with the core codes identified (L.Spearman, personal communication, May 8, 2014; T. Hryniuk, personal communication, May 16 & 17, 2014). In the case of the committee member, the focus of the feedback was the procedures by which themes and subsequent codes were arrived at. Regarding the latter, the codes themselves were commented on for verification that such activities represent social work actions taken at SMHC. Noteworthy was a former

SMHC social worker's confirmation was the observation that there are qualitative differences in how a social worker may have performed the same activities than a non-social worker at SMHC (T. Hryniuk, personal communication, May 16, 2014).

Additionally, a social worker with experience in mental health participated in reviewing the social work related patient entries of approximately 10% of the patient files, for inter-rater reliability. The social worker is Albert Hajes, who worked in mental health from 1980 to 2006 – both as a direct service provider and later as the Regional Director for Mental Health Programs with the Brandon Regional Health Authority Mar 2003 – Mar 2006 and a consultant for the Mental Health Commission of Canada from 2007 to 2008. Mr. Hajes' signed confidentiality agreement is located in Appendix D.

The way this was done is via a detailed conversation around the ways that the social work actions are derived. The file entries were then provided to Mr. Hajes, absent of the demographic data, patient or staff names and other information not relevant for this purpose. The codes that had initially been applied to the entries are all removed so Mr. Hajes was able to code freely. The results of his coding were compared to my original ones and any differences were discussed to see if these were substantive or semantic. Inter-rater reliability was achieved (A.Hajes, personal communication, August 26, 2014).

The codes arrived at totalled 15. As already stated, they are the composite of social work activities or tasks (i.e. functions) in mental health as derived from the literature (see Appendix F). For clarity, these will now be reviewed in more detail below.

Social Work Codes

“Advocacy” related to any work done by staff related to “on behalf” of the patient. One instance has a medical superintendent (recoded chart number 160) advocating for a patient to receive British VA benefits and going to great lengths to do so. If the chart explicitly refers to an activity as advocating for, this entry would be coded in this manner.

The code “Education” included themes related to patient education, social skills training, family education, and education of informal supports. It refers to the activity of education and is broad to the point that it doesn’t discriminate whether the education is directed at the patient, their family or any other informal support. The code also does not discriminate as to content of education and can take the form of education around mental illness, mental health, how to manage the activities of daily living or social skills training.

For the code “Housing”, while this may be self-explanatory, this involves any reference in the patient record entries to arranging, looking for or planning for housing.

“Linking” is a code based on the tasks of staff to connect patients to resources both internal and external to the hospital requires knowledge of what is available. Linking is the task of connecting patients to these resources and is the code used whenever there is evidence in the patient file of such activity.

In considering the use of the code “Referral”, it is seen as a more formal approach to ensuring that needed services are available to the patient and involves completing relevant documentation or making records available as needed to a source where the patient is to be referred. This is sometimes quite explicit when samples have terminology that expresses that a referral is or needs to be made, for a given identified service need.

In conceptualizing the code “Working with Family” it was understood that this is a broad code that is employed whenever staff are either meeting with family or communicating with them. This can take the place of correspondence notifying the family of the client’s current status. At times this is in response to a family’s query and sometimes it is simply a status update. The main point here is that including family by keeping them informed or seeking their assistance in discharge aftercare planning, are aspects of social work functional activity. This, I would suggest, lines up with the idea that “social work brings the client out of the medical model into the real world/environment” (T. Hryniuk, personal communication, May 16, 2014)

“Assessment” included what could be identified as the collection of family history and/or social history by the author of a given sample. Given the focus of this study, this code refers to any activity that relates to information gathered regarding the family history or the social history of the patient. While documents may have a title such as “Social History” it may be embedded as a heading within a document. This code is also used whenever there is reference to the patient’s social functioning or family constellation.

“Case Management” refers to a number of themes that emerged during collection and analysis. Many categories are subsumed under this code, as case management is a concept that accommodates a variety of functions. Management of the patient chart is understood to be a function of case management and hence all references that reflect such activity are included here. Managing aspects of a patient’s external environment that involves coordinating services, communicating with referral sources and ensuring access to medication are all legitimate activities within case management. Finally, work focussed on effective termination that involves effective discharge aftercare is a part of case management that is evident in documentation of said activity and in summary form upon case closing in a termination summary. Finances were

included in this code whenever this topic involved the ongoing managing of a client's finances. This could take the shape of requests from payer sources for additional funds or the budgeting and use of available dollars on behalf to the patient.

Given the literature on "vocational rehabilitation" (Becker, Drake, Naughton 2005; Mueser et al., 2003) this code encompasses all functional activity related to employment. While linking or referral codes describe the way this may be approached (with a referral to employment training service for example), this code makes it explicit that what is being focussed on is employment as a legitimate function of social work. Examples would be patient record entries that refer to vocational rehabilitation or job training, vocational assessment, assistance in a job search as well as access to education. Given that the patient file would frequently refer to access to education as a prelude to education, it is included within this code as well.

"Collateral" is a code used whenever a secondary source is being consulted to secure additional information pertinent to the identified patient's care. "Crisis Intervention" involves the functional activity of staff in returning a patient to in-patient status and invariably appeared to relate to whenever a given patient was decompensating.

"Counselling\therapy" involved a number of concepts that are incorporated that relate to the interpersonal supportive stance taken by staff. This could take the shape of working with the individual or with additional members of the family, including family or marital counselling. While this may be explicitly stated as an intervention, whenever there was reference to interactions in which staff were supportive of concerns raised by a patient that was aimed at allaying anxiety or fear, this code was used.

“Benefits” referred to the data included here that has to do with applications for eligible benefits either initially or repeated reporting of required information to maintain these resources.

“Monitoring” involves any functional activity where staff are keeping in touch with the patient, directly or indirectly, to document and report on the activities and functioning of the patient. Included in this code is when staff are ensuring systematic medication administration where failure to adhere to the regimen can be ascertained, as well as where the occupational functioning is tracked. This can take the shape of meeting with the patient, interacting with secondary sources such as landlords and employers or family. It should be noted that any indirect measures such as phone calls and letters are considered eligible for this code designation as well.

“Consultation” as a code is used whenever there is evidence of multidisciplinary activity between a treatment team and a staff person that is performing an activity (i.e. function), or with someone as identified from the field of social work. For example, this can take the shape of a social worker and a physician discussing treatment strategies prior to initiating these.

Once the codes had been subsumed under said original categories, numbers were assigned to each code for ease of entry into Excel spreadsheet. Another review (i.e. the fourth) of the patient record entries followed, during which these numbers were then assigned to them and entered into a separate Excel spreadsheet. During this review and entry phase, descriptive data related to the actors and stages of intervention were collected as well. It should be noted that social work related patient record entries may contain actors as well as authors and multiple codes assigned to them.

What this means is that a social work related patient record entry may be entered into the spreadsheet with multiple lines. One being the actor (e.g. a physician looking for housing) as well as a request by the actor (e.g. here the physician referring to or requesting a social worker to connect the patient to local job options in the community). In such a case both would be entered into the spreadsheet for the same patient entry. One entry would indicate the actor and their actions, the other indicating an additional actor and their activity (i.e. function).

During this review process, one social work related patient record entry was omitted from the study and all descriptive statistics impacted by this were recalculated accordingly. The entry concerned remarks made by a physician, and upon third review did not appear to be relevant to the study. Furthermore, a few patient record entries were found to be incomplete and these were reviewed at a follow up visit at the SMHC archives. This visit resulted in further adjustment of the total number of document samples collected, and related statistics were recalculated for their inclusion in the study. For further details, the reader is referred to the results section of this paper.

Quantitative analysis of codes along with accompanying descriptive data in bivariate analysis such as contingency tables to examine relationships between authors and their actions was performed. The results of this analysis, as well as the construction of the Excel spreadsheet of the social work action-coded patient record entries, form the basis for guiding the following qualitative analysis below.

Constructing the Narratives

Initially, the narrative around the social work functions was constructed. This took a number of stages. First, the existing Excel spreadsheet that has all codes for the social work related patient record entries was filtered by each of the 15 social work action (i.e. function)

codes. This was done by filtering the spreadsheet by each social work code separately. Each code was then filtered by social worker as actor in order to then examine the Word document that has all social work related entries by chronology. The relevant social work action code then provides the relevant dated entries for examination that illustrate the code in question. These were then examined for common elements that describe the code being analyzed. A suitable quotation was then identified and, after a brief summary of its relevance, was pasted in a Word document that was constructed for the purpose of capturing examples from each of the 15 codes.

At the conclusion of the above activity, the selected examples from the patient record were reviewed multiple times and a narrative was constructed for each of the 15 codes in how examples of each action or function were encountered in the patient record. Relevant descriptive statistics are added to this narrative, serving to increase understanding of the qualitative findings. The following is a description of the steps taken to present the findings of the social work actions.

Based on the findings of the quantitative analysis of themes and the memo writing done during data collection and analysis, specific codes of social work related functions were revisited. Relevant patient record entries of similar activity by social work and non-social work staff were examined to identify similarities and differences based on analysis of their content to get at an aspect of the form of social work.

During the construction of the narrative of social work actions or functions as they are found at SMHC, selected descriptive statistics preface each action before the narrative in order to add deeper context to the relevant action – such as prevalence in the sample – as well as justifying why some actions are receiving a larger narrative in the findings. Given the time and

logistics constraints of this dissertation, this is not a comprehensive but rather a selective process. Prevalence of a social work action is the guide for performing a more extensive analysis of specific social work actions. Descriptive statistics were used to guide the selection process in this way.

Those actions that are most prevalent in the patient record were therefore subjected to additional analysis and reported on in the findings. For the most common social work actions, the most common actors that aren't social workers become the focus for additional analysis and those findings are included in the narrative of the relevant social work action by social workers at the conclusion of these sections.

The original Excel spreadsheet that has all codes applied to the patient record entries was filtered to show only relevant non-social work actors. They are then subjected to analysis of only the most common social work actions or functions. The spreadsheet was filtered by a specific social work action in order to perform the analysis. These coded entries were then organized chronologically. Every tenth code applied to a patient entry was selected from each non-social work actor and was collected in a separate Word document related to a given non-social work actor. This document was used to locate these specific coded entries in the original Data Collection document. Next, these verbatim entries were subjected to examination and analysis in the same fashion as the above mentioned social worker related social work actions. The social work related patient record entries were examined for any pattern or explanation they can offer to understand how a given action is performed by the non-social worker. This was expanded upon in a narrative and salient verbatim illustrations were selected to be included in chapter 4. In that chapter the social work actions by the non-social worker are then presented at

the conclusion of the sections, which refer to the corresponding action performed by the social worker.

To illustrate, if the doctor is identified as a common actor for a social work action that is prevalent in the patient record, the original Excel spreadsheet that contains all codes applied to the social work related patient record entries is filtered to only show the codes applied to a doctor as actor. These are then sorted by year of patient record entry. Then, this spreadsheet is filtered by a social work action. For example, if housing is a common action, the spreadsheet is filtered to only show the entries that are coded for this action and attributed to a doctor as the actor. Next, only every tenth social work related patient record entry in this spreadsheet is selected. This becomes a finding aide for returning to the original data collection document that contains all social work related patient record entries. Then the identified patient record entries are located and copied into a new word document. In this case it would be a document dedicated to the entries that were coded as “housing performed by a doctor”.

For chapter 5 a similar approach is employed. The existing Excel spreadsheet that has all codes for the social work related patient record entries was filtered only to show the social worker as actor. This selection was then sorted by chronology of date of the entries from the patient record. The result is a separate Excel spreadsheet by which to locate all entries in the chart that refers to the actions of a social worker.

Next, using the newly arranged spreadsheet, all verbatim patient record entries involving the social worker were arranged by copying and pasting them by date of entry into a new Word document. This document was then analyzed to get at implications of the verbatim entry in how it shows the evolving social worker role at SMHC. This was done via review of verbatim

illustrations, the information available off the data collection document of the demographic data (author, title of patient entry etc.) and consultation of memos/notes taken during the collection process, of new memos generated from this, as well as looking at comments and feedback from social workers who have practiced mental health social work in Manitoba (Hajes and Hryniuk).

The final step in this part of the qualitative analysis process is the construction of the narrative itself. In writing the narrative, additional connections are made that serve to present a coherent profile of how the social worker role emerged at SMHC. Part of the analysis here is the inclusion of material from archival records. This material is from both SMHC in the form of the patient entries, but also federal reports for the period of time within the period of study (1953-1975). Further archival material includes annual reports from the provincial government to the province of Manitoba (1947-1979) that provide context and a point of reference for how social work emerges at SMHC. To improve analysis and provide a deeper understanding of the findings, this is then provided in a section called “context” prior to each decade of the patient entries in the chapter on the emerging social work actor. The writing of the context as well as the summaries of what was found (along with illustrated quotes from the patient record) then formed the basis for analyzing the qualitative findings. What emerges is the social worker, rendered visible by both the statistical record as well as by patient file entries.

Conclusion

The purpose of this study is to explore and describe the social work form and function via the actions and actors at SMHC from 1947 to 1979. It is during this period that significant changes occurred both at SMHC and in the field of mental health in the US and Canada (Johnson, 1980; Grob 1991; Grob 1994; Linhorst, 2006; Regehr & Glancy 2010). A qualitative descriptive methods approach to reviewing patient records at the SMHC archives for both

demographic data as well as the frequency of qualitatively-identified themes via random selection of patient files from 1947 to 1979 was completed. Social work related activity was collected verbatim for further analysis, and the demographic data as to patient age, LOS, gender, diagnosis and number of admissions and the occupation/degree/professional designation of the author. The collected verbatim social work related patient record entries were further analyzed to clarify themes of social work action as well as actors involved in such actions performed. Relationships among data collected – both demographic as well as qualitative themes- were examined in order to see how and by whom social work was performed at SMHC.

A narrative was constructed on the emergence of the role of the social worker at SMHC from 1947-1979 inclusive. Another narrative was constructed seeking to describe how patient care evolved in terms of social work actions. The story of social work as function and as form consists of a description of the codes, along with social work related patient record entries to illustrate these. Included in the narrative are discussions of where the codes are most frequently located based on the demographic data collected. This was done for both the social work actions as well as the emerging social worker (i.e. form). The descriptive statistics serve both as a tool to illustrate relationships as well as to guide the narrative. By compiling an aggregate narrative, I am seeking to identify common ways that social work – both form and function - was understood and treated by staff at Selkirk and how social work commonly emerged there.

Social work related functions that are more frequent are given more space for the narrative as well as additional analysis to examine who the most prevalent actors (e.g. doctor, social worker) are. The narratives are presented in a temporal fashion, beginning in 1947 and ending in 1979, inclusive. Additional data from provincial and federal reports are part of the

analysis as they are presented in the results chapters to add context and further understanding to the findings.

What follows in chapter 4 will be a reporting on the social work actions performed at SMHC during the identified time period (1947-1979). This will serve to present an understanding of the functions of social work. The form of social work is then the subject of the chapter 5, where the emerging social worker role is described, based on what chapter 4 will provide on social work actions.

Chapter 4: Social Worker Functional Activities

Introduction

This chapter focusses on the functional activities of social workers or other helping professionals doing social work functional activities as identified in the social work related patient record entries. As this dissertation seeks to understand how social work emerged, this section will illustrate how the social worker performed the most common social work actions. This chapter begins with descriptive statistics collected from the patient records sampled at the SMHC archives. Its purpose is to describe the characteristics of the social work activities occurring at SMHC. What follows then are some descriptive statistics noting the prevalence of each of the 15 codes of social work actions encountered in the patient record. Then, the 15 codes are explored through examples of each, as found in the patient record. The examples of patient record entries for each code are prefaced with a brief explanation to help the reader gain an understanding of the conceptual framework employed. This includes some reference to the descriptive statistics that show their prevalence in the sample, as well as which actor was most commonly involved in a given social work action.

Descriptive Statistics from the Patient Record

Within the sample of 132 patient records, the total number of patient record entries collected is 893. In terms of distribution, the mean is 6.77 with the mode being 2 social work related patient record entries collected per patient file. Fifty percent of patient files selected had 3 or less social work related patient record entries collected per file. When it comes to range, the largest number of social work related patient record entries collected from a given patient file was 47 and the lowest was 0.

Patient Population Features

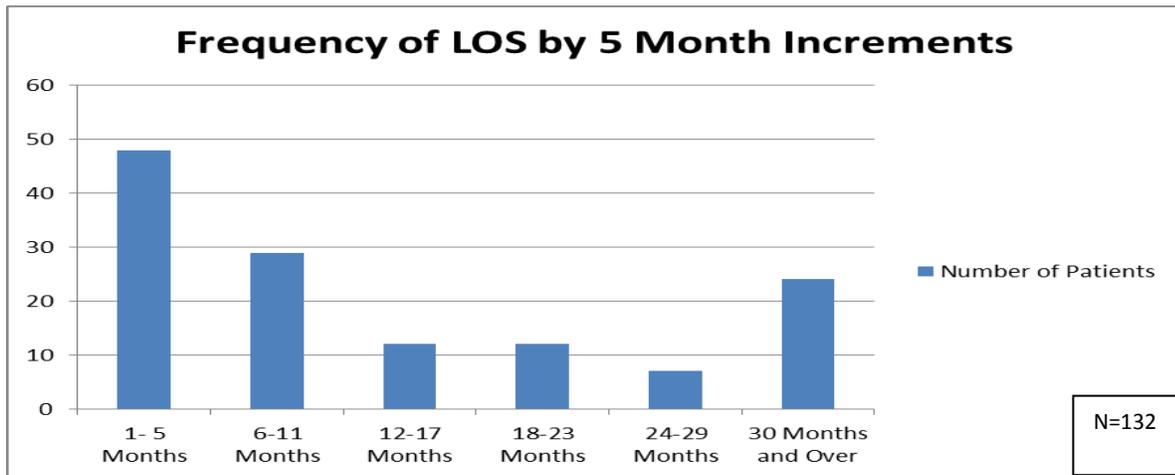
The mean age of patients at first admission (the point of selection for this study) is 43.4 years. The most common, or mode, was 43 with half of the population sampled being less than 39 years old at first entry into SMHC. The oldest patient entered SMHC at 89 while the youngest was 15 years of age.

“Thought Disorder” was the most commonly encountered diagnostic category. In terms of percentages, 40.15% of patients had a thought disorder. The remaining categories in descending order are “Thought Disorder d/t General Medical Condition” (18.18%), “Addictions” (15.15%), “Mood Disorder” (14.4%), “Personality Disorder” (6.06%), and “Other” (6.06%).

LOS is the sum of amount of time spent as an inpatient at SMHC (see Appendix B). What this means is that, regardless of number of admissions, it is the total length of time that is calculated while at SMHC. This is based on the assumption that LOS will be indicative of severity of symptoms or treatment conditions. LOS was calculated in months rather than years and then compressed into ranges for analysis. This was due to the extreme range (1- 577 months) of LOS.

LOS was coded to calculate within 5 month ranges culminating in a final group of 30 months or more (see Figure 4.1). The majority of patients sampled had a LOS of 5 months or less (48 or 36%). More than half (77 or 58%) of the population sampled had a LOS of less than a year. In sum, the most patients seen at SMHC and sampled for this study had a LOS of 5 months or less. Given that there were 24 or 18% of patients selected for this study with a LOS beyond 29 months, this group was examined to see if there were any differences from the rest of the sample.

Figure 4.1: LOS at 5-Month Increments



Features When LOS greater than 29 Months versus Total Sample

When sorting by the group of patients with a LOS beyond 29 months (n=24), diagnosis tended to be similar to the total sample (N=132) with “Thought Disorder” (13 or 54.17%), “Thought Disorder d/t general medical condition” (6 or 25%) and Mood Disorders” (2 or 8.33%), “Addictions” (2 or 8.33%), “Personality Disorder” (1 or 4.17%).

In terms of Gender, the patients with a LOS beyond 29 months (n=24) most frequently were female which differs from the total population sampled. In effect, the frequency of males is 11 or 45.83% and 13 or 54.16% female compared to the total population sampled (N=132) of 70 or 53.03% male and 62 or 46.97% female.

The number of admissions ranges from 1 to 7 admissions per a given file in the total sample (N=132). Three quarters (98 or 74.24%) of patients had been admitted only once to SMHC. For the population of patients with an LOS beyond 29 months (n=24), half (13 or 54.17%) were admitted only once to SMHC.

A frequency distribution was run to look at the patient files with a LOS beyond 29 months. The majority of such files were admitted in the first decade of the study (15 or 63%). The lowest amount was in the final decade of the study (2 or 8%), which would be consistent with ideas around what is known about deinstitutionalization.

One relationship among the data explored involves the amount of activity based on the time of year. The question to explore here is whether the time of year has a relationship with the amount of documentation around social work activity in the patient record. It was found that comparing season and date of first admission of the patient record showed that less social work related patient record entries were collected for patient files first admitted in the summer months (July – September). Only 170 of the 893 or 19.04% of total social work related patient record entries were collected in the summer months.

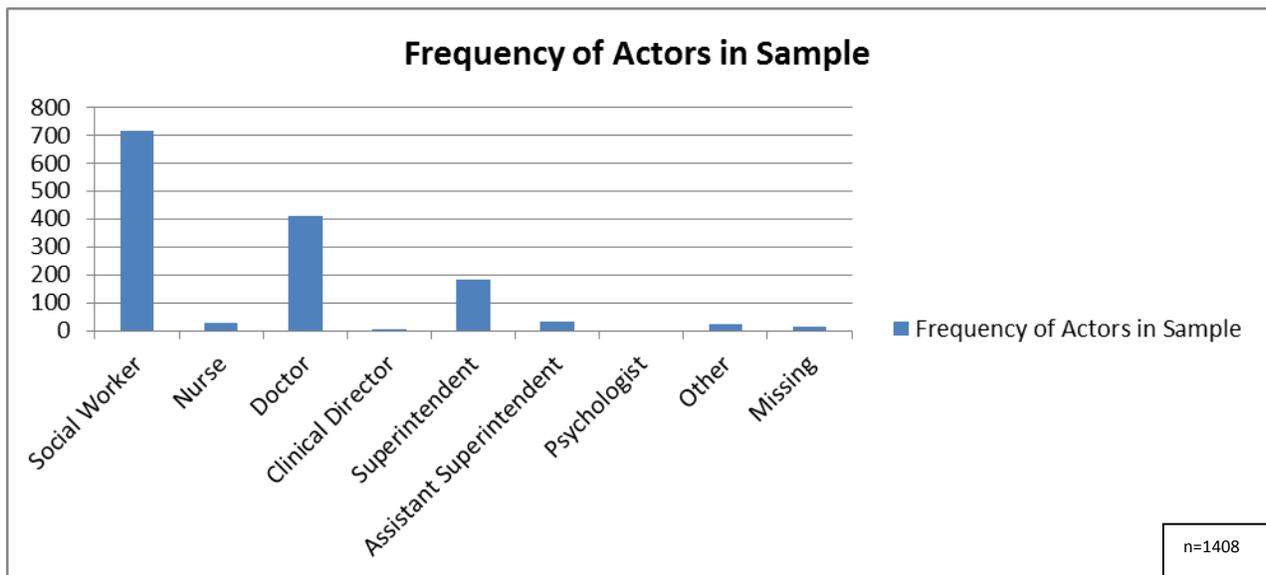
Actors

The following results show that there are some similarities as well as differences between who is represented as an actor of social work functional activity, versus an author of a given patient record entry. The reader will note the adjusted sample size. This is because what is counted are the codes of social work action identified for each patient record entry (see figure 3.1, p. 39 for reference). Given that an authored entry may identify more than one social work action and attribute these to more than one actor at times, the number of total codes collected is used (N=1408).

As can be seen in figure 4.2, a large number of social work related patient record entries included reference to actions taken by a social worker (714 or 51%). The next most common actor identified in the patient file entries is the doctor (412 or 29%). A frequent actor identified is the superintendent (181 or 13%). At times the assistant superintendent appears and functions

in a role similar to the superintendent (31 or 2%). The nurse is another source for 27 or 2% of the total identified codes collected. While the psychologist is not identified as an actor, those identified as “other” constituted 21 or 1% of total codes identified for collection. Sixteen or 1% of the total number of codes applied to the patient record entries is missing the information for the author who constituted the actor in such cases.

Figure 4.2: Frequency of Actors in Samples



The relationship of various factors with type of social work intervention

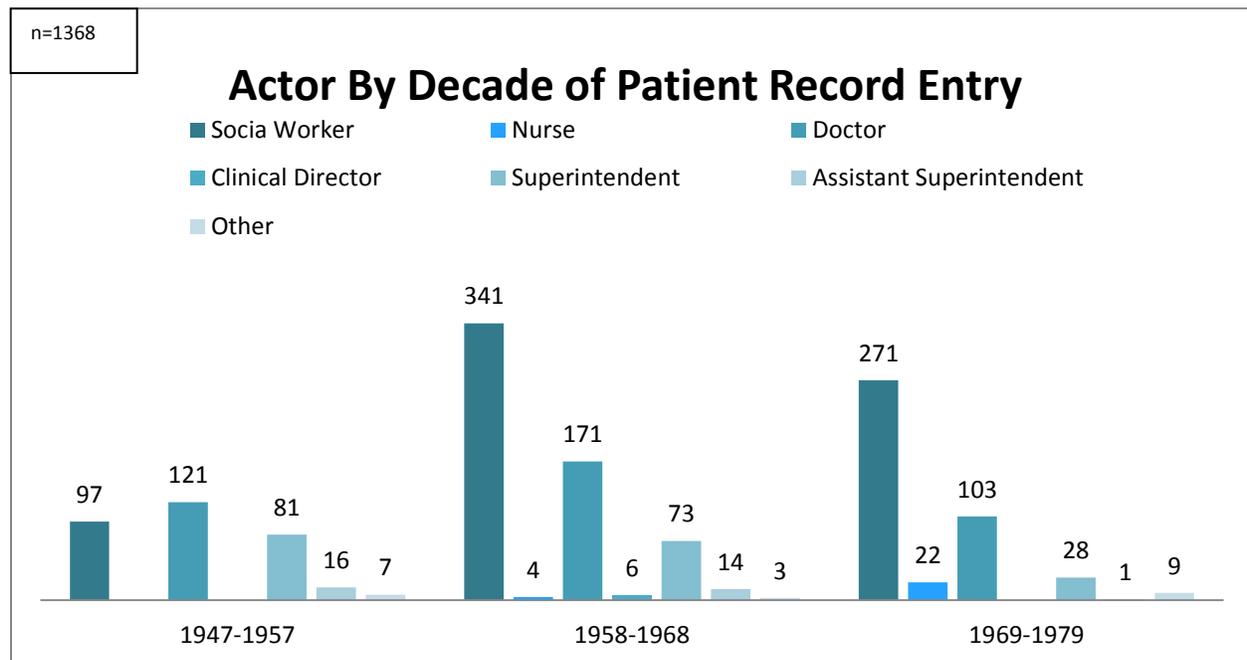
A number of relationships are explored in the following pages. The aim of these explorations is to see if various factors – such as the vocational nature of the actor, the time of the intervention or the date of service provision would relate to the type of social work intervention.

The social work functional activities or codes, are assigned dates of entry based on the patient record entry date in which they occurred. These dates were collapsed into ranges of decades (1=1947-1957; 2=1958-1968 and 3=1969-1979) in order to ease the analysis process. The actor legend relates to the actor codes as outlined in the codebook in Appendix B. The

psychologist is omitted because the frequency count was 0. “Other” refers to other actors not identified in the other categories. Figure 4.3 shows a frequency count of social work related patient record entries. This does not include patient files absent of entries of social work action. Furthermore, patient record entries that have identified social work action codes but are missing dates of entry are also omitted from Figure 4.3 as well. Hence there is an adjusted sample size (n=1368).

Figure 4.3 counts which actor was most likely encountered in the patient record over time. This is collapsed into ranges by decade (1947-1957; 1958-1968 and 1969-1979). As can be seen in the bar graph (Figure 4.3), the largest number of codes assigned was performed by the social worker, notably with 341 in the second decade of the study. It is this number that constitutes 25% of the grand total of all codes assigned. While there is a drop in the number of codes assigned in the final decade of study, it is still more than in the first decade. Of note, in the first decade of study, the doctor (121 or 38% of first decade codes) is the most frequently identified actor of social work functional activity. This clearly changes as the most common actor in the two final decades is the social worker.

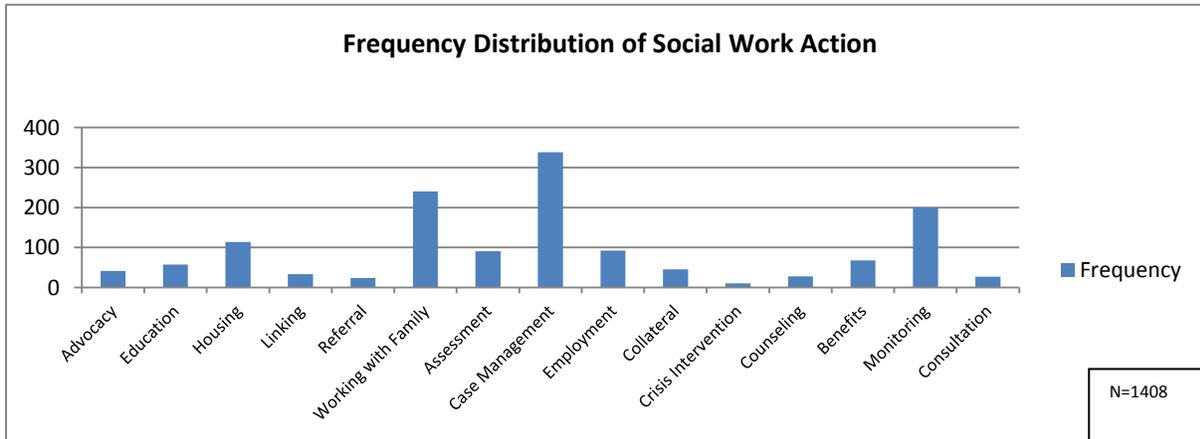
Figure 4.3: Actor by Decade of Patient Record Entry



The number of codes applied to patient record entries rises from 322 in the first decade to 612 in the second. Even when the total number of codes for patient record entries is decreasing in the final decade of study, on balance; it is the social worker (271 or 62% of third decade codes) that is the most prominent actor identified with the coded social work action.

The following statistics focus on what kinds of social work actions were performed. As can be seen in this bar graph (figure 4.4), the largest activity identified in the patient record entries is case management (338 or 24%) followed by working with family (240 or 17%) and monitoring (200 or 14%). Housing (114 or 8%), employment (92 or 7%), and assessment (91 or 6%) completed the most common actions found in the patient record entries collected. It should be noted that there were no missing values for data collected here and only six files from the 132 selected patient files that didn't have data of a social work related nature and are hence omitted from the analysis.

Figure 4.4: Frequency of Type of Social Work Action found in Patient Record Entries



As stated in the introduction to this chapter, when reviewing the examples of social work actions encountered in the patient record, additional space will be made to go over the most frequent social work actions. Table 4.1 is an example of additional statistics run on the 4 most commonly encountered social work actions.

Table 4.1: Social Work Action by Actor

SW Action	Actors							Total
	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	
Housing	83	1	23		4	1	1	113
Working with Family	59	1	73	1	93	9	4	240
Case Management	158	1	89	2	59	19	6	334
Monitoring	143	11	44					198

The psychologist is absent in this distribution as the frequency count is 0. Table 4.1 illustrates only the most frequent activities. The adjusted sample size here (N=1392) is the result of omitting any identified social work action related entry that is missing the value of an identified actor. For a complete account of all social work actions taken by actor, the reader is referred to the corresponding table in Appendix E.

As the table 4.1 shows (note bold numbers in frequency distributions), of the aforementioned most frequent activities – Case Management (158 or 47%) and Monitoring (143 or 72%) - the most likely actor is the social worker. The exception is only for “Working with Family” (59 or 25%) where the superintendent (93 or 38.75%) is followed by the doctor (73 or 30.42%) as most frequent activity taken. Another way to view this is that the most frequent code of all activities is Case management, constituting 24% of all services provided. Of this number, the most frequent actor providing Case management is the social worker. The second most frequent activity is identified with the administrator. This is “Working with Family” (17% of all interventions), of which 39% is provided by the administrator.

Appendix E has the complete table for all social work actions, both those dominated by social workers and those by other professions. Table 4.2 only focuses on those actions not

dominated by the social worker. Regarding other activities not dominated by social work, it is consistently the doctor who performs these. These, in descending order are Assessment (50 or 57.5%), Collateral (30 or 66.7%) and Education (27 or 48.21%). When calculating percentages, for Assessment, social workers represent 30 or 35% of the total number and doctors constitute 27 or 58% making up 93% of the total number of such social work actions. Social workers accounted for 13 or 29% of the Collaterals performed versus doctors who made up 30 or 67% for a combined total of 96% of these actions. The most even distribution in terms of percentages of a total action performed was “Education” which social workers performed 20 or 36% of the time versus the doctor with 27 or 48% for a lower combined total of 84% of this action performed. What this implies is that the action of education was a more shared action as both the doctor did this less, and the social worker does not constitute the balance of the difference. For the other actions, it appears that the social work actions are primarily performed by the doctor or the social worker.

Table 4.2: Social Work Action by Actor not dominated by social worker

SW Action	Actors							Total
	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	
Education	20	3	27		5	1		56
Assessment	30	1	50		1		5	87
Collateral	13		30		1		1	45

The relationship of additional factors with type of social work intervention

Other dynamic factors influencing relationships are probed further in what follows. The purpose is to see if various factors – such as the diagnosis of the patient, their length of stay or the date of service provision, would relate to the type of social work intervention provided to the patient at SMHC.

One question tested is whether the social work action differed based on diagnosis. The contingency table below (Table 4.3) illustrates what kind of social work action was most commonly applied to a given diagnostic profile. This table only shows the most frequent social work functional activities as identified in figure 4.3. For this question, an unadjusted number of identified codes from the social work related patient record entries was used (n=1408) as the focus is not related to an identified actor, rather simply the identified social work action and the patient's diagnosis. For a complete accounting of all activities by disorder, the reader is referred to Appendix E.

It is apparent that thought disorders received the most social work related functional activities with 648 social work actions identified in the patient record entries or 46% of the 1408 identified codes (see Appendix E) related to this diagnostic category. The type of action that was most common for this disorder is "Case Management" (167 or 26%), followed by "Working with Family" (115 or 17.75%) and "Monitoring" (91 or 14.04%). Thought Disorders due to general medical condition was the second most common diagnostic profile requiring social work action, where 269 of the 648 codes identified in the patient record entries or 19% of all social work functional activities found here. The distribution within this group of disorders has "Monitoring" as the most common social work action (57 or 21.19%), followed by "Case Management" (52 or 19.33%), then "Working with Family" (48 or 17.84%). As these two diagnostic classifications are most commonly attributed to challenges with reality testing, and significant mental impairments (APA, 2000; Zide & Gray, 2001), it is noteworthy that these two groups are indeed the populations most in receipt of social work actions.

Table 4.3: Social Work Action Codes by Diagnosis

SW Action	Diagnosis						
	Thought Disorder	Mood Disorder	Addictions	d/t medical condition	Personality Disorder	Other	Total
Housing	46	28	4	24	11	1	114
Working with Family	115	41	12	48	15	9	240
Case Management	167	62	29	52	18	10	338
Monitoring	91	25	7	57	8	12	200

The mood disorders show a similar distribution to the thought disorders diagnosis with the most common social work functional activity being “Case Management” (62 or 25.83%) followed by “Working with Family” (41 or 17.08%). Here the divergence is that “Housing” is more frequent (28 or 12%) than “Monitoring” (25 or 10.42%).

Addictions appear to be the third most frequent diagnosis receiving social work related actions at 102 or 7% of the total number of codes assigned to the patient record entries (n=1408). “Case Management” once again is the most frequent action taken (29 or 28.43%) followed by “Assessment” (15 or 14.71%) and “Working with Family” (12 or 11.76%). Yet “Assessment” is not identified as one of the most common social work actions, see Appendix E for the complete table. The personality disorders appear to have a similar distribution constituting also 7% of the total number collected. “Case Management” is the most frequent (18 or 18.18%) followed by “Working with Family” (15 or 15.15%) and then “Housing” (11 or 11.11%). ‘Other’ makes up 3.5% of the total number of social work actions identified in the patient record. Here the tasks named were “Monitoring” (12 or 24%) followed by “Case Management” (10 or 20%) and “Working with Family” (9 or 18%).

Another diagnosis/treatment relationship explored concerns the question whether social work as action changed over time. Here the focus, relevant to the study, was about the distribution of social work actions over the years. Again, this was done via sorting by decade of the date of a patient record entry.

Figure 4.5: Number of Social Work Action by Decade

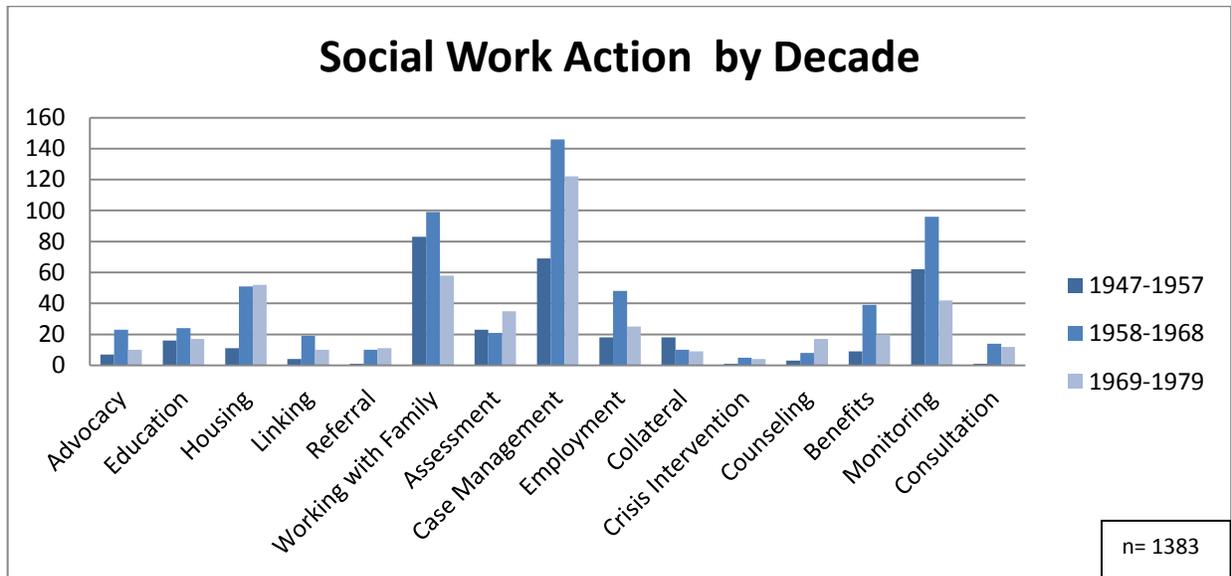


Figure 4.5 illustrates the number and type of social work actions done in each decade.

Social work related patient record entries missing dates of entry are omitted hence the adjusted sample size (n = 1383). The most frequent activity done in the first decade (n= 326) is “Working with Families” (83 or 25.5%) followed by “Case Management” (69 or 21.16%) and “Monitoring” (62 or 19.02%). In the second decade (n=613) of this study, “Case Management” (146 or 23.82%) and “Working with family” (99 or 16 %) and “Monitoring” (96 or 15.7%) were the most common social work functional activities albeit the total frequency of all actions had increased. This order does not change in the final decade (n=444) of the study (1969-1979) with the exception that “Housing” (52 or 11.7%) replaced “Monitoring” (42 or 9.5%) as the third most common activity. “Case Management”, the most common activity during the final decade,

now comprises 122 or 27.5% of the total of all social work actions identified during the overall period covered from the patient record entries.

