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A Social Rehabilitation Program Implementation and Analysis: A Demonstration-Experimental Proposal

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A SOCIAL REHABILITATION PROGRAM IMPLEMENTATION AND ANALYSIS (A DEMONSTRATION-EXPERIMENTAL PROPOSAL)

A RESEARCH ESSAY

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by

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OUTLINE

I

INTRODUCTION

A brief historical background to this research proposal is necessary for the reader in order to place the problem to be dealt with in proper perspective. The intent of this proposal is to institute a social rehabilitation program on a ward of approximately 45-50 patients and then to assess and analyze the results of the program. Evaluation is to be undertaken through the utilization of a control group of approximately the same size, composition, and general philosophy located within the same hospital.

To describe hospital culture and the general orientation to treatment it would be safe to say that the overall approach is custodial, by which I mean that the patients receive a modicum of care, that is, the basic essentials are provided for them. Active treatment consists of chemotherapy, limited Occupational Therapy and Industrial Therapy, both of which are extremely restricted due to the physical plant. There is no individual or group therapy offered by and of the Psychiatrists or members of the para-medical team.

Patients upon admission are indoctrinated into the hospital and ward culture which emphasizes conformity to the rules, regulations and routines all of which diminish patient responsibility and negate individuality. Conformity to routines are rewarded whereas individuality evokes negative reinforcement. Patients are not encouraged to utilize initiative and the longer the length of hospitalization the more severe are the results of depersonalization and institutionalization. It is to counteract

these informal practices and to promote individuality that this social rehabilitation program is intended.

My interest in active patient treatment resulted from my work experience in this hospital and the sense of frustration that I felt for the patients, both in the hospital and when they returned to the community. A basic assumption of this paper is that the custodial hospital culture is anethema to patient reintegration back into the community. No period of gradual transition is provided to counteract the difficulties that patients must face in changing from a subservient to an individualistic culture. This area can be described under role theory, for it is the individual that is most affected by the system. The patient role in the hospital is one of dependency and passivity. He is expected to abide by the routines by which the wards operate and staff expectations for patient behaviour mesh with this routine approach. Everything in the ward is done for the patient and job assignments, whether they be ward house-cleaning, kitchen or laundry work, are all geared to the smooth operation of the total hospital as a custodial system.

In designing a research proposal for such a hospital, three important issues must be addressed as the effects of the program have ramifications that radiate throughout the hospital structure. The three issues, in the order of the manner they will be outlined, are operational problems, administrative problems, and finally methodological issues.

II

OPERATIONAL PROBLEMS

Operational problems can be approached from two interrelated perspectives - the overall hospital structure as it now exists, and the ward structure as a result of the proposed changes.

> In a system in equilibrium, the needs of the interacting persons are satisfied and mesh with the requirements of the system. This intermeshing results from persons in the system sharing certain common social norms which define their respective roles and obligations... Individuals usually tend to have vested interests in the status quo which helps them maintain the gratifications involved in an established system of role-expectations. Any attempt to introduce change is a threat to these vested interests and will meet with resistances.[1]

It is this question of resistance that must be addressed before a project is undertaken to increase awareness of possible areas of conflict that may result as the effectiveness of the project is increased if these conflicts are being dealt with while the hospital program is changing. Such an approach makes changes in the system less abrupt and if phased properly the new program offers an alternate medium of treatment that can be instituted at the same time that the existing program is being phased out, thus diminishing the effects of such a change.

To understand the implementation of the proposed research as well as the operational problems, schematic diagrams will be used to outline the present hospital structure as well as the proposed ward structure. The diagrams, although neglecting large segments of the

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