“Housing” as a social work activity increases strongly from the first decade (11 or 3.4%) to the second (51 or 8.3%) and maintains in the third (52 or 11.7%). “Education” increases from the first decade (16 or 4.9%) to the second (24 or 3.9%) but drops off again (17 or 3.8%) in the final decade of the study. The same can be said for “Employment” as a focus (18 or 5.5%, 48 or 7.8%, and 25 or 5.6%, respectively). “Assessment” experiences a modest increase after dropping in the second decade (23 or 7%, 21 or 3.4%, and 35 or 7.9%, respectively).

What is evident is that most activities – with the exception of “Housing” and “Counseling”, regardless of distribution or growth, experience some decline in the final decade. One could presume that this is due to the shifting of the mental health landscape away from institutional care towards community-located mental health in Manitoba.

Did Patient Length of Stay Impact SW Actions?

The following section will probe whether social work actions changed, based on a patient’s LOS. The longer a patient is in treatment, the more persistent or chronic the condition ought to be. The data was sorted by patient population sample by LOS and social work action. The date of entry of patient record entries was included to see whether LOS of the patient, along with the decade within which the social work action was taken, would relate to the kind of social work functional activity performed.

Tables 4.4-4.8 indicate the number of record entries for social work actions relative to patient’s LOS. Note that the only contingency table showing “Crisis Intervention” is table 4.7. This is due to the fact that there was no record of this action being performed for patients with a

LOS less than 12 months duration. Table 4.4 indicates for each study decade how many social work codes were identified in the social work related patient record entries.

Table 4.4: Social Work Action by Decade for Patients with Length of Stay 1-3 months

1: LOS 1-3 Months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Action	76	101	122	299
Advocacy	3	8	5	16
Education	4	4	4	12
Housing	4	4	8	16
Linking		3	2	5
Referral	1	3	5	9
Working with Family	16	10	16	42
Assessment	5	5	16	26
Case Management	12	30	26	68
Employment	6	11	12	29
Collateral	3	1	5	9
Counselling		5	3	8
Benefits	1	3	7	11
Monitoring	21	14	10	45
Consultation			3	3

Already one can assume that patients with longer LOS have more serious issues prompting a “Crisis Intervention”. As can be seen in the Table (4.4) the most common social work functional activity for patients with a LOS of 1-3 months was “Monitoring” during the first decade of the study (21 of 76 or 27.6%). In the second decade of the study, “Case Management” (30 of 101 or 29.7%) was the most common service rendered. This remained the most common service in the final decade of the study (26 of 122 or 21.3%) as well.

Table 4.5 indicates that for patients with a LOS between 4 to 7 months received “Case Management” was the most frequent social work service provided in the first decade (7 of 29 or 24%) and “Working with Family” (12 of 38 or 31.6%) was most frequent in the second decade. There is a larger influx of overall patient record entries coded, available in the final decade of

study, documenting services provided for this patient population (85 or 56% of total codes identified in the patient record collected for this LOS group). Hence, there are greater frequencies for a number of social work codes. While “Working with Families” remains strong (15 of 85 or 17.6%) it is once more “Case Management” (24 of 85 or 28%) that is the most frequent social work code.

Table 4.5: Social Work Action by Decade for Patients with Length of Stay 4-7 Months

2: LOS 4- 7Months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Action	29	38	85	152
Advocacy			1	1
Education		2	5	7
Housing		1	7	8
Linking			1	1
Referral			1	1
Working with Family	4	12	15	31
Assessment	4	1	10	15
Case Management	7	6	24	37
Employment	3	3	2	8
Collateral	6	1	2	9
Counselling			6	6
Benefits		4	5	9
Monitoring	5	7	4	16
Consultation		1	2	3

Table 4.6 indicates that for patients with an LOS between 8 and 11 months there was a near even number of social work functional activities collected during dates of entry in the final two decades of the study (75 & 74 respectively). During the first decade of the study (n=41), “Working with Family” was most prominent (15 of 41 or 36.6%) whereas this was split as most frequent with “Case Management” (17 of 75 or 22.7% each) in the second decade. In the final decade of the study, entries were coded more as “Case Management” (23 of 74 or 31%) with

“Housing” becoming a more prominent feature (15 of 74 or 20%) than “Working with Family” (10 of 74 or 13.5%). The population of patients with a LOS between 8 and 11 months in this sample did not show any frequencies for actions related to “Referral”, “Employment”, and “Crisis Intervention”. It does not appear that they received such services.

Table 4.6: Social Work Action by Decade for Patients with Length of Stay 8-11 Months

3= LOS 8-11 Months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Action	41	75	74	190
Advocacy		4	1	5
Education	1	1	4	6
Housing		11	15	26
Linking		1		1
Working with Family	15	17	10	427
Assessment	4	4	3	11
Case Management	10	17	23	50
Collateral	4	2		6
Counselling			1	1
Benefits	1	3	2	6
Monitoring	6	12	10	28
Consultation		3	5	8

Table 4.7 illustrates the number and type of social work actions taken for patients with LOS 12 months and beyond. All 15 social work actions are present during this time period. As shown, for patients treated for a year or longer, during the first decade of the study (n=182), the most common action is “Working with the Family” (49 of 182 or 27%) followed by “Case management” (40 of 182 or 22%) and “Monitoring” (30 of 182 or 16.5%). In the second decade (n=400), “Case Management” becomes the most dominant (94 of 400 or 23.5%) followed by “Monitoring” (64 of 400 or 16%) and “Working with Family” (60 of 400 or 15%). It is also of note that for this patient group, the most frequently collected patient record entries codes

available were during this decade (400 of 742 or 54% of total). In the final decade of the study (n=160), the most dominant intervention remained as “Case Management” (48 of 160 or 30%) followed by “Housing” (22 of 160 or 14%) and “Monitoring” (17 of 160 or 11%).

Table 4.7: Social Work Action by Decade for Patients with Length of Stay 12 months & over

4: LOS = 12 months & over				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Action	182	400	160	742
Advocacy	4	11	3	18
Education	12	16	4	32
Housing	7	35	22	64
Linking	4	15	7	26
Referral		7	5	12
Working with Family	49	60	16	125
Assessment	10	11	6	27
Case Management	40	94	48	182
Employment	9	34	11	54
Collateral	5	7	1	13
Crisis Intervention	1	5	4	10
Counselling	3	3	7	13
Benefits	7	29	6	42
Monitoring	30	64	17	111
Consultation	1	9	3	13

Regarding trends based on LOS, “Case Management” appears to be the most common intervention for all patients regardless of LOS in the final decade of study. In looking at each patient group, some interesting observations can be made.

While modest increases in overall social work actions coded in the social work related patient record entry occurred for those treated within 1-3 months and 8-11 months, as the decades went by, this was not the case for some of the other patient groups. Those treated between 4-7 months would experience a sharp increase from the second (38) to the final decade

(85) of study. The majority of social work actions coded in the patient record entry collected for those treated for a year or more occurred during the second decade of the study (400 or 54%) and dropped off in the final decade of the study.

Compressing ranges by 5 months showed some utility for understanding the more frequent LOS distribution at the lower end of LOS. Social work actions are examined here in cross tabulation (see table 4.8). The intent was to see if more can be learned about patients with a LOS of a year or more.

As shown in Table 4.8, the largest volume of codes from the social work related patient entries are collected in the second decade of the sample (110 of 152 total or 72%). The least collected was the first decade of study (13 of 152 or 8%). Codes applied to social work related patient record entries missing a date of entry were filtered out for this analysis. One could infer that there was more service provision in terms of social work related activity in the years 1958 to 1968 than the other two decades of the study for patients with a LOS of 12 to 17 months. During this period of time (n=110), “Case Management” (28 of 110 or 25.5%) continues as the most prominent activity, followed by “Monitoring” (14 of 110 or 13%), “Employment” (12 of 110 or 11%) and “Benefits” (12 of 110 or 11%). While there are fewer samples in the final decade (n=29), “Case management” (8 of 29 or 28%) continues as the most common activity.

Table 4.8: Social Work Action by Decade for Patients with Length of Stay LOS 12 months -17 Months

LOS 12 - 17 months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Action	13	110	29	152
Advocacy		2		2
Education	3	3		6
Housing		4	3	7
Linking		10	3	13
Referral		3		3
Working with Family	3	12	2	17
Assessment		2	3	5
Case Management	3	28	8	39
Employment		12	3	15
Collateral	1	1		2
Crisis Intervention			1	1
Counselling		2	2	4
Benefits		12		12
Monitoring	3	14	4	17
Consultation		5		5

With patients having a LOS of 18 to 23 months (see Appendix E), “Monitoring” becomes more prominent being the most frequent in the first two decades of the study (15 of 67 or 22.4% and 22 of 91 or 24.2% respectively). “Case Management” and “Working with Family” become equally the most frequent action in the final decade of the study for this patient group (8 of 42 or 19% each). Again, the trend of most patient record entries being collected in the second decade of the study continues (91 of 200 total codes from the social work related patient entries or 45.5%).

While patients with a LOS of 24 to 29 months (Table Appendix E) did not represent a large amount of material coded from the patient record entries (n=66), there are some interesting observations that can be made here. Even though the largest number of social work actions were consistent with the other patient LOS groupings, the lowest number of patient entries coded was in the first decade (n=8). “Case Management” was the most frequently identified task for the final two decades of study (12 of 38 or 32% and 10 of 20 or 50% respectively) while “Working with Family” (4 of 8 or 50%) was the most common in the first ten years of the study. “Crisis Intervention”, “Benefits” and “Consultation” are absent for this population and hence are not included in the table.

Social Work Function Determined by Patient Age

Another relationship that was examined is that between the age of the patient at admission to SMHC and the type of function as well as the frequency of social work functional activity. This is based on the idea that younger patients may receive different services, presumably based on assumptions of chronicity or the potential to being a productive member of society.

Table 4.9 is based on the number of entries coded that have ages (N=1408). In this case, patients that are ages 15 to 33 have the most social work actions or functions involved in their treatment at SMHC (522 or 37%). This is followed by patients aged 34 to 52 (376 or 27%). Patients aged 53 to 71 are the next most frequent to receive social work actions (343 or 24%). Notably, patients aged 72-90 are the least likely to receive social work actions (172 or 12%). Given that ages aren't equally distributed in the original sample (N=132), the above figures need context.

Table 4.9: Frequency of Coded Patient Record Entries by Age

Age	Frequency
15-33	522
34-52	376
53-71	343
72-90	172

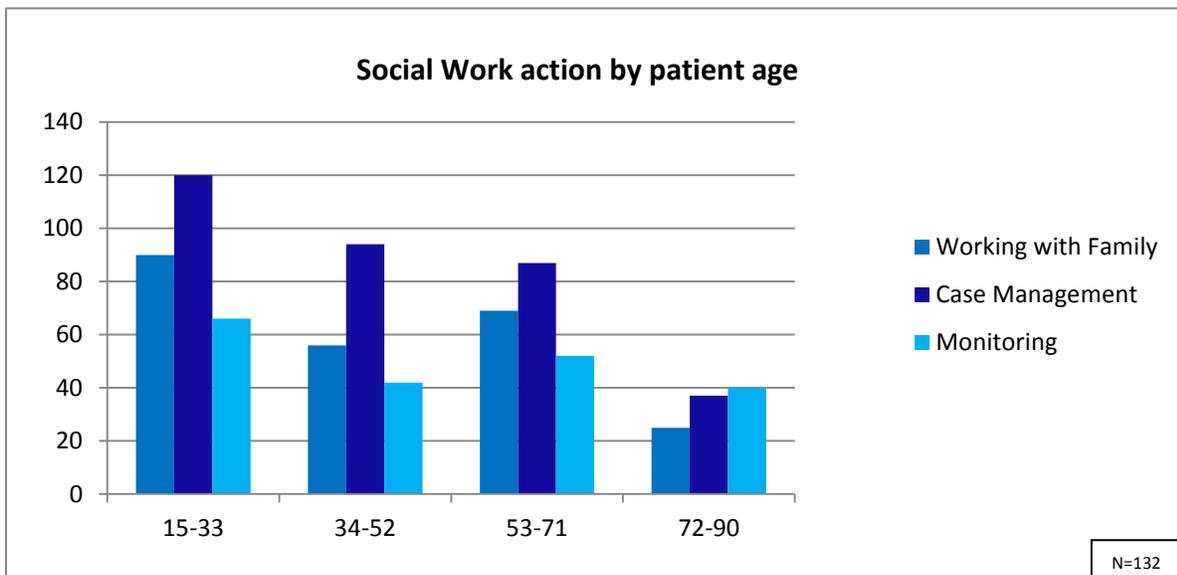
Table 4.10 is the distribution of ages found in the sample (N=132). As can be seen here, the largest number of patients in the sample is in the age range of 15-33 (50 or 38%). This is then followed by patients in the age range of 34 to 52 (41 or 31%). Patients older than 71 years of age (n=18) may be receiving more services than the prior statistics suggest. In calculating the proportions of social work activity by number of patients in an age group, the following emerged. Dividing the number of coded patient record entries by the number of patients in each age group, yielded the proportionate number of social work actions per patient. For patients in the age group of 15 to 33, the number of social work actions per person is 10. Patients in the next age group (34-52) get 9 social work actions identified per person. Patients in the age range of 53-71 receive the most attention proportionally, 15 per person. Finally, those patients older than 71, on average receive 9.55 or 10 social work actions. What this shows is that, aside from patients between the ages of 53 to 71 inclusive, there is not much difference in the number of social work actions or functions being provided to patients of different ages.

Table 4.10: Frequency of Samples by Age

Age	Frequency
15-33	50
34-52	41
53-71	23
72-90	18

Figure 4.6 shows the most frequently identified social work actions as they are distributed by age group. The reader is referred to Appendix E for a display of all codes by age. For the first three age groups, there is no appreciable difference in which action is the most frequently identified. “Case Management” is followed by “Working with Family” and then “Monitoring” in the first three age groups. For patients in the final age group, “Monitoring” is first then “Case Management” and “Working with Family”.

Figure 4.6: Most frequent social work action by age



The Gender Factor

A larger number of codes were collected for social work related patient record entries when the patient is male (757 or 53%) but the difference is minimal, leading to the conclusion that gender is not a factor in amount of social work actions taken on behalf of a patient.

Table 4.11: Frequency of Coded Patient Record Entries by Gender

Gender	Frequency
Male	757
Female	651

Social Work Codes found in the Patient Record

As the prior statistics show, each type of social work function was encountered in the patient record. The following section provides data with illustrations on the prevalence of each below.

Advocacy

This code did not receive much attention in the patient record but a number of social work related entries fell into this category. In the 863 social work related patient record entries, advocacy was identified only 41 times of which 27 are attributed to the social worker. Generally, advocacy as a functional activity was found in the actions taken on behalf of the patient towards some favourable outcome.

For the social worker, advocacy first appears to be employment related. In a November, 1962 entry for a patient (223), the social worker is advocating for an employer in community to consider a patient with 4 years of post-secondary education prior to the onset of the psychiatric condition resulting in the SMHC admission. "I then emphasized the fact that this [patient] had a tremendous potential and...was willing to start at almost any job. "

Another example of social work advocacy efforts included writing to a financial collections department to request that the patient be given a break due to the current financial challenges of being admitted to hospital.

[The patient] made... monthly payments from...welfare cheques, but since [the patient's] admission here...is not receiving welfare. As [the patient] has absolutely no income while in this institution, we would ask that [the patient's] account be frozen from the

date of the last payment until ... discharged from hospital and is able to resume ...payments.(4462)

In summary, advocacy was not located very frequently in the patient record. When identified, it took the shape of doing something on behalf of a patient towards the end of convincing – usually an outside service or agency – to consider or reconsider a practice as it impacts the patient and their family.

Providing Education

Education is not a code that figured prominently in the analysis of the social work related patient record entries. Education was encountered in the patient record primarily around doctors and social workers. Doctors were the most frequent providers of education followed by social workers. When doctors were involved, education would involve pragmatics around health matters which would be appropriate given their role as medical experts.

In contrast, a social worker approaches education regarding occupational functioning in the community. “When a few things are pointed out as – you are further ahead to stick to a job – and in any work there are times of discontent ...[the patient] agrees with all you say...” (280)

Ten years later, in the fall of 1958, for social work, there is evidence of education being done with community supports. In the following entry, the social worker, responding to concerns by a friend of the patient in providing housing after release from SMHC, provides this information: “I assured [the patient’s friend] that we had jurisdiction for 6 months and that we are pleased of this opportunity for [the patient] to go to friends and that I would see [the patient] in a week and see what had taken place during that time. “ (2879)

Finding Housing

While this function was not the most frequently encountered, it is clearly the social worker that is most commonly identified as performing this. “Finding Housing” is attributed 83 times out of 113 in the social work related patient record entries to the social worker.

Early entries refer to placing patients in the community as early as 1949, but it is unclear what the process is. “[The patient] obtained temporary employment with a very fine firm.....will live at Mrs. [Name] for the next few weeks.” (579) Suffice it to say, social workers are frequently tasked with obtaining housing or ensuring family is willing to take the patient.

There is a better glimpse in the following 1960 entry regarding how housing was arranged by a social worker at SMHC. “...taken to Winnipeg to obtain living accommodation. A great number of ads were used and many of the places were not at all attractive and [the patient] finally decided on a 2-room suite...[The patient] was extremely pleased about this accommodation...” (3160). What is remarkable in this entry labelled “Report of Social Worker” is how one not only sees how the process took place, but that the patient’s own preferences are included.

It does not appear to be a standard of practice to provide this much agency to the patient regarding their housing as the following entry from 1962 shows.

Taken to a board and room situation....[the patient]is to pay \$75.00 a month for a single room and board. This is an old house but is rather pleasantly renovated and I believe [the patient] should be quite content here. During the drive into [the city], [the patient] again mentioned how ...would like to live in ... own house but

in spite of this [the patient] seems resigned to the fact that at least for the time being [the patient] must not assume so much responsibility. (632)

As this entry illustrates, the agency of the patient in having input regarding housing appears to have to do with how much responsibility it is believed the individual can handle at the point of discharge into community.

For housing in community, by 1968 there is reference to the social worker assessing whether homes are suitable for placement of the patient.

...the home of [the patient's sibling] was visited by the worker today with the purpose of carrying out a pre-discharge home report; as will be noted in this report, this home appears to be quite satisfactory...and the worker has recommended that [the patient] be probate to this home. (1255)

What can be inferred from the formal title, "pre-discharge home report" and the fact that the worker refers to it as a document "as will be noted in this report", is that there was a formal process for approving housing in community during this time. Clearly, the social worker is expected to complete this report prior to any approval by SMHC to release the patient to housing in community.

As the annual reports to the province already made plain, part of housing is the management of foster home placements in the community, something that the social worker is expected to do. The following "Social History" from 1966 illustrates this well. In this case, the marital discord for a patient has resulted in a situation where a return home is not possible. A foster home arrangement is thus negotiated by the social worker for the patient.

This has been discussed with [the patient] and [the patient] has agreed to live in a foster home and to visit [the spouse] on [the spouse's] agreement. Since November...has shown gradual improvement. (2332)

In fact, according to the patient record, foster home placement was a fairly standard practice wherein which the social worker would make all the necessary arrangements.

Another practice when it comes to housing is that of the social work supervisor completing formal applications for personal care homes en masse. For example, a patient (1255) is included in a larger application in 1975 with a number of other patients for a personal care home. "Enclosed are the reviews for [the patient & others]....This completes the list of applicants..." The language used is fairly consistent each time a supervisor completes such a bulk application for personal care home placements, suggesting that this is a form letter.

Linking

This function, while present in the social work related patient record entries, was minimally encountered with only 26 times by a social worker and 6 times by a doctor. "Linking" began to appear in the 1950's. At times this function involved simply connecting the patient to a service as the following 1954 entry shows. "Dental appointment has been made for today and... is being taken in the company of [the Landlord]..." (892). As this illustration makes plain, the social worker makes the arrangements for the appointment and then ensures the patient is linked to the service via the use of local supports. In this case the local support is the landlord/employer who is willing to take patient to the appointment.

Another example in 1962 is useful to illustrate this action as well. The social worker documents that the patient – along with other residents at a placement in the community- are

without meaningful social activities over the summer months, when programming appears to be less active for them. The social worker documents writing to a local community center and asking if the patient can access this service. There is no evidence of a formal referral, rather a simple request for access to explore alternatives to link with the patient in community.

...director of the [Name] Day Care Centre called...to say that [the patient] and ... friends are most welcome in the centre.....This information was passed on to [the Foster Placement] who will help the [patient and friends] choose the afternoon to attend... (3923)

Ensuring follow through includes providing transportation. Frequently it was the social worker that was expected to provide transportation for the patient to link to community resources as the following entry in 1969 will show. “Patient probated, today, condition improved, to the care of [foster placement]. [The patient] was taken by [Name] of Social Service. “(7556) If the social worker is not providing transportation directly, it is arranged. “Patient probated today....to the care of the [Name] Nursing Home.....Transportation arranged by [Name] of Social Service.” (7556)

Making a Referral

This social work function, according to frequency encountered in the patient record, was low appearing only 15 times by a social worker and 8 times by a doctor. For referrals, it continues to be the social worker that is most commonly identified as the actor. Referrals are usually detailed and formalized requests for other service providers to work with the patient. This usually includes detail around the patients’ history – both at SMHC and any relevant social histories – as well as the treatment goals of the SMHC treatment team. Sometimes the referral is a direct request to assume aspects of care currently provided by the SMHC treatment team. The

following 1962 entry is prefaced with a detailed outline of what services are requested to be performed by the author. This includes monitoring of the patient's condition as well as ensuring that medication is taken as prescribed. The concluding sentences illustrate the reason for the referral.

Although we recognize that what we are requesting is within the function of our own Social Service Department, at present our staff situation does not allow us to provide services of this nature where great distances are involved. We would, therefore, be most appreciative if your agency could accept this referral. (4462)

Clearly, when the patient leaves the area, a referral is pursued with an alternate treatment facility. In a 1964 physician's note (5062) it is apparent that, when the patient moves to Brandon, that the social worker is to work on a referral to Brandon Mental Health Centre (BMHC) as part of their tasks.

By 1966, forms are emerging for the purpose of referral. For patient 6825 an entry is titled "Employment Referral" and outlines via checking of boxes and completion of brief summary all the information deemed important to refer the patient for employment. The fact that it is prefaced as a "Memorandum: Employment Referral" may mean that this was an internal document. Regardless, it provides information to the reader as to how the referral process may have been conceived by social work at SMHC in the 1960's. What is on the form is information to complete on prior employment (listed as education and work history) as well as physical limitations, as well as a check box if the patient is on medication. For this particular entry (6825) further comments include the following entry.

-likely good average intellectual potential. –difficulties controlling impulsive...behavior.-...had ability and interest tests – not a candidate for further training. Expresses interest in joining [Military Branch] or working in [transportation industry]. Otherwise should be able to function as a waiter, porter, etc.

What this entry demonstrates beyond the formalizing of the referral process with an actual document to complete, is that information deemed appropriate for a referral includes the opinion of the worker as to the suitability of the patient for a relevant referral.

Working with family

As previously discussed above, this was a frequent social work action and was most frequently found in the patient record attributed to the superintendent (see table 4.1 & table 4.12). This is followed by the doctor, then the social worker.

Table 4.12: Frequency count of Actor performing Working with Family

Actors								
SW Action	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	Total
Working with Family	59	1	73	1	93	9	4	240

Given the larger frequency of this social work action in the patient record, a more thorough description is given, including how this action appeared when performed by the most common actors – the doctor and the supervisor – versus when performed by social work. Since the focus of this dissertation is the social worker, this section will primarily illustrate how this action or function evolved for the social worker.

The involvement of family in patient care took a variety of forms at SMHC for the social worker. Surprisingly, the physician already identifies the utility of the social worker in helping a patient along with their spouse as early as 1947. The physician's case summary concludes with a plan of treatment that includes, "Better marital adjustment if this is possible, also with [the patient's] own family. Follow-up through social service." (172). While it is not stated what the social worker could do, it is expected that this staff person be involved in addressing the family problems that this patient is dealing with.

Frequently working with family involved the social worker, when checking up or monitoring a patient's status, meeting or talking to family in order to complete this procedure. The following 1948 patient record entry illustrates this activity.

[The Patient] is not at home. [The spouse] states that [the patient] has had many jobs but is "hot-headed" [quotations in original] and leaves at the least provocation.....[the patient] doesn't seem to appreciate...obligations to his family sufficiently to put forth the effort to hold a job in the face of irritations.....[the spouse] thinks [the patient] is not so different from what [the patient]was before ...took ill. (280)

However, as early as 1949, the social worker shows evidence of speaking with family members to hear their perspective. In the following entry, the context is around the social worker meeting with family to explore whether the patient could reside there after being released from inpatient care.

They are both anxious to do all they can to help [the patient].They are really strangers to one another and would have to learn to be friends. If [the patient] would be happier or better away from home, they would be most agreeable. (579).

Another way that working with family takes place is in trying to locate patients that have dropped off from services during the probationary period. The following 1951 entry is illustrative of this activity.

Seen at [patient's] home. The address was obtained from [sibling] who reported that [the patient] was not working...drinking again...The [sibling] asked that I not let [the patient] know that such a report was given by [the sibling].... (892)

This entry shows the social worker collaborating with a family member to locate a patient who is beginning to relapse or decompensate. The fact that the sibling doesn't want the patient to know and is urging the social worker to be complicit in keeping this quiet is interesting. One could infer that this is further evidence of the kind of relationship that the social worker has developed with members of the patient's family.

How the social worker works with family is further illustrated in another entry for this patient (892). This 1952 entry begins with the social worker writing how the doctor is suggesting that the sibling be involved in helping the social worker locate and hospitalize the patient.

...whether [sibling] would invite [the patient] to [sibling's] place and notify us so that we may pick [the patient] up there. With regard to this I contacted [the sibling]but...is very loathe to do this saying [the patient] would be so bitter about the duplicity that [the patient] would never trust [the sibling] again and ... would be unable to help [the patient] at a later date. (892)

Clearly there is evidence here of working with family where the resource is partnered with but their concerns are also recognized and even honoured since this strategy was thus abandoned. Further to this approach with family, the following entry shows how working with the family can involve maintaining a patient at their best in community.

[In-law] interviewed..... [the patient] is fairly acceptable in [the sibling's] home, though [the patient] and [the sibling] do argue somewhat... They are anxious to give [the patient] an opportunity to get on [the patient's] feet..... [The sibling] feels that in a short time we will have to assist ... to find living quarters ... but [the sibling] feels as I do that in quarters of [the patient's] own ... will deteriorate rapidly. It seems wise to just let things ride as they are at present. (892, 1953)

In this patient entry it is evident that the social worker is sitting down with family members to discuss what the best living situation for the patient is. The social worker and the sibling are in agreement about what is in the best interest of the patient's recovery. As such, the worker feels compelled to make this recommendation, presumably to be read in the patient record by treatment team members such as the physician.

The 1968 entry below is interesting since here the social worker is not only talking about attempting to get the patient to be released from inpatient status to family members, but "to the care of the family". The language here seems to suggest that it isn't just about locating housing but for family to assume responsibility for the patient in some fashion.

...if a suitable home can be found for [the patient] ... should be probated. To this end, contact has been made with ... family.....If either of these relatives shows

sufficient interest, then an attempt will be made to probate [the patient] to the care of the family. (1255)

Clearly at the end of the 1960's the expectation is that the family, when involved, is included in the logistics around providing care to the patient.

By the end of the 1970's working with family included a therapeutic focus. As the entry by an MSW –level social worker shows (13191), the focus of the meeting between the patient and their sibling is on "...the maladaptive problem solving patterns which have been frustrating solutions to the many extra-familial problems " and the worker stating in the entry that the point of the meeting "...is to enable them to resolve interpersonal conflicts between them, clarify their respective roles in intra-familial and extra-familial matters, and correct deficiencies in their problem solving pattern."

When the Superintendent or Doctor work with family

For the doctor, the functional activity of working with family is initially less collaborative and more directive. A 1954 entry shows how the doctor speaks with a patient's pastor, followed by a discharge decision rendered. "...The patient was called into the office in the presence of Rev....The patient was probated to the care of [the patient's spouse] (underline in original). Rev....drove [the patient] back to Winnipeg to deliver ... home." (1657). The language in this entry makes it clear that - while informal supports and family are involved -their role is rather passive.

In 1968 there is evidence of the physician considering the input from family as part of the decision to release a patient from inpatient status. The entry suggests that the family and the physician have been in touch on how the patient did, staying with them. "[The patient's] family

has been contacted over the last month or so and they were so impressed with [the patient's] improvement that they are willing immediately to have [the patient] live with them..."(1255)

The superintendent is similar as actor in that the purpose of working with family at the beginning is really about ensuring that contact information is available for the record, and to put the family on notice that their cooperation is expected. "It is of the utmost importance and in your responsibility that the hospital be notified at once of any change in your address in order that you may be promptly communicated with in case of necessity." (121). This 1947 entry is an illustration of a form letter that frequently is sent out to next of kin if there is information available on them. In fact, much of the entries by superintendents in working with family involve this or a similar form letter seeking contact. That said, the superintendent does provide information as well to family on the condition or status of the patient.

For the remainder of the period of study, it is the superintendent that notifies family of any change in the status of the patient at SMHC. "This letter is to confirm the discharge of your [spouse].....effective August [day], 1975". (11959)

In summary, while both the doctor and the superintendent worked with family, there seems to be little change in the nature of the action. The purpose of interacting with family primarily seems to be to pass on information. The relationship in effect is a passive one – where family are notified about what is going on. When they are consulted it is again to evaluate the feasibility of housing or other community based supports. While both would update families on a patient's status, the superintendent was exclusively the actor responsible for sending out contact letters.

Performing Assessments or Social Histories

Assessment is most frequently performed by the doctor followed by the social worker see. In fact, of the 87 times this action was identified in the patient record, 30 were performed by the social worker and 50 by the doctor.

In 1962 this functional activity emerges for the social worker. There is a notation in the patient record of a social worker meeting with a patient to assess their needs and capacities in contemplating discharge from inpatient status. This entry provides a glimpse as to what the social worker is looking for in determining patient functioning.

Worker interviewed [the patient] on the ward...is able to use support and a structuring of thoughts as [patient is] engaging to weigh things out.....likely [the patient] will have to be taken care of completely at the beginning with encouragement to feel a little confidence in doing for [themselves]. [The patient] will probably fit apathetically into the new situation and providing... foster home sponsors are not too threatening, [the patient] can with support and stimulation, become more involved... (3923)

The assessment is focused on patient functioning – both cognitively in regards to problem solving, but also the level of social engagement. The conclusion of this entry seems to give a rudimentary framework of what would be the best strategy by the foster placement to help the patient integrate socially. What is also of note here is how the worker – rather than make a firm pronouncement of the patient’s abilities and limitations, is rather wanting to state that potential is present but limited by a level of self-confidence.

In 1962 there is the first reference to social histories being completed by social workers (4948). The following 1963 patient record entry is an example of a transfer summary which captures an assessment focus. The document has a section titled “social functioning” and addresses a growing awareness of the patient’s functioning based on the fact that a new worker who can speak French is now able to get a fuller picture of the patient’s status.

In regard to social respect, the situation seems to have deteriorated over the last three months. Several factors have come to light which were not too obvious, mainly brought out by the new [social worker] who can talk with [the patient] in French. (4462)

While the patient record didn’t have much source material to examine what a social history would constitute, patient file 5975 included a four page document in 1964. This entry was titled “Social History” and refers to informants as being key family members such as the spouse and children. The form has headings that are of interest to gauging the focus of the social history. Along with listing informants, there is a heading titled “Cooperation of Informants” which gives a sense of the degree of willingness of the information being shared.

In this case, a detailed family history emerges that breaks down family members of patient’s nuclear family (parents and siblings) as well as the dynamics of the relationship: “There was a very poor relationship between father and patient.....Mother has always been a troublemaker. Domineering personality.Always ‘needling’ patient.” The document then goes further to explore the current breakdown in relationship between the patient and their mother.

In effect, this comprehensive document gives a glimpse as to what a social history would entail in 1964 at SMHC. It is apparent that the focus is on the social functioning of the patient, their particular family dynamics as well as what the environmental forces are that shaped their current presenting issues.

By 1968, assessment includes determining whether social work services are needed for a patient. “Worker interviewed [the patient] today in an effort to see if Social Service was needed. [The patient] is unemployed and has been living on Welfare for the past year.” (8466)

By 1970 the format of the social history evolves somewhat to include more detail regarding the psychosocial aspects of mental health. The following 1970 patient entry is a social history that includes headings and content that illustrates the changes. “Format: Social situational-Family Background, Family Interaction, Psycho-Social Problem, Social Treatment Potential, Goals.” (10216). This is then followed by headings for address, birthplace, racial origin, education, and marital status, number of children, occupation, religion, and citizenship. After sections in the social history that focus on the patient’s family of origin and childhood development, a section called “Habits” is present. This section details recent psychosocial stressors that contributed to presenting problem. In this patient’s case it involves the marital dissolution of parents of the patient and the disability of the spouse.

[The spouse] states that during this time [the disability from work]... was quite snappy towards [the patient], who was becoming increasingly easily upset by [the patient’s] children. (10216)

Hence, the assessment, by virtue of the headings and the content of the findings, illustrate a more direct focus on the environment in how this contributes to the mental health matters that resulted in this case in an admission to SMHC.

The assessment for suitability of housing options continues into the 1970's - a notation from a physician (9769) contains references to the need to have a social worker do this prior to granting probationary status for a patient.

It is apparent that the social worker-constructed document is viewed as an important contribution to applications for disability as the following 1971 entry demonstrates. "Please find enclosed a social history, psychiatric assessment and completed application form for Infirm Social Allowance regarding the above named..." (10335). This application is penned by a "Social Services Supervisor" to the welfare office. Clearly the social history here is viewed as an important document that can help make the case for this particular patient to receive benefits.

Social Assessment Emerging

By 1976, a form called "Social Assessment" emerges. This form appears to be similar to a social history but the focus is even more clearly on what factors in the patient's environment need to be addressed to promote optimal rehabilitation.

A priority for social intervention would appear to be within the network of family relationships and to this end a family assessment interview will be scheduled in the immediate future. Assistance in terms of vocational and residential planning will follow. Consideration should also be given to assisting [the patient] in structuring social outlets with ...peers in order that [the patient] can foster some productive relationships in an autonomous way apart from the family. (13191)

Clearly there is a pragmatic focus to the assessment here, with a targeted intervention in mind – to increase the independence of the patient by strengthening the social network outside of the immediate family system.

Case management

This functional activity is the most frequently encountered in the patient record (see table 4.1). Table 4.13 shows how social workers are the most common actors with 158 of the attributed actions of case management in the patient record. This is followed by the doctor and the superintendent. Just like with the action working with family, at the conclusion of the narrative on how social workers performed this action, case management performed by doctors and superintendents will be illustrated to contrast how this compares to the social worker. Case management is a broad category, containing a number of actions. The following illustrates the various actions included under case management.

Table 4.13: Frequency count of Actor performing Case Management

Actors								
SW Action	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	Total
Case Management	158	1	89	2	59	19	6	334

One of the features of case management is the handling of patient financial affairs on their behalf. This is a fairly common practice encountered in the patient record. As much of the focus is on the patient in the community on probationary status, financial affairs involve managing all the aspects for the patient in that setting. The following patient record entry from 1963 illustrates this well.

[The social worker] had to send the monthly rent of \$55 but since [the patient] did not have [the landlord's] first name nor initials and since (landlord) is not listed in the telephone directory, [the social worker] dropped in this morning...to get the information. (4462)

Another aspect of case management involves the coordinating of resources to facilitate effective discharge/aftercare as this 1951 patient record makes plain.

[The patient] was taken to Winnipeg by [the social worker], and arrangements were made for room in [city] on a temporary basis until something better could be obtained, and arrangements were also made for [the patient] to go back to ... previous employment. (892)

The social worker is also doing case management when ensuring, after a patient goes missing, that their possessions and any other loose ends are dealt with in one entry in 1961(3160). The purpose here, it is assumed, is to ensure that the next time a discharge from inpatient is performed; the patient will be able to transition to community with a minimum of barriers or inconveniences incurred from the prior unsuccessful attempt. In fact, 10 years later, a physician note makes it clear that this is actually an expectation for the social worker to perform as an aspect of case management. "...[the patient's] Social Worker was instructed to keep [the patient's] former board and room placement open to meet the likelihood that [the patient] should be probated in the next 2 or 3 weeks."(8466)

Case management also includes referral relations. The 1962 entry below illustrates an exchange involving the reference to the supervisor and how this will be an ongoing relationship

designed to ensure that the patient, upon stabilizing from a mental health related crisis, has a place to return to in community.

.....Worker assured [Room and Board Manager] that [the social work supervisor] would be talking to [the room and board manager] soon, meanwhile the patient would be returning to hospital. [The room and board manager] says ... will try to explain to [the patient] that they would like to have [the patient] back again as soon as [the patient] is settled on ... medication. (632)

Part of case management is also to ensure that patients have access to information that they are either requesting or need regarding community appointments not necessarily related to their patient care. The following is an entry in 1963 regarding a legal matter for custody of the patient's children.

[The patient] wants to know the date of the court hearing and ... wants to attend so [the patient] can get ... children back. [The social worker] told [the patient] would inform...of such. (4462)

The social worker later accompanies the patient to this appointment when it takes place.

Another aspect of case management is the management of communications with payer sources.

This is in reply to your letters....concerning the above mentioned.....The above mentioned was voluntarily admitted here....[The patient] discharged ... against medical advice.....On discharge [the patient's] condition was improved.....We

regret that [the patient] was not under treatment here long enough for us to comment on prognosis.(5492)

This 1963 entry highlights what the chief social worker in this case is expected to do – most likely in response to a request from an Officer in the Rehabilitation Services, Veterans Welfare Services Branch – to provide a summary of the course of treatment, concluding with outcome. The reference to prognosis would suggest that the Veteran’s office is seeking to find out about severity of psychiatric condition, most likely involving the determination of benefits. It is up to the social worker to complete the report and be in touch with this office. This is supported in other entries as illustrated in a 1964 letter from the National Employment Service (NES) where the chief social worker is directly contacted in order to get clinical information about a the patient (5382).

Chart management is also a part of case management.

Since the transfer summary of the previous worker all attempts to contact [the patient] has ended in failure. At this time I would suggest that this case become inactive until further referral is made. (6462)

This entry from 1966, labelled “Social Service Department” is a notation in the chart by a social worker where the six months’ probation status has ended and the patient has not followed up with social work.

Chart management also deals with managing who has access to the chart and the appropriate release of information. In the following, the letter from 1969 is a social worker’s response to a welfare benefits officer’s request. “We have no record of any other interested relatives, so we are returning the Consent forms unsigned.” (3350)

Another feature of chart management is to ensure that those services providing benefits have the information they need to stay in touch with the patient. “This letter is to advise that [the patient] was probated from this hospital affective [sic] [Month, Day]...[The patient] is residing at [address given]”(6709). This letter from 1965 is written to a Casework Supervisor from the Family Service Department at the Children’s Aid Society of Winnipeg.

Discharge aftercare is also a part of case management. In the next entry from 1964 it is clear that the expectation is that the social worker be involved in making all the necessary arrangements, including preparing by checking on the patient’s financial resources, before discharge from inpatient is done. The reader can also note how this entry refers to matters of geographical areas of responsibility for patient follow up care.

Dr. [Name] plans that [the patient] will be leaving hospital.....to go to [northern town in Manitoba], via train. The Bursar’s Office has informed me that some \$23.00 is available in [the patient’s] account for purchase of the ticket. This file is being passed to [the social worker] to make these arrangements. [The social worker] should also decide with Dr. [Name] in what way follow-up arrangements are to be made and how [the patient]is to receive...medication, since it may be possible that we may have to make a referral to Dr. [Name] of the Brandon Mental Hospital who goes in to this area on a regular basis for clinics. If this type of referral is not considered possible then some arrangement should be made either with the Department of Welfare worker in the area or through the Public Health Service. (5062)

This entry clearly shows the number of tasks expected of the social worker under case management. The worker is expected to be able to manage the cost and arrange transportation. There are also the comments around medication access and management, that the social worker is expected to consult with the physician.

The social worker, in performing case management is the one expected to tie up any loose ends for the patient and even accompany them, or provide transportation to, where the patient is choosing to go to upon release from inpatient status. “Picked up the remainder of [the patient’s] funds.....Took [the patient] to C.N.R. station where [the patient] was to board the 4:00 p.m. train for [northern city]” (5062).

In the following 1964 entry, a note from the physician –involved in providing outpatient services during the patient’s probation from SMHC – shows how the social worker is responsible to deliver medications to the patient.

In today forvisit. [The patient] states that [the patient] received a supply of medications two days ago by [name] Social Worker. (5062)

Transportation to and from doctor’s appointments appear to be expected case management tasks for social workers at SMHC. “Worker picked up [the patient] at [the landlord’s address] and brought [the patient] out for ... out-patient appointment.” (5062)

Case management at times can mean the management of all aspects of a patient’s life upon release from inpatient.

The patient will require supervision and something to occupy his time when [the patient] returns home. Certain conditions will have to be met -1... will have to

turn over... entire pension cheques to [spouse] for handling, 2. [The patient] must go to the day centre....in the afternoon, 3. There is some possibility that a ... companion may be found for [the patient] for morning so that [the patient's] time will be filled while [the spouse] is away at work. (7128)

What is apparent in this patient entry from 1966, with the title "Social History", is that the social worker is planning an intervention that is comprehensive, addressing both the management of finances as well as structuring the patient's daily life in order to maintain this individual in community.

Discharge from the facility is also case management when a patient is no longer in the catchment area for SMHC to be involved. In the following entry from 1969, a social worker learns that the patient is being seen by another psychiatric facility in another geographic area of Manitoba. "Worker will therefore inform the treating psychiatrist and will prepare the necessary papers for transfer..." (3996)

By the 1970's there is evidence of case management including an interest in the social or community integration for the patient. This is well demonstrated in the following entry where a patient is a recent immigrant.

...If there is a [patient's nationality] immigrant community, [the patient] might be encouraged to take part in some of the activities. [Patient's sibling] could be helpful in those matters too. (8936)

As an aforementioned Social Assessment shows in terms of case management, towards the end of the 1970's it continues to be expected that the social worker provide, "Assistance in discharge planning related to vocational, residential and recreational matters." (13191). This

section on case management reveals a broad variety of interventions. It captures both the work with the patient to address a myriad array of social and economic challenges, as well as the management of the patient chart. The latter also reveals how case management involves working with outside agencies, to address resources to acquire and or to manage, on behalf of the patient.

Procuring Employment

Finding or procuring employment (see table 4.14) is a functional activity most likely performed by the social worker followed by the doctor. Procuring employment is an early focus for rehabilitation at SMHC. It is evident that being able to secure employment for a patient is viewed as necessary to ensure proper patient recovery. Hence, the social worker is dispatched to address this aspect of rehabilitation.

Table 4.14: Frequency count of Actor performing Employment Assistance

Actors								
SW Action	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	Total
Employment	46		40	2	1		1	90

As the following entry from 1949 by a social worker shows, this involves physically taking the patient to employment options for both testing and placement. “Taken to [City]. Stenographic test at Employment Service. [The patient] did well at this in both typing and shorthand. [The patient] obtained temporary employment with a very fine firm....” (579)

Getting work wasn’t enough for social workers. By 1962, there is evidence that there was an interest in finding work for patients that would actually meet not only their needs but might lead to fuller and more satisfying work.

There is a possibility that [the patient] could get a job as an orderly at the General Hospital. As this would be likely be a “dead end”[quotations in original] job at

best. I will first attempt to find [the patient] a different job in a hospital setting.

(223)

Social workers did have some consistent resources to draw from for employment. The patient would frequently be referred to NES or to a vocational rehabilitation program in community as this 1964 entry shows. “The worker is attempting to get [the patient] into Skills Unlimited as soon as possible.” (5062). This is a program frequently referred to in connection with patients securing employment training prior to getting a job in community outside of programming.

Then there are times when the social worker simply goes job hunting with the patient rather than working through programming. “[The patient] has been taken to several places....looking for work. [The patient] has so far been unsuccessful but continues to look with the assistance of Social Service Department.” (4184)

By 1966, forms are implemented to complete when social work is looking to get someone connected to employment. While this example has been used to look at referrals as a social work action, an entry for patient 6825 in 1966 is a good example. This form involves completing and filling out any past work and education history, a summary of current interests as well as results from aptitude testing.

The social worker is expected to keep helping the patient with employment after a successful referral has been made with a vocational rehabilitation program, “We are now arranging to give [the patient] the odd day off in order to look for work in [city]. [The social worker] will be helping [the patient] in this regard” (11097). This 1974 entry in the patient chart is from the vocational rehabilitation program. One might expect such a program to complete

their work by helping the patient get a job in community but here it is evident that this task is once more expected of the social worker from SMHC.

A letter in 1977 to a local employer shows that it is the social worker that continues to get employment worked out for the patient in community. In effect, the point of employment is to, “...give [the patient] every chance of rehabilitation in the community” (11321).

In summary, procuring employment is a task expected of the social worker. As stated in the previous chapter, the physician will hold off on discharge for the patient until this has been arranged. As such, the social worker employs resources such as vocational rehabilitation and other programs but will also directly assist in job hunting with the patient. What is remarkable is that even the vocational training programs expect the social worker to find the actual job at the conclusion of their programming. This section on employment also shows the influence of professionalization in that increasingly there emerge standardized forms for employment in the record.

Collaterals with family and other informal supports

Collaterals are the collecting of information from someone other than a primary source. Collaterals taken by social workers took the form of meeting with family –either in person or over the phone - with the express purpose of getting more information about the patient. The information in a collateral can sometimes be about filling in the blanks of a patient’s history- personal, family or social. This was not a common functional activity found in the patient file entries for this sample. The majority of collateral actions were by doctors with 30 followed by the social worker with 13 out of 45 attributed actions identified in the patient record

An entry in 1950 illustrates how early social workers approached collaterals. This patient entry chronicles a home visit due to a letter received about the legal separation by spouse from patient. What takes place is a family collateral regarding client's ongoing behaviour resulting in the family split. This entry captures the voice of spouse.

[The patient] has always displayed childish and erratic tantrum-like behaviour when [the patient's] actions were criticized. [The patient] is a good worker but finds it difficult to hold [their] temper and get along with [the patient's] co-workers. (280)

By 1962, this is formalized more with the social worker using headings such as "Informant" and "Personal History" locating both the source of the collateral and the content for the purpose of establishing a social history. In the case of one patient (4571) the 1962 entry illustrates how this is done. For this entry, the parents are the informants for the collateral. "Personal History: Patient was always a happy [person] with lots of friends. Schooling to Grade XI." This information was gleaned from the parents as part of the collateral. The focus here is on prior functioning, both socially as well as academically.

By 1964, this formal document captures also the state of mind of those participating in the collateral. "Cooperation of Informants: All three informants were willing to give as much information as was possible. They demonstrated hostility towards patient because of [the patient's] past behaviour due to [the patient's] alcoholic intake." (5975) What is clear is that family were viewed as a resource for collaterals.

Crisis intervention

Crisis intervention is a functional activity that did not appear very often in the social work related patient record entries. Of note here is that aside from the social worker's six identified actions, the next most frequent actor is not the doctor but the nurse with three.

Crisis intervention is an action performed by the social worker to get involved with helping a patient return to SMHC if decompensating. This is also understood to be the domain of the social worker's function by other disciplines. A doctor's entry in the patient record shows this clearly. In this 1961 entry, the physician - upon noting the patient's landlady report of symptom increase- makes the following statement making it clear that crisis intervention is a task reserved for the social worker. "We will have [the social worker] make a home visit and return [the patient] to hospital" (3160).

What is entailed in an emergency readmission includes communicating with services such as the police to activate the legal measures needed. The following entry from 1962 makes this plain, after the social worker consults with the physician; further measures were taken by the social worker.

On Dr. [name] direction a retake warrant was completed and the necessary arrangements made with the Chief's office to return the patient to hospital.

Worker telephoned [Room and Board Manager] about these arrangements....

(632)

While the prior entry is documentation by the social work supervisor, the next is from the front line social worker.

They had to watch [the patient] constantly all day and during the time I was there the hospital car arrived to return [the patient] to hospital following a phone call and report by [Room and Board Manager]. (632)

In other words, the supervisor engages the legal mechanism while the front line staff remains with the patient to ensure that the act of physically returning the patient to SMHC takes place.

Seen at [the patient's] boardinghouse..... [the doctor] hoped that I would be able to persuade[the patient] to do so[return to SMHC] on a voluntary basis. [the patient] registered a little surprise but cooperated and packed [their]clothing while I made another visit. (3160)

The above entry from 1964 illustrates how the relationship between social worker and patient is leveraged to try to negotiate the avoidance of legal mechanisms to have an involuntary readmission to SMHC.

In summary, crisis intervention, while not a frequently encountered action, is firmly located with the social worker. By the 1960's there is even evidence of growing professionalization of this action, where both the supervisor and the direct clinical social worker are involved in a carefully coordinated action.

Providing Supportive and Interpersonal Counselling

Again, this code was not used commonly when reviewing the social work related patient record entries. However, the social worker is most frequent with 13 followed by the doctor with 10 out of 28 attributed actions identified in the patient record

When it comes to clinical work such as providing counselling, as early as 1947, there is reference to involving the social worker to address marital problems. As this entry by the

physician shows, the social service is responsible to follow up regarding marital matters. “Better marital adjustment if this is possible, also with [the patient’s] own family. Follow-up through social service.” (172). While there are not any further entries to provide further detail around what the social worker is expected to do, in 1971 it is evident that this is the focus of social work.

The main problem was helping [the patient] come to terms with the reality of [the patient’s] marital situation. [The spouse] indicated that [the patient] had no wish to live with, or support the patient again... (9769)

The aforementioned entry is from a Social History written by a social worker. In 1977, another entry by a social worker makes the family work even more explicit.

The goal of my intervention is to enable them to resolve interpersonal conflicts between them, clarify their respective roles in intra-familial and extra-familial matters, and correct deficiencies in their problem solving pattern. (13191)

What is apparent at the end of this period of study is that the expectation remained that the social worker is the one involved in addressing family and marital matters if needed. This entry in 1978 by a physician makes it clear who is expected to address marital issues. In commenting how the identified problem remained unaddressed, the physician comments how,

On the other hand [the patient] showed some interest in trying to work on ... marital problems. Therefore [the patient] was referred to [the social worker] for appropriate counselling.....arrangements were made with [the social worker] for appropriate marital intervention. (13841)

Another aspect of counselling is supportive in nature. What this means is that the social worker is trying to keep the patient motivated and orientated towards recovery. “[The patient] would like to come back to the hospital.....with persuasion [the patient] agrees to ‘try it for another week’...” (3923). This is even more explicit in the following patient file entry from 1965 by a social worker.

[The patient] is talking about quitting again (at vocational rehabilitation program) and has to be convinced and re-convinced of the value of the work that [the patient is] doing and of the fact that it will pay off in the long run.” (5062)

Social workers are also expected to be a supportive presence to the patient when things don’t go well for the patient. In one entry from 1974, the physician is writing about how frustrating it is for a patient as they are unable to find a job at present. Hence, the physician writes about how at this time all that can be done is to be a support to the patient as this is going on. This is then followed by a reference to the social worker. “[The social worker] will also be talking to [the patient] and try to encourage [the patient] today.” (11097). Hence, the focus is here on a collaborative approach by both the physician and social worker to provide supportive counselling for the patient so that they do not despair in community.

Securing Benefits for Patients

While securing benefits as a functional activity are only identified 66 times in the patient record, 49 or 74% of the time it is the social worker that is the actor. Patients frequently have little resources to aid them in returning to community. As such, staff at SMHC has to apply for benefits that patients are eligible for. As the following entries will show, the process of application becomes more sophisticated as time progresses.

The first entry by a social worker is in 1958 and is a casual description of applying for benefits for the patient in community due to the landlord needing to be paid and the patient not having any employment.

City Public Welfare was contacted and a covering letter presented. They understand the situation and are willing to assist [the patient] through the landlord.....The necessary information is being submitted by me from [the patient's] file. (2879)

What can be gleaned from this entry is that there is a process for application. A cover letter and what seems to be a conversation with the relevant office occurs where the approval of benefits appears to be already determined. The reference to “necessary information” from the chart being submitted by the social worker afterwards appears to be a formality.

By the 1960's, benefits applications appear to be more complex. The following patient entry from 1963 also chronicles the complexities around ensuring financial resources are present for a patient who recently became unemployed.

Came to hospital this a.m. to say that this job as a painter...expired 2 weeks ago. [the patient] will owe [the foster parent] room and board on Oct. 15 and ...has no money. I.S.A. [Infirm Social Allowance] forms are being sent out and will be forward to Eastern Region, An attempt is being made to get welfare from the [city]...until I.S.A. cheques arrive.....[the patient]will be visited to determine the actual situation at the foster home.(3996)

What this entry shows is that for benefits such as I.S.A., actual forms are completed and that this process may take time. Local resources such as city welfare have to be contacted and involved

in ensuring that the patient can pay to remain at their current foster home. The social worker is the one that has to arrange for all of these things. In fact, this seems assumed to be status quo – for the social worker to apply for benefits – as another entry from 1963 documents the intentions of a social worker to be proactive given the patient’s unique job situation. “Since the job with (new employer) will last only until freeze-up, I.S.A. will still be applied for.” (3996) At this time, it does not appear that the patient is given the information on how to do this, but rather it is expected that the social worker does this on their behalf.

As a part of applying for benefits, the social worker kept the office in the loop whenever there were changes for the patient, such as moving to a new address. “...Eastern Region was notified of [the patient’s] move....It was asked that the application for I.S.A. not be cancelled, but held until further notice.” (6462)

Since social workers are managing the finances on behalf of patients, they are called upon to report to benefit programs on these matters – presumably to aid in the benefit determination process. The following 1966 patient entry is from a social work supervisor to a regional welfare department.

....during that time [the patient’s] Old Age Security accumulated in our Bursar’s Office. When[the patient] left July 15, [the patient]was given \$284.00 out of which [the patient] was to pay for the first month at the Nursing Home.....[the patient] has no assets other than... Old Age Security. (6938)

This entry appears to be in response to a query by the welfare department on how solvent the patient is. Presumably this will help qualify the patient for additional financial resources via the welfare department.

Another entry in 1977 shows how the social worker, when no longer directly involved, educates the patient on how to manage benefits in community.

[Name] is your financial worker and if you are unsure of how to declare these benefits I would suggest you telephone [the worker] requesting an interview. You should also be aware that should you obtain a full time job that you would not be eligible for Social Allowance or Canada Pension benefits. You should be hearing from your new worker quite soon, but in the meantime should you require any help please telephone me at... (11097)

The front-line social worker writing this letter to the patient is making sure that, after the patient’s case is not even within the worker’s bailiwick, benefits aren’t lost due to an oversight. The patient is given the information needed to have some agency over their own benefits in community.

Monitoring the Patient’s Status

A common functional activity performed by the social worker has to do with checking up on the client and reporting on their functioning (see tables 4.1 & 4.15). Social work by far is the most frequent followed by the doctor.

Table 4.15: Frequency count of Actor performing Monitoring

Actors								
SW Action	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	Total
Monitoring	143	11	44					198

The first patient entry by a social worker in 1948 is of a monitoring nature (280). The content of monitoring entries initially is a report, primarily, on how the patient is readjusting to life in community.

Seen at home. [The patient] appears extremely well...[the patient] has washed up everything freshly and is enjoying getting things in order. [the patient] does not appear under pressure... [the patient's spouse] is very pleased with [the patient's] progress. They have spent several Sundays at the beach. (483)

What is interesting is how as early as in 1949 an entry begins to show how social workers are trying to establish a baseline of functioning that is particular to the individual being monitored.

...in the past year four visits have been paid to [the patient's] home. [the patient] has worked at laboring jobs fairly steadily [sic] though is easily angered and leaves in a huff. Whenever seen [the patient] is talkative, loud, and boisterously affable. It would seem that [the patient's] present behavior is normal for [the patient]. (280)

In this case, the social worker is commenting on social functioning and seeking to establish what would be considered "normal". If a social worker at SMHC is engaging in surveillance when monitoring, compliance to a norm does not appear to be encouraged in this entry. It is rather a seeking to understand what this individual patient's standard of "normal" is - rather than enforcing a norm.

In 1949, the first language emerges in monitoring that suggests the use of medical terminology. "[The patient's] face appeared bright and relaxed" (632). This terminology could be a precursor of commenting on a patient's bright affect to connote a patient's emotional state.

This emerges even more clearly in 1962, when a social worker – while monitoring a patient in community describes them as "to be making a slow but on the whole satisfactory

adjustment. [The patient] has become oriented as to time and place in [the patient's] new environment..." (3923). The social worker's comment about the patient's orientation to their surroundings-couched in this language- seems to imply greater use of such terminology.

Monitoring as functional activity would also include meeting with informal supports – with or without the patient- to get their input on how the patient is functioning in community.

[The patient] visited with [patient's spouse] and [sibling] yesterday. [the patient's spouse] is very pleased with [the patient's] present condition....[the patient's spouse] states[the patient] is mixing well socially, is happy with [the patient's]old friends and has shown no indication of [the patient's] old agitation and depression or negativism towards [the patient's spouse]. (632)

Here we have an entry from 1949 where not only the perspective of the spouse on current functioning but a frame of reference of what to compare with – in effect, the patient is not antagonistic to the spouse.

When the social worker goes to community to check on patients, this would happen in a variety of contexts – from meeting the patient's home to their place of employment. "Seen in [local department store].....[the patient]is, as usual, quite acceptable in ...manner and speech." (579). While this social worker's entry from 1951 is ambiguous about what is meant by "acceptable in manner and speech", the entry shows that the social worker is willing to meet in the natural environment of the patient. In this case, the visit takes place at the patient's place of employment.

Even when no contact has been possible, the social worker will monitor via informal supports, even taking this information as valid without being able to check on the patient's status by themselves.

[Sibling] contacted. [Sibling] had not seen [the patient] this week but seemed to think that [the patient] had been doing quite well up till this time. [the patient] is still working and has moved from the room [the patient] originally took.... This is a little better part of town and no doubt it is a nicer room. It would seem that [the patient] is holding up a bit better this time than on... previous trial. (892)

This social worker, in 1953, is monitoring the patient through contact with the sibling and is taking the information from the sibling, along with the patient moving to a "better part of town" as evidence of improvement in functioning.

Medication compliance is another piece that the social worker is monitoring. This entry form 1959 shows that it isn't just the monitoring of symptoms and compliance with medication regimen.

[The patient] sounded under pressure, seemed quite willing that [the social worker] should visit... in fact invited it, said that [the patient] was taking ... medication in half quantity as the full prescription made [the patient] very sleepy. This information will be discussed with the doctor and no doubt [the patient] will be contacted at an early date. (892)

There is reference by this social worker in this patient entry of consulting with the doctor based on this information with the expectation that this would modify the schedule. The social worker is expecting that they will need to visit sooner than planned.

There are entries by social workers that illustrate that – when monitoring – the patient’s insight is observed and commented on as well.

[The patient] paid the board and room for the month of March and has some money to spend in ... purse. [The patient] is very careful with... money and realizes that ...hasn’t an unlimited income. [The patient] will be visited again soon. (632)

Here in this 1962 entry the social worker is noting how the patient is able to manage finances with insight as to its finite nature. This seems important enough to include in the entry as a way to monitor how the patient is faring in community.

The next entry from 1962 is an illustration of what the social worker documents when a patient is clearly decompensating. In fact, this entry concludes with the psychiatric hospitalization of the patient.

[The patient is] very distressed in appearance.....not too tidily dressed, voluble but almost incoherent at times.... The day I called, [the patient] had had no food at all. [The patient] has been taking her medication as far as [the foster home staff] know....They had to watch [the patient] constantly all day...(632)

The social worker here is commenting first on clinical impressions related to presentation. The patient’s appearance and behaviour are the focus, followed by evidence of functional impairment. This is captured by the fact of the patient not having any food in the home. Medication adherence is information that is not verified by the social worker directly and is made plain in the way of the phrasing “as far as [the foster home staff] know.”

In another entry, from 1962, the chief social worker is asking another outside agency to take over monitoring the patient due to limited resources. What is interesting in this entry is how this further illustrates what is understood to be the function of monitoring.

If this is possible, we would appreciate knowing what your worker's assessment of [the patient's] condition is – as [the worker] sees it; how [the patient] seems to be functioning at home, and whether or not [the patient] is continuing to take ...medication, which is supplied by this hospital. (4462)

It is apparent that the main focus for monitoring involves how the patient is functioning in their immediate environment and whether they are medication compliant.

Another way to think about the function of monitoring is in looking at the entries as ways to update staff on the life of the patient while on probation - filling in the blank – until the next doctor's appointment. The social worker does not document an intervention per se. The social work team receives the following entry from 1964 as a request from a physician after the patient fails to attend a doctor's appointment.

We feel that this is a pretty outdated report and would appreciate knowing what [the patient's] present situation is. Would you please be kind enough to look in to what is happening and bring us up to date on this.....we would appreciate knowing just what the actual status of [the patient's] condition is. (5062)

Monitoring wasn't always viewed as clinically necessary but part of maintaining a patient's eligibility. The following entry in 1967 is from a physician on commenting on the need for monitoring. "[The patient] will be followed up about every three months by the Social

Service Department. This is being done because it is required for [the patient] to continue on [benefits].” (892)

Another reason that monitoring is mentioned in the patient record appears to be that this is shared strategically to send the message that the person is indeed receiving a lot of support. The following 1972 entry from a social work supervisor requesting benefits from an outside agency, illustrates this well.

[The patient] will be followed by the Selkirk Mental Hospital, both psychiatrically and through the Social Service Department. [The social worker] intends to keep close contact with [the patient] for the next few months. (11321)

This entry makes plain that “close contact” by the social worker connotes a degree of disability. It is this displaying of the social worker’s plan to monitor the patient closely that is part of the petition for financial support to the patient

Collaborative Consultation with Treatment Team Members

While minimal evidence of consultation exists in the patient record entries reviewed it is again the social worker that is the most likely actor (26 or 96%). Consultation is a collaborative action, most likely with the physician, in arriving at decisions on what the best approach to care for the patient entails.

Much of the interactions between physician and social worker were requests or directions. In effect, rather than consultation, the relationship seemed more top-down, from physician to social worker. There is an entry in 1952, written by a social worker that appears to be more like a social worker consulting with the physician.

[The patient] was phoned....[the patient] promised to let me know if [the patient] was able to obtain an address for me. After discussing this with the Doctor he advised me to ask [the patient's sibling] whether [the sibling] would invite [the patient] to [the sibling's] place and notify us so that we may pick [the patient] up there. (892)

One could argue that the entry continues to demonstrate the authority of the physician, but in this case, the focus is on the social worker and the action of speaking with the doctor to develop a plan of action for returning a patient to SMHC who is decompensating. Another entry in 1958 is a further illustration of how the social worker did this.

Landlord states that [the patient] was looking very poorly, is not going out to attempt to get work.....it would appear that [the patient] will not be able to remain out of hospital. This will be discussed with the doctor. (2879)

Consultation may not have always been a passive endeavour - where the social worker is merely going to the doctor for advice. In fact, a 1964 entry shows the social worker taking the lead due to having greater knowledge of the patient than the physician.

Dr.was contacted. [The doctor] did not remember [the patient] from former years. I was able to give [the Doctor] the medication on which [the patient] had been well maintained.....I knew for the last 2 or 3 months [the patient] has not been taking medication. (3160)

Another entry by a social worker in 1964, states the expectation of a consultative relationship between the doctor and the social worker. “[The social worker] should also decide with Dr. [Name] in what way follow-up arrangements are to be made and how [the patient] is to receive

[their] medication...” (5062. What this entry implies is that discharge/aftercare plans are made by the social worker in consultation with the doctor.

Consultation by the end of the 1960’s is also about the social worker sharing the results of a screening or evaluation for suitability of social work related services in order to plan an intervention or plan of treatment. “...I will discuss this [patient] with Dr. [name] as to the role we can play.” (8466). This entry was written by a social worker after documenting the meeting with the patient where a tentative plan was formulated.

Sometimes housing would break down for the social worker and, what one Manitoban social worker referred to as a “social admission” (A. Hajes Personal communication, August 20, 2014), would occur. This required the consultation of the social worker with the physician as illustrated in this patient record entry from 1971.

Since worker was unable to find a vacant care home to provide the necessary supervision and care for [the patient], worker was faced with no alternative than to return [the patient] to Selkirk Mental Hospital. Worker presented the problem to Dr. (name), the treating psychiatrist, who agreed that [the patient] should be re-admitted to S.M.H. [Selkirk Mental Hospital]. (1255)

In 1971, the first “Inter-Departmental Memorandum” (for this sample) appears, that documents the consultation of a social worker with a physician, where the decision is made about whether to involve an attorney to address a patient’s financial matters.

I have discussed this situation with Dr. [Name], the treating psychiatrist, and we are in agreement that what is needed in this case is legal assistance for [the patient] in this matter... (1255)

Summary of Social Work Functional Activities

The prior section illustrates how the 15 social work functions are encountered in the patient record. What is evident is how much of the actions pertained to case management, monitoring and working with family. The prior section also showed how each function became more sophisticated over time. It was not unusual to discover actions becoming more formalized. This took the shape of supervisors becoming involved and/or standardized documents encountered in the patient record. While staff such as doctors, nurses and administrators may at times have performed these actions, this differed from the social worker. As an illustration, the reader is referred to the social work function of working with families, where the social worker took a more egalitarian or inclusive approach. The purpose of working with family was to seek their perspective, their input. Generally, when this wasn't a social worker, the family was directed or informed by staff rather. When staff other than the social worker was working with family, the interaction was one sided and directive in nature.

Conclusion

A number of questions can be examined based on this chapter. The first question is whether there are some professions who engage in specific social work related tasks. As the chapter has shown, it is indeed the social worker who is actively involved in providing many of the social work actions. When social work actions are dominated by a non-social worker, it is the doctor or the superintendent who is most involved in providing care to the patient. Even in such cases, it is likely that the social worker is also identified for those social work actions, even making up the remaining minority number of relevant social work actions identified in the patient record.

Next, the question of whether social work action and profession have changed over time at SMHC can be seen both in this chapter and chapter five. Indeed, changes did occur. As the previous statistics above have shown, actions changed over time as, presumably, the institution evolved and changed as did the external environment as well. Social work actions are most frequently performed by doctors in the first decade of the study (1947-1957). For the remaining period of the study (1958-1979) the patient record revealed that social work actions were most commonly performed by the social worker.

The question whether diagnosis or chronicity affected the type of social work functional activity provided was also addressed in the preceding statistics above. Higher LOS appears to relate to certain actions becoming more prevalent as well as when the patient is identified as having a thought disorder. The increase in social work activity related to thought disorder will be addressed more fully in the discussion chapter of this dissertation.

As this chapter has shown, social work is most prevalent during the stage of treatment related to discharge and aftercare. While there is some evidence of social work activity in the ongoing treatment stage, it is most likely that it will be located at the stage of treatment where plans are made to engage the patient back into community.

Gender did not have an impact on the kind of social work actions performed, with the exception of perhaps more monitoring observed for women. Social work actions appear to be distributed almost equally between the genders. Age did not seem to influence how much social work activity is dedicated to the patient, especially when looking at average number of social work actions per patient by each age range. The average number of actions for each age group is

approximately 10, with the only exception being those aged 53-71. For this group it is higher to around 15 social work actions per patient.

This chapter has shown how each of the 15 social work action codes is represented in the sample (N=132). While certain actions are most dominant, each action was reviewed with salient examples to demonstrate how they took place at SMHC between 1947 and 1979. When possible, the illustrations from the patient record demonstrated how a social work action evolved at SMHC.

For the most prevalent social work action codes, there were differences between how the social worker action and that of the other most prevalent actors was presented. This gets at uncovering the form of social work as it emerges at SMHC. For example, in “Working with Family” what emerges is how the doctor and the superintendent tended to deal with family in a one sided way. Families are communicated with in order to inform them or remind them of their role, these professionals informing them on the patient’s status. Their input is seldom sought out regarding a patient’s care. The social worker is clearly more engaged with families in seeking their views, while communicating the wishes of the doctor. The focus of the social worker evolves toward an interest in working actively with family to create conditions that would facilitate optimal recovery for the patient. By the end of the period of study, this includes active therapy efforts to address challenges in the family system that prevent such optimal recovery for the patient.

Case management also turned out to be an evolving activity, with the social worker beginning as the de facto staff person who deals with financial affairs, to being the one responsible for the chart, its management as well as negotiating access at the end of the 1970’s.

The superintendent, when performing case management, is more likely to approach the financial management piece of case management. This is done by requesting money as needed from whatever payer source identified or reporting to these same sources the patient status in order to ensure proper payment schedules. The doctor, when performing case management, tended to focus more on the chart management aspect of this function.

Monitoring focused on the functioning of the patient in their home environment. The social worker does this by direct contact as well as seeking out information from family and loved ones. The function of social work becomes clearer here. It appears that the social worker is engaging in this action to fill in the blanks for the treatment team between official appointments with the doctor. Furthermore, as physician entries show, the six months' probation is contingent on how the patient is functioning in the community, underlining the importance of the social worker's performance of this action. The doctor engages in monitoring as well, even commenting on actions not directly related to the medical but the social functioning of the patient. However, this tends to be during doctor's appointments, not while in community. The nurse monitors as well but tends to do this while the patient is inside the SMHC facility.

In conclusion, this chapter shows the breadth of social work actions. All 15 social work codes of function are present in the patient record. The representation of these in narrative format provides a glimpse of what these services looked like in practice. The descriptive statistics serve to illustrate trends in the findings as well as to provide the reader with a sense of which social work functions are considered more common – both for the total sample as well as groupings based on date of entry, gender of patient, age, and patient chronicity. Furthermore, the chapter illustrates, via the longitudinal narrative of social work actions, how social work activity

becomes more sophisticated and elaborate over time. What becomes clear is that social work functional activity was seen as essential in the array of services provided at SMHC.

In looking at how some actions differed depending on which actor performed them, it begins to become clear how the form of social work emerges at SMHC. While this chapter looked more at the specific actions performed, the question as to what distinguishes an action when performed by the social worker shifts the focus to the following chapter. Chapter five emerges, in effect, from the cumulative observations of social work actions in this current chapter, then. It is the intentional review and observations of the identified social work actions in the patient record with a view towards uncovering what the patient record entries can show of the emerging role of the social worker. The following chapter is the product of this process.

Chapter 5: The Emerging Social Work Profession

Introduction

This chapter shows how the various sources complement and extend our understandings about how social work steadily emerged as a distinct profession within the institutional setting at SMHC. The patient files consulted are a rich resource for identifying what social workers were doing, as well as how other staff members perceived them.

This chapter will begin with descriptive statistics drawn from the federal reports, in order to frame the larger context for what was encountered in the patient record. What follows then, are the qualitative findings about the roles of the emerging social worker. These findings, broken down by decade, are presented in a narrative to show how the social worker emerged at SMHC. Each decade is also prefaced by source material from the Manitoba Archives to provide context and to enable a deeper understanding of the patient file entries. Finally, the author constructed a narrative of the social worker emerging at SMHC as found in the patient record content, also organized by decade. There are verbatim illustrations, edited to ensure no identifying information about the patient or the practitioners involved. The focus for each decade will be on new or changing themes of the emerging form of social work. Themes that persist or are consistently present across decades are assumed unless remarked upon.

These verbatim illustrations emerged from reviewing all social work related patient record entries retrieved, based on the criteria for social work actions or functions as outlined in the methods chapter (see figures 3.1-2 for reference). These were then sorted and filtered by social worker as actor. If an entry was about what a social worker did – either the actor or referring to a social worker's actions, that entry was reviewed. The social work related patient record entries were sorted chronologically by date of entry. At this point, the focus was less on

the specific actions performed, but rather on what the entry could contribute to helping understand the evolving role of the social worker at SMHC. The exposition of the *social work actions* performed at SMHC, was discussed in more detail in the corresponding chapter on social work actions.

Authors of Patient Records

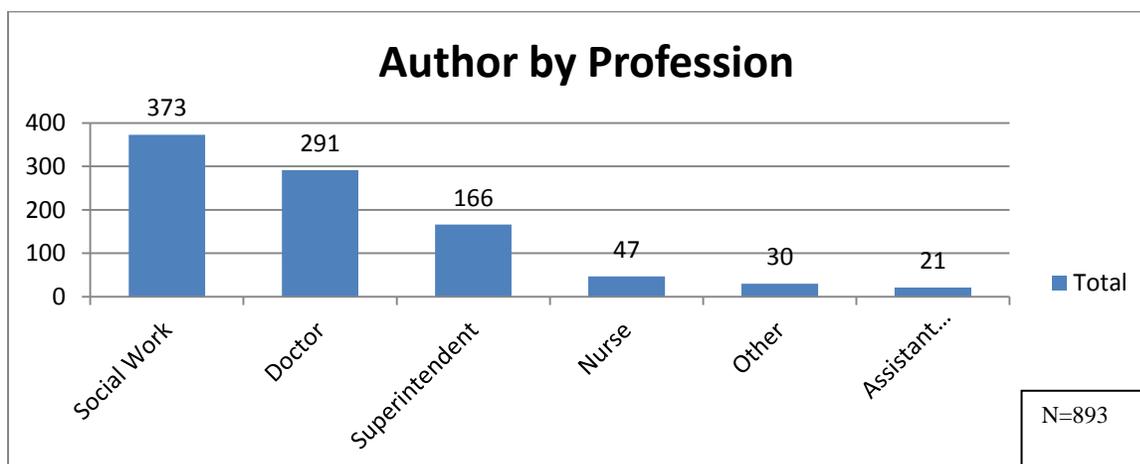
The remainder of this chapter is based on a detailed examination of the 893 collected patient file entries with reference to social work from the sample patient files (N=132). Specifically, the entries that were either authored by social workers or made reference to social work became the focus for this chapter. Operational definitions as defined in the methods chapter around what constitutes the social worker are adhered to throughout. There are a variety of ways that a patient file entry referred to a social worker. Most clearly, when a social worker is mentioned by name or the entry is addressing a social worker, it is apparent that this is a legitimate entry for analysis. When a patient entry is about plans to involve social work, this entry is included as well, since it illustrates what others, usually but not always the doctor, view the social work role to be at SMHC.

Authorship in a patient record can mean a number of things. It can suggest that the author, as the term implies, has authority in the patient record. As such, identifying authorship can facilitate an observation about who has power or authority in the record. This may be confounded by the perceptions of the archivist in what constitutes a valuable chart entry. Since at times the author is passively commenting on the actions of another that is considered social work or a social worker, there is some utility in looking at both author and actor in the patient file.

Further, in looking at the social work actions identified in the collected social work related patient file entries, I will describe the characteristics of the identified actors, since this isn't always the same as the author of a given file entry.

Based on 893 samples of collected social work related patient record entries, the following is known about the authors in the patient files who documented social work activity. As can be seen in the figure 5.1, 373 (40%) of the authors can be identified as Social Workers. The second most common profession is the Doctor (291 or 31%) followed by the Superintendent (166 or 18%). This is followed by the Nurse (47 or 5%), the designation of "Other" (30 or 3%) and finally by the Assistant Superintendent (21 or 2%). The Clinical Director and the Executive Assistant had been given their own designation given their prevalence in the patient record. However, the two actors contributed minimally to the total frequency count with the Clinical Director once and the Executive Assistant only three times.

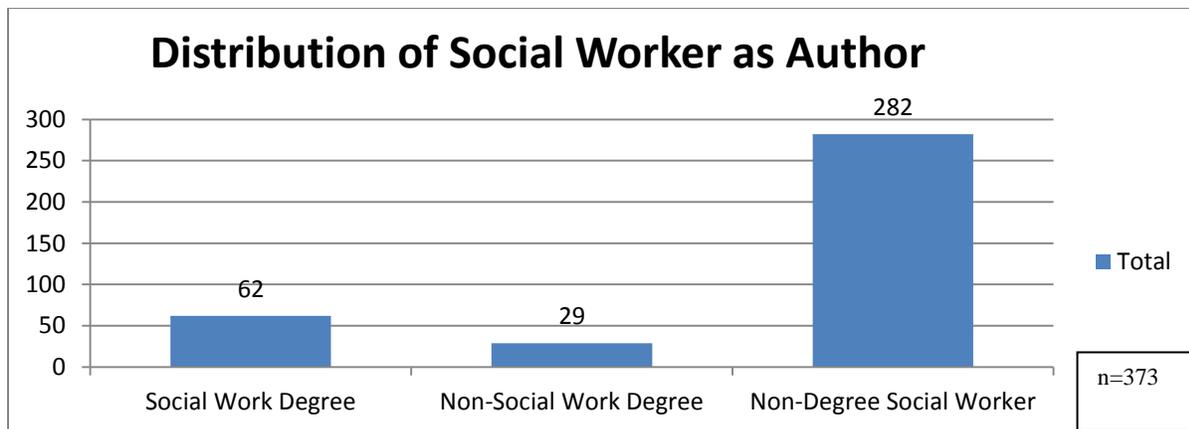
Figure 5.1: Patient File Entry Author by Profession



While reviewing the total sample, it became apparent that titles and degrees were only identifiable when the author self-identified in their signature. Hence, all data around the degree

status of a social worker invariably came from the social worker as author. There were 373 patient record entries authored by identified social workers. As shown in figure 5.2, some patient record entries had been authored by staff with social work degrees (62 or 17%). A number of staff identify themselves as social worker by profession but have degrees that are not social work (29 or 8%). By far, the largest number of entries is authored by staffs that are social workers without any university degree or are non-degreed social workers (282 or 76%).

Figure 5.2: Distribution of Social Worker as Author



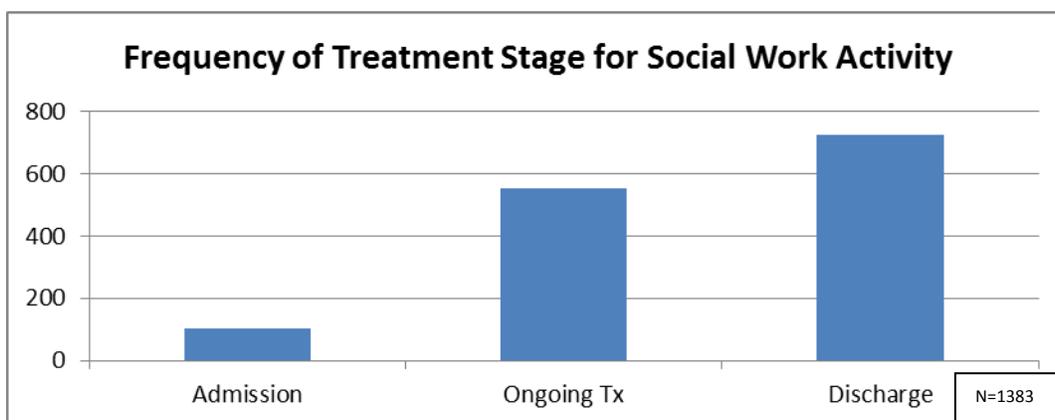
The breakdown of the areas of practice, in which the social workers are located, indicates 54 social work related patient file entries, or 14.5%, that are author identified via their signed job titles as administrators of some kind. There are 4 instances where a social work supervisor was identified but no degree provided. In all other cases the designation was present (50). What this means is that 85.5% of all social workers authoring entries in the sample are clinical in their function. This is based on the idea that the supervisor primarily performs a function that involves the direction of clinical staff and consultation with the treatment team rather than direct service provision.

Worker as Actor

Since a given entry can have multiple references to actions taken, along with an identified actor, the focus is not on the number of social work related patient record entries collected (n=893). Rather, it is a larger number, based on the number of identified actions in each entry of the patient record (n=1408). In other words, a given patient record entry collected, upon multiple analysis and review, can be identified as containing a number of separate social work related actions. These actions were then re-examined with a focus on how they serve to illustrate the emerging role of the social worker.

The following data show where most of the social work activity took place at SMHC. This is intended to provide the context for greater understanding of the narrative in this chapter regarding the emergence of the social worker and their function at SMHC. The results in this particular calculation are based on 1383 identified social work actions in the patient entries, given that 25 of the patient entries had insufficient data to determine the treatment stage. It is apparent that the majority of social work related actions occurred during the discharge stage of treatment - 731 identified codes or 52% of the total (see figure 5.3).

Figure 5.3: Location of Social Work Action in Treatment Stages



This result is likely related to the perception of the function of social work – to address the discharge needs of the patient into community. It will be commented on more fully in the discussion chapter of this paper.

Treatment Stage for Social Work by Decade

The following data show how the location of the treatment stage in which social work actions were performed changed over time. Adjustments in the total number of coded social work functional activity are based on when the date of a given patient record entry was unknown. In such a case, the coded entry was omitted from the analysis.

For each decade of this study, the patient record sampled showed the most frequent social work activity at the probation/discharge stage of treatment, followed by ongoing treatment and finally during admission. See Appendix E for pie charts showing the treatment stage concentration of social work actions for each decade.

What is apparent is that although the location of social work action over the decades shifted slightly, it tended to reside in the same locations throughout. While there is representation in social work activity across treatment intervention stages, it is most prominent in the probation/ discharge stage, followed by ongoing treatment. The most social work actions in the admission process appears to have occurred in the 1st decade at 52 or 16% of total social work activity encountered in the patient record. While this data captures all social work activity, regardless of actor, it serves to show where social work actions were most likely performed the most.

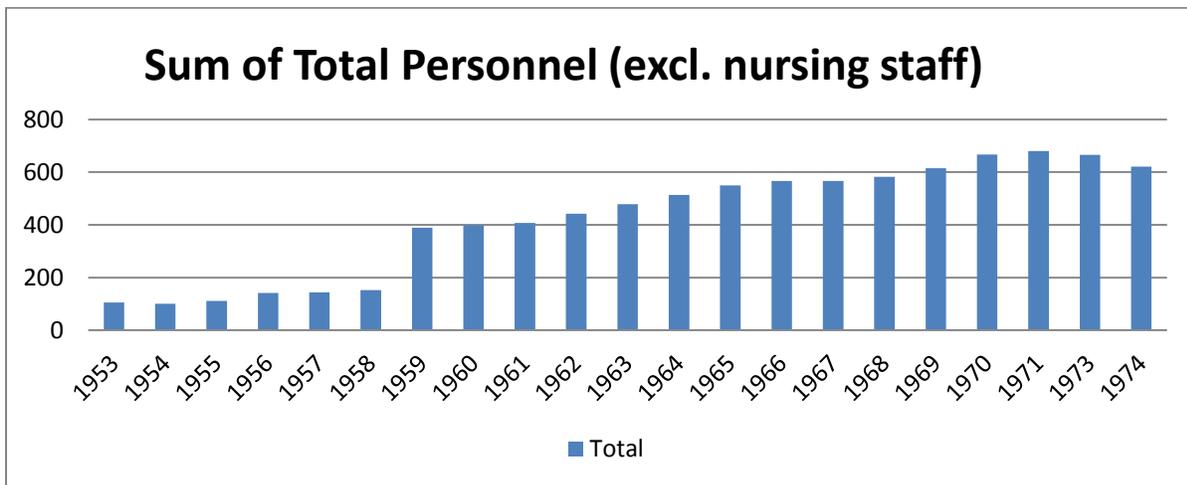
Statistics from Annual Federal Reports (1953-1974)

The following statistics are from annual reports (available at the SMHC archives) made to the Federal Government that provide greater clarity and insight into the staffing patterns, as

well as the patient census during a significant period of time at SMHC. They serve to place the findings in this dissertation within the larger framework of the greater population at this institution. The annual federal report for 1972 is absent from this collection, however. When looking at the data, it must be kept in mind that 1972 is not included in any statistics.

As figure 5.4 shows, there is a sharp increase in the number of personnel not a part of the nursing staff in 1959. After 1962, there is a steady increase until 1971 where there is a downward trend once more. As there is no further annual report available post 1974, it remains unknown at present whether this downward trend continued. Regardless, it is 1971 when there is the largest amount of non-nursing staff (n=680) at SMHC.

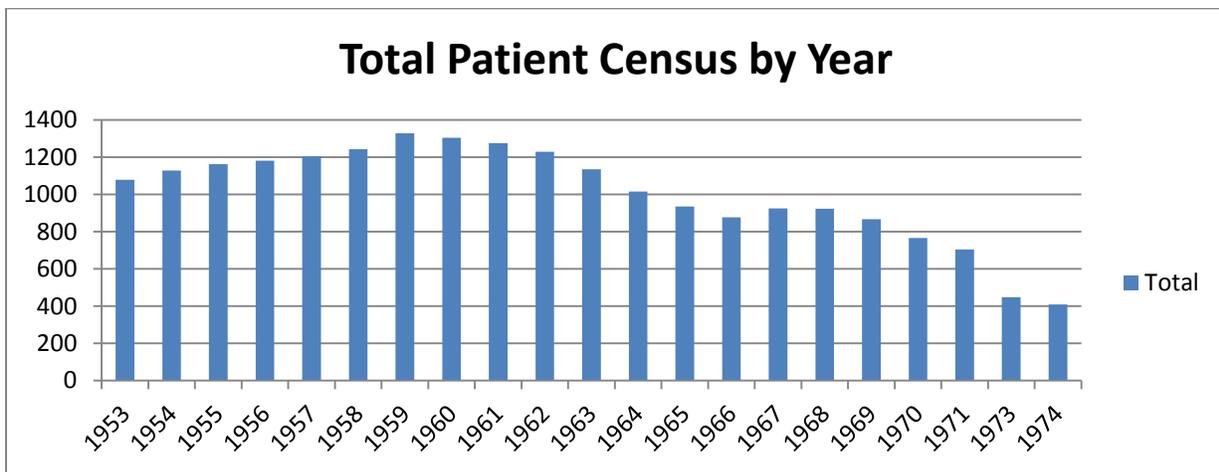
Figure 5.4 Sum of Total Personnel Adapted from “Annual Return of Mental Institutions – General by Government of Canada [Dominion Bureau of Statistics; Dominion Bureau of Statistics-Ottawa; Statistics Canada], 1953-1971, 1973-1974



Considering the previous figure, it is interesting to see how the patient population dropped from its highest in 1959 with 1,328 to 1974 with 409 (see figure 5.5). In other words, while the hospital staff increased, the patient population was decreasing. Whether this is due to improving mental health treatment or a sign of a growing hospital bureaucracy may be open for

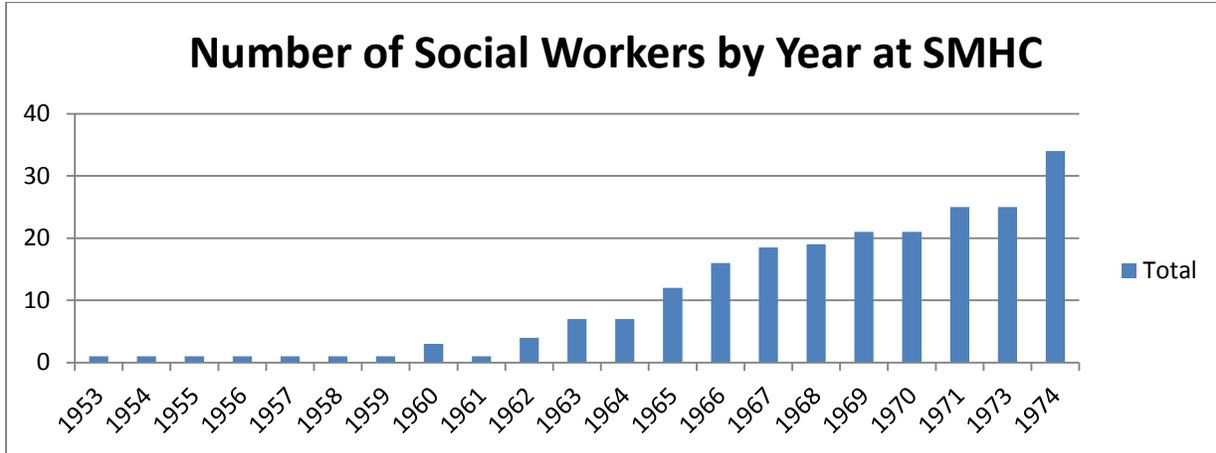
discussion. Most likely it is both. What is known is that deinstitutionalization occurred due to a change in how the patient was viewed and an increasing focus on community mental health, brought about by innovations in psychopharmacology and the emergence of a critical view towards institutionalization (Glancy & Regehr, 2010; Grob, 1994; Linhorst 2006).

Figure 5.5 Total Annual Patient Censuses Adapted from “Annual Return of Mental Institutions – General by Government of Canada [Dominion Bureau of Statistics; Dominion Bureau of Statistics-Ottawa; Statistics Canada], 1953-1971, 1973-1974



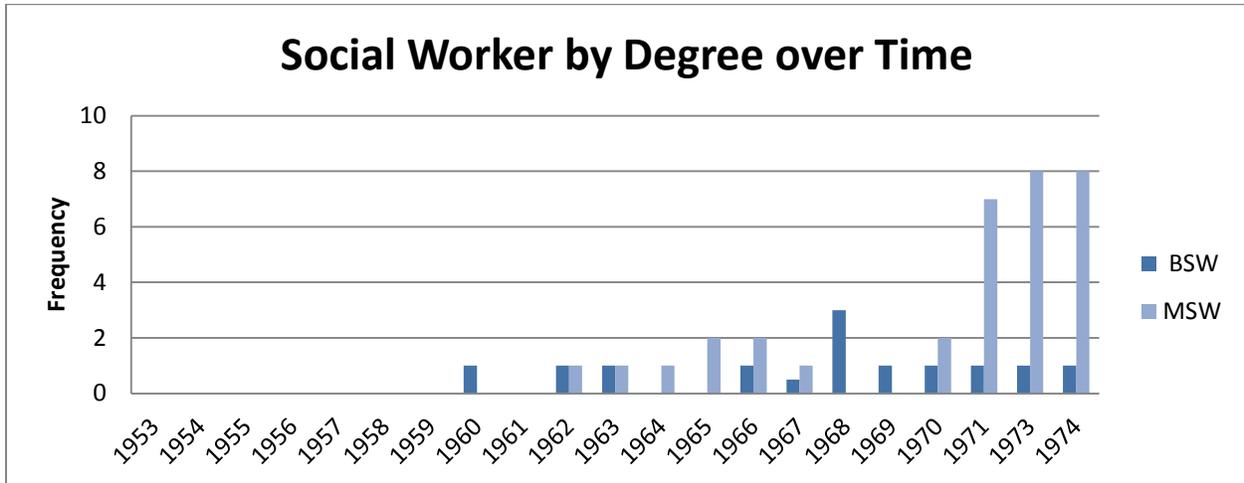
There is only one social worker for SMHC until 1960. From 1961 to 1963 this jumps to 7 (see figure 5.6). Between 1964 and 1967, this jumps to 18.5. There is a consistent increase after this until the final year of the reports where the number of social workers listed increases by 9, from 25 to 34.

Figure 5.6 Total Annual Numbers of Social Workers by Year. Adapted from “Annual Return of Mental Institutions – General by Government of Canada [Dominion Bureau of Statistics; Dominion Bureau of Statistics-Ottawa; Statistics Canada], 1953-1971, 1973-1974



As this figure (5.7) shows, the social worker did not get identified with a social work related degree until 1960, when it was the BSW. In 1962, the MSW degreed social worker is first identified with one identified staff. While the BSW remains minimal, the MSW degreed social worker is doubled (2) for two years (1965-66) only to drop off to one in the following year and to none until 1970, when two staff members are identified as having this degree. By the following year this jumps to 7 and then to 8 for the remaining two annual reports. The reader is reminded that 1972 is a missing file and cannot be consulted for this data.

Figure 5.7 Total Annual Numbers of Degreed Social Workers Adapted from “Annual Return of Mental Institutions – General by Government of Canada [Dominion Bureau of Statistics; Dominion Bureau of Statistics-Ottawa; Statistics Canada], 1953-1971, 1973-1974



Both figures (see figures 5.6 & 5.7) can be compared to see that, while social work is on the rise, it is predominantly staff without a social work degree. Looking at totals for number of social workers reported to be employed at SMHC each year, where compared to the number of degreed social workers at SMHC, it is only 21% or 45.5 Full Time Equivalents (FTE) out of 220.5 FTE. The descriptive statistics from the patient record shows, that of the total number of social work related patient file entries collected from the sample (N=863), two thirds of the social workers encountered do not identify with a degree in their signatures. This is fairly similar to the federal reports data above that capture a larger staff population than the sample.

The Emerging Social Work Profession

How can the patient record entries serve to paint a picture of the emerging profession of social work? In order to make the narrative easier to follow, the years of study will be broken down into equal intervals, with each section prefaced by material from the annual provincial

reports regarding SMHC. This serves to provide the context within which the data can be interpreted and understood.

Context: 1947-1957

At the beginning of this period of study, overcrowding plagued all provincial psychiatric facilities, resulting in a trend to respond to this problem by attempting to discharge patients as soon as feasible from inpatient status (Department of Health, 1948). This trend, of high discharge rates for those admitted in the same year, continues throughout the 1950s (Department of Health, 1951; Department of Health 1952; Department of Health, 1953; Department of Health, 1954) until 1954.

Regarding SMHC, 40% of first admissions are Schizophrenia related in 1947 (Department of Health, 1948). SMHC was then experiencing serious overcrowding (40% over capacity) and, according to the provincial psychiatrist, this was part of a vicious cycle. Due to overcrowding, it was not possible to prep people adequately for discharge, so they tended to return at the same time as more first admissions arrived at SMHC.

The provincial psychiatrist voiced a concern in 1947 about the need to retain trained staff at the agencies (Department of Health, 1948). Along with staffing concerns and overcrowding, the psychiatrist articulated a vision of community mental health, but made this contingent on institutional overhaul. Community services were seen as something the province wants to move towards, but needs to first get the institutional component of MH services under control, so that the institution can provide assessment and advice to the community (Department of Health, 1948)

Further advances are dependent upon the obtaining and training of medical, psychological and sociological staffs. Our medical staff must be maintained at full strength, and our institutional obligations thoroughly covered so that we can have time, as it were, to spill some energy into community services in the hope that preventative work will bring future rich rewards. (p 225)

To this end, SMHC is announced as having recently added a psychiatric social worker at the beginning of November, 1947 (Department of Health, 1948). In a later report there is also further reference to this having included the formation in 1947 of a “Department of Social Work” (Department of Health, 1959). This professional was recruited from the ranks of the nursing department.

In the first few years, the actions of the social worker are described as related to making a large number of phone calls to the community, either to check up on patients and their families, or interacting with various resources such as the NES.

It was possible for the social service worker to straighten out problems relating to the rehabilitation of many of the patients probated from hospital.....she receives excellent co-operation from various social agencies and from the special placement division of the National Employment Service (Department of Health 1950, p.188).

It is apparent that at the beginning of the period of study, SMHC is poised to examine how to improve care, in order to reduce length of stay, as well as the returning of patients. Efforts to impact the current trend of overcrowding and recidivism were described in the reports.

This emphasis is bookended by plans to construct more facilities, to provide adult outpatient services that are ready and available for "...trained psychiatrists, nurses and social service workers.. "(Department of Health, 1948, p. 259). Much of this was possible via the Federal Mental Health grants that became available to the province of Manitoba (Department of Health, 1949).

According to the SMHC website, SMHC claims to have been actively involved in community mental health activities as early as the late 1950s, including "...a corresponding active program of outpatient follow-up" (Selkirk Mental Health Centre Archives, 2013, p. 3). According to the annual reports to the provincial government, there is evidence of the social worker performing home visits as early as 1952 (Department of Health, 1953). As the patient file entries will show below, home visits actually began even earlier, in 1948.

In the 1953 annual report to the Manitoba Department of Health, the psychiatric social service worker is described as having made 753 visits, either to the patient themselves or to their relatives. According to this report, the Social Service Department is seen as a valuable resource - "The Social Service Worker materially assists in the re-establishment of patients" (Department of Health, 1953, p. 163).

In 1954, the function of the psychiatric social service worker, while still making many phone calls, is further described as monitoring "...the progress of patients probated from the hospital. These patients are assisted in dealing with domestic problems and given help when necessary to re-establish themselves economically" (Department of Health, 1955, p. 190). The relationships that have been cultivated and are effective towards this end, are various social

service agencies, as well as what appears to be a greater understanding or support by said groups “...to assist us in their rehabilitation” (p. 190).

At this point in time, training and education become priorities at SMHC. The staff at SMHC is now being viewed as needing specialized training. This can be seen in the application of Federal Mental Health grants to pay for “Post Graduate training of nurses, physicians, and laboratory and social worker” (Department of Health, 1954, p. 157).

In the mid-1950s, the use of psychotropics brought about a significant decline in the chronically mentally ill population residing at SMHC, enabling either full discharge or monitoring in the community on probationary status (Department of Health, 1956). This appears to have had a dramatic impact on the number of patients remaining at SMHC with Schizophrenia. “..it is no small achievement that the residue of such cases has fallen from 68% to 15% in twenty years” (Department of Health, 1956, p. 159).

In the 1956 report to the Department of Health the Superintendent clarified that in terms of admissions, it is still Schizophrenia that constituted 40% of all admissions, and that these admissions are almost equally split between admissions and readmissions. In other words, while medication is an improvement, those with chronic and significant mental illness continue to account for a large number of the overall services provided at SMHC.

Medication is seen as a tranquilizing asset for managing patients, either in open wards or when monitored in the community. It is in these reports that there is reference to how SMHC sees the function of the social worker in working with this population. “These patients will probably continue to require the drugs in order to maintain an acceptable level of behaviour in the community. Our Social Service Department will have to accept this added responsibility”

(Department of Health, 1956, p. 200). The burden of additional work identified for the social worker is the argument made for the hiring of an additional social worker. But, as can be seen in figure 5.6 above, social work staff doesn't increase until 1960 when it jumps from 1 to 3 staff. The tasks of the social worker identified include monitoring of patients on probation in the community, but also consulting with the physician involved in the patient's care. This is done in order to ensure that the patient's progress or recovery while at SMHC is not undone.

Otherwise the work carried on in the hospital will be nullified in the community with respect to patients who require guidance or direct assistance in maintaining themselves and adjusting to the problems of their domestic and economic life (Department of Health, 1956, p. 201).

In 1957, the rising admission rates are seen as a concern - with Selkirk identified specifically as struggling with admissions and readmissions due to patients with Schizophrenia (Department of Health, 1958). Solutions explicitly state that social workers are needed via SMHC to enter the community in order to prevent readmissions for this patient population. "We should consider providing for these patients, in the community, the service of psychiatrists and social workers in sufficient measure to assist them to adjust at a satisfactory social level" (p. 187).

This report further makes the point that even geriatric cases could avoid in-patient care if treated by psychiatrists and, "...followed up by qualified psychiatric social workers..."(p.187) in their own homes. One of the reasons why the social worker is seen as essential is the increased reliance on medication, as they require a 30 day medication monitoring protocol that is further stretching staff resources necessitating more of said staff (Department of Health, 1958).

Illustrations from the Patient Record (1947-1957)

Family Support

The patient files hold little content for the social worker in the first year (1947). What is known can be gleaned from an entry, made by a doctor at the facility, referring to how social service needs to be involved upon discharge. The social worker is supposed to provide support to patients in community struggling with family issues. In this entry, the doctor prefaces the plan of treatment by describing the strained social relationships between the patient, their spouse and extended family. “Feels rejected by both sides, reacted to situation with irritability, anger, over-activity, confusion and delusions....” This is followed up with a section in the entry regarding the planned treatment which states as outcomes “Better marital adjustment if this is possible, also with...own family. Follow up through social service” (172, 1947). Nothing else is available in the patient record to shed light on what this looked like, but it is apparent that the social worker, in the first year of being at SMHC, is perceived as providing support to patients in addressing social factors that cause distress to the patient in community.

Financial Resources Expert

In the following year, the social worker is viewed by the physician as being the staff person that is involved when addressing financial matters such as those related to benefits. The doctor describes a situation where there are questions around a patient receiving financial aid.

It may be that on account of the patient’s mental condition the government is sending out cheques to the [Patient’s spouse] but [the Patient] says [Patient’s spouse] denies that they have been coming. We will likely have [The social worker] look into this matter so that the patient could be definitely informed about it (329, 1948).

Early Home Visits

In the first few years, annual reports to government describe the actions of the social worker related to making a large number of phone calls to the community to check up on patients and their families with the first home visit reported on in 1952 (Department of Health, 1953). However, the very first actual patient record entry authored by the social worker themselves was encountered in a 1948 entry regarding a home visit. In this visit, the worker not only documents the patient's social functioning, but reports on emotional content as well. Furthermore, the entry shows that the spouse is consulted during the visit.

Visited at home. [The patient] is doing some part-time work for the garageman across the street. [The patient] seems fairly happy and though not entirely settled. [The patient] says ... feels a little lost at times. [The patient's spouse] says [that the patient] was restless the first few days but is better now. [The patient] presents a rather boisterous and slap-happy picture just now (280).

For the first few years (1947-1949) the social worker is checking in on patients, either by phone or by performing home visits. The social worker would not only visit patients, but meet with former patients as well. The patient records show that it is the social worker that frequently is the one that transports patients into the community upon discharge from inpatient status. The following July, 1949 entry illustrates how the social worker does more than transport patients to community but actively assists in helping the patient connect with community resources such as employment and housing.

Taken to [City] Stenographic test at Employment Service. [The patient] did well at this in both typing and shorthand. [The patient] obtained temporary employment with a very fine firm...[The patient]will live at Mrs. [name] for the

next few weeks. [The Patient] liked the employer very much and fell in love with [The Landlord] [The Patient] is to commence work [month, day]. (579)

In fact, it appears that a lot of the work being done by the social worker involves a focus on the community – either to check-in with probated patients or preparing the community resources in order to facilitate probation. In fact, this quote, taken from the “Report of Social Worker” in August of 1949, shows how the social worker is meeting with informal supports to discuss the possibility of a patient being able to stay at this resource’s home.

They are both anxious to do all they can to help [the patient]They are really strangers to one another and would have to learn to be friends. If [the patient] would be happier or better away from home, they would be most agreeable. (579)

This entry appears to be a report to the treatment team at SMHC as to the possibility of a patient residing with family upon leaving the institution. One can see that this report is an exposition regarding the state of mind of the informal supports or supporting persons, both their commitment as a support to the patient and the challenges that the patient would be facing if this became the housing option for them.

Social Work focused on In-Patient

However, there are instances of social work having a focus on the patient while in hospital. This 1949 entry illustrates how the social worker is interacting with other members of staff at SMHC with an eye towards ensuring that financial needs, while in-patient, are taken care of.

The Administrator’s office was visited regarding [the patient’s] belongings... Whatever [the patient] needs can be obtained as [the patient] has

\$150.00 cash with the Administrator's office plus bonds and there is the monthly rent from [the patient's] furnished house. This will be discussed with [the patient] (632).

What is apparent is that in the first few years of the social worker being active at SMHC, there was more going on than making phone calls. Treatment staffing notes were not present in the record, but based on the entries made by staff, the social worker is relied on to go on trial run visits in community with patients to see if they are progressing and are ready for inpatient discharge to probation status. The following 1949 entry is a rich example of how the social worker would work with patients to evaluate them for whether they are ready to be probated to community.

[The patient] spent the day yesterday with [social worker] in Winnipeg visiting out patients and x-patients.Throughout the day she was extremely bright and talkative.....ate in a restaurant and walked through crowds with no apparent anxiety or tension, ...[The patient] remained quite diffident during the day whenever [the patient] was told how well [the patient] was doing.....I feel that [the patient] is making very favourable progress and as soon as part time work can be found for[the patient] out of hospital I feel[the patient] will prove to [themselves]that [the patient] is able to get along quite well outside the hospital (579).

Here we have an example of how the social worker, clearly planning to engage in a community visit, is having the patient tag along to see how they fare in community. While engaging in the mundane tasks of visiting other individuals, the social worker is evaluating how the patient is

responding to the visit. The social worker's opinion is included as to what steps are necessary to have in place prior to discharge from inpatient status to community on probation.

Outside Agency perception of Social Work

The 1950's began with much the same focus for the social worker – of calling and personally visiting patients in community and to monitor their social functioning. This now includes notations in the chart about interacting with the patient's landlord, family and employer. For patients at the inpatient level, an entry on July, 1953 is instructive. In a letter from the Administrator of Estates of the Mentally Incompetent, responding to the request of providing funds directly to a patient while still in hospital, this file entry appears.

....to send to the hospital for the benefit of the patient while still confinedWe are glad to note that [the patient] will accept responsibility in the way of accounting for the sum advanced until the patient is probated, and it is suggested that [social worker] obtain from [the patient] a receipt for any sum of money that is passed over to [the patient] (579).

In this entry there is evidence of the perception by outside service providers of what the purpose of the social work professional is at the institutional level – the management and record keeping of financial affairs of patients residing at SMHC.

Social Work as the Link between In-Patient & Community

Keeping track of the status and condition of patients in community means also that when a patient is struggling, other features of the relationship between the social worker and the SMHC staff become apparent. In a 1952 entry where a patient had been relapsing on alcohol and getting evicted from their residence, the role of the social worker as the link between the inpatient and community setting is obvious.

[Family member] was phoned.[the family member] promised to let me know if [the family member] was able to obtain an address for me. After discussing this with the Doctor he advised me to ask [the family member] whether [the family member] would invite [the patient] to [the family member's] place and notify us so that we may pick [the patient] up there. With regard to this I contacted [the family member]but... is very loathe to do this saying [the patient] would be so bitter about the duplicity that [the patient] would never trust [the family member] again and [the family member] would be unable to help [the patient] at a later date (892).

Clearly the social worker is located here as the one that is to contact family to locate the patient and to pass on the strategy for how to re-admit the patient, using the family's relationship to the patient to do so. It is interesting that the social worker, rather than providing an opinion or judgment, aims to capture the perspective of the family only in curtailing this strategy.

Social Work as Monitor in Community

In a 1952 entry from the above quoted patient file, another role of the social worker emerges – that of being the representative of the voice of authority of the institution as to what is appropriate behaviour to remain in the community. “I will see [the patient] as soon as possible, and remind [the patient] of the conduct we expect and emphasize the fact that anything short of this will result in [the patient] being returned to hospital” (892). By the end of the decade, the nature of the role of social work to monitor and enforce compliance is evident.

Arrangements were made for [the patient] to go to Winnipeg with [social worker] today. The Social Worker will check [the patient] every 2 weeks and

patient will see us regularly once monthly. [The patient] has been told that any break in this routine will lead to hospitalization (892).

Social Work as House (and job) Finder

What is apparent is that the treatment team relies on the social worker to be the one to locate housing in the community for patients soon to be released from inpatient status.

This patient seems to have done fairly well [The family member] has been very interested in getting [the patient] out.....therefore [the social worker]has been able to find a situation for[the patient] In view of this it is felt that a trial is justified, especially as [the patient] will be very near to us and can visit the O.P.D. [Out Patient Department] very regularly. Therefore [the patient] has been given a trial and after being out on pass for 2 weeks, appears very well (892, 1952).

This entry makes it clear that it is the fact that the social worker was able to secure housing that moves the treatment team towards authorizing a trial discharge to community. Furthermore, the social worker found a location close to the institution to ensure greater likelihood of the patient being able to access supports to ensure greater success out of the institution. Other entries make it clear that it is not just housing but that it is expected that the social worker address other factors of successful community placement. “This patient has been seen by [the social worker] today who will endeavor to find suitable employment for [the patient]” (1987, 1955).

Social Work as helping maintain patient in community

By the mid 1950’s, the social worker is spending time to help patients in the community. What this means is that tasks such as getting employment involves more than a few phone calls, but an extensive search with follow up – both for the patient’s initial employment as well as

ongoing monitoring of progress in this regard. This is then captured in the patient record. A good example is patient file 1987 where the focus on employment included not only searching for employment and establishing that the patient have the requisite educational credentials to get successfully employed, but regular check ins at the home of the patient. In this case, the initial contacts in July that serve to highlight the most concentrated period of the job search are days apart. By fall, the visits are weekly as the patient now has a steady job. The concern doesn't end there as the social worker not only monitors how the patient is doing but tries to address a more holistic view of community living.

Home visited...[The patient] is very fond of work that takes[the Patient] outside..... [The patient]does not have much surrounding activity, I was wondering whether [the patient] might consider going to the Y [YMCA] for some extra companionship. [The patient] appears to be keeping well (1987, 1955).

The social worker is aware that an employment focus by itself is incomplete. Social activities that serve to ground and locate the patient in the community more are needed to ensure successful placement. This is evident in the file quoted above as the focus on social outlets continues to be a topic in future entries. "Parents seen....does very little going out on his own...parents feel that [the patient] is lonesome..."(1987, 1956).

Summary of First Decade Findings

In summary, the 1950's involved SMHC wanting to increase social worker staffing according to the annual provincial report (Department of Health, 1956) as their role was being seen as more essential to SMHC. With the innovation and promise brought by medication, there is the hope that more patients can be returned to the community. The first social worker, hired in 1947 was the default staff responsible for arranging discharge and follow up from SMHC. As

the discharge rates increase, in large part due to the aforementioned psychotropics making treatment portable, it falls to social work to manage discharges and plans are made to increase this staff at SMHC. In fact, when struggling with rising readmission rates for patients with schizophrenia, the annual report in 1957 specifically refers to additional social workers as being part of the solution to keep them in community.

By the mid-1950's, the social worker is described in these reports as performing monitoring of patient's progress in out of hospital and working with community resources to ensure a network of support is available. In 1958 the matter of medication as a major influence in the increased work load is made apparent as the annual report refers to a monthly medication monitoring protocol. This is the reasoning behind needing more social workers to keep up with all of the medication monitoring

While annual reports were making the case for increasing social worker staffing to address the challenges of a growing census, it should be noted that- according to the Federal Report- social work staffing only increased in the 1960's (see figure 5.6). This meant that the social worker - while still called on to handle the financial affairs of patients at the inpatient level – was primarily focused on community. The shape this took was generally a large number of phone calls and home visits to monitor the status of patients. This took the form of actual interactions with the patient or other social supports that had access and information on how the patient was doing. What the findings show is how community visits actually occur earlier than the annual reports indicate. The patient record entry in 1948 shows how the social worker is already visiting patients in community and monitoring their progress. It is apparent that much of the work of the social worker is directed by the physician at SMHC and that the reports

completed by the social worker are for the review of this professional to determine if inpatient release is feasible to community.

As the decade progresses, it is the social worker that is more involved than merely finding housing. In helping patients with other aspects of community integration that include preparing for and getting employment, welfare benefits, as well as being available and informative to informal supports and exploring community activities for patients, the social worker is expected to have a broader focus for life outside of the institution. There are also social work related patient record entries that show how outside agencies begin to view the role of social work to involve the handling of the financial affairs of patients.

Context: 1958-1968

At the end of the 1950s, census figures show a decrease in the patient population at SMHC (Department of Health, 1960). At that time the rate of first admissions had risen and readmissions had decreased from the previous decade. This was explained as largely due to the innovation in treatment with reference to new medications and psychotherapy. Once more there is the acknowledgment of the need for community focused treatment.

The very satisfactory results which have been attained in other centres by the development of an adequate psychiatric social service in the community encourage us to expand our services outside the hospitals. These psychiatric social activities should be directed from the psychiatric hospitals and co-ordinate with those of the local health units to utilize and improve all aspects of mental health.... (Department of Health, 1960, p. 107)

What this means is that the psychiatric institution is expected to take the lead in forging community psychiatric social services that then are linked to, or collaborating with, resources in the community. Services that deal with rehabilitation and the prevention of readmissions are the focus and social work is seen as essential in this regard.

Our Social Service Worker is our main resource for rehabilitation services. She is in constant liaison with social agencies, and the Unemployment Insurance Commission, arranging work, assistance and training for discharged patients. In addition, during the year she made 809 visits to patients in their homes for follow-up care. It will be noted that this number of visits has not changed from last year, although the patient load has increased. This means that the maximum load for our worker has been reached and surpassed for even minimum follow-up of patients (Department of Health, 1960, p.135).

This quote is telling not only in describing the overload due to the ever increasing patient population, but also in what it is that social work is doing at SMHC. Home visits as a way to follow up makes it clear that SMHC is depending on the utility of this discipline to ensure that the patient's progress from in-patient services is shored up.

The beginning of the 1960s sees SMHC with an increasing discharge rate and decrease in overall patient census. This is attributed to the impact of the outpatient rehabilitation process referred to above. The open ward concept is also seen as a factor in improving patient outcomes, from which one third are now benefitting (Department of Health, 1961).

The 1961 Annual Report to the Department of Health is markedly different in format as it now included more statistical data to describe the progress of patients at the psychiatric

institutions in Manitoba (Department of Health, 1962). Discharges outnumber admissions throughout the province this year. By 1962 the open ward concept is a staple at SMHC throughout the facility (Department of Health, 1963). This concept had to do with the idea that you unlock hospital wards to allow for greater freedom for patients at the institution. The focus, in terms of rehabilitation at SMHC, is now to prepare "...patients to return to full economic status in the community" (Department of Health, 1963, p. 21).

By the mid 1960's, the patient census continues to drop, despite continued admissions. In regards to social work, "...the Social Service Section opened 394 new files, developed a case load of 3,843 persons who were seen for 14, 842 interviews and 7,479 follow-up visits." (Department of Health, 1965, p. 52) What is clear from this quote is that the social service staff would have repeated contact with patients. The reference to follow up visits implying that this was in a location other than the home office, most likely in community.

Nineteen sixty-four appears to be a year for education to become a part of the ongoing development of staff at SMHC. The training that social workers receive is referred to as "Experience seminars" but there is the expectation that in the next year "... formal connections with the School of Social Work; School of Occupational Therapy; and the Ph.D. Psychology course are to begin" (Department of Health, 1965, p. 53).

SMHC is described as becoming a regional locus for community psychiatric treatment "...and the days of a strictly 'hospital' [quotations in original] role appear to be over" (p. 45). SMHC is now linking and co-ordinating with all health and welfare organizations in the community. Treatment is dynamic according to the unique needs of patients in order to reduce relapse and promote greater community rehabilitation. The community and acute care unit is run

by the Chief Psychologist and is comprised of occupational therapists, nurses, social workers and physicians.

In terms of education, staff at SMHC is identified as providing lectures "...and demonstrations for the School of Social Work, University of Manitoba" (Department of Health, 1966, p. 48). Regarding the function of social work at the outpatient end of treatment, it is apparent that this includes the supervision of foster home placements. "Social Service during the year, opened 390 new files, developed a case load of 9,549 follow-up visits and 20,299 interviews. The department now supervises 120 foster homes for 229 patients" (Department of Health, 1966, p. 50).

The year 1966 sees SMHC assuming a greater role in terms of training and educating new staff while struggling with retaining trained staff (Department of Health, 1967). The relationship with the University of Manitoba has now yielded both training programs for psychiatric nursing, occupational therapy and social work as well as "...financial assistance to students who desire to qualify as psychologists" (p. 28).

For social work in Manitoba, a significant milestone towards professionalization of the discipline occurs in 1966. The Manitoba Institute of Registered Social Workers Incorporation Act is proclaimed in 1966 (MacKenzie 2002, p. 495) which enables social workers to register with a voluntary regulatory body. Social workers that register with the Manitoba Institute of Registered Social Workers (MIRSW) can now use the "Registered Social Worker" (RSW) designation. This is found in the patient record as well. When looking at the patient file entries collected from the 132 patients in the sample, only 18 authors include the RSW designation.

A simple frequency distribution (see Table 5.1) shows that the first time a recorded entry is signed with the RSW designation is in 1968. The most frequently encountered RSW designation is in 1971. This drops off to 1 (with a notable omission in 1974) in 1975. After 1975 there is no further evidence of this designation encountered in the files.

Table 5.1: Use of RSW Designations in the Patient Record

Year	Frequency
No Date	1
1968	1
1969	2
1970	3
1971	5
1972	3
1973	2
1974	0
1975	1

Why only 18 instances of the RSW designation appeared in the patient record remains unknown, but one can venture a few observations about what the records show. First, all 18 entries, with the exception of one letter to a family member, are letters directed at outside agencies or service providers. All entries are signed by staff identifying themselves as administrative in capacity – either as supervisor or administrator of social service/social work. One can speculate that perhaps there was a tendency to view the RSW as a professional designation for superiors within the social worker hierarchy and are employed to outside resources as symbols of this status. Regardless, it remains unknown why even staff with credentials such as the MSW did not identify with an RSW designation in the chart during the years shown above.

Illustrations from the Patient Record (1958-1968)

By the end of the 1950's the role of the social worker in ensuring successful community placement becomes more developed. An entry completed in 1958 details the degree to which the social worker goes to address the anxieties of a patient's informal supports.

Taken to Winnipeg.....on further discussion with [the friend] it was learned that [the patient] had been quite disturbing to the other roomers when he was there previously and [the friend] seemed to wish some assurance that we would be interested in that [the patient] and if this did not work out that we could be contacted regarding ... [the patient's] behaviour. I assured [the friend] that we had jurisdiction for 6 months and that we are pleased of this opportunity for that [the patient] to go to friends and that I would see ...[the patient] in a week and see what had taken place during that time (2879).

What is remarkable here is that the social worker documents extensively the steps taken to educate the informal support about the policies at SMHC, as well as ensuring the lines of communication remain open in order to facilitate the placement.

Social workers as procurers of Financial Resources

By 1958, there is reference to the social worker applying for benefits on behalf of the patient. File 2879 has entries by the social worker documenting advocating for benefits to pay for housing through City Public Welfare as well as attempts to engage the city "...to get street cleaning or some simple type of work for [the patient]". The social worker, writing in this particular patient file, also continues to follow up when the financial support doesn't occur in a timely manner.

Up to this time there had been no money received from Public Welfare, however I did check with them later and the holdup was in trying to establish that [the patient's] residency. The money will be forthcoming at once.

Social Workers Retrieve Patients to SMHC

At the beginning of the 1960's social workers continue to assist in the transfer of patients into the community. This included the process of looking for housing and financial resources to ease the transition, along with regular contact- both with the patient and with their additional social supports (such as family, friends, employers and landlords). The patient files show how the social worker is also depended upon to help return patients that aren't doing well in community back to SMHC. For patient file number 3160, a March, 1961 entry shows, upon learning from a landlord regarding a report of symptom increase, how the physician perceives the role of the social worker. "We will have [the social worker] make a home visit and return [the patient] to hospital."

More Social Workers & Increasing Sophistication in the chart

However, in 1962, the patient record for the first time gives a glimpse into a new purpose for the social worker: the collecting of collateral information towards a social history. For patient 4571, an April, 1962 entry makes this clear.

Informant: Parents... [The father] answered well, but [the mother is] very belligerent throughout interview.....States they had a happy but poor home life, Only the youngest child was breast fed. All normal births.....Personal History: Patient was always ...happy ...with lots of friends. Schooling to Grade XI.Parents state emphatically there is nothing wrong with [the patient]

What is of further interest here is that the author of the entry identifies as both a social worker as well as listing the RN and MA degrees in the signature line. It is apparent that more social workers are now available and are entering their activities into the patient chart. Figure 5.6 would confirm this, since the number of social workers increased to 4 in 1962 from 1 the previous year.

The social worker also appears to assume a more evaluative function for the institution. The following quote from the patient file entries illustrates how the social worker is now expected to assess patients for suitability to foster home placements. Given the annual provincial reports regarding the assumption of the supervision of foster home placements by this profession years later, (Department of Health, 1966), this could be seen as a growing awareness that this area of practice fits with the social worker.

Worker interviewed [the patient] on the ward....[the patient] is able to use support and a structuring of thoughts as [the patient] engaging to weigh things out....likely [the patient] will have to be taken care of completely at the beginning with encouragement to feel a little confidence in doing for [themselves]. [The patient] will probably fit apathetically into the new situation and providing [the patient] foster home sponsors are not too threatening, [the patient] can with support and stimulation, become more involved....

Arrangements have been made re nursing and pharmacyA letter has gone to [Administrator of Estates for Mentally Incompetent] regarding payment of accommodation and spending money (3923).

What this patient record entry from 1962 shows is how the social worker not only assesses for suitability of placement but what to plan for or anticipate regarding supports that may be needed to maintain the patient in community. This can be seen as a shift from following the directive of the physician, to providing guidance, and even taking the lead, in determining patient care and needs, at least for community placement.

Medical Model Language Emerging

Along with increased autonomy in performing assessments, the language appears to change in the patient file entries. For instance, in 1962 the social worker (in this case identifying as having an MSW) reports that the patient, when seen at a foster home placement is “... oriented as to time and place in [the patient’s] new environment” (3923). The former entry seems to suggest a language based on performing mental status examinations – a more clinical focus in terms of reporting patient functioning.

Social Worker as Reconciler and Point Person for Family

What is also apparent in another entry from 1962 is that the social worker is also directly involved in working with family to facilitate successful community placement for patients. The language that follows allows the inference that the family has expressed its frustration with the limited information regarding the patient’s status. It is unknown if the social worker was dispatched to de-escalate the situation, but the language may suggest just such a scenario.

I regret very much the inconvenience caused you by our failure to notify you of [the patient’s] foster home placement....I am most interested in[the patient’s] progress out of hospital, and will be seeing [the patient] each week on a regular basis. Therefore, if you have any questions about ...[the patient]in the interim

between your visits to [the city], I will be pleased to be of assistance in trying to answer them (3923).

Here it is interesting to note that the language used is both conciliatory and pragmatic – that there is a shared interest in helping the patient remain in community, and that further communication with family is viewed as something the social worker is anxious to facilitate. The letter makes it clear that the intention is for the social worker to be the point person for the family if they have any questions about the patient. The purpose of social work practice as providing mediation here is clear.

Changes in community monitoring

Another shift in the work of the social worker emerges by 1962. The nature of monitoring the functioning of the patient in community becomes more active. Rather than passively reporting on the way the patient functions in community, there is evidence where the social worker is meeting with the patient and assisting in developing ways to increase social integration activities, such as joining a day center because the senior citizen's club is closed in the summer months (3923), and staffing with the physician whether the foster placement worker ought to have greater access to patient records. In the former entry, this is then followed up with a letter where the social worker is advocating for the patient to participate in a day care centre. "During the summer months the Senior Citizens Centre is closed and [the patient] and the other three [foster home residents]...are pretty much without social activity" (3923).

Early Strength Based Focus?

The entry in August of 1963 that illustrates how the social worker is already looking to build on the strengths of the patient, in order to decrease dependence on the institution, fostering a stronger self-concept and promoting recovery.

...whether your agency might be able to offer the above mentioned some functional responsibility such as teaching bridge to a group of your clients.

.....our present problem in teaching [the patient] revolves around helping [the patient] feel more adequate in social situations,as the first step in lessening [the patient's] dependency on the hospital while simultaneously helping [the patient] to feel socially more adequate. [The patient] ...must demonstrate to himself that he is capable of handling some social responsibility...(223).

Early Geographical Boundaries

In August of 1962, a letter written to a community resource makes it clear that the social worker is asking their staff to perform the community monitoring activities – both how the patient is functioning in the community placement, as well as whether the patient is taking required medications. SMHC is simply unable to have someone go into community beyond a geographical boundary.

Although we recognize that what we are requesting is within the function of our own Social Service Department, at present our staff situation does not allow us to provide services of this nature where great distances are involved. We would, therefore, be most appreciative if your agency could accept this referral. (4462)

Getting patients employed

Aside from monitoring the patient in community and ensuring successful placement, the treatment team continues to expect that the social worker be involved in helping patients get jobs in community as well. In one entry, after advocating with a potential employer for a job that is more intellectually stimulating for a patient with a 4th year education in medicine prior to illness, it is apparent that barriers exist for patients to reintegrate. The following entry from 1962

illustrates how the social worker is advocating for the patient, as well as noting the lessons learned about what to say.

I then emphasized the fact that this [the patient] had a tremendous potential and ...was willing to start at almost any job. Dr.[name] then asked what [the patient's] diagnosis was, and when I told him I lost all effective control of the interview.....In future I will attempt to discuss[the patient] in terms of ... present behaviour without mentioning [the patient's] diagnosis (223).

This lesson is reflected in the following entry from the patient record in 1962 which illustrates well how the social worker advocates for a patient to receive employment by writing a letter to a prospective job option.

[The patient] will be removed immediately [underline in the original] from any job that you may give ..., as soon as you feel that [the patient] is not carrying [their] full work load. [The patient] behaviour in the job setting will be like that of anyone leaving an extremely dependent situation to one where [the patient] must stand alone. [The patient] will, therefore, likely respond well to encouragement. Although not homicidal or suicidal, [patient] has tended in the past to get into difficulties by developing odd theories and ideas and expounding them to other people. It is possible that this will not happen, however if it does, information on how best to handle this situation will be provided by us, and we will remove [the patient] immediately from his job if it interferes with his work (223).

What is of note in the above entry is not only the advocacy but also the level of education conveyed to the potential employer to anticipate and normalize any behaviour associated with

the patient's mental illness. Clearly, the assurance of removal at the earliest evidence of challenges is designed to ease the anxiety of the potential employer and increase the likelihood of employment for the patient. The education of the employer of what to look for and expect of the patient is designed further to decrease anxiety.

The reliance on the social worker to effectively connect patients to employment is such that doctor's entries chronicle the expectation that the social work department's role in securing employment for patients will mean that the "...[patient] will be probated as soon as suitable employment is found" (3996, 1963).

Social Work seen as providing expertise on the condition of patient functioning

Outside agencies are also seeing the utility of involving the social work department at SMHC in assisting to evaluate the health and functioning of patients for benefit eligibility. To illustrate, the following patient file entry involves correspondence by an Employment Branch Supervisor from the NES addressed to the Chief Social Worker at SMHC.

[The patient] recently applied at this office seeking help in obtaining employment and, during the interview ... disclosed that [the patient] has been under your professional care. We are anxious to assist ... in finding suitable employment which will not endanger [the patient's] health. In order to do so we need your advice on the following: 1. What is the nature of ... health problem? 2. What is the present physical condition? 3. What working conditions, if any, should be avoided? 4. Are there any other conditions which should be considered before placing [the patient] in employment? This matter has been discussed with [the patient] and ... has signed the attached release. (5382, 1964)

Clearly the NES worker perceives the social worker as being qualified to comment on the patient's status to be able to work in the community – either by having access to patient record materials or their own professional judgment.

Internally at SMHC, the role of the social worker in being knowledgeable or an expert on a given patient's functioning begins to emerge in 1964 as this entry shows.

Dr.was contacted. He did not remember [the patient] from former years. I was able to give him the medication on which....had been well maintained....I knew for the last 2 or 3 months [the patient] has not been taking medication (3160).

This entry documents how the knowledge of the social worker regarding the patient's condition, as well as medication regimen, results in the worker taking an active role to ensure patient needs are managed appropriately. More to the point, the doctor takes a passive position here, deferring to the knowledge the social worker has, in order to facilitate best treatment for the patient.

However, the doctor is still dominant when it comes to treatment decisions at SMHC.

Seen at ...boardinghouse..... [the doctor] hoped that I would be able to persuade ... to do so [return to SMHC] on a voluntary basis. [when talking with the patient], [the patient] registered a little surprise but cooperated and packedwhile I made another visit (3160, 1964).

Emerging Social Work Hierarchies

By the mid 1960's the differentiated roles of the social worker at SMHC become clearer. While the work of the social worker continues in finding housing, employment and or benefits, there is another social worker at a higher position at SMHC. What appears to be the case is that

the social worker identifies the needs at the ground level and then the supervisor – usually with a formal title and degree – writes the correspondence officially requesting the identified need in community. To illustrate, in 1964, a social worker writes that a referral has been received by a physician to assist a patient. It is identified that the patient needs to find a job and housing. The social worker comments on having managed to establish financial security and housing and that, “[The patient] is now ready to leave hospital for work.” (5062). A few days after this note, a letter to the NES is crafted by the “Chief Social Worker” where the office is asked to help the patient get employment near to SMHC so assistance from the Out Patient Department is possible. It is of note that this letter is also completed with contact information for the NES. They are directed in the letter to contact the original social worker from the 1964 entry for follow-up. This is even more apparent when the Chief Social Worker writes about how a physician wants a patient to leave the hospital.

This file is being passed to [the social worker] to make these arrangements. [The social worker] should also decide with Dr. [name] in what way follow-up arrangements are to be made and how [the patient] is to receive... medication, since it may be possible that we may have to make a referral... (5062, 1964).

This hierarchy in social work appears also to impact work with the rest of the hospital. In an August, 1964 entry, there is reference to a probation conference wherein the doctor is consulting with the Chief Social Worker.

After discussing the case with [the Chief Social Worker] we both agree that we should not place [the patient] on ISA [Infirm Social Allowance]...I do not feel I

need any help in this regard. I shall be seeing [the patient] in a week or 2 and shall be probating [the patient] (5739).

This is also evident in a January, 1965 entry when the physician refers to psychology testing being made for the patient and that “I [the doctor] will ask the psychologist to contact you inturn [sic] will let [the patient] know his aptitude testing date has been setup for” (5062, 1965). This shows that the physician is trusting the Chief Social Worker will ensure that the patient will indeed have an appointment scheduled– most likely via social workers at the front lines. This is confirmed in a later entry for this particular patient in February, 1965 by a social worker from the “Social Service Department”.

The role of the Chief Social Worker may be further understood as ensuring that the work between outpatient resources and inpatient services is harmonious. To illustrate, a letter by the Administrative Officer of the Department of Health, Rehabilitation outlines the progress of a patient at a vocational program. It is addressed to both the Chief Social Worker and a social worker assumed to be providing direct services to the patient. In this quote, there is an implicit assumption being stated – that social work ensures medication review takes place by the doctor responsible at SMHC.

[The patient] completed three months of Work Training under Schedule “R” at [Vocational Rehabilitation Program] [City]....we are pleased to forward the attached copies of the report from the Shop. This case was discussed with Dr. [name] and [staff at vocational rehabilitation program]....it was the Panel’s decision that [the patient] continue on with Work Training.....Dr. [name]has requested that Dr. [in-patient doctor]review this file regarding the medications

prescribed,....We will be pleased to keep you advised of future developments.

(5062, 1965).

A few days later the social worker, who had been included in the “attention” to in the prior entry, writes about meeting with the patient, stressing how the patient had to be convinced to continue at the vocational treatment program, as well as ensuring that the patient be aware of a pending meeting with the in-patient doctor (5062, 1965). Hence it is apparent that the practice of notifying both the Chief Social Worker, along with the designated social worker involved in the patient’s direct services, is a way to ensure that there is accountability. This is clearly evident in another entry where the doctor writes to the Chief Social Worker, attention the social worker. In a February, 1965 entry, the expectation is voiced that the Chief Social Worker present at a “panel” on the status of getting a patient “...going on this pre-vocational course as soon as possible.” (5062). Here it is apparent that the purpose of the Chief Social Worker is to report to the treatment team regarding the status of actions performed by social work front line staff. Hence, it is in the Chief Social Worker’s best interest to ensure that the social work front line, or direct service, staff performs the task that is being requested by the physician.

In 1965 there is a patient record entry that is illustrative of what a presentation by the Chief Social Worker at a panel meeting may have been like.

This is a [age]year old[the patient’s] illness began in [year]...Problems in holding on to employment seemed to be related to... family situation in which there are ...children who have been living with the[parent of patient] since the [patient and spouse’s] separation. Recently they [sic] [parent of patient] has suffered at least three cardiac warnings and the family has seemed to rallied around the [parent of patient] and to some

extent seem to be rejecting [the patient]. ...is currently looking for a living [healthcare related occupation] and this seems to be the best possible employment for [the patient] at this time. [The social worker] is advised to contact the N.E.S. as quickly as possible to arrange an appointment interview for [the patient] (4184).

What is interesting here is to notice how the report is focused on the psycho-social factors that locate the patient within a larger family system. The report describes factor such as family dynamics and concludes with recommendations – in this case to have the front line social worker arrange employment resources as soon as possible.

Changing role of the social work supervisor

Another change in the role of the social work supervisor at SMHC emerges via an entry in October, 1965. The supervisor is able to make a claim about the status of the patient's condition in order to keep them on disability benefits. This entry is a letter written to the Supervisor of Care Services at the Department of Welfare and is written by a "Social Services Supervisor" with an RN designation and co-signed by the Assistant Medical Superintendent. "...still needs the care and supervision of another person and retains ...chronic psychiatric disability. We would ask that Infirm Social Allowance be continued on the present basis"(3350). It is unclear whether the RN designation influenced the fact that this social work supervisor was able to make this claim as there was no evidence of such a form having been completed by staff with a social work degree. Clearly, the co-signing of the Assistant Medical Superintendent played a role as well in giving the claim credibility. Nevertheless, this entry is by a social work supervisor and involves making a legitimate claim on the status of a psychiatric condition rather than a deferral to the medical professional. While not as evident a claim regarding the psychiatric condition of the patient, in September of 1967 a Chief Social Worker, with a MSW,

formally requests for a patient to receive Infirm Social Allowance (ISA) from the Welfare Services Supervisor.

We feel that [the patient] will receive adequate care from [the landlord] who plans to take [the patient] to his business during the day and will be home with [the patient] during the evenings.....[the landlord's] situation is such that he requires assistance to continue caring for [the patient]. We would request that you enroll [the patient] in Infirm Social Allowance (892).

A few comments can be made here. First, the author is not using an RN designation. There is no co-signing from a physician either. The focus for eligibility does not appear to be a disability per se, but rather the impact that the patient's functioning has on a third party – the landlord. What remains unknown is who is meant by “We”. This could infer that the physician and/or the treatment team are behind this request, thus lending the legitimacy needed for the appeal for benefits. Regardless, there are a number of entries throughout the late 1960's that are written by the RN Social Service Supervisor, co-signed by the physician, of the type illustrated by the October, 1965 (3350), entry above.

Regarding the work of the social worker at the front lines, there is reference not only to helping manage finances, but teaching patients how to manage money.

Worker helped[the patient] to work out some kind of budget in order to reply [sic] [the landlord] the money which [the patient] owesWorker is to call at [Vocational Program] when [the patient] gets paid in order to give [the patient] a lift home to ensure that [the patient] pays [the landlord].” (5062, 1965).

While this appears to be instructive, there is clearly also an element of supervision and coercion involved – that paying for one’s housing is essential to remain placed successfully in community.

Emerging Chart Management

In 1963 there is evidence of social workers now completing treatment summaries and updates as can be found in the patient 329 file under “Summary of Personality and Environment” dated in October, 1963. Here there is a summary of the patient’s behaviour prior to onset of illness, a description of the progression of illness and a plan for care “...At present the patient is on Ward 2 and is still quiet, but will be placed back with [the patient’s spouse] when financial arrangements are completed.”

By September of 1965 there is the first evidence of the social worker at the front line being tasked with chart management duties. What this means is that the social worker, not the social work supervisor, is able to complete formal documents intended to pull the chart together, summarizing key information about patient progress and plan. The following is an example of a worker completing a transfer summary. For patient file 6462 a 1965 entry outlines the work that has been done leading up to current situation, along with recommendations to be followed by future workers involved in this case, along with the contact information of the psychiatrist who is involved in this case at the outpatient level.

Present Situation: Patient is presently living in [the patient’s parent’s] home.....is not on medication and [the patient’s parent] refuses to allow [the patient] to see Dr. [Name] or have any connection with the hospital...Future Plan: Worker should attempt to see [the patient] alone, and discuss ... the possibility of moving to a more desirable situation [foster home or supervision] where ...will be able to receive I.S.A. benefits

By January, 1966, this social worker comments on the failures to engage this patient since the transfer summary and moves towards making the case inactive "...until further referral is made" (6462). An entry in May, 1966 shows that the front line social worker, without identified degree, is expected to complete social histories (2332).

At the end of the 1960's, management of the chart means that the social worker is also ensuring that patient care follows wherever the patient resides geographically. In one case, a patient is admitted to another psychiatric institution.

...the foster home sponsor...informed worker...[Name]Mental Health Centre....had been admitted to this Centre for some two weeks and had then been returned....a further appointment to see the doctor...been informed by the [Name]Mental Health Centre that they would be continuing [the patient]followup [sic]. Worker informed [the foster mother] that she should continue to take her instructions from the people at [City] and that worker would transfer the case to the [Name] Mental Health Centre. Worker paid a visit to the [Name] Mental Health Centre and was there ... the social worker, who agreed that [the patient]should be transferred to their care then stated that contact had already been made with Selkirk regarding this matter. Worker will therefore inform the treating psychiatrist and will prepare the necessary papers for transfer... (3996, 1969)

This entry shows how again the social worker is the point of contact between SMHC and other service providers in the community and that it is ultimately this staff person's job to prepare the patient file contents for transfer. True to how the hierarchy was operating, a letter to the Regional Director of the relevant Department of Health and Social Service is written by the

Social Services Supervisor at SMHC in July, 1969 addressing the transfer of the case to this mental health facility. The letter (with attention to the original front line social worker) concludes with "...any further communication should therefore be directed to the [Name] Mental Health Clinic..." (3996).

Contrasting focus of clinical versus administrative social work

While it appears that the division between the administrative and the front line, or direct service providing social worker seems clear, it does allow for a further interesting observation. While the Chief Social Worker appears to employ a more formal approach when interacting with other agencies, as well as with the supervisor for the direct service social worker, there may be contingencies when either staff member was expected to seek and request supports, on behalf of the patient. This is best captured in the following two patient record entries. In a May, 1965 entry, it is the Chief Social Worker that is contacting the Care Services Supervisor at the Department of Welfare. "[The patient] is badly in need of some clothing. The following articles with the prices estimated from Eaton's catalogue will be necessary..."(3350). The other entry made by a front line social worker in May of 1965 details a number of phone calls made on behalf of the patient to ensure ongoing financial support, as one benefit expires and another resumes over the next several months.

Telephoned [Name] at the Estates Office.....The funds at the Estates Office should cover [the Patient's]board and room for approximately two months.....Telephone[d] [Name] at City Welfare Office. He will arrange to have [the Patient's] welfare allowance cut off for the months of [month ranges] (5062)

It is odd that both types of social work staff – administrative and direct services – are performing the same function. Both have to do with ensuring that the patient has financial resources and involve welfare services. Where they diverge is in their focus. For the chief social worker, the patient was currently inpatient while for the front line social worker the patient was about to be probated to community and needed resources for housing. Another difference is the entry itself. The chief social worker is writing a formal letter requesting financial support, while the front line social worker is reporting on actions taken in a progress note located under the title “Social Service Department”. This is further illustrated in 1967 with a letter that an author with an MSW degree and a formal designation of “Social Service Supervisor” writes to a collection service, advocating for a freeze on a patient’s account. The letter is written with “attention” to a Rehabilitation Counsellor at SMHC, presumably for follow up.

[The patient] made ...monthly payments from ...welfare cheques, but since [the patient's] admission here ...is not receiving welfare. As [the patient] has absolutely no income while... is in this institution, we would ask that [the patient's] account be frozen from the date of the last payment until ... discharged from hospital and is able to resume ... payments. (4462)

The Social Work Team

Regarding the way the social work team operated at SMHC, we get a glimpse of this in 1965. Apparently the front line, or direct service providing, social workers would participate in a panel at SMHC. It is unclear whether this is departmental - just the social workers amongst themselves – or if this was referring to the greater panel that the chief social worker is expected to report at. To illustrate, in the following entry where a number of challenges regarding City Welfare and a patient’s rent emerge, the social worker shows how the decision making process

for the next steps are to take place. “At this point I don’t know what is going to happen but this situation will also be discussed at the panel tomorrow afternoon”(4184, 1965). What this suggests is that social workers are involved in some consultation process to guide their steps while addressing the work they do in community.

Access to Physician by Social Work

While one can presume that the social worker had less authority than the physician, they had ready access to such staff at SMHC when needed. In April of 1966, a social worker is working on finding employment for a patient (3160) and has a sudden breakthrough.

Worker called at[City] and inquired about the possibility of obtaining work in the Dietary Department.....manager informed me there was a vacancy and asked that [the patient] be in his office the following morning for the purpose of interview. This was arranged with Dr. [Name] and a two week pass for ([the patient] was granted...

What this entry illustrates is that the front line social worker, despite hierarchies at SMHC, has direct access to the physician involved in this patient’s care. The worker seems to get the needed permissions to follow through on a community placement within a fairly short period of time, as the appointment is for the following morning.

There are some instances where the relationship between the social worker and the physician appears to be consultative and collaborative. One entry in August of 1969 documents a doctor’s impression of a meeting with the patient and the social worker.

I have discussed [the patient’s] case and follow-up after discharge with [the social worker] [the patient’s] presence.....Both myself and [the social worker] suggested

that [the patient] should come to see us once or twice after discharge before [the patient] can make arrangement to see Dr. [Name] (9372).

Problems with community and Social Work

Things didn't always go well between the SMHC social work staff and community resources. Patient file 6462 involves multiple entries in 1965 that document efforts by both the chief social worker and the front line social workers to ensure the patient receive the proper benefits that wouldn't jeopardize the patient's access to own children. What follows are multiple attempts by the SMHC workers to get it right but - due to a failure from the welfare services – the opposite occurs and communication between the patient and SMHC break down.

Worker went to home to tell [the patient] an appointment had been arranged Tuesday but [parent of the patient] refused to let me speak to [the patient] and rained curses on me, the hospital, the doctors....I delivered my message and left. Will return Tuesday to pick [the patient] up (6462).

This break down ultimately leads to the patient disappearing from services at SMHC, despite efforts by the social work team to locate the patient.

Information Broker

An entry in September, 1965 makes it apparent that the social worker was expected to pass on information between the professional community and the patient.

Visited [the patient] again and [the patient] was not home. I left a note under... door explaining the results of the Rehab Panel informing [patient] that [patient] had an appointment withN.E.S. at 9 a.m. tomorrow. (4184)

In fact, outside agencies are coming to expect the social worker to be the one to provide information from patient records as a letter from Child and Family Services (CFS) to the Chief Social Worker makes plain. This letter from 1965 is seeking information from the social work department at SMHC in order to figure out what to do with the patient's children who are being kept in care.

[The patient's]ability to maintain this child for extended period of time is uncertain, It is important therefore, for our Department to know, if possible, the length of [the patient's]hospitalization and [the patient's]prognosis.... (6462).

The fact that this letter is addressed to the Chief Social Worker suggests that outside agencies were beginning to expect that access to patient information went through the social worker.

Forms Emerge

By early 1966 the patient record begins to include more formal documentation by the social worker. A form titled "Memorandum (Referral for Employment)" is found in a March, 1966 entry that has specific sections to complete such as on prior employment (education and work history) as well as physical limitations, if on medication (yes or no) and other comments to complete. This patient entry is a good illustration of what would be included in the referral for employment.

...likely good average intellectual potential...difficulties controlling impulsive...behavior...had had [sic] ability and interest tests – not a candidate for further training. Expresses interest in joining [military service].... Otherwise should be able to function as a waiter, porter, etc. (6825).

The form in this entry is completed by staff previously identified as the Chief Social Worker. It is unclear where this form is to go as it does not identify an addressee and is assumed to be a form to be kept with the patient record.

Value of Social Work to Doctors

While there are multiple entries in the patient records about awaiting the work of the social worker before the doctor is willing to probate or discharge a client, it is at times unclear how much the work is being valued by the physician. This is best illustrated in the following two entries. For the patient file coded as 892, there is a September, 1967 entry that makes it clear that the follow up in community by the social worker is purely a formality to maintain benefits.

[The patient] will be followed up about every three months by the Social Service Department. This is being done because it is required for [the patient] to continue on.... Medicare.

In contrast, another entry from 1967 entry “Probation Summary”, completed by a doctor, shows how the same physician is relying on the feedback from the social worker.

Social worker ... having visited the residence feels that [the patient’s] care there will be adequate. [The patient] will then be discharged and released.... then be followed up in one month by Social Service.... (892).

Another social work related patient record entry appears to reflect this paradox as well. A doctor completes a probation summary for patient 1255 in 1968. In this entry, it is identified that the patient is being probated to significant family support in the community. The patient, according to the doctor is seen as quite stable. “Follow up will be this hospital particularly by

social worker ... as psychiatric follow up requirements are minimal...” One view of this entry is that the social worker is elevated to the role of being the de facto representative of the hospital, SMHC. A contrary or complimentary perspective is that the patient is doing well enough that only minimal intervention is needed in community and a social worker can handle this. In either case, the value of social work is being commented on.

By the end of the 1960’s, there is evidence that the social worker was actually able to assess and recommend if a patient would need social services prior to probation or discharge. A 1968 entry by a front line social worker makes this apparent.

Worker interviewed [the patient] today in an effort to see if Social Service was needed...I will discuss this [patient] with Dr. [Name] as to the role we can play (8466).

From this one can infer that perhaps a request had been made by the attending physician for the social worker to evaluate whether the patient could benefit from social work –related services. As the above entry implies, the status of the social worker may have shifted to one of being relied upon to deliver a judgment on certain aspects of the patient’s care. Building on the earlier entry from patient 892 on the evaluation for a suitability assessment of a potential residence in September, 1967, an entry in May, 1968 appears to formalize the procedure.

...the home of [the patient’s sibling] was visited by the worker today with the purpose of carrying out a pre-discharge home report; as will be noted in this report, this home appears to be quite satisfactory....and the worker has recommended that [the patient]be probate[d] to this home (1255).

Summary of Second Decade Findings

This decade sees SMHC decreasing in the inpatient census for readmissions especially. The new technologies such as psychotropics and innovation in psychotherapy are seen as the primary explanations for this trend in hospitalization rates. There is a growing urgency and focus around community based alternatives and the social worker is seen as the "...main resource for rehabilitation services" (Department of Health, 1960, p. 135).

What this means for the form of social work is that greater attention is given this profession during this decade. This includes SMHC working with the University of Manitoba to establish formal connection to their School of Social Work.

The findings show how the increase in social work staff and the education of these employees bears fruit. Social work becomes professionalized. How this is illustrated is not only in the increase of degreed social work staff but the emerging hierarchy within the profession. The social work supervisor initially monitors the work of the clinical or line staff social worker, but findings towards the end of this decade show how the supervisor is also involved in formally applying and speaking to the status of patients as being eligible for benefits. Clearly their authority is being validated both internally as well as by outside agencies. This decade shows an increasing perception outside of SMHC by community agencies of the value of the social worker as being an expert on the patient's functioning. This is either due to the social worker's access to the patient record or their professional judgement. Given that discharges were at times contingent on what a social worker does; their rapid and easy access to physicians is further validation from inside the institution of their valued role on the team as well as their emerging form.

Another finding that shows this increasing professionalization is the emergence of forms being used by social workers in the patient record. While this tendency for formalized documents will grow in the final decade, early entries show that this began in the second decade of this study.

There is also evidence in the language used by social workers in the patient record that reflect a knowledge and use of medical concepts and terminology. Further evidence of the professional status of the profession can be seen in the emerging role of chart management. Social workers are able to complete treatment summaries and chart transfers.

There is a growing expectation that social work provides an expert knowledge base on all things related to community integration and connection. This includes benefits applications, home assessments and emergency interventions to return patients to SMHC if they relapse in their psychiatric condition.

Further findings illustrate this growing perspective that the profession of social work is responsible for community integration in mental health services. Not only is the foster home placement system under the supervision of social work now, but the patient is being assessed by this discipline for suitability of housing placements as well. This is significant because assessment of the patient with a recommendation to the team is a shift in how this profession has agency and authority. Another role that becomes apparent is the use of the social worker to engage with informal supports such as family to de-escalate potential conflicts.

Some of the social work functions change during this time and speak to the emerging form of social work in mental health. For instance, community contact with patients is less a passive monitoring and more of an active collaboration with the patient to assist in community

integration. Another aspect of community integration is employment. In this decade, the social worker takes on the role of directly helping the patient get a job. This takes the shape of advocating for a patient with an employer. The dependency upon the social worker in this regard goes so far that doctors will note in the patient record that they will hold off on discharging a patient until a job has been found.

In summary, social work evolved as a profession in this decade that sees changes such as education, professional hierarchies and a rise in the value and esteem of the profession. The increasing professionalization of social work carries forward in to the final decade of this study as the following sections will show.

Context: 1969-1979

The 1969 annual report to the provincial government describes the current staffing pattern in social services at SMHC. Twenty Social Service Personnel are listed in this report with their academic credentials under a heading for “Professional Services”. Two have a MSW and two more have a BSW. Eight social service workers are identified as having a BA and one staff member is identified as having a “Welfare Technology Course”. Under another heading, “Social Work Services”, the 1969 annual report notes that of the 21 staff listed here, only 4 are “Qualified Social Workers” and there is an average monthly caseload of 925 patients which is stretching this department beyond what it can do (Department of Health, 1969). Areas of practice that are identified for this staff are: “...acute and family services (9 personnel), rehabilitation services (6 personnel) and community clinics (3 personnel)” (p. 132). There are 313 foster homes being monitored by this department, housing 526 in community in this way. Two more workers are involved in the running of a weekly group meeting of adolescents discharged to community, along with the aid of the YM/YWCA. Social service now has 21 of

22 possible positions filled. Regarding education, there are students doing field placement at SMHC. Five are post graduate students from the University of Manitoba; two are from the Brandon Vocational Centre's Welfare Services Training Course (Department of Health, 1969, p. 132).

By 1970, SMHC identifies its catchment area as Metro Winnipeg and Central Interlake (Department of Health and Social Development, 1971). Much of the inpatient population is aging, as is evidenced in the reference to the geriatric unit being 66% over capacity, as many of the population are now residing there. In the following year, there is reference to this population being either moved into personal care homes or efforts are made to convert units into more of a psycho-geriatric focus (Department of Health and Social Development, 1971). What this means is that the units providing the bulk of service to this aging population are now more similar in services and in appearance to personal care homes found in the community.

In 1972, the annual report documents the continuing trend towards a community focus regarding treatment at SMHC (Department of Health and Social Development, 1973). The census continues to drop and an array of services is in play to locate patients in the community.

Out-patient services were provided for 1,981 people in 1972....This included social service follow-up for 208 people placed in foster or boarding homes, 239 placed in homes of relatives and 55 placed in nursing homes, in addition to approximately 900 persons still being supervised following their placements in 1971 (p. 34).

Efforts are now being made to collaborate with community providers (including community social service providers) to have them take on more of the direct service provision even though

some of this is still provided by inpatient personnel at SMHC (Department of Health and Social Development, 1973).

A number of items from the 1973 annual report bear remarking on. It is the first time that there is formal acknowledgement that Selkirk is now known as “Selkirk Mental Health Centre”. Rather than the term “Hospital”, “Centre” is an indication of a paradigm shift in care towards a community focus (Department of Health and Social Development, 1974, p. 34). The 1973 report also makes it clear that the move towards community mental health is not without problems for SMHC. The Winnipeg area is more of a challenge regarding discharge aftercare with about 1,000 persons who were inpatient needing supports in the community. It seems at present that SMHC is keeping track of them and helping them but “The hope is that, in the coming year, arrangements can be made for the transfer of this responsibility to a Winnipeg-based service.” (Department of Health and Social Development, 1974, p. 37)

In effect, the strain of providing outpatient services as an inpatient service has resulted in one unit formerly dedicated to patients with chronic and persistent mental illness closing down. This caused some overcrowding in other units but is done so that the staff from the closed unit could be freed to address community issues more (Department of Health and Social Development, 1974). Another solution that SMHC is looking at in 1973 is working with public housing to expand placement options. This includes looking at more group homes in the community (Department of Health and Social Development, 1974). Nevertheless, SMHC remains committed to redirect focus and energy to the community mental health services, including, “...to enhance the role of other agencies in the mental health system, and to decrease the emphasis on the role of in-patient services.” (p. 38). In other words, SMHC is continuing to provide community services in the absence of community based resources for SMHC patients.

By 1974 inpatient census continues the downward turn anticipated from a community mental health focus. While the Selkirk Team and others expand service in community, inpatient census continues to decrease as discharges exceed admissions. Admissions are approx. 21-25 per month, with discharges exceeding these by 5 (Department of Health and Social Development, 1975). Treatment at the inpatient ward focuses on training in daily life skills, a family therapy program and there is more work being done on Day Care as well as Reality Therapy for "...psychogeriatrics and in biofeedback systems." (Department of Health and Social Development, 1975, p. 42)

A big change by 1975 is the regionalization of services for the center so now patients and caregivers are grouped according to the region they are from. What this means in terms of pragmatics is that there are challenges with being able to maintain the same standards of care due to pressure to allocate staff "for re-deployment without sufficient alternative care facilities to accommodate patients ready to leave the hospital" (Department of Health and Social Development, 1976, p. 33).

In 1976, there is the expectation that 60 community mental health workers are anticipated as created positions, of which many (if not most) are intending to come from current staff at the institution relocating to these positions in community (Department of Health and Social Development, 1977). SMHC reports that 21 staff members have already been "re-deployed" to field positions in the Winnipeg region.

This contingent, composed primarily of Social Service and Psychiatric Nursing staff have been providing a range of front line services in conjunction with a

contingent of the Selkirk Mental Health Centre. Included in this latter group are the services of Psychiatry, Psychology and Occupational Therapy (p. 49).

The sole focus for this group of staff appears to be the care and maintenance of former SMHC patients. From the contents of the annual report the main challenge for this population appears to be housing. There are some further changes now in terms of geographic application of resources for the institution. While an earlier patient entry documents the challenge of providing social work services outside of a geographic boundary (4462, 08/02/1962), the provincial annual reports now refer to this challenge. SMHC now provides fewer services to the north as the north has its own community mental health staff but SMHC still provides all the inpatient resources. The regions of community support/consultation are the Northern part of Manitoba and the Eastman Mental Health Team. Regarding inpatient services at SMHC, it remains the full mental health team comprised of psychiatric nurses, social workers, occupational therapists, psychologists and psychiatrists (Department of Health and Social Development, 1977).

In 1977, there is acknowledgement that there may be patients whose mental health issues are beyond the scope of community options and that in such cases, "...individuals experiencing psychiatric difficulties need the separate but coordinated talents of professionals in psychiatry, psychology, nursing, social work and occupational therapy" (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1978, p. 42).

The 1977 report refers to concerns raised by SMHC in that they continue to provide Winnipeg-based services for approximately 1,200 chronic patients from SMHC, even though there had been intentions raised in the 1976 report above for local supports to take over. There

is no reference to who is providing this service, but it appears to continue to be hospital staff (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1978).

SMHC is going through physical space revisions in 1978. At this point there are three active units at SMHC. The first is called the Reception unit that is staffed by a multidisciplinary team (psychiatrist, Psych Nurse, Social Workers, psychologists and occupational therapists). It appears to function as a crisis stabilization unit. There is reference to an increase in forensic cases on this unit as well (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1979).

The next unit is referred to as the Selkirk Psychiatric Unit (S.P.I). Inpatient services here are to the greater regions (Thompson, Interlake, Norman, Eastman) as well as wherever consultation is provided to these regions aside from Reception cases (from the Selkirk region). This unit has both acute and chronic patients located here (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1979). Finally, the Infirmary Unit is there for the aging patient, and their increasingly more physical needs for care.

At the end of the 1970's, SMHC now has a home finding service for clients as housing is a concern (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1980). This program keeps a registry of approximately 100 homes in Winnipeg that are friendly to those with chronic mental health issues. Other living arrangements include an Independent Living program in collaboration with Manitoba, Selkirk and Winnipeg Housing Authorities. What this also seems to suggest is that SMHC, despite earlier attempts,

remained involved in community due to inadequate community supports taking over the work in helping patients successfully reintegrate.

Summary of Context

During this decade, social work increases in staffing but continues to have the majority be non-degreed staff. This is despite the use of social work field placements at SMHC. The Social Service Department is stretched to provide a range of services. This includes the ongoing supervision of foster homes and the running of youth related group meetings. At the beginning of this decade, social workers are dealing with large caseloads and are struggling to keep up.

Institutionally, the shape of SMHC is changing. The predominant population at the inpatient level is aging. Hence these units that are housing more chronic patients resemble personal care homes. The institution, previously tasked with addressing the gap in community mental health, is trying to get out of this role and tries to work with community resources to negotiate a transition. These efforts do not bear fruit and SMHC remains involved in community mental health. This further results in structural changes at SMHC as one unit is closed to make staff available to work outpatient in community.

At the end of this decade, SMHC is equipped with a critical stabilization unit, a longer term care and a geriatric unit. This is the result of a falling inpatient census, an increased community mental health focus as well as the regionalization of the patient services based on the geographical location of the patient.

Finally, due to the ongoing challenge of locating housing for patients, the social work department at SMHC, once again illustrating the growing professionalization of the discipline,

has developed an index for housing. This systematic compilation of housing that is friendly to those with mental health concerns is lauded as an effective resource in the 1979 annual report.

Illustrations from the Patient Record (1969-1979)

At the end of the second decade, the overcrowding at SMHC is impacting the role of social work. A physician, in response to bed shortages and thus the need for alternative placement of a patient (8766) pens this memorandum to a front line social worker: “Patient admitted to S.M.H. [Selkirk Mental Hospital] on [Month, Day], 1968.....To be referred to Social Service for placement” (1968). Now the social worker is tasked to find a place for patients, admitted and hence eligible for inpatient services at SMHC, in lieu of residing at the hospital. A formal entry on behalf of this social worker in September, 1968 addressing personal care home placement is the result. What this means is that the social worker isn’t working on successful placement for a patient on probation but is seen as the staff to go to ease the overcrowding issue at the inpatient level.

Working with Personal Care Homes

What is also clear is that it is expected that the social worker remain in touch with the personal care home and continue to visit with both the patient and the staff at the home. An entry for this patient (8766) in October, 1968 documents this.

Worker visited [the patient] in [personal care home] today.seemed to be functioning well. [The patient] had no requests nor complaints. The nursing staff said that [the patient] did not present any management problem.

What can be inferred here is that concerns around the management of the patient by the staff at the personal care home are being addressed by virtue of these visits from the social worker. In doing so, the social worker is ensuring the placement succeeds.

Community Placement

The early 1970's continue as before, with the social worker continuing to be the one that arranges for community placements, even arranging for patients out of region to stay overnight at a hotel near the airport and arranging flights with 3 month-supplies of medication (8936, January, 1970).

On behalf of (other agencies)

It is the social worker that is counted on to manage the financial affairs, especially benefit related, as is illustrated by an entry in April, 1972 where there has been an overpayment to a patient's (9443) foster placement. "...Dept. of Health & Social Development, has written to me stating that they have made an over-payment to you.....I would appreciate it if you would forward a cheque...." As this entry shows, the benefits provider is contacting the front line social worker with the expectation that the matter of overpayment will be handled by this professional on behalf of Health and Social Development.

Being a resource to informal supports

The social worker continues to perform home visits, but it is evident from some patient record entries, that family has come to depend on the social worker beyond being supportive of the patient.

...worker received a telephone call from....[the patient's] [family member], in which ...requested that worker visit [family member]and [the patient],.....received some papers which [the patient] was required to sign and she was not sure that [patient]should do so. Worker visited and discovered that the papers concerned were the usual accounting of a person's estate.....The worker has checked this accounting and finds no problems with it, therefore advised [the patient] to sign the necessary release... (1255, 1970)

What is of interest here is that, while the issue involves the patient, it is the family member that needs help understanding the paperwork and this family member deferred to the social worker as the authority that can provide assistance.

Another entry shows how the social worker is also the one that will bring the patient back when psychiatric conditions warrant a readmission to SMHC. As one physician note in June of 1970 shows: “This patient was admitted from probation [Month, day], 1970. [The patient] was brought in by Social Worker...” (329). This note involved a foster home placement where the patient had gotten violent and unmanageable according to the foster home worker.

Geographic Challenges

Given the changes in where SMHC sees its area of practice (Department of Health and Social Development, 1971), there is evidence of social work supervisors reaching out to local communities and seeking their help in constructing resources available, where SMHC is unable.

We are concerned that [the patient] should have some follow-up in [town in northern Manitoba] as [the patient] is basically quite dependent.....would it be possible for one of your field workers to visit the [the patient] periodically, check on medications, look for any possible deterioration and lend some support to the family?....Could you also recommend a physician in[town in northern Manitoba] who might follow [the patient] and handle ... medications as we are not familiar with your medical resources? (9443, 1970)

This entry is reminiscent of the 1962 entry but shows an evolution around the ideas involved for successful community placement of a patient. What this entry shows is how the supervisor is trying to implement a plan for aftercare and follow up via the resources available locally. The

letter is addressed to that region's Department of Health and Social Services in an effort to gain their support.

Housing Authority

At the informal level, the front line social worker, in a letter to a family member, makes it clear that their input is valued in helping determine a housing solution for the patient residing at SMHC (8936, 1970). However, as the following doctor's entry from 1970 shows, the social worker continues to be responsible for determining the suitability of any housing option prior to placement. "[The social worker] will check out the [the family] household and if it is a suitable placement, [the patient] will be encouraged to go there" (9769).

The practice of using hospitalization at SMHC as a temporary solution to housing problems continues. The following 1971 entry not only illustrates this but also shows the relationship between the doctor and the social worker.

Since worker was unable to find a vacant care home to provide the necessary supervision and care for [the patient], worker was faced with no alternative than to return [the patient] to Selkirk Mental Hospital. Worker presented the problem to Dr. [Name], the treating psychiatrist, who agreed that [the patient] should be re-admitted to S.M.H (1255).

Problems within SMHC & Social Work

It appears that collaboration and consultation did not always take place at SMHC as the following quotation from a patient file (10553) in 1971 shows.

Worker was initially very involved with [the patient] and was trying to get [the patient] back on [the patient's] feet in the community. Worker did a lot of work withthe Superintendent for the [Juvenile Detention Centre]

...[Superintendent] was [the patient's] previous Probation Officer and showed a very great interest in [the patient's] future and ...present condition.....during the course of the Worker's involvement.....could probably do very well if given more help, but such is not the case, Apparently, [the patient] was discharged without the worker's consultation and therefore Worker will not involve [themselves] any further in the case until the situation warrants it. Therefore the case is closed.

What is apparent is that the social worker is still fulfilling the duties of the station by completing a case closing summary. Within the text, however, there is evidence of the social worker articulating their frustration over missed opportunities to help a patient achieve a better outcome. In one section of this document, the social worker illustrates an almost strength based perspective in that, despite being difficult to work with, "immature and...demanding" (10533), the patient had succeeded in completing a school course, despite what is described as "...under severe conditions." This worker makes it clear that they wanted to work with this patient and build on the patient's apparent intelligence and tenacity to persevere. Clearly, there was not enough consultation between the treatment team and this worker and thus the patient is discharged without services. The fact that the case is being closed indicates that this was a discharge and not probation.

From Benevolent to more Client-Centered

Another entry that year by a different social worker makes it apparent that social work is benevolent but not client centered. This entry is a progress report where the patient is stating their desire for a professional course but the social worker has other ideas.

...it would appear to me that [the patient] lacks both intellectual and emotional ability to be able to undertake such a course...plans of a board and room placement in [city] and working at [local vocational rehabilitation program].
Aptitude testing will be requested (9443).

Here the language is plain – the social worker volunteers their assessment of the patient's aptitude and does not include the patient's own desires for professional education as the plan being developed. No strengths are identified in this report.

In 1974 a letter is penned to the Director of Income Maintenance but does not indicate it is written by a supervisor, rather a front line social worker. It is not the application of benefits but rather a form of advocacy on behalf of two patients treated at SMHC.

We are requesting that your office send the balance of these [patients] 1974-1975 Special Needs to them for the purpose of buying more adequate spring outfit or furniture. We believe that they will improve in their mental health if they are able to share in making these decisions together regarding their special needs. (11097)

It is unknown whether the patients referred to in this entry are aware of this request but it is apparent that there is an interest by the social worker to find ways to empower them and seeing the benefits of this. This is also seen in another entry where the social worker documents the work being done with a patient and their request to look for work on their own. The worker, in writing about the patient (11097) articulates how this is handled.

Our plan is to allow [the patient] to look for work [by self] for two weeks and if... does not succeed in finding it to refer ... to the Department of Vocational

Rehabilitation for probable placement at [Vocational Rehabilitation Program]
(1974)

What this infers is at least a willingness to allow for patients to assume as much control as possible over their steps towards recovery.

Housing Kept in Place

While it is certainly true that housing is becoming the domain of the social worker, it is sometimes the case that the worker is not tasked with finding housing but in maintaining it while the patient is in SMHC to ensure that they have a place to go back to. “[The patient’s] Social Worker was instructed to keep ...former board and room placement open to meet the likelihood that [the patient] should be probated in the next 2 or 3 weeks” (8466, 1971). The social worker, in a later entry documents how the landlord is kept in touch, to coordinate placement back at the same location, and plans to reactivate welfare benefits as well. “This patient was probated....to the care of [the patient’s] lanlady [sic]. [The patient] is staying in the same boarding home...” (8466, 1971).

Summary

Much of the findings for this decade are about how roles identified in prior decades evolve, thus speaking to the emerging form of social work. In terms of housing, it is now not only the procuring of housing but the active intervention at other facilities such as personal care homes that is part of what a social worker is expected to do. The overcrowding at SMHC, due to structural changes such as units relocating or closing, is a factor that results in the social worker finding housing alternatives. These alternatives are not necessarily based on discharge status of the patient but rather a redistribution of bed space. The social worker is expected to address this.

In terms of chart management, the social worker is not only more prominent but it becomes more systematic. Increases in the use of social work specific forms illustrate the growing professionalization of social work during this time as well.

The social worker continues to be expected to manage non-medical aspects of patient care as it relates to finances, employment and housing. In this decade, findings show that clinical aspects of social work become more prominent. This change is first observed in the language involving patient care that reflects a shift from benevolence to a more client-centered paradigm.

Evolution of Chart Management

While in the 1960's there is evidence of transfer summaries being completed by social workers, it becomes clearer that there is a practice or design to this in the 1970's. For one patient (10335) this becomes clear as there is a transfer summary completed in 1971 by a front line social worker during the end of the probationary 6 month period. The next entry after this is post probation and by a different author. The title of the document is "Transfer Summary" and focuses on the history of the patient – both in community with a prior functioning profile as well as the history of treatment at SMHC. It concludes with recommendations "...perhaps be encouraged to [perform part time job] again....[family member]..is interested in [the patient]...might consider having [the patient]..."

Social History Evolving (1970)

While social histories-crafted by social workers- continue in the 1970's, there is evidence of the content reflecting an awareness of the social causes of mental illness.

I spoke with ...patient's [parent], by telephone regarding possible causes of [the patient's] hospitalization...[The parent] can not [sic] give any idea of a clear cut cause for [the patient's]mental illness....." (11097).

The fact that the social worker is asking the family in this 1971 patient record entry what they think may have caused the mental health issues of the patient, suggests that there is an interest in exploring factors in the environment. Another feature of this particular entry from the patient record is how it details a collaborative theme with the patient's family. This social history continues to outline the family member's report, including the preference to have patient return to home address on weekend visits at first.

Another social history goes even further to illustrate how the social worker is thinking about the relationship between the social environment and the mental health of a patient.

...there is a clear need for some kind of family investigation to discover the degree of pathology that does exist and how this will affect [the patient's]re-entry into [their] family. (11321, 1972).

This entry seems to suggest that not only does the environment need to be considered in understanding the mental health of the patient, but that one needs to consider and prepare the patient for how to cope with this social environment.

A 1976 patient record entry titled "Social Assessment" makes it clear that the social worker stresses a focus on the social environment and sees this as key towards successful recovery.

In summary, [the patient] has experienced impairment of functioning in several social roles including marital, parental, vocational and peer. It is speculated elsewhere in this file that these adverse social factors have contributed to an increase in the incidence of [physical health issue] ... as well as contributing to the secondary depression. A priority for social intervention would appear to be within the network of family relationships and to this end a family assessment interview will be scheduled in the immediate future (13191, 1976).

Clearly this entry highlights the belief that the patient's mental health is warranting a follow up with family. Whether the intervention is family therapy of any kind is not clear, but, given what is known about the theoretical orientation of social workers at SMHC at this point in time it would make sense. According to a former social worker who had worked at SMHC during this time, family therapy was initiated during this time, but the patient record wasn't equipped to accommodate this as "a legitimate therapy mode" (T. Hryniuk Personal Communication, 07/06/2014). It required social workers- collaborating with clinical records staff- to modify the patient record to accommodate family therapy.

Social Work perspectives on relationships with patient

A social work related patient record entry titled "Progress Report" completed in 1972 sheds some light on the nature of the relationship the social worker may have had with the patient. This entry, while documenting the ongoing successful community placement of a patient (11321), shows another aspect of the relationship. "...The [foster placement] gave [the patient] a birthday party which worker...had attended." The attending of a birthday party infers a willingness to participate in personal aspects not necessarily expected of a professional. It isn't

stated why the worker attended the birthday party but one could assume that this is another way to support the patient in making social connections in their environment.

An entry in 1974 shows another aspect of the relationship with the patient beyond monitoring status or procuring resources. In this entry, the doctor is referring to how the patient has been struggling to find a job but failing.

The Social Worker can do little but to give [the patient] some encouragement..... [The social worker] will also be talking to [the patient] and try to encourage [the patient] today. (11097, 1974).

At minimum, it seems inferred that part of what the social worker is to the patient is a supportive counsellor during challenges encountered while trying to establish themselves in community.

Social Work and Family Therapy

An entry in 1977 shows how the social worker is now in a position to work in a therapeutic fashion. The language in this entry illustrates a theoretical orientation of family therapy.

[The patient] and [the sibling]...were seen by appointment...today. The focus in this interview was on the maladaptive problem solving patterns which have been frustrating solutions to the many extra-familial problems involvedThe goal of my intervention is to enable them to resolve interpersonal conflicts between them, clarify their respective roles in intra-familial and extra-familial matters, and correct deficiencies in their problem solving pattern. (13191, 1977)

This entry concludes with the scheduling of a follow up appointment for both the patient and their sibling. What this entry shows is how the focus is not on monitoring the functioning of the

patient or in procuring resources. Clearly, the focus is in working with both the patient and the family member to improve their inter-personal functioning by actively engaging both in a therapeutic fashion.

While the following entry is not a direct expression of therapy, it has elements of working therapeutically with family in order to facilitate better reintegration of the patient back to the spouse's home.

Worker, over a period of time, was able to calm [the patient's spouse] using the approach that [the patient] was clearly sick, that under the present circumstances ... was probably angry and hostile and that [the spouse] should not, at this point in time, place too much importance on ...angry, hostile outbursta person in [the patient's] situation often is hostile and lashes out at the closest thing ... which in this particular case was [the patient's spouse].....gradually began to talk in a more rational and reasonable manner and at that point worker was able to obtain the following information ... regarding [the patient] (13841, 1978).

The remaining portion of this entry is then a detailed social history. What is curious is that this earlier portion was part of the entry. Its function, almost a preamble to the social history, seems to infer that this practice, of being supportive to sources of collateral information in order to decrease psychic distress and promote understanding (of the patient), is expected at SMHC.

How Doctor Sees Social Work (1972)

The perspective of the physician toward the social worker in the early 1970's continues to be as one of the staff that can be designated to be in touch with family or other informal supports and ensure probation is effective. "Since I am concerned about medical follow-up and proper

medical supervision, Social Service [name of social worker] was asked to inquire with family and assess situation” (759). The social worker, in the view of the physician, is the staff member relied upon to meet with and assess a patient’s family. They are then to return with a report as to whether the patient’s family is able to help address medication compliance –presumably both in taking any prescribed medications and following through with keeping medical or psychiatric appointments. This is confirmed in another physician entry for this patient (759) two days later.

Dr. [Name] felt that the ptient [sic] is getting more depressed and should be seen psychiatrically....our Social Worker arranged a visit here and [the patient] came here today with [the patient’s spouse].....I do not think, at this point, [the patient] should be hospitalized...[the social worker] will do follow up care more frequently and [the patient’s spouse] is to report once a week to me about patient’s condition (759).

Here it becomes apparent that it is not only a reliance on the social worker to check in with the patient and their family, but hospitalization is avoided due to this staff person’s involvement. It is expected that the social worker’s increased involvement with the patient, along with the spouse’s weekly reporting of the patient’s clinical symptoms, are what is needed to keep the patient from decompensating further.

The physician defers matters of community related functions to the social worker. In one case in 1972, the patient returns to SMHC in what appears to be a self-referral.

Returned from... foster home where [the patient] had been living on pass. [The patient] returned because ... felt that the work was too hard, winter was coming, and...couldn’t take it on the outside. [The patient] talked about staying here for

the winter and going to groups until spring. It was suggested... that [the patient] remain overnight and discuss the situation with [the social worker] (11321).

A later entry documents then the efforts by the social worker to set up employment options for the patient, resulting in referring to vocational rehabilitation. What is interesting to note here are that the efforts of contacting the various employment options are documented in a progress report by a social worker, who appears to be direct service or front line. The formal letter of referral -consisting of a brief summary of the patient's diagnosis, course of treatment and history – is completed by a social work supervisor once more. Hence the hierarchical relationship remains as stated before. The direct service worker reports on what was done, while the supervisor makes the formal appeal.

Although the physician has the greatest authority, the relationship between the social worker and the physician can be collaborative at times. In a 1972 entry by a front line social worker, this becomes plainer. After noting the results of monitoring the patient's condition, the progress report shifts towards issues around housing and community supports.

[Spouse] is most accepting of foster home placement for [the patient].....The case was discussed with Dr. [Name]. [The patient] will be approached by Dr. [Name] of the possibility of a foster home placement.....Social Service follow-up on a regular basis will continue (759).

What is interesting in this entry is how the idea of foster home placement emerges from the bottom up. The social worker meets with family and the concept of alternative placement is a result of this meeting. Then the social worker consults with the physician about this idea. Finally, the physician takes up the action of speaking with the patient about this to encourage

him or her to consider foster home placement. In effect, the physician modifies his plan for the next doctor's appointment to incorporate a housing strategy suggested by the social worker.

Regardless of how the social worker is perceived, they are members of the treatment team as an emergency "Treatment Team Progress Note" in February, 1974 shows. A situation involving a patient (12048) in community warrants the attention of the complete treatment team.

At this time the Treatment Team had an emergency meeting [listing all the names, including social workers]...It was our decision that I would call [the family member of the patient] and advise ... to call the Police, press charges with respect to the threats....

What this shows is that the input of the social worker as a member of the "complete treatment team" is valued at SMHC during this time.

Another utility that the social worker appears to serve for the physician is that of handling the at times complex task of identifying where the patient ought to be located in care, due to the shifting lines of regionalization. This is best illustrated in a 1979 entry. First, there is a call from the patient seeking mental health supports. What follows are a flurry of meetings with a physician and phone calls with another doctor. At first, another location for services is identified for the patient given the history of residence at that location. Then the final call is received for this entry.

Writer received a call from Dr. [Name]....[the patient] is working as a casual laborer.....and is living with [sibling]...Dr. [Name] recommended that this follow-up be out of [City], probably [local hospital]. Writer will pass this suggestions to [Social Work] and Dr. [Another Doctor's Name] (12635).

Clearly it is at times difficult to figure out where patients ought to receive follow up care. The doctor contacted the social worker after hearing from the patient. It is the perception of the doctor that social work deals with this issue. It is apparently the role of the social worker to untangle who is either best equipped or most responsible to provide services. This includes passing on the doctor's recommendations to other doctors involved in the care of this patient.

Psychiatric and Social Service Follow Up

Language emerges by 1972 where patient entries refer to community follow up services that draw the line between social work and the rest of the work being done by staff at SMHC. "Dr. [Name] will provide medical and psychiatric follow-up and [name of social worker] will provide Social Service follow-up" (2879, 1972). What this implies is that whatever it is that is suspected the social worker does, it is not related to medical or psychiatric aspects of patient care.

What another entry from a physician makes clear, however, is that "Social Service Department is closely involved in this [patient's] rehabilitation with co-operation from [the patient]" (11752, 1973). What the term "rehabilitation" implies is not clear, but it is identifying a service social work can provide that is viewed by the physician as essential in promoting best outcomes in community placement. A glimpse of what can be understood as a factor in rehabilitation, from the social worker's perspective, can be understood to include employment. "We wish to refer the above named [vocational rehabilitation service] for assessment and training.....We feel [that this service] can help in assessing [the patient] and recommend a program of rehabilitation" (11321, 1973).

The social work hierarchy remains in place in the 1970's with formal applications for such things as benefits belonging to the supervisor, with copies of such applications sent in care

of the acting front line social worker. In terms of chart authority, the front line social worker continues to have access and authority to perform case closings.

Forms Continue (1973)

As the final decade of this study progresses, the trend of the patient record becoming more formalized continues. For social work, this means that there are documents now in the record that are forms, with sections that are standardized to complete. A glimpse into what is on such a form reveals a systematic approach to social work, but also what is being deemed important to know, for social workers to provide services.

An entry for a patient (11959) is a form that is highly prescriptive of information to complete for the social worker. In a May, 1973 entry there are two forms completed by a social worker. The information sought are the Demographics, Most Recent Diagnosis, Treating Doctor, Finances, Medicare Number, Living Situation, Agencies and Services Active with Patient and Family. Under the heading of Agency there is room to fill out the file number, name of worker and their phone number. Other information includes headings such as “Member of Patient’s Household” – which involves entering their name, their relationship to the patient, and their age. There is also a section to complete regarding any interested relatives and friends- their names, address, as well as phone. On the back section of the form there is a section for the Secretary, apparently with pertinent info to cover. What is of interest here is a check list of whether medical records has been notified of any change of address of the patient, as well as whether a “Master Index Rotary” is completed. There is room on this form also for ” Pertinent Comments re Revised Assessment of home recorded on Foster Home File” which suggests that the previously mentioned assessments of homes for suitability are being kept in a record or file for future use. Another section for the secretary to check is if the, “Homefinders’s Card System

Updated “(11959). This can be seen as further evidence how the social work department had developed a working inventory of what kind of housing is available in the community. Clearly, this form suggests that social workers were engaging in a deliberate and systematic procedure of indexing community resources. This is interesting since it is only in the 1979 annual provincial report that there is the first reference to a home-finding system at SMHC (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1980). The other check boxes make it clear that there is consistency in notifying all relevant resources about the location and status of the patient to ensure a smooth transition at probation/discharge.

It appears that the increasing use of forms to manage the chart and the needs of the patient included documents created for the intention of streamlining such things as benefit applications. In 1974 a form is in the chart that appears to be created by the social work department, for the physician to check off boxes and sign that can then be used to formally apply for Provincial Social Allowance.

Summary of Third Decade Findings

In this final decade, the social worker continues to be able to have access to the chart. This is for both the supervisor and the direct service providing worker. Treatment summaries and case closings all show how the social worker is being expected to perform this function. Social workers grow more sophisticated in their patient record entries during this final decade of the study. Social histories become more grounded in the awareness that there are social or environmental factors for mental health. This is reflected both in the entries themselves and the underlying focus on social factors. Overall, social work forms grow in their number and utility. Standardized social work documents are present in the patient record that streamlines essential information that the department deems important to perform their tasks on behalf of the patient.

By the end of the 1970's there is evidence of social work related patient record entries speaking to the emerging role of the social worker as providing clinical care. This takes the shape of family therapy. Entries by the doctor show the reliance on social work to assess and interact with a patient's family, lending further support to the idea that this clinical aspect is an expected role for the social worker to perform.

Another change is how the physician relies on the visits by the social worker with the patient and their family as key for preventing hospitalization. The physician makes it unclear what this role would look like in practice, but does establish that it is distinct from psychiatric or medical services and refers to this as "Social Service follow-up" (2879, 1972).

In summary, the final decade shows the ongoing presence of the social worker at SMHC. Their role continues to involve what they had been expected to do earlier, but with a stronger focus on community based mental health, doing so either by helping patients locate housing or remain in community with increased social worker visitation. There had emerged by the end of the decade a more clinical role by degreed social workers. Ultimately, findings here show how social workers are an essential member of the treatment team and are relied on to provide their expertise as mental health professionals.

Conclusion

Locating this study at SMHC, as this chapter shows, is indeed a fitting site to collect data to investigate how social work evolved at the institutional level in Manitoba. There is a history of social work as a profession being actively involved at SMHC. The annual reports to the province of Manitoba make this clear. Social workers at SMHC were actively involved in helping patients successfully return to community. Social workers, like many of the other professional disciplines at SMHC, increased in number throughout the decades examined in this

study. As the pressure increased to provide more supports to patients in order to reduce recidivism, it was evident in this chapter that SMHC became more reliant on social workers as one of the disciplines to help address this issue. Furthermore, as this chapter has shown, SMHC clearly has evolved, from the early days of primarily institutional care to a more community based approach to mental health care.

Social work evolved from a position created to address a rising patient census and was initially occupied by a nurse. Over the decades of this study, social work emerges as a profession with not only its own department at SMHC, but a hierarchy. While most social workers at SMHC are non-degreed, social work degrees become visible, especially at the supervisory level.

The emergence of the profession is marked primarily by a focus on the outside of the institution, towards arranging suitable housing and connecting to community resources to reduce relapse or recidivism. This chapter documents the evolution of the profession, from being an arm of the physician, to a professional that is tasked with managing foster home placements, completing home assessments and managing the patient record. The social worker begins by completing tasks as directed by the physician and concludes as a member of the institution who is asked to assess patients for suitability of services, as well as is consulted by both members of the treatment team as well as outside agencies. By the end of the 1970's, the social worker had some limited autonomy. This involved both in the profession having some decision making power and in offering recommendations focused on the needs and resources for effective community placement.

By the final decade of this period of study, the social worker is a legitimate member of the treatment team, with a hierarchy, and forms, that speak to the increasing professionalization of the profession at SMHC. Towards the end of the final decade, there is evidence of social workers performing clinical interventions that appear to be family therapy-oriented.

This chapter by integrating findings from the Manitoba Archives, Annual Provincial Reports, SMHC Annual Federal Reports, and the SMHC patient record from 1947-1979, focused on the emerging social worker role at SMHC. The findings show that social work evolved as a significant staff role as the institution sought to address rising populations and changing theories of practice, most notably community mental health. The material findings also document how SMHC was trying to address gaps in community resources by –in effect – creating a resource via the social worker. It is this absence of a response by community to ‘take over’ this role, which results in the increasing role of the social worker at SMHC in spending greater time in community, rather than in the institution.

Essentially, the role of the social worker began with being the member of the treatment team that addresses community integration. What is not defined as medical or psychiatric becomes the domain of social work. When changes swept the institution resulting in deinstitutionalization, there was no community present to provide the mental health. It fell to SMHC to create the community mental health option. Given that they had staff with the training and experience to address community integration, the burden fell upon social work to address the service gap. One could say that SMHC’s community mental health program is the legacy left by social workers from the institution.

What this current chapter has shown, is how social work begins as a functional activity performed by hospital staff. At the end of the period of study, it is a profession with its own legitimate place within the treatment team at SMHC. The evolving or changing functions described in this chapter illustrate how the form of social work emerges at SMHC as well. The following chapter presents a fuller composite picture with findings from both social work actions and social work form chapters, and broader reflections on implications for teaching social work and further research.

Chapter 6: Discussion, Limitations and Conclusion

The International Federation of Social Workers (IFSW) has a definition of social work ("Global Definition of Social Work", 2014). Their statement makes it clear that social work is a profession grounded in practice as well as an academic discipline. The central tenet for social work is working towards social change and growth. This involves promoting social cohesion while addressing ways to empower marginalized members of society. The purpose of social work, then, is to help people and address structures that impact problems in life and increase wellbeing for all. From a theoretical standpoint, social work aims to address social justice and human rights with a focus on shared responsibility and honouring diversity. More specifically, social work is informed by theory that seeks to include both indigenous ways of knowing with social science ("Global Definition of Social Work", 2014). The question may be asked in what way social work at a psychiatric institution meets this definition.

Some aspects of the IFSW definitions, in particular the emphasis on shared decision making and helping address structures that impact problems are present in this study. The sections in this chapter referring to the qualitative difference in social work activity when performed by the social worker and the importance of social work in the development of proxy community mental health services by SMHC speak to these aspects of the IFSW definition.

This chapter will review the most salient results from the findings and engage in a critical discussion around their implications. The actions or functions of social work, as well as the profession itself, were rendered visible in the findings chapters. What may previously have been seen as an occupation primarily concerned with finding housing for patients became between 1949 and 1980 at SMHC a much more complex story. This chapter will look at social work related actions or functions and examine the emergence of social work practice. Both aspects

unpack the emerging role via form and function of social work in this area of practice. This includes looking at the literature reviewed to examine how this helps understand how social work as a legitimate role emerged in mental health practice.

This chapter will examine a number of key findings in greater detail as they pertain to the emerging role. In summary, they are that *social work emerges from practice or function first*. Furthermore, *social work as practice or function is qualitatively different when performed by a social worker*. There is also a *strong congruence between the literature on mental health social work and social work at SMHC*. Another finding is that *the social worker role evolves into recognized professionals with expertise in their domain*. Social work was also *essential for SMHC to manage patient flow and a burgeoning community mental health*. Social work practice also has *a relationship with severe and persistent mental illness as a population served*. Finally, the presence of educated social workers coincided with the increasing professionalization of the discipline.

Throughout the period covered in this study, this social work profession was shown to be engaging with patients in their community environments, engaging family and other informal supports in providing a network of support, as well as increasingly becoming an extension of the treatment team outside of the walls of SMHC. Social work activity is found throughout the period covered in this study, showing how such actions were at first performed by a medical professional. Over time, with a rising patient census and a more complex system of aftercare supports in community, these actions were left to the social worker to perform. In fact, as the patient record entries show, there was not only a growing reliance on the social worker to perform these tasks, but a growing acknowledgment of their expertise in performing them.

Social work emerges from practice first

Many of the expected activities by social workers as educated generalist practitioners (Zastrow, 1989; Zastrow & Kirst-Ashman, 2013) are performed at SMHC. The findings showed that all 15 social work functional activities were encountered in the patient record. As the results chapters show, social work emerges at SMHC during a time of change. When a growing patient census threatened to overwhelm staff at this institution, a nurse for the role of a social worker was hired, in order to address issues in community that seemed to contribute to the patient returning to SMHC. There are references, in fact, in annual provincial reports during this time of needing social work to address the rehabilitation of the patient to community (e.g. Department of Health, 1948; Department of Health, 1955; Department of Health, 1958). In effect, thereafter the medical team is tasked with active treatment within the institution but rehabilitation is seen as the domain of social work.

Social work role as recognized professionals with expertise in their domain

Over time, the role of the social worker becomes more complex. With the growing reliance on the social work functions, the social worker starts being viewed in the expert role, as being the expert for assessing homes, arranging for discharge aftercare, and figuring out/managing finances. In fact, when it comes to the social work action or function of case management, the most frequent actor for case management activity is the social worker (see Table 4.1, p. 78). The degreed social worker begins at SMHC in 1960 (see Figure 5.7, p. 151) and appears in the signature lines of staff (in this sample's patient records) beginning in 1968 (See Table 4.1).

Given that social work functions as identified in the patient record form the foundations of how the social worker role at SMHC can be understood, a number of such actions bear further discussion.

Advocacy

While advocacy was seen as something that is more Canadian in the area of social work mental health practice (O'Brien & Calderwood, 2010 p. 3), there was little of this activity located in the study (see figure 4.5, p. 82). Regehr and Glancy (2010, p. 4) detail what can be understood as advocacy in this field of practice. While the patient record could not show any memberships on boards or committees, one could argue that what was present did show efforts to address system gaps for the patient at SMHC. One could argue that the minimal evidence in the patient record of advocacy efforts is due to the fact that many of the social workers employed at SMHC were working with either a non-social work degree or did not have any formal degree, so their training would not have emphasized advocacy. As the findings - and this chapter - show, social work education emerges alongside the years of this study. Hence, the concept of advocacy and its importance for the social work professional may be developing rather than fully formed. What was found, however, can be understood as case advocacy (Dolgoff, Loewenberg & Harrington, 2009, p132) where the focus on seeking change is directly related to the person served by the worker.

Another related question here is the degree to which the social worker is representing the interests of the employer. Is the social worker generally going to side with the employer over the patient if this choice becomes necessary? Current social work education would approach this via courses in ethics, where questions of this sort are addressed (e.g. Dolgoff et al., 2009, p. 132). The absence of actions that can be identified as advocacy in nature may show a lack of awareness in this regard by the social worker. Dodd and Jansson (2004) suggest that reasons for a lack of advocacy efforts by social workers have to do with an assumption that their input is undervalued, as well as a lack of knowledge by the worker in how to enter into a discussion for change in the first place. It is also possible, as the limitations section will point out, that

archivists simply did not keep records that illustrated advocacy efforts, particularly if they cast the institution in a less than favourable light. Regardless of the reason, it is something to consider.

If this is a current area deemed essential to social work practice in mental health, the absence of this in the past may need further study. Further investigation of where advocacy efforts occurred in this sector of social work practice may give current models of social work practice in mental health a sense of continuity. In effect, this potential for further research could give social work professionals a sense of how and when advocacy took place in mental health. Given the challenges of a hierarchical distribution of staff at SMHC, it may be helpful to investigate further the ways in which resistance to practices that further marginalized patients was engaged in by social workers. If there is an absence of such activities, the question can be explored as to why social workers did not practice advocacy. Learning about these activities can only enhance understanding and deepen current approaches to social work practice in mental health.

Case management

The social work action of case management bears further discussion. For one, it is interesting that – when SMHC first identified the need for someone to address the growing returning patient census – they called for a social worker, not a case manager. In my personal experience working for a psychiatric facility in the US, the term for what is identified here would be the in-patient case manager. It is true that the person inhabiting this position likely has a BSW, but the occupation described here is that of a case manager. SMHC did not state this (Department of Health, 1948), preferring to hire a psychiatric social worker. Hence, at SMHC, case management is one of the things a social worker does, not is. This directly gets at the

challenge of form versus function. The verb becomes the noun. Social work is an action and the actor is defined hence as a social worker. A social worker is one who social works.

Case management as a function of social work in mental health is not without controversy. A social worker, in commenting on how social work evolved at BMHC, raises the concern that too much of a focus was on case management.

I became pretty offended at how social work at BMHC was viewed by Nurses and Doctors (such as they were). Even within the Department itself, which included Psych Nurses who referred to themselves as social workers, many of the staff simply saw themselves as being facilitators of housing, benefits and liaisons to community programs and families. Many saw, and had little knowledge or skills, in therapeutic activities even though at that time, social work still had a kind of proprietary jurisdiction over Family Therapy and Systems Theory knowledge.

(A. Hajes, Personal communication, August 20, 2014)

The email excerpt, printed with permission by Mr. Hajes, illustrates perhaps a larger trend of how social work is viewed in mental health. He makes the point that in the early 1980's the perception of what social work is, remained mired in non-clinical work, and echoes what Clarkson says in his report of SMHC's under-utilization of the social worker (Clarkson & M.D.T. Associates, 1973). In the 1972 report, the criticism was that the social worker is a home-finder and that the therapeutic aspects for this profession were not being tapped.

The powerful dominance of the psychiatrist in the present service will have to change so that the full exploitation of the services of other professionals can be achieved. In more progressive programs, social workers and psychologists are being used to a greater

extent as therapists, and not simply as home finders and psychometric testers. (Clarkson et al., 1973, p. 78)

This issue will be returned to when discussing findings on the social work action of “Counselling” identified in the patient record, as well as considerations around the decision to limit case management as a category for coding. Suffice it to say, the patient record showed that much of what is seen as case management is performed by the social worker. In fact, their expertise in this area is even acknowledged at times, to sort out complications and determine needs. Furthermore, this professional is identified as creating systematic resource guides to perform case management more efficiently.

It is easy to dismiss case management as an aspect of social work that is simply the grunt work or the trivial side-missions of work needing to be done at the institution. This is missing the findings of this study, however. Social workers, when performing case management, began to assume control over the chart. There is a burden here to manage the patient record and ensure that communication as well as organization of the patient’s care is coherent. Case transfers or summaries reflect a growing awareness that the record needs to be useful in order for the patient to receive the right supports both in community and while involved with the institution. One could even make the case that – since SMHC was providing a proxy community mental health program due to a lack of legitimate supports from community – case management is an essential function best performed by the social worker. It is the social worker that is spending most of their time working with the patient in community, ensuring that communication flows in an elaborate web of informal and formal supports.

Furthermore, current models of social work practice encourage a Generalist Practitioner model that views case management as an essential function of social work. The social worker is

taught to approach case management from an integrated or holistic perspective (Zastrow & Kirst-Ashman, 2013). This perspective makes it possible for social workers to be uniquely qualified to view all components impacting the individual in their environment and to take steps at maximizing best community integration.

The prevalence of case management activities in the record speaks to the literature on social work (Fuchs, 2002). In fact, Fuchs' point that case management ought to be a blending of informal and formal supports can be found in the patient record as social workers interact with both community resources via benefits and employment as well as family. While Fuchs is not speaking to social work in mental health it is interesting to see his position on case management reflected at SMHC. In terms of mental health and social work, case management is seen as a core function (Fellin, 1996, p. 3; Regehr & Glancy, 2010, p. 4).

Monitoring

The social work action called "Monitoring" received a lot of attention in the patient record entries. The fact that this was high (see figure 4.4, p. 77) and most likely performed by the social worker (see table 4.15 p. 131) bears consideration. Monitoring can be seen as the exertion of power or dominance over the patient. Certainly the social worker, in earlier entries, asserts an expectation of what is appropriate behaviour. The consequence of failure to comply is hospitalization. "I will see [the patient] as soon as possible, and remind [the patient] of the conduct we expect and emphasize the fact that anything short of this will result in [the patient] being returned to hospital" (892, 1952).

Interestingly, monitoring is an action that as early as 1949 shows evidence of attempts by the social worker to define what is "normal" according to the patient's prior functioning and not some universal standard (280). While it is difficult to know whether this was a subversive

attempt to locate the person first over pathology, it is an interesting observation that speaks to an emerging difference in the form of social work. What is clear is that monitoring is an important activity. Any evidence of the patient struggling with their mental health is shared with the doctor. Treatment is modified by this input from the social worker. Ultimately, the policy of SMHC to provide a six month window post release from inpatient is dependent on the observations of the social worker. While at the facility, everyone sees the patient and comments on their status. Once the patient has left the facility, it falls to the social worker to be the eyes and ears of the institution. Monitoring is the way that this is done. There is certainly tremendous power and authority bestowed upon a social worker in this case as they are able to shape the life of the patient according to their observations. The patient's status on the outside is dependent on the social worker being able to meet and observe them.

Monitoring as a function has implications. The act of observing or “keeping tabs” on a person in community can be seen as a form of surveillance and dominance by the system.

Generally speaking, all the authorities exercising individual control function according to a double mode; that of binary division and branding (mad/sane; dangerous/harmless; normal/abnormal); and that of coercive assignment of differential distribution (who he is; where he must be; how he is to be characterized; how he is to be recognized; how a constant surveillance is to be exercised over him in an individual way, etc.). (Foucault, 1975, p.196)

The above quote is from Michel Foucault, while he is referring to the ideal Panopticon – the surveillance of a population where nothing can be hidden and power is absolute. In effect,

compliance to conditions is monitored. This is captured well in the patient entry above (892, 1952).

The attempts to define a baseline unique to the individual by the social worker can be seen as an act to resist this narrative. In essence, it is the qualitative data itself serving ways to challenge grand assumptions of what is normative getting at what Fook (2003) may have been referring to regarding the benefits of mixed methods in addressing issues of critical social work. The patient entries where social workers appear to seek to capture the views or impressions of others, rather than advancing their own views is perhaps another example to consider.

Job with [employer] ended on Nov.23rd. On Nov. 27th [the patient] came to the office ...getting back on welfare. After paying back rent to [foster parent] and buying some winter clothing, [the patient] is without funds.

[The patient] plans to go down to N.E.S.in Selkirk on Friday and then to Welfare. (3996)

The 1963 entry above is worth reflecting upon. The entry is based on what was observed but does not advance an opinion by the social worker. There is no value placed on the activities. While it may not be possible to know the thoughts of this social worker one could suppose a positivist orientation, where an impartial report is rendered. However, it could also be seen as the efforts by the social worker to allow the patient's actions to speak for themselves, reflecting a more client-centered focus. The patient gets to define their own progress and success in recovery, echoing the current recovery based literature (Adame & Knudson, 2007). Regardless of the motivations of the social worker in documenting their monitoring activity, with few exceptions, the entries appear to focus on non-medical definitions of the patient's functioning in community. There is power inherent in monitoring another person and documenting this in a

patient record. The fact that social workers are keeping to a focus that shifts the focus to non-medical aspects speaks not only to their orientation but ensures that the patient is rendered visible beyond a medical diagnosis.

Another concern with monitoring is that this act has ethical implications. The social worker's monitoring of another person can result in rehospitalisation. Conversely, poor monitoring could result in harm coming to the individual in community. How is the social worker trained or equipped to perform this function? The findings do not shed light on this question but may be important for future study. In an indirect way, this point is revisited in the section around academic/professional social workers. Here the assumption can be made that education of the social worker would get at ensuring aspects of ethical concerns around monitoring are addressed.

Housing

Regarding the social work action of finding housing, one would expect this to be fairly common in the patient record. This is based on the criticism around social workers being used primarily for this function at SMHC (Clarkson & M.D.T. Associates, 1973). This is indeed a social worker dominated action found in the patient record. However, it is not the most frequent. Social workers emerged not only as the ones to manage the foster home program (Department of Health, 1966) but also as those finding ways to make the housing process an efficient one. Pre-discharge home assessments (1255, 1968) appear to be the formalization of a process to ensure that where the patient is going is optimal for recovery. The annual reports to the province show a home finder service that is developed by social work (Department of Health and Social Development and Ministry of Corrective and Rehabilitative Services, 1980). The social work related patient record entries show how a "...Homefinders's Card System [is] Updated..."

“(11959, 1973). What this means is that the social worker is already dealing with a working home finding index that is updated as needed in real time. In effect, the idea that a social worker is simply calling around for a place to stay is debunked. As social workers were tasked with housing, they began to create a sophisticated system to ensure greater success in helping patients return to community. Furthermore, there is evidence that, when possible, the patient’s views are included in deciding housing (3160, 1960).

Working with family

Figure 4.5 (see p.82) illustrates how initially “Working with Families” was the most frequent activity in the first decade of the study. This goes to the idea that, while community supports options are slim, the social work actions reflect a focus on working with informal supports available to ensure the patient has somewhere to go upon discharge from SMHC. Involving the family seems to be a frequent activity at SMHC (see Table 4.12, p. 103). It is the social worker, while not the most frequent, who is the one that is the most inclusive. Working with family on behalf of the doctor and superintendent appears to be a passive relationship. It makes sense, if the social worker is trying to ensure that the patient does well in community that they work with the family to ensure this indeed succeeds. Social work related patient entries show how the social worker is trying to capture the views and opinions of family and report these back to the physician (e.g. 579, 1949). While families may be getting status updates from the superintendent, they are able to interact with the social worker in community with the shared goal of helping the patient avoid hospitalization. Social workers are meeting with family not only to find out about the patient and how they are doing, but to locate them when they are struggling. When the hospital is deciding to take legal action, it is the social worker that is the one that reaches out to family to get their input (7556, 1970). While therapeutic interventions are more the domain of counselling as a social work function, there is evidence at the end of the

1970's that the social worker begins to employ therapeutic strategies to improve any dysfunctional factors in the family that impact the patient (e.g. 13191, 1977). This is a collaborative activity with family and patient together.

Employment

It is apparent that employment served as a measure of recovery at SMHC. Throughout the period of study (1947-1979), there is reference to efforts in the patient record, to get the patient employed. This echoes current models of recovery that refer to meaningful activity as a measure of recovery (Becker et al., 2005; Bond & Campbell, 2008; Major et al., 2009).

There are a variety of ways that the social worker helps the patient find employment. Initially it seems that the task of getting the patient employed is looking for work directly. Sometimes the social worker will go into community with the patient and engage in traditional job hunting (e.g. 4184, 1965). At other times this includes connecting the patient to a vocational rehabilitation program or working with employment services. Regardless of how it is done, the social worker is actively involved in helping the patient find work. In fact, the social worker is called upon to perform this function when a vocational rehabilitation program concludes. It is not this program's responsibility to insure alternative options for employment, but the social worker who is expected to do this (e.g. 11097, 1974).

One could question whether this is the imposition of an expectation of what recovery is – defined as a normative concept rather than a collaborative model of the patient's own expectations or standards. This point is raised by proponents of the recovery model as employment may not be what the patient is either able to do or to define themselves by (Adame & Knudson, 2007). There is no evidence in the sample of a patient record during this time (1947-1979) that reflected this dissonance. When employment is the focussed action, there is no

record of the social worker reporting on the reluctance of a patient to seek employment. There is also no record of the social worker questioning the assumptions around employment and recovery. In other words, the findings are not able to speak to this question. In the absence of any information about whether employment was an option or a condition for recovery, one is left with making assumptions. This goes to the challenge of aspects of the form of social work being left unknown, given the limitations of the patient record and the chosen method of research which will be discussed more under limitations below.

Counselling

A social worker consulted for this study expressed his frustrations with the mental health system, as experienced at BMHC, how the clinical side of social work is neglected (A. Hajes, Personal communication, August 20, 2014). In fact, this matches the critique in the early 1970's regarding the social worker not being used in a therapeutic fashion at SMHC (Clarkson & M.D.T. Associates, 1973).

This brings us to counselling as a social work function as encountered in the current sample. Figures 4.4-5 (see pp. 77 & 82) show how minimally this code is represented in the sample's patient record entries. However, there is early evidence that there was a perception that the social worker be involved in dealing with marital issues for a patient (e.g. 172, 1947). The lack of a clinical focus in the sample may be related to the impact of history. A social worker at SMHC shared that he was instrumental in creating an inpatient program based on family therapy from 1972 to 1977 (T. Hryniuk, Personal Communication, September 1, 2011). In other words, the climate was conducive to the introduction of this therapeutic approach and social workers lead the charge.

Social workers were viewed as the de facto provider of family therapy at SMHC to the point that medical records had to address including such entries in the patient record (T. Hryniuk, Personal communication July 06, 2014). At BMHC, one social worker confirmed that the social worker later in the 1980's was seen as the one providing family therapy - regardless of the fact that many other aspects of social work activity were seen as something anyone in the treatment team could do (A. Hajes, Personal communication, August 20, 2014).

It may be history at work in explaining the minimal documentation of this social work action. Since it is likely that – given that the social worker is only beginning to really provide such therapy at the end of this period of study – there would not be many entries in the record yet. This is partly the reason why space is dedicated in chapter 4 to this social work action – despite its low frequency. Clearly this service is seen as relevant for it is indeed included in the patient record. The physician makes this plain in the entry in 1978 (13841) that the patient's desire to work on marital problems is best handled by the social worker.

While the clinical entries are minimal, an analysis of their influence in terms of theory and practice is necessarily limited; but there are some clues that bear further comment. In one entry, the MSW degreed social worker comments on providing assistance to "...correct deficiencies in their problem solving pattern." (13191, 1977). In 1976, Haley publishes "Problem Solving Therapy" as a significant contribution to the field of family therapy (Nichols 2013, xvii). One can infer from this that the language used by this social worker shows the influence of models of family therapy that were cutting edge at this time in North America.

When looking at this function more closely regarding when it was performed, some explanations emerge. While the number of times this action is identified in the patient record

entries is small ($n= 13$), 7 or 53% of the times it was encountered in the final decade of the study (see table 6.1). In fact, 4 of the 7 times, this action was found in a patient record entry between 1976 and 1978. The case can be made, based on these findings that this social work action was only beginning to emerge at SMHC.

Table 6.1: Frequency distribution of Counselling by Decade

Decade	Frequency
1947-1957	3
1958-1968	3
1969-1979	7

Future research may want to explore how this action is represented in the patient record post 1979. Such research could follow up with this finding to see if later patient records can show how social workers expanded their clinical function at SMHC. This may be significant in that it could strengthen the argument for social workers to provide clinical services such as counselling as part of the mental health staff at psychiatric institutions.

Social work is qualitatively different when performed by social workers

Rather than repeat, the reader is referred to the prior comments around social work actions, where the distinctions are found, especially in monitoring and working with family. Aside from the majority of actions that were performed by a social worker, there was also a difference in quality that became evident. This gets at the form of social work. For instance, in working with families, it is more likely that the social worker would engage in a collaborative fashion, going to great pains at times to document the views of family and other informal supports to the doctor. In the case of the Superintendent or Doctor, efforts at working with family were more directive or primarily passing on information. This shows that the difference

relates to the form of social work – to work with the patient and their environment towards providing aftercare that is supportive and conducive to reducing recidivism.

One could infer that this qualitative difference is due to the influence of the educated social worker at SMHC. This is not necessarily the only explanation. This study was able to show a qualitative difference in the patient record that preceded the influence of the degreed social worker. Furthermore, the fact that at SMHC there is always a larger majority of the non-degreed social worker ought to be considered as well. Perhaps another explanation could be that the direct experience of getting to know a stigmatized individual in their world/environment may have a profound effect on the social worker. Perhaps social work related theories are naming and formalizing what practice wisdom had taught these social workers. What is the implication here? We don't know how far the influence of education went but assume it did via the supervisor. Certainly the last decade's entries show how the social worker is being shaped by the theory of the time, especially when looking at how social histories and assessments are performed, aside from the emerging clinical family work.

In fact, in the 1964 report, *More for the Mind* (Tyhurst et al., 1963), the expectation is spelled out that the social worker be the conduit to the outside world for the patient and the treatment team. In a sense, the nurse is almost cast as the inverted social worker in this report. The social worker is to focus on the outside of the institution to pull together and organize in such a fashion that the patient can return successfully to community. The nurse, on the other hand, is to do the same with a focus on the inside of the institution. Given that this perception was espoused at the national level, it makes sense to expect to find social workers performing similar tasks at SMHC – thus distinguishing themselves from nursing in role.

There is evidence in the findings that show that social work was relied on to perform certain tasks. While this may have initially been the result of efforts to offload non-medical tasks by an overburdened staff at SMHC, it is clear that social workers were being seen as experts in these areas of practice. The reliance on these experts to assess, evaluate and plan discharge/aftercare plans, as well monitor the well-being of patients in the community, speaks to this idea.

In terms of form, Sullivan and Rapp (2002, p. 188) refer to the social worker as providing a “social prosthesis” for patients unable to adjust to community life. One illustration from the patient record is the reference to the social worker as attending a birthday party at their foster home placement (11321, 1972). Presumably, in the absence of friends or family, the social worker participates as a proxy informal support to this patient.

Regher and Glancy (2010, p. 4) claim that the roles of educator and supervisor are part of social work practice in mental health. The patient record reflects these roles as well. The emerging hierarchies in the discipline show how the supervisor is a role performed by social workers at SMHC. There are references in the record to social workers educating both patients as well as supports in the community. Notably for the latter this is done with the intention to decrease misinformation and increase the likelihood of a successful placement or hire for the patient (e.g. 223, 1962).

Palmer et al. (1984) claim that social workers do not spend much time with community supports. This study showed that much of a social worker’s time is spent in community – working with patients and their community supports. In this case, the study would appear to tell a different story. Correspondence by outside services to social work also show a lively

interaction involving the patient's resources and even providing patient information as managers of the patient chart. In fact, one could argue that the patient record entries that show visits with families – with or without the patient present – illustrate further work done by this discipline with community supports.

Another finding by Palmer et al. (1984) is that social workers are primarily understood to be the members of the staff that perform and report on assessments in mental health. This function was present throughout the period of study but increases in the final decade (see figure 4.5, p83). In terms of role, the social worker is increasingly relied upon to perform assessments – first in terms of housing but then also in terms of determining whether social work services are of benefit to the patient. This again reflects the growing acknowledgment of this profession's expertise. By the final decade, there are social histories that reflect the growing sophistication of the social worker in performing assessments.

The literature on social work in mental health refers to form in that social workers are to address more than a medical orientation, to champion approaches that speak to the whole person (Heinonen & Metteri, 2005 as cited in Schwartz & O'Brien, 2010, p. 107; Kerson, 2004). In effect, social workers are challenged to focus on the whole person within a climate that may prefer to address pathology only. This speaks to some of the patient record entries that seek to privilege the views of family. When compared to other disciplines in this field of practice, the social worker is less directive and more collaborative. This study shows how this is reflected in the patient record at SMHC. In fact, the concern with non-medical factors is illustrated as early as 1964, when a social history focusses on the family dynamic via a collateral with members of the patient family (5975).

Perhaps this last point gets at the emerging form of social work at SMHC the best. It is the underlying values of social work that are the focus here. Social workers are to look at a person in environment perspective to address the environmental forces that shape and influence people and is even seen as a distinction from other helping professions (Weiss-Gal, 2008). This study shows how the work of procuring resources and connecting with community to help establish the patient outside of the institution evolves towards a person in environment perspective. In fact, the social worker appears to be increasingly effective in this regard. A social work related patient record entry in 1972(759) shows how a doctor relies on increasing the social worker's contact with the patient as a way to avoid further hospitalization.

This study has shown how social work has emerged with knowledge relating particularly for practice within the field of mental health. The 15 social work functions are present in the patient record and reflect the range of roles needed to navigate a complex social environment as defined in the generalist practitioner model (Zastrow & Kirst-Ashman, 2013, pp. 49-51). Social work related patient record entries show how social workers tried to ensure that the preferences and perspectives of both the patient and their families are known and documented. In essence, this study has shown that much of what is seen as social work in the general literature can be found in the mental health field at SMHC as well.

Social work and the chronically mentally ill

Another finding worth reflecting upon involves the nature of the patient served by social work. The patient encountered in the sample usually has some kind of thought disorder. While social work actions provided are fairly similar across the board, the more chronic patient-as identified via longer lengths of stay at SMHC, tended to get a lot of social work activity. What this means is that patients with significant challenges due to a thought disorder are in receipt of

more social work. This means that a population that is identified in the literature as struggling with Serious and Persistent Mental Illness (SPMI) and is the subject of evidence based practice models currently (Bond & Campbell, 2008), is actually historically receiving social work support at SMHC. Given that the majority of social work functions are located at the discharge/aftercare treatment stage (see table 4.3) it makes sense, considering the history of SMHC in carving out its own community mental health solution. Regardless, the implication here is that there is a historical connection between the SPMI and social work at SMHC. When it comes to who made up the SPMI at SMHC, this study would refer most likely to those patients identified with a thought disorder. The most frequent or 40.15% of patients had a thought disorder in the sample. The provincial reports are even more explicit.

Table 6.2 is an illustration based on data from the annual report for SMHC (Department of Health, 1964). What is readily apparent (see bold numbers) is that across all lengths of stay, it is Schizophrenia that is most represented for discharges. Particularly the strong representation of this diagnostic profile at LOS 12 months and beyond speak to the chronicity of this population at SMHC and the likelihood that this represents the SPMI at this facility.

Table 6.2: Discharge by Dx & LOS

Diagnosis	0-3 months	4-6 months	7-12 months	1-2 years	2-5 years	Over 5 years	totals
Schizophrenia	96	84	43	24	12	61	320
Affective Psychosis	22	10	3	2	0	9	46
Paranoid Condition	5	1	0	1	4	3	14
Psychosis	11	6	1	3	0	2	23
Psychosis Associated with Old Age	6	2	4	1	1	0	14
Psychosis Secondary to Organic Disease of the Nervous System	10	2	0	2	1	2	17
Other and Unspecified Psychosis	13	6	0	2	1	2	17
Chronic Alcoholism	24	9	0	1	0	0	34
Psychoneurosis	23	1	4	3	1	0	32
Pathological Personalities	32	8	3	3	2	2	50
Other Non-psychotic Disorders	16	3	3	4	4	7	37
TOTAL	258	132	62	48	25	86	611

Adapted from: Department of Health, 1964. Province of Manitoba. Annual Report. Report Number 42. Winnipeg Manitoba. Queen's Printer of Manitoba (1965)

An article, documenting the rise and fall of the Winnipeg Psychopathic Hospital (Hendrie & Varsamis, 1971, p. 186) refers to the shift in the 1940s of relegating those identified as chronic and disturbed as being sent to the Selkirk mental hospital for long term care in segregated wards. One ought to expect therefore that the social worker is involved in helping this population at SMHC.

A strong congruence between the literature on mental health social work and the study

In order to avoid repetition, the reader is referred to the social work actions that speak to their location in the literature for more detailed illustration. With the exception of advocacy,

there appears to be strong congruence in the patient record to what the academic literature would say about the role of social work in mental health. In light of the finding regarding the relationship between social work and chronic mental illness, a few additional observations can be made supporting social work and its role with mental health in the literature.

The following is a summary of material from the academic literature reflecting both the condition and the care approaches for this particular population, as well as the rationale why social work ought to be directly involved in this area of mental health practice.

As schizophrenia has been understood to be a profoundly disabling condition (Bond & Campbell, 2008, p. 33), it would stand to reason that psychiatric institutions would have a significant population of individuals diagnosed as such. Reaume's research at the Toronto psychiatric institution appears to confirm this assumption as he found that a form of Schizophrenia was the most prevalent diagnosis in the medical record (2000).

As stated in the introduction chapter, social workers have an ethical obligation to work with marginalized and oppressed groups of society (Walsh, 2002, p. 273). People with serious and chronic mental health conditions such as schizophrenia are indeed such a group.

A hallmark of schizophrenia is the marked deterioration of a person's routine functioning in social and occupational spheres that are most often due to the expression of the negative symptoms (Regehr & Glancy, 2010, pp.128 & 130). Other features related to schizophrenia are social withdrawal, a disturbed sense of self, poverty of speech and abnormal motor behaviour (Weiten, 1994, p. 390). Faris and Dunham (as cited in Regehr & Glancy, 2010, p. 124) referred in 1939 to the devastating impairments in these spheres as a "social drift". By this, the authors

were referring to the tendency for people diagnosed with schizophrenia to become indigent, to experience a lower socioeconomic status than their families.

The support for the idea that social workers be active in working with this client population can be found in the contextual data from the Manitoba annual reports as well. The impact of medication is felt at SMHC in 1955, resulting in greater discharges of patients with Schizophrenia (Department of Health, 1956). These results bring about the assertion that such patients would need to be managed in community on medication and that SMHC's "...Social Service Department will have to accept this added responsibility" (p. 200).

The point here is that social workers are in a unique position to work with and assist this patient population to manage outside of institutional settings. This would lend support to the idea that social work education should acknowledge this relationship and provide training to the BSW student. It ought to be expected that the social worker be active in this environment and have some knowledge of the challenges that this population faces.

Social work essential to manage patient flow and community mental health

The findings have shown that it was not the social worker that was most prevalent in the first decade of the study. What this means is that there were less entries in the patient record found in the sample when an entry is dated prior to 1958. What is known is that SMHC was asking for additional social work staff as early as 1956 and didn't add such staff until 1960 (Department of Health, 1957; Department of Health, 1958; Government of Canada, 1960). The implication here is that all of the entries located in the first decade of the study are for only one social worker. Putting this in context, it is impressive that as many entries as were found are the product of one staff person at SMHC. One could imagine how much more would have been found if SMHC had been able to increase their social work staff sooner.

After SMHC was able to hire more social workers, it is this discipline that is most frequently encountered as the primary provider of social work actions in the patient record. This would make sense, given that more staff is present to provide services. As the findings have shown, once more social workers are hired; the services provided become ever more sophisticated. Furthermore, it is apparent that SMHC relied on social work to manage foster homes in community as well as all other aspects related to successful community reintegration for the patient. When SMHC was struggling with community alternatives, it was social work staff that stepped in to provide and manage a proxy community mental health option for the institution.

Characteristics of the Social Worker at SMHC

Given the earlier section on the qualitative differences in how a social worker performs their tasks, the following section reviews the main findings of what can be known about the social worker at SMHC. This includes both the educational qualifications as well as the status of registration for this professional. Furthermore, given the purpose of this study, space is provided to discuss the distinctive aspects of this profession. Of particular interest here as well is how the patient record can help promote further understanding of the location for this particular profession within the mental health treatment team at SMHC.

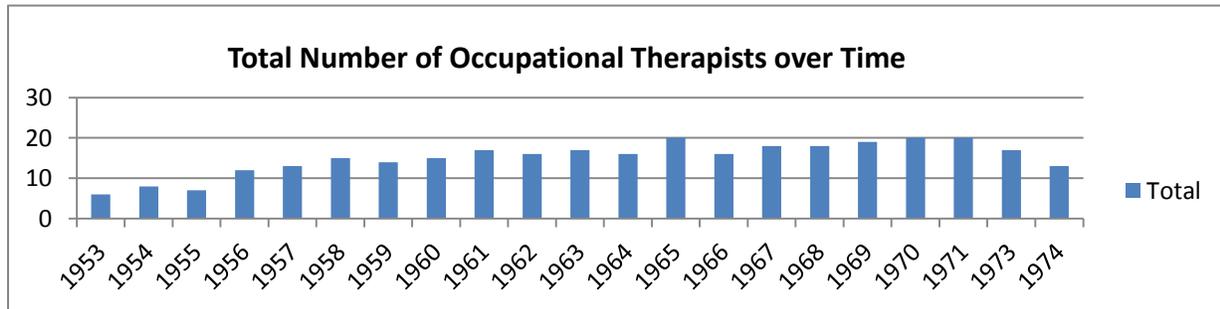
Social work & Academic/Professional credentials

In terms of education, the two results chapters show how social work shifts from training programs to academic degrees. In the 1970's the expectation is that the University of Manitoba will be increasing their BSW graduates for mental health service provision in the province (Division of Research, 1972; Manitoba Department of Health and Social Development, 1975). What is interesting to note is that this differs from the CMHA report calling for the MSW as the national standard in mental health (Tyhurst, et al., 1963). The hierarchy that emerges for social

work shows how at SMHC the BSW and MSW emerge. Figures 5.6 and 5.7 (see pp. 150 & 151) are instructive here. What the federal reports show is that there is no significant change in BSW graduates at SMHC but the MSW becomes more prominent. It is apparent via figure 5.7, that the MSW is the most common degree for social workers by 1974. Regardless of this finding, it is consistently the non-degreed social worker that is most commonly employed at SMHC. This holds true throughout the period of study.

Most likely, it is the staff with the MSW that can be found in the supervisory role. What this means is that the degreed social worker functions as a de facto standard of social work practice. One could assume that it is this professional that then is responsible for ensuring social work is performed according to the standards learned while completing their degree- presumably at the University of Manitoba. As an aside, it would be interesting to look at what SMHC was doing when providing lectures or education to the University Of Manitoba School Of Social Work (Department of Health, 1966). There may be some further clues about the way mental health practice was viewed by social work professionals at the burgeoning school at the University of Manitoba. In any case, the degreed staff appears to be in positions of administration and supervision, becoming solely responsible for ensuring that a non-degreed staff person follows and behaves as does the degreed social worker in practice. This may not have been unusual for SMHC since Occupational Therapy appears to have done the same thing.

Figure 6.1 Occupational Therapists over time Adapted from “Annual Return of Mental Institutions – General by Government of Canada [Dominion Bureau of Statistics; Dominion Bureau of Statistics-Ottawa; Statistics Canada], 1953-1971, 1973-1974



There is a steady increase of occupational therapists being added to the SMHC roster until 1971 when this drops off by 7 and is down to 13 in 1974 (see figure 6.1). The majority of occupational therapists at SMHC are not identified as registered in the federal reporting form. It is only in 1965 that there is reference to 2 registered occupational therapists. In 1969 there are 4 and by 1970 there are 5. This drops to 3 in 1973 and only 2 by 1974. One way to reflect on this information is to note how advanced degrees and registration of non-medical personnel are encountered at SMHC. For social work, the BSW and MSW is the minority for the profession, in occupational therapy, the same can be said for registration of the profession. What this implies is that perhaps it is status quo at SMHC to have degreed professionals at the top that are responsible to train and supervise non-degreed staff in performing the duties of a profession.

The reason why this is a profound question has to do also with training. While annual reports refer frequently to trained staff, it is unclear how frequently the training occurs or what the focus would be. For instance, if monitoring is something non-degreed staff is frequently doing, how are they trained to perform this task? How is it ensured that this important activity, that staff is entrusted to perform, is accurate and fair? One could argue that degreed staff are trained and ultimately vouched for by their institution upon the completion of an education.

When the annual reports then refer to “experience seminars” (Department of Health, 1965, p. 53) it would be worth pursuing what this actually meant and how often this was an expectation that social workers complete. It is possible that further exploration of what constitutes these seminars and the agency policies around who must attend will add further understanding of how social work practice was shaped at SMHC. For instance, if social workers are expected to attend or even lead experience seminars at monthly or annual intervals, it is possible to examine how these impacted their work at SMHC.

The theoretical orientations of social work at SMHC can be seen based on what is known about social work education in Canada. One can see the influence of both diagnostic and functional case work as it was practiced in Canada during the 1950’s (Hick, 2002, p. 51). The diagnostic approach is echoed in the assessment of the patient and the exposition of causative factors in their developmental history. The evolution of more systematic development of a framework for support in the community in detailed after care plans points to a functional approach to practice. As more degreed social workers emerged at SMHC at the end of the 1960’s until the end of this study’s time frame, the influence of other theory becomes apparent. As stated under counselling, entries at the end of the 1970’s reflect a theoretical orientation by social workers influenced by the problem solving approach. Canadian social workers were learning models such as the behaviour modification, the integrated, the structural and the problem solving approach during the 1960’s and 1970’s (Hick, 2002, p. 51). Hence, it is reasonable to assume that what the patient record entries show is the influence of what was most likely taught at the University of Manitoba, School of Social Work during this time.

A related issue is the matter of registration. Since other professions at SMHC have registered staff, it is reasonable to explore how this took place for social work. Registration with

a professional association can provide an additional layer of accountability - both in performing ethically and in continuing a training regimen. Table 4.1 shows the distribution of the RSW designation in the sample.

Most social workers at SMHC do not appear to have the RSW designation. Registration of a profession can be seen as establishing credibility within an area of practice such as the health professions. It is therefore quite interesting that the RSW designation was not encountered very frequently in the patient record. For a social worker to become registered is voluntary. There is no mechanism in Manitoba during this time by which this is mandatory. All RSW signed entries are by social workers functioning as a supervisor in some capacity. One can speculate why these supervisors chose to pursue registration as it is not known whether this was an internal expectation by SMHC. The assumption that degreed staff would do this doesn't hold when encountering authors signing with an MSW but not the RSW. Since most of the entries that include the RSW are addressed to outside agencies, one could speculate that this is an intentional demonstration of the authority of the author. As the RSW designation is associated with a social worker's supervisory role, one could speculate how this influenced the supervision provided. The increasing professionalization of the work being done by social workers speaks to the likelihood that training of non-degreed and unregistered staff was impacted by the degreed and registered social work supervisor.

The RSW issue is a timely one, given Manitoba's current issues around the new act to make this a mandatory designation for social workers in the province ("The Social Work Profession Act," 2008). This has not been an easy task. In fact, at the time of writing this dissertation, a new Manitoba College of Social Workers (MCSW) has yet to be established. In other words, Bill 9, the Social Work Profession Act, 2009 is not yet coming to fruition. This bill

would make it mandatory for anyone calling themselves a social worker to be registered by the MCSW. The current organization, the Manitoba Institute for Registered Social Workers (MIRSW) has made it plain that their primary concern is to have a registered body of social workers in the province in order to protect the public (<http://www.mirsw.mb.ca>). As such, registration would intend to protect patients at SMHC being served by a social worker. This has implications for SMHC. As this study has shown, not only are the majority of social workers without a degree, they are not registered. If status quo at SMHC is to have a registered and degreed social worker providing supervision for a team of staff that is ineligible for registration, the question must be asked how this act will shape future social work practice at this institution. If it becomes mandatory for any social worker at SMHC to be registered with the new College of Registered Social Workers, will this result in turnover as those without degrees or qualifications must leave? Will the additional requirements for registration result in changes of how social workers practice? The point here is that there may be pros and cons to how mandatory registration may impact social work practice at SMHC. For now, the findings make plain that the practice of non-degreed and unregistered social work staff was supervised by degreed and registered social work professionals at SMHC.

This latter issue may be partially resolved. Currently at SMHC, the supervisory structure as outlined above by social work administrators is no longer being practiced. According to J. Emerly - a social worker currently at SMHC- there are ten social workers within the institution. nine carry active caseloads while the other is directed to function as a geriatric resource and runs groups. Currently, social workers do not supervise paraprofessionals in any capacity (Personal communication October 1, 2014). In fact, supervision is provided by program heads for multiple disciplines. Most common for such supervisors is a nursing degree.

A related issue involves the nurse being a social worker. The first social worker was a nurse by training (Department of Health, 1948). The first BSW and MSW appear in the 1960s (see Figure 5.7, p. 153). One could assume that nurses with a degree are more likely to go on for the MSW rather than pursue a BSW. This raises the question as to how many social workers are actually benefitting or being shaped by a prior nursing degree. How this impacts the way social work is perceived and performed may be another point to consider as this gets at the form of social work.

Related to this is the fact that the first BSW was apparently hired in 1960. The first BSW in Canada was offered in 1966 (Hick, 2006). In Manitoba, the BSW was offered at U of M in 1968 (Fuchs, 2005). While it is unknown where this staff person received their BSW, it is likely that it is an American degree. Further research may require exploring the ways in which an American social work education would have influenced social work practice in a Manitoba context such as what transpired at SMHC.

Limitations and areas for future research

As with any study, there are areas left unexplored and decisions made that result in limitations and recommendations for future research. Some recommendations have already been alluded to in the body of this chapter. These will be expanded on as well as some additional considerations.

Research Design

This study utilized historical research employing a qualitative descriptive design. Great pains were taken to ensure that sampling procedures are systematic and randomized. This has been largely successful, but the reality is that the source of data is not necessarily a consistent one. While the chance of selection was present, there may have been files still within the

sampling frame that meet exclusion criteria. Given the constraints of the research, only their selection would have exposed their exclusionary status. Hence, the sampling frame may have included files in multiple years of admission that weren't detected in this study. The way this was managed was the best possible alternative, given the limitations of this study.

Even if each eligible patient file had an equal chance of selection, the reality is that patient files did not consistently have the same files included in their collection. Much has been said about the benefits and drawbacks of using patient records (Creswell, 2007; Dworkin, 1992; Stake, 2005). There are a number of considerations for this study to keep in mind. This goes to what Dworkin (1992, pp. 5-10) refers to in regards to disorganized or incomplete medical records. The Manager of Health Information Services Technology at Selkirk (personal communication, September 19, 2012) shared that the method that had been used to compile the microfiche records had been fairly unstructured. She gave me a copy of a policy in 1979 as the only reference point she was able to locate and that it appeared that at that point they had simply filmed everything that was present in a patient chart. It is her contention, that, while there may have been changes in the personnel collecting the patient files for conversion to microfiche, the policy of gathering all materials available remained consistent throughout (Manager of Health Information Services Technology at Selkirk, personal communication, September 19, 2012). When examining the patient record, it was at times not possible to discern why some material is present and others are not. That said, some forms were indeed present on a consistent basis – such as the Patient Registry Data Sheet.

Another issue is the force of history itself. It makes sense to expect early charts to have less volume or less data about patient care beyond medical interventions. This is a valid concern for this study. As I am interested in an aggregate, I resolved this issue by compiling enough

material to offset any deficits in what was collected. The results chapters are the product of this effort. In fact, the descriptive statistics in the results chapters are efforts to capture how social work interventions increasingly emerge in the patient record over time.

Despite the information the Manager of Health Information Services and Technology at the Selkirk Archives has provided (personal communication, September 19, 2012), the reality remains that I am beholden to what various staff felt was important enough to preserve in the patient file. When looking at records from 1947-1980, I have little knowledge why the available material was collected and what may have been omitted. I was not present during these events and must rely on what is now available.

Verification & Triangulation

Another challenge is the fact that I was not able to triangulate with living patients or staff for much of the sample frame. Again, this is a reality of the nature of this kind of research and I have noted in my methods chapter the ways I frame what my findings are, in order to be as thorough as possible, when exploring the evolution of social work related in-patient care at the Selkirk facility.

Multiple methods can function as a form of triangulation. According to Denzin (1978, as cited in Patton, 2002, p. 247), two ways of employing triangulation find resonance in this study. The first is data triangulation, which is using more than one data source in a study. By employing archival annual reports – both provincial and federal – as well as the patient record, this can be seen as a way to engage in this form of triangulation. The second way is methodological triangulation. This study sought to do this via the use of both qualitative method and descriptive statistics to achieve a useful triangulation in this study. By using patient record

entries to explore frequencies and to examine qualitative aspects of these entries, this study engaged in methodological triangulation.

It is important to note that Patton (2002) would not be thinking of triangulation as simply verifying data. There are times when there are divergences which may be as instructive as agreement.

Finding such inconsistencies ought not to be viewed as weakening the credibility of results but rather as offering opportunities for deeper insight into the relationship between inquiry approach and the phenomenon under study. (Patton, 2002, p. 248)

Hence, an approach in method that employs both qualitative and quantitative elements has the advantage of both triangulating findings as well as deepening the analysis of what is found.

Reflexivity

Another consideration for this study is the researcher's own experience in the field. While I refer to this experience and how it guides the decisions of defining social work practice in mental health, it is important to note that this is based on working at an American psychiatric institution. This included a career spanning in-patient work as well as outpatient case management and therapy. Hence this experience is invaluable in looking in particular to a period of history where mental health treatment evolved from an institutional to a community based model of care. However, the experience is fundamentally different. Social workers in the US enjoy a strong role in mental health (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008). It is likely that my experience impacted how I viewed the data. This is not necessarily a limitation but the reality of a unique vantage point. One way that this was dealt with was via

consulting with social workers that have practiced here in Manitoba in mental health. However, a social worker with Canadian experience in the field may provide another perspective and potentially enrich further what can be understood regarding this topic in future research.

Case Management versus Linking, Referral and Housing

A review of the literature (Bentley, 2014; Corcoran & Walsh, 2009, p. 178; Fuchs, 2002, pp. 362-365; Sands, 2001, pp. 258-267; Sullivan and Rapp, 2002, pp. 183-184; Summers 2009; Vanderplasschen et al., 2007; Walsh, 2013, p. 25; Wu et al., 2014) as well as consultation with a Manitoban social work professional (A. Hajes, Personal Communication August 20, 2014), did not yield a consistent definition of case management. The reality is that this term can be defined in different ways. The case can be made that some of the social work actions such as linking, referral and housing could fit under the heading of case management. There are some reasons why this was not done. First, as mentioned before, the criticism has been made that social workers were under-utilized and only searched for housing on behalf of patients (Clarkson et al., 1972). For this reason it became important to understand more about this action – who is doing it and is it the only thing a social worker does at SMHC? This illustrates another reason why some actions are not included under case management but collected and coded separately. By doing this, having mutually exclusive categories apart from case management, it is possible to look at the statistics around these codes encountered in the sample. This is a case of being able to use basic statistical calculations to challenge a prevailing narrative that was reductionist about the role of social work at SMHC. The results of this dissertation show indeed a broader and richer role that social work played at SMHC.

Qualitative Descriptive Method Revisited

This gets at the heart of the assumptions around frequency in the record leading to a certainty of being able to pronounce what makes for social work in mental health. Evolution, by

definition means change. This research shows indeed how the role of the social worker evolved. Holding to a historical record as dogma or doctrine is missing the point of this kind of research. In fact, the conflicting data around when home visits occurred at SMHC make this plain.

What the results of this study can attest to is that social workers were indeed present and relied on at SMHC. Hence, the trail in the record can be resumed, to draw forth how social work continues to be present in mental health – not just in community but at the institutional level.

While some actions were low in frequency count, it remains unknown if this can tell the story of social work. If therapeutic value of the social worker emerges at the end of the study, it would make sense that there wouldn't be much in the patient record on therapy performed by the social worker. Future studies could extend their search into the 1980's and 1990's to explore whether this indeed is the case. Since low frequency in the previous illustration may be due to the time frame of this study, other actions minimally encountered may also benefit from future study as well. Another potential limitation of this form of research lies in its focus. Qualitative descriptive approaches differ from other inductive approaches in that one remains close to the data, seeking to describe it over interpreting or implying what it may show (Lambert & Lambert, 2012). Hence, certain aspects of this study, such as exploring the form of social work, were less well represented. The method thus may have created the condition that limited induction.

Rehabilitation

Why is the non-clinical aspect of social work activity a lesser one? Current questions of what social work ought to be in the mental health field remain salient and relevant. The idea that mental health social work is reserved for the MSW and is a clinical practice is missing what this dissertation has shown. Throughout the patient record, there is reference to the need for social workers to address rehabilitation in the community. In other words, any progress at the

institutional level is rendered pointless if the social worker cannot assist in the rehabilitation of the patient in community. The non-clinical aspects of patient care are essential for recovery. Hence, it would be unfortunate to dismiss non-clinical work as less relevant or important in the field of mental health social work. Further research into the role of the supervisory hierarchy may help show how social workers in different types of functions co-existed in order to provide patient care. This may shed further light on how both the clinical, the non-clinical and the administrative roles of social work function in this particular field of practice. Adding further understanding into these roles can only improve the status of the profession in this field.

Limitations of the Patient Record

Another reality is that this study can only comment on what was found in the record. It is possible that social work actions were not documented or found important to retain for posterity. The reality is that I am dealing with artefacts that are the work of people keeping medical records for a variety of reasons not including any notions of posterity with said information filtered through the views of the author of the document (Dworkin, 1992, p. 4). In terms of historical research, this can be understood as the reliability or the authority and competence of a source (Howell & Pernier, 2001; Tosh, 2006). I may need to accept that these questions remain largely unanswered. Specifically, certain aspects of the form of social work, that aim to uncover the knowledge, skills and values are not available for analysis from the patient record entries.

In other words, the ideas around reframing (Spearman, 2005 as cited in Schwartz & O'Brien, 2010, p. 112) or redefining a problem as consciousness raising (Mullaly, 2007 as cited in Schwartz & O'Brien, 2010, p. 112) make the case for a structural approach to social work in mental health (Schwartz & O'Brien, 2010, p. 112) If such references had been evident in the patient record, this would have been useful to reflect on for this study. The social work related

patient record entries did not have any content where this could have been inferred. In other words, the content did not allow for much analysis of the state of mind or philosophical orientation of the author. What little there was that could be determined tended to reflect a theoretical orientation as it pertains to clinical interventions. Regardless, this study is about verifying what is in the record as it helps unpack the emerging role of the social worker at SMHC.

What happened after 1979?

It is true that temporal limits mean that post 1980 changes in patient care will not be considered and may need to be for future studies. For example, the issues around supervision of paraprofessionals or staff that are social workers but do not have a degree. It is possible that this is no longer a concern and hence the implications of this finding are reduced.

Related to this issue are the decisions made as a single researcher. The findings in this study are based on 4 patient files consulted per year of the study. In future research, it is worth considering the advantages of multiple researchers. A research team could review these current findings, and choose to do a more in depth study of a given year or decade. Using findings from this study could be used as a guide for where to go for a future research team. Multiple researchers could look at specific actions and sort by categories (e.g. diagnosis, age of patient) to see if the patient record entries can be organized this way and examined for differences or similarities with a larger sample size.

Conclusion

According to Fendler (2004), it was Foucault who claimed that all ontological assumptions are products of particular historical circumstances and discursive interpretation. What is known is based on what we say occurred. How this translates into patient file research is

best illustrated when Risse and Warner (1992, pp. 201-202) note how what was known in medical circles as a standard of care was actually not occurring at all when local files were consulted. They distinguish between rhetoric of the ideal and the evidence of the actual. This is certainly a salient point when looking at the conflicting reports around when community visits first were made by SMHC staff. While the SMHC website and the provincial annual reports generally agree on a date in the 1950's, the patient record entries show how this already occurs in 1948. Patton (2002) would refer to how this is not a bad thing but could serve to further understanding. In fact, another salient example would be the issue around the home finding tool. The provincial report notes this at the end of the 1970's while the patient record shows that social workers were completing and updating this home finder index already in the early 1970's. One way this can be explained is that this illustrates the delay between work on the ground and news of innovation reaching those in administration responsible for completing government reports. Hence, the discrepancy does not undermine but further explains what is found. What this study has demonstrated is that it is possible to employ a qualitative descriptive method in historical research. Specifically, it is feasible in the field of patient record research. Future explorations of later decades up to the present may add even greater understanding regarding how social work evolved in institutional psychiatric care.

Fook (2003, pp. 127-129) asks the question what ought to constitute social work research. One can certainly find support for such research advancing the cause of defining and refining the discipline of social work. This research helps locate the discipline within a historical context. The presence of social work throughout these crucial decades of significant changes occurring in the field of institutional mental health, gives legitimacy to the profession going forward. Future research in mental health by social workers can be supported by the findings of this document in

that this profession can claim space here. The profession can add this piece of knowledge to how it sees itself. Social work is rendered more visible now, in this field of practice.

This research can be understood as a way to lay claim to this area of practice. The opportunity exists to build on what is clearly evident from the findings. Social workers have shown in the patient record how they have had to innovate and improvise. Not only this, but they have capitalized on innovation to build systems that improve the delivery of social work services to the people they served. Social work research can benefit from this.

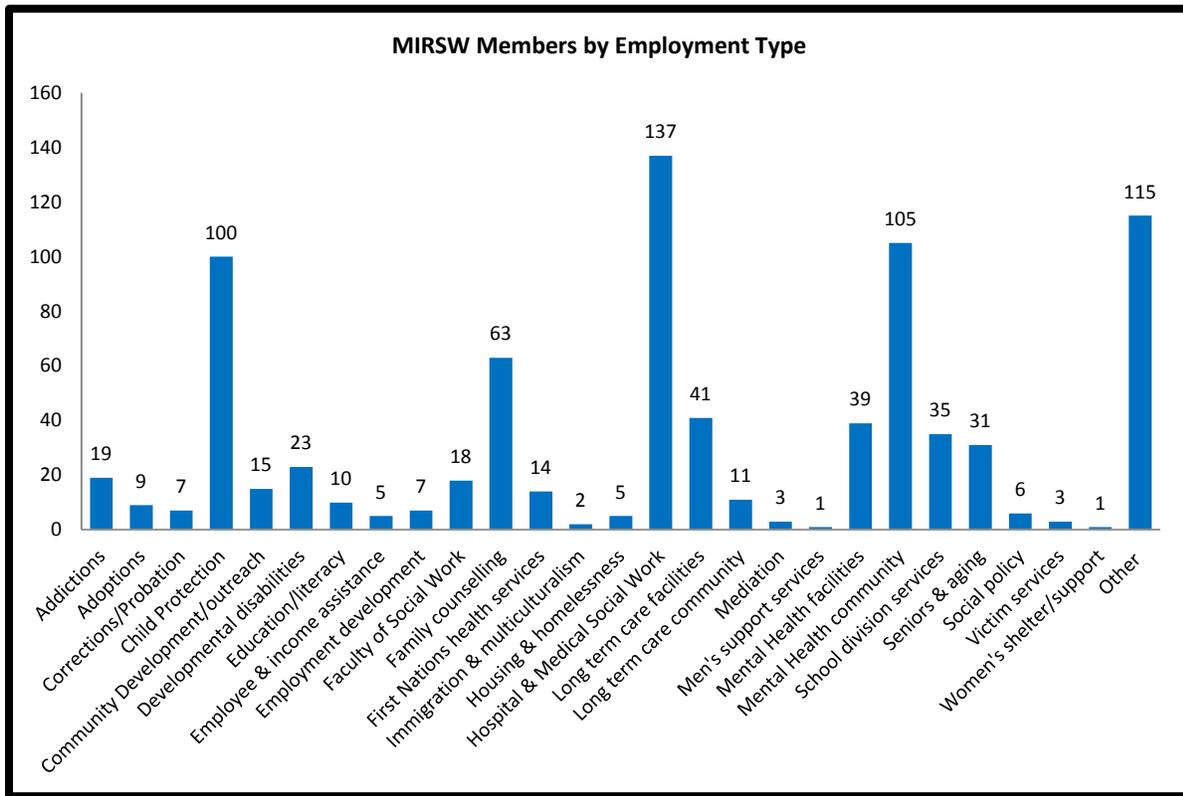
Future research can involve social workers partnering with people involved in the mental health system towards improving systems of care. Their involvement in this field of research is further legitimized by these findings. This gets at what a former SMHC social worker said about the need to often be creative problem solvers, figuring out how to deal with gaps in the service (T. Hryniuk, personal communication, July 06, 2014). While working on the standards committee for MIRSW, he even called for social work to have a standard be “Innovator”.

The concerns with clinical social work receiving short shrift bears further reflection. The case has already been made that the time frame of the study is such that this wouldn't have much content as models of social work in terms of psychotherapeutics that were just emerging by the time the study concludes. Rather than lament that case management appears to be what social workers are seen as doing (A. Hajes, Personal communication, August 20, 2014), one can explore whether this is a legitimate function to claim for social work. Solomon (1998) makes the case that case management is a direct result of de-institutionalization. Calicut and Lecca (1983) make it even plainer in that they say it is social work itself that was needed in the deinstitutionalization era as services were rare and difficult to access in community. Fuchs (2005) claims that it is the confusing and complex nature of support services and resources in

community that make case management essential for social work to perform in Canada. Given the values of social work (Canadian Association of Social Workers, 2005a; Manitoba Association of Social Workers & Manitoba Institute of Registered Social Workers, 2004; Walsh, 2002, p. 273), case management can be regarded as a social work action that is legitimate in Manitoba mental health. The CASW Guidelines for Ethical Practice (Canadian Association of Social Workers (CASW), 2005 b) make it plain in section 1.0 of this document when referring to the ethical responsibilities to clients. This is especially salient when looking at 1.6, regarding vulnerable persons, and 1.7 that deals with the maintenance and handling of the patient record. From a Manitoba Standpoint, this is best captured in 4.10 of the Standards of Practice (Manitoba Association of Social Workers & Manitoba Institute of Registered Social Workers 2004) which refers to brokering services in what appears to describe case management actions.

A report completed in 2012 for MIRSW (A. Hajes, Personal communication, September 8, 2014), indicates the current areas or fields where registered social workers in Manitoba practice.

Figure 6.2: MIRSW Membership by Occupation



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Clearly, social work today remains in the field of mental health. As figure 6.2 shows, 39 registered social workers (N= 1026) work for mental health facilities. This is only 4% of all registered social workers in Manitoba. However, when combined with the number of registered social workers performing mental health in community (n=105), the combined number of mental health related social workers in Manitoba make up 144 or 14% of the total registered social workers.

This dissertation makes the case that social work is an important discipline that has long been present in the field of mental health in Manitoba. The 2012 MIRSW statistics show that currently the social worker remains located in the mental health sector.

There are no set ways to engage in patient record research. In this case, the focus is historical in nature. The way patient record research was approached for this study may lend itself to other research in this field. For instance, the case in this dissertation is made that what impacted the evolution of social work was SMHC's own unique location. It is close enough to the capital of Manitoba, Winnipeg, to have an influence there. Rather than community mental health emerging from the city itself, it is SMHC that is tasked with extending its reach, creating a proxy community mental health option. This may have been a unique situation which influenced social work's evolution at SMHC or it may have been more common than previously assumed. Further research may want to explore this. Finally, there is an intriguing possibility that historical research can offer the evolving discipline of social work: to quiet or resolve divisions among the discipline.

This struggle is reflected also in the dichotomies which appear to exist in social work between psychological and environmental protagonists:
 System Maintenance versus System Change: the Therapist versus the Activist; the Clinical Social Worker versus the Social Worker; the Specialist versus the Generalist. This polarization does not exist in institutional clinical social work practice, as many of us can attest. (Lurie 1979, p. 81)

This is an excerpt from a speech made by a social worker in the US during a National Association of Social Workers conference in 1979. What makes this quote so interesting is how a member of the practice of social work articulates the position that divisions among social work based on theory are illusory. This particular speaker attests to the belief that social work, when performing at the institutional level, is less rigid and more dynamic in how it sees itself.

Granted, this is a US based source, but historical research can help locate parallels in Canada. While this study didn't show much in the way of the theoretical orientation, a former social worker provided his own view based on working at SMHC. He makes it clear that the social worker at SMHC had to be a member of the treatment team, being able to share the work, including what one could take to be the domain of social work.

Right off the top, my comments would be for a social worker to do competent work he/she needs to have team skills in collaboration, coordination, consultation and cooperation. There are times when I passed off my current role to a nurse who may have had a superior relationship with a client/patient and a rigid demarcation of roles would be counterproductive. (T. Hryniuk, Personal Communication, May 16, 2014)

The concerns around the identity of social work, the theoretical and ideological positions, may become less divided and distinct, the closer we move towards the practice of social work. Performing historical research may give us glimpses, perhaps, of how to approach and resolve such theoretical and ideological divides. Certainly, this study's methodological approach sought to show how the practice of social work can help unpack how the role of social work evolves. The little of form that was possible to infer from the patient record may speak to this phenomenon as well.

This study shows what social work contributed in the field of mental health at the institutional level. Furthermore, these findings are intended to stimulate further discussion and research to continue unearthing this discipline in this important area of practice.

This study has shown that there is a rich source of data available in the patient record that can give voice to this emerging profession at the institutional level. What this study has shown is how social workers are relied on at SMHC not only to fill the void of an absent system of support for patients in nearby communities. Social workers are rendered visible as they toil to co-create a community mental health option for patients in Selkirk and Winnipeg. Such a legacy ought not be dismissed or forgotten. Further research must continue to examine how this discipline contributed to institutional psychiatry past this time period of study into the present day. Understanding this role better can only benefit the discipline in the coming years as it continues to evolve and see itself.

Some of the ways that further research past 1979 can be continued is similar to this current study. Patient record research has shown to be an effective way to examine the work of this profession. Another advantage of continuing research into more recent decades involves the opportunity to speak with social workers directly. An oral history may be feasible to explore with living staff members from SMHC.

Finally, this study has sought to fill a gap in what is known about Canadian social work in the field of mental health. There is material available for current approaches to social work in mental health here in Canada post 1979. In 1984 a report was issued that shows that social work is indeed a profession present in mental health at the institutional level (Palmer et al., 1984). The survey results for another report around this time showed that social workers are included as part of mental health treatment teams (Mental Health Division, 1985).

In 1999, a national Social Work Sector study found that mental health is one of the domains where this profession is represented (Westhues, 2005). In fact, the report actually

called for the curriculum in social work to be more dynamic in responding to the needs of this sector of practice.

Regehr and Glancy talk about current approaches and refer to early writings in Ontario (Teichert (1952) as cited in Regehr & Glancy, 2010, pp. 2-3). Little is known about what social workers did at psychiatric institutions after 1952 and before current models of intervention. Little is known about social work within psychiatric institutions at present (O'Brien and Calderwood, 2010).

Teicher (1952) provides a blueprint of what can be identified as social work practice at the psychiatric institution post World War II. The findings in this dissertation extend and further the understanding of how social work evolved in this sector of practice during and after this period of history. This dissertation contributes to knowledge around social work in that it adds a missing chapter to the story of institutional psychiatric social work practice. Some of the ways that Teicher (1952) describes social work practice can be found in the social work related patient record entries at SMHC. What is different in the patient record, however, is the level of detail and the contribution to understanding the evolution of the social worker role and social work practice. Working to help patients integrate back into community life grows and develops here. Social work at SMHC becomes responsible for a foster home system and evolves into a hierarchical structure, developing more formal approaches to helping that reflect the increasing professionalization of this discipline. In effect, this study has contributed to the growing knowledge base of social work by broadening the understanding of intervention functions as they took place at SMHC. Furthermore, it has shown how interventions move from instrumental to clinical by the end of the 1970's at SMHC. Social work interventions were rarely found to be a singular action. There tended to be an interconnectivity of functions. For instance, the social

worker would engage in data collection via social history while also performing counselling as an example.

This study examined both the form and function of social work as the role emerged. What this means is that social work as form is the foundation of theory while social work the function is the emergence of practice. The form speaks to the profession of social work while the function speaks to the actual intervention or the doing of social work. What was found in the patient record and the annual reports is that over time form increasingly directed the function, while initially it had been the other way around. During the early days of social work, actions were performed by a nurse; hence the work or function of social work was being performed. This then defined the practice of the social worker role. As more social workers are hired with social work degrees, the role of the social work profession established the foundations of theory and practice. That said the role of social work is more clearly uncovered than the form, due to the mentioned limitations inherent in the patient record.

Payne (2005), in writing about professional social work, stresses how the professionalization project remains an important one to strive for in the 21st century. He refers to how social work itself is a product of history. “I argue that social work constantly redefines itself as it is influenced by others, by social need and social change and by its own internal discourse about its nature” (Payne, 2005, p. 2). This dissertation contributes to the answering of the question what is professional social work by following the line of logic he proposes. The findings here illustrate how social need – of addressing a rising discharge and recidivism rate at SMHC and social change – a perception of community mental health being a better way to treat patients – influenced the emerging and evolving role of social work in mental health.

Social workers were employed at SMHC to address areas of the patient's life that did not relate to medical aspects of mental health. It is clear that SMHC saw the management of these non-medical aspects of care as important in both reducing the inpatient census as well as recidivism. As this profession increased in value to the institution, more social workers were hired. With the increase in staff came more education. Social work itself became more complex with a growing patient population. Findings illustrate the way social work responded to the challenges by becoming more sophisticated in the management of the various responsibilities expected of this discipline. It is also apparent that not only did SMHC value social work as an essential ingredient in patient care, but other disciplines, notably the physician, came to rely on the social worker. This dissertation has shown that the connection between social work and mental health goes back to the early days of psychiatric care, even before deinstitutionalization was to have begun formally.

By examining these findings, the contribution to knowledge will lead to further discourse on the nature of the social work profession as it continues to evolve and grow. Certainly, the question no longer is whether social workers were historically involved in the field of mental health, but what this will mean for the continuing role of this important professional in this sector of practice.

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Zastrow, C. (1989/1981). *The practice of social work* (3rd ed., p. 581). Chicago, Il: The Dorsey Press.

Zastrow, C., & Kirst-Ashman, K. K. (2007). *Understanding human behavior and the social environment* (7th ed.). Belmont, CA: Thomson Brooks/Cole.

Zastrow, C. H., & Kirst-Ashman, K. K. (2013). *Understanding human behavior and the social environment: Instructor's edition* (9th ed., p. 766). Belmont, CA: Brooks/Cole, Cengage Learning.

Zilde, M.R., & Gray, S. W. (2001). *Psychopathology: A competency-based assessment model for social workers*. Belmont, CA: Wadsworth/Thomson Learning.

Appendix B

Codebook

Gender: 1=Male; 2=Female

LOS: Length of Stay is the total time receiving treatment admitted inpatient to SMHC. This includes 6 month probationary period as well as inpatient stays across all years of admission to SMHC.

LOS Rec.: LOS was recoded to number of days (months simply multiplied by 30 and years by 365 for statistical analysis, not essentially an accurate reflection of actual days)

LOS Recode: 1 = 1-3 months; 2 = 4-7 months; 3 = 8-11 months; 4 = 12 months & over

LOS2 Recode: 1= <9 months; 2 = 10-19 months; 3 = 20-29 months' 4 = 30-39 months; 5 = 40-49 months; 6 = 50-59 months; 7 = 60-69 months; 8 = 70-79 months; 9 = 80-89 months; 10 = 90-99 months; 11 = 100-109 months; 12 = 110-119 months; 13 = 120-129 months; 14 = over 129 months

LOS3 Recode: 1=1-5 months; 2= 6- 11 months; 3 = 12 - 17 months; 4=18 - 23 Months; 5 = 24 - 29 Months; 6 = 30 months and over

Diagnosis Recode:

Diagnosis examples Code	Code Categories	Assigned Number
Schizophrenia	(Any of the Schizophrenias)	1
Manic Depression Psychosis, Manic Phase 2	(Bipolar Disorders)	
Depression		3
Senility with Arteriosclerosis (Thought Disorder due to general medical condition) 4		
Alcoholic Psychosis 5	(Substance Induced Psychosis)	
Manic Depressive Psychosis, manic, recurrent Alcoholism, Parkinson's Disease 6	(Dual Disorders)	

Chronic Alcoholism	(Substance Dependence)	7
No Psychosis	(No Diagnosis)	8
Immature Personality with Emotional Instability	(Personality Disorder)	9
Psychoneurosis Obsessive-Compulsive Reaction	(Anxiety Disorder)	10
Adult Situational Disturbance/Immature Personality Disorder (Adjustment Disorder)		11
Other		12

Compressed diagnosis

Categories (with frequencies):

Schizophrenia	1 (53) = 1
Bipolar Disorders	2 (08) = 2
Depression	3 (08) = 2
Thought Disorder d/t general medical condition	4 (24) = 4
Substance Induced Psychosis	5 (03) = 3
Dual Disorders	6 (07) = 3
Substance Dependence	7 (10) = 3
No Diagnosis	8 (1 6) = 6
Personality Disorder	9 (08) = 5
Anxiety Disorder	10 (02) = 2
Adjustment Disorder	11 (01) = 2
Other	12 (07) = 6

1=1; 2=2, 10=2, 11=2; 3=2; 4=4; 5=3, 6=3, 7=3; 8=6; 9=5; 12=6

Diagnosis Compression: Thought Disorder = 1; Mood Disorder = 2; Alcohol/Drugs=3; Due to General Medical Condition= 4; Personality Disorder = 5; Other = 6

***** broader categories are based on the DSM-IV definitions of such larger categories (regarding dual disorders this is SA & MH, not Cognitive Delay and MH – in that case the MH is coded) When dealing with some of the categories, judgment calls were made. For instance, when chronic (also referred to as habitual at times) use of substances was part of the diagnosis and there was no significant Axis 1 diagnosis (e.g. an Axis 2) then it was coded as Substance Abuse only, not dual.*

Psychosis with Mental Condition was treated as “1” since the LOS was 6 years and hence precluded a minor or less severe form of thought disorder and hence more likely a form of the Schizophrenias

Social Worker Activity= 1 = Social Worker; 2 = No Social Worker Involved

Social Work Degree Freq.: A frequency count of degrees listed (i.e. MSW)

Non-SW Degree Freq.: A frequency count of non-SW degrees (e.g. RN)

Season Coded: January –March = 1; April-June = 2; July – September = 3; October – December =4

This is the codebook addition for the worksheet Descriptive Data Actor/Action

I include the first 7 given their roles at the institutional level. Under other I include those who do not conform to these labels. These include administrative assistants etc. as well as when author is unknown (e.g. N/A)

Actor: Social Worker = 1; Nurse = 2; Doctor = 3; Clinical Director = 4; Superintendent = 5; Assistant Superintendent = 6; Psychologist = 7; Other = 8

Code:

1. Advocacy
2. Education [patient education, social skills training, family education, education of informal supports]
3. Housing
4. Linking
5. Referral

6. Working with family
7. Assessment [family history, social history]
8. Case management [treatment plan review update, networking, community integration, transportation, referral relations (working with referral sources/reporting to outside agencies providing services (resources etc.), medication access, case closing, termination summary, working with family, finances, Discharge aftercare, aftercare]
9. Employment [v's vocational rehabilitation, vocational, job search]
10. Collateral [v's family collateral]
11. Crisis intervention [facilitating\hospitalization]
12. Counselling\therapy [supportive counselling, interpersonal support, family counselling, marital counselling]
13. Benefits [resource management, resource acquisition; completing reports to benefit services]
14. Monitoring [medication monitoring, occupational functioning]
15. Consultation [working with treatment team]

Intervention Stage: Admission = 1; Ongoing Treatment = 2; Probation/Discharge -3

NOTE: there is coding needed to reflect the nature of missing data. In some cases it is missing information off the patient record for a given sample. Other times, it is that at file has no data of a social work nature. Hence two codes will be used to reflect this in analysis. Missing data is incomplete sample while absent means no data available at all. These codes are applied for all (Actor, Activity, Stage) in the spreadsheet related to collected social work actions from the patient record entries.

99 = Missing

98= Absent

Missing Date of Entry (DOE) = 01/01/1900

DOE Recode: 1 = 1947-1957; 2 =1958-1968; 3=1969-1979; 99= No Date (Missing)

Actor Compressed: Social Worker= 1; Medical Staff=2; Administrative Staff =3; Other (neither of the other 3 categories this includes missing or "99") = 4

1. Social Worker = 1
2. Nurse = 2

3. Doctor = 2
4. Clinical Director = 3
5. Superintendent = 3
6. Assistant Superintendent = 3
7. Psychologist = 4
8. Other = 4

Age Recoded: 15-33 = 1; 34-52 = 2; 53-71 = 3; 72-90 =4; missing = 99

Appendix C

Terms of Reference

Absent Files: Patient records that met inclusion criteria and are part of the study but did not have any patient entries for qualitative analysis (i.e. no documentation of social work actions on file)

Codes: The 15 Social work action codes identified in the Methods chapter that are used to analyze the patient record entries

Doctor: Interchangeable with Physician

Front-line Social Worker: Any social worker not identified as supervisory in function (i.e. no title identifying administrative responsibility)

Patient: used to designate individuals treated at SMHC

Patient Record Entry: verbatim selections from the patient record that illustrate a social work action, sometimes more than one action performed

Physician: Any staff with a Doctor designation (as the term psychiatrist was not encountered as a designation, this assumption is not made).

Sample: the actual number of patient records selected and meeting inclusion criteria

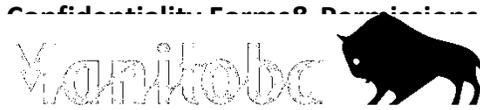
SMHC: Selkirk Mental Health Centre. This term is used throughout the period of study for consistency even though the institution went through name changes, finally resulting in the use of this name

Social Work Supervisor: Any social worker identifying in job title as having a supervisory function (e.g. Supervisor, Chief Social Worker)

Provincial Policy & Programs

Appendix D

Confidentiality Agreements & Permissions



Health

June 10, 2013

Selkirk Mental Health Centre

P.O. Box 9600, 825 Manitoba Avenue

Selkirk, MB CANADA R1A 2B5

Mr. Alexander Sawatsky, MSW, RSW, PhD Candidate
306 Washington Avenue
Winnipeg MB R2K 1L6

E-Mail : Alexander_Sawatsky@BoothUC.ca

Dear Mr. Sawatsky:

Re: Research Study Request – Selkirk Mental Health Centre

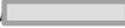
The Selkirk Mental Health Centre Research Team and Research Ethics Team has reviewed your request. We are pleased to confirm that your request was approved by Management Team on June 10, 2013.

Respectfully,



Chair
Research Team
Selkirk Mental Health Centre

Confidentiality Agreement

I,  do hereby agree to not disclose any and all identifying information I am privy to in the course of reviewing edited patient file samples from Selkirk Mental Health Centre (SMHC) for the purpose of the doctoral research entitled: "The evolution of social work mental health practice: Patient records research at Selkirk Mental Health Centre (SMHC), 1947-1980" by Alexander Sawatsky, MSW, RSW, PhD Cand. By signing this confidentiality agreement, I acknowledge that I am reviewing quotes taken from patient files where efforts have been made to remove all identifying information for the purpose of strengthening the reliability of the study.

Signed,



Date: 11 August 2014

SELKIRK MENTAL HEALTH CENTRE

Pledge of Confidentiality

As an employee or associate of the Selkirk Mental Health Centre (SMHC), I understand:

- that all patient information is private and confidential.
- the policies relating to the use, collection, disclosure, storage and destruction of patient information and how to locate them.
- that unauthorized use or disclosure of such information **may** result in a disciplinary action up to and including termination of employment/association, the imposition of fines pursuant to *The Mental Health Act* and *The Personal Health Information Act*, and a report to my professional regulatory body.

I hereby agree, pledge and undertake that I will not at any time, during or after my employment or association with SMHC, access or use patient information, reveal or disclose to any persons within or outside SMHC, any patient information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and the SMHC's policies governing the release of patient information.



Signature of individual making pledge
I have been informed of and understand the contents of SMHC's policies with respect to confidentiality and security of patient information and the consequences of a breach.

Alex Sawatsky

Name of individual making pledge (Print)

17/06/2013

Date signed

SMHC Employee (Staff ID #) _____

Student (List name of Education Program and Facility) *The evolution of social work in the field of mental*

Researcher (List Name of Research Project) *health practice: Patient records research at Selkirk Mental Health Centre (SMHC), 1947-1980*

Other (Please specify) _____



Signature of individual administering pledge
I have discussed the contents of the SMHC's policies with respect to confidentiality and security of patient information and the consequences of a breach with the above-named employee/associate.

17 Jun 2013

Date signed

Appendix E

Descriptive Statistics

Figure 1: LOS for Files Absent of Patient Record Entries

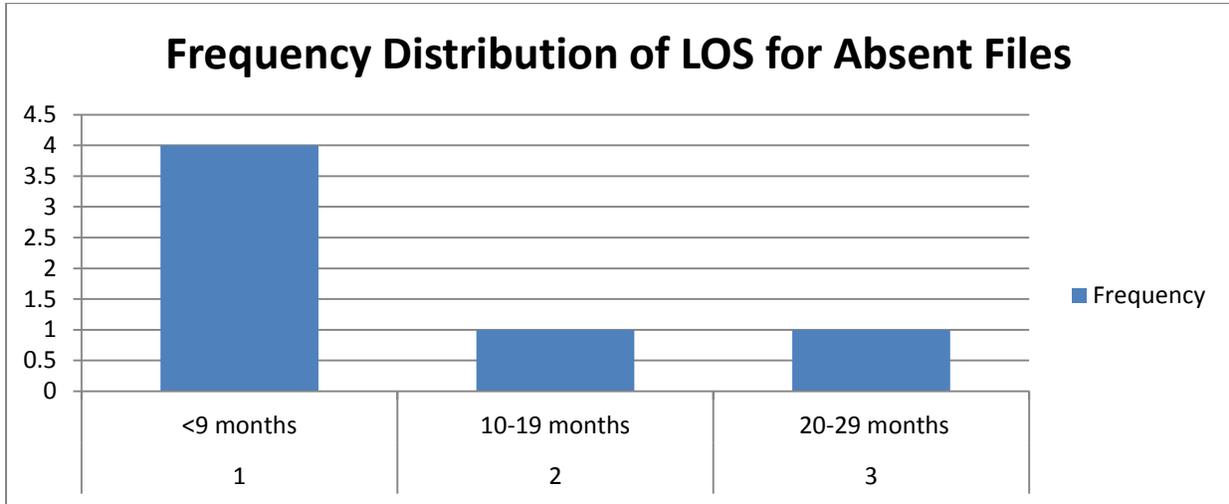


Figure 2: Admission Dates for Files Absent of Patient Record Entries

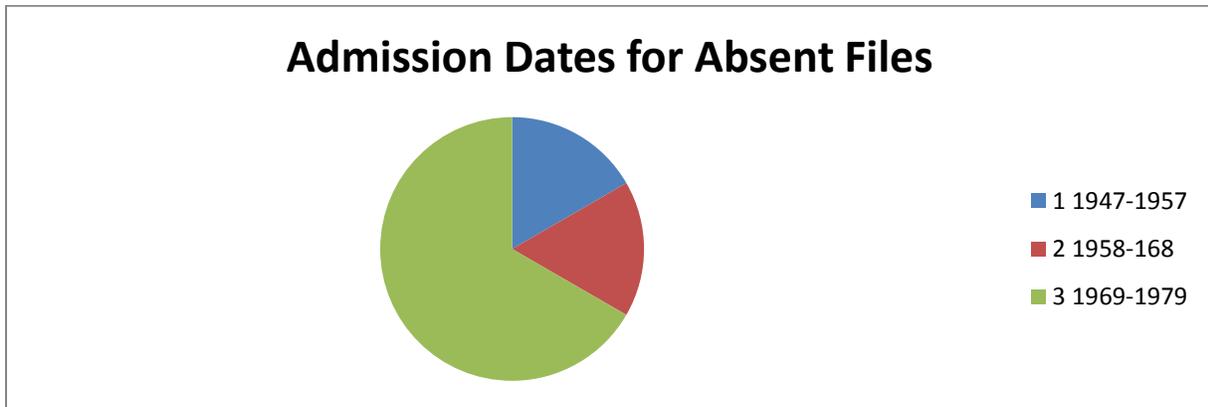


Table 2: Admissions by Season for Files Absent of Social Work Related Patient Record Entries

Season Values	Labels	Frequency
1	January –March	0
2	April-June	2
3	July – September	3
4	October – December	1

Figure3: Date of Sample Entry by Treatment Intervention Stage Decade 1

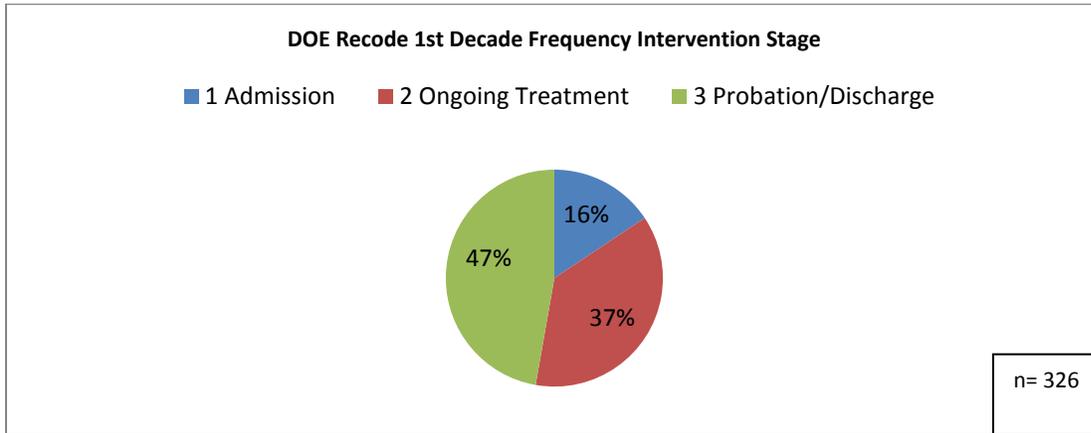


Figure 4: Date of Sample Entry by Treatment Intervention Stage Decade 2

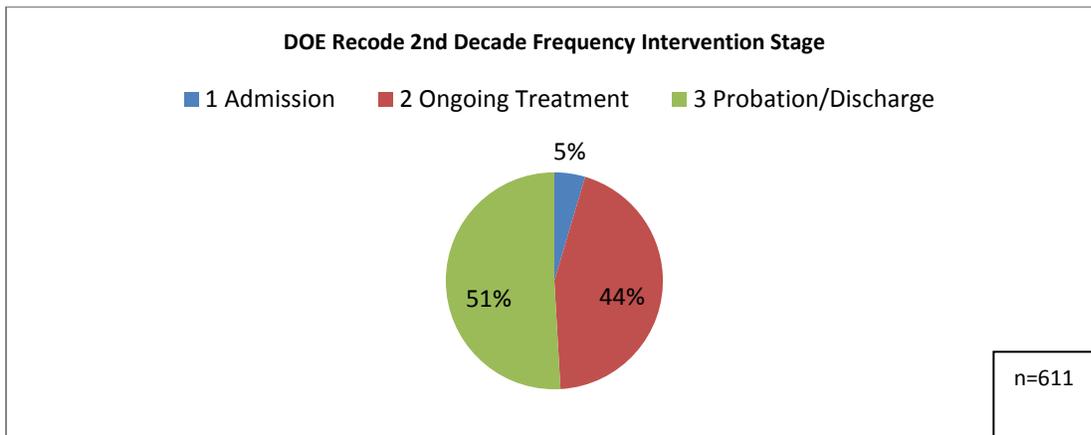


Figure 5: Date of Sample Entry by Treatment Intervention Stage Decade 3

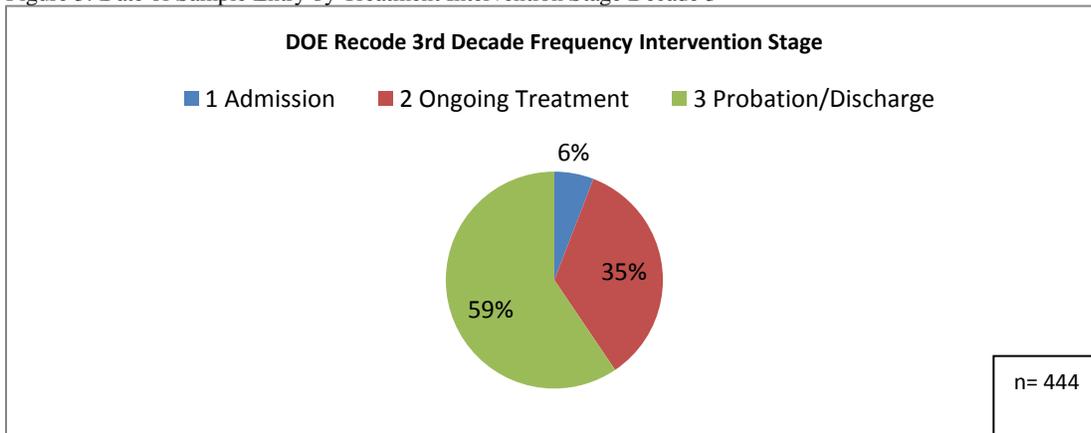


Table 2: Social Work Action by Actor

SW Codes	Actors							Grand Total
	Social Worker	Nurse	Doctor	Clinical Director	Superintendent	Assistant Superintendent	Other	
Advocacy	27		5	1	6	1	1	41
Education	20	3	27		5	1		56
Housing	83	1	23		4	1	1	113
Linking	26		6				1	33
Referral	15		8				1	24
Working with Family	59	1	73	1	93	9	4	240
Assessment	30	1	50		1		5	87
Case Management	158	1	89	2	59	19	6	334
Employment	46		40	2	1		1	90
Collateral	13		30		1		1	45
Crisis Intervention	6	3	1					10
Counselling	13	5	10					28
Benefits	49		6		11			66
Monitoring	143	11	44					198
Consultation	26	1						27
Grand Total	714	27	412	6	181	31	21	1392

Table 3: Social Work Codes by Diagnosis

Row: SW Codes	Column: Diagnosis						
	Thought Disorder	Mood Disorder	Addictions	d/t medical condition	Personality Disorder	Other	Grand Total
Advocacy	18	12	1	6	3	1	41
Education	24	13	2	12	4	2	57
Housing	46	28	4	24	11	1	114
Linking	25		1	6		1	33
Referral	8	5	5	1	5		24
Working with Family	115	41	12	48	15	9	240
Assessment	36	14	15	12	7	7	91
Case Management	167	62	29	52	18	10	338
Employment	38	19	6	15	10	4	92
Collateral	18	7	7	7	4	2	45
Crisis Intervention	2	1		7			10
Counselling	7	3	7	8	3		28
Benefits	41	5	3	8	10	1	68
Monitoring	91	25	7	57	8	12	200
Consultation	12	5	3	6	1		27
Grand Total	648	240	102	269	99	50	1408

Table 4: LOS 18 - 23 Months

4: LOS = 18 - 23 Months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	
Social Work Codes	67	91	42	200
Advocacy	2	3		5
Education	2	5	1	8
Housing	5	6	5	16
Linking	4	2		6
Referral		2		2
Working with Family	13	15	8	36
Assessment	2	4	1	7
Case Management	12	19	8	39
Employment	5	3	1	9
Collateral	3	3	1	7
Crisis Intervention	1	2	3	6
Counselling	2		4	6
Benefits		3	2	5
Monitoring	15	22	7	44
Consultation	1	2	1	4
Grand Total	67	91	42	200

Table 5: LOS 24 - 29 Months

5: LOS = 24 - 29 Months				
Date of Entry by Decade	1947-1957	1958-1968	1969-1979	Grand Total
Social Work Codes	8	38	20	66
Advocacy		2	1	3
Education			1	1
Housing		4	1	5
Linking		1	3	4
Referral		1		1
Working with Family	4	6	3	13
Assessment	1	3		4
Case Management	2	12	10	24
Employment		2		2
Collateral		1		1
Counselling	1			1
Monitoring		6	1	7
Grand Total	8	38	20	66

Table 6: LOS by Actor

Actor by LOS							
LOS by 5 Months							Total
Actor	1-5 Months	6-11 Months	12-17 Months	18-23 Months	24-29 Months	30 Months & Beyond	
Social Worker	188	141	88	90	41	166	714
Nurse	8	6	2	9		2	27
Doctor	122	74	43	75	14	84	412
Clinical Director	1					5	6
Superintendent	58	34	5	18	11	55	181
Assistant Superintendent	3	2	14	1		11	31
Other	7	4		6		4	21
Grand Total	387	261	152	199	66	327	1392

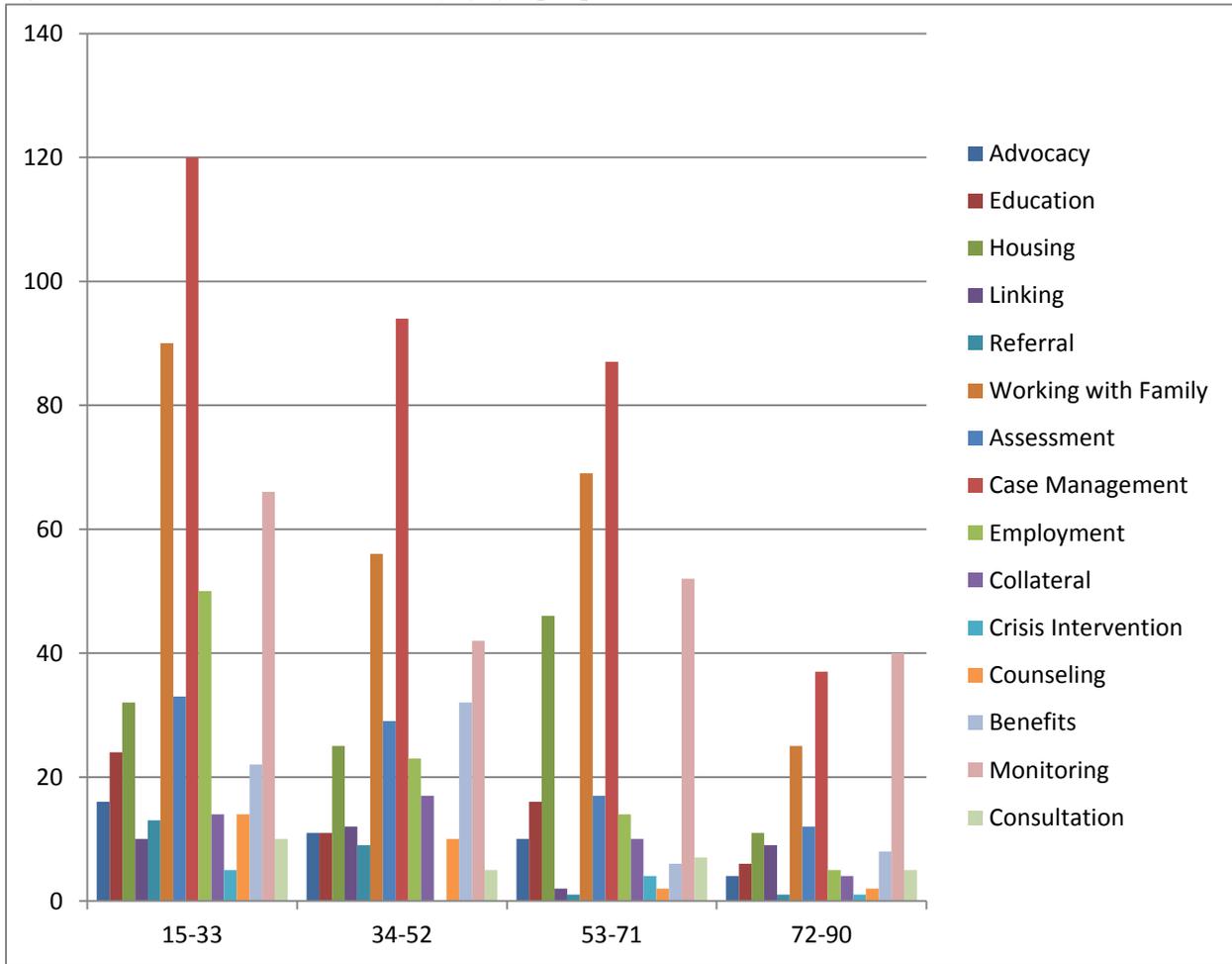
Table7: Social Work Action by Doctor and LOS

Doctor							
LOS (in Months)	1-5	6-11	12-17	18-23	24-29	30 and over	Total
SW Actions	122	74	43	75	14	84	412
Advocacy	2		1	1		1	5
Education	5	3	4	6		9	27
Housing	5	5	2	4	2	5	23
Linking	1		2	3			6
Referral	5		1	1		1	8
Working with Family	9	18	5	16	1	24	73
Assessment	18	13	6	4	2	7	50
Case Management	31	11	8	15	6	18	89
Employment	19	1	4	5	2	9	40
Collateral	8	10	3	6		3	30
Crisis Intervention				1			1
Counselling	5	2		2		1	10
Benefits	2	2		1		1	6
Monitoring	12	9	7	10	1	5	44
Grand Total	122	74	43	75	14	84	412

Table 8: Social Work Action by Superintendent and LOS

Superintendent							
LOS (in Months)	1-5	6-11	12-17	18-23	24-29	30 and over	Total
SW Actions	58	34	5	18	11	55	181
Advocacy	2	1		1	1	1	6
Education	2					3	5
Housing	2	1		1			4
Working with Family	30	17	5	8	7	26	93
Assessment	1						1
Case Management	16	15		8	3	17	59
Education	1						1
Collateral	1						1
Benefits	3					8	11
Grand Total	58	34	5	18	11	55	181

Figure 6: Distribution of Social work action by age group of patient



Appendix F

Lists of tasks performed by mental health social workers

From: Long, D. (2004). Introduction to social welfare. In A. Sallee (Ed.), *Social work and social welfare: An introduction* (pp. 1-23). IA: Peosta: Eddie Bowers Publishing Co, Inc.

1. Therapy
2. Psych Rehab services
3. Psychosocial Assessments
4. Working with families
5. Linkage with community mental health services
6. Discharge Planning

From: O'Brien, A., & Calderwood, K. (2010, 16/06). Living in the shadows: A Canadian experience of mental health social work. *Social Work in Mental Health*, 8(4), 319-335.

1. Assessment & Referrals
2. Supportive Counselling
3. Crisis Interventions
4. Psychotherapy
5. Advocacy
6. Case management
7. Education
8. Discharge Planning
9. Addiction Counselling
10. Outreach
11. Administration
12. Research
13. Teaching Activities of Daily Living

From: Regehr, C., & Glancy, G. (2010). *Mental health social work practice in Canada*. Ont: Don Mills: Oxford University Press.

1. Psychosocial assessment
2. Counselling and psychotherapy (From a social work perspective)
3. Psycho-education
4. Case management
5. Consultation
6. Supervisor
7. Advocacy
8. Teaching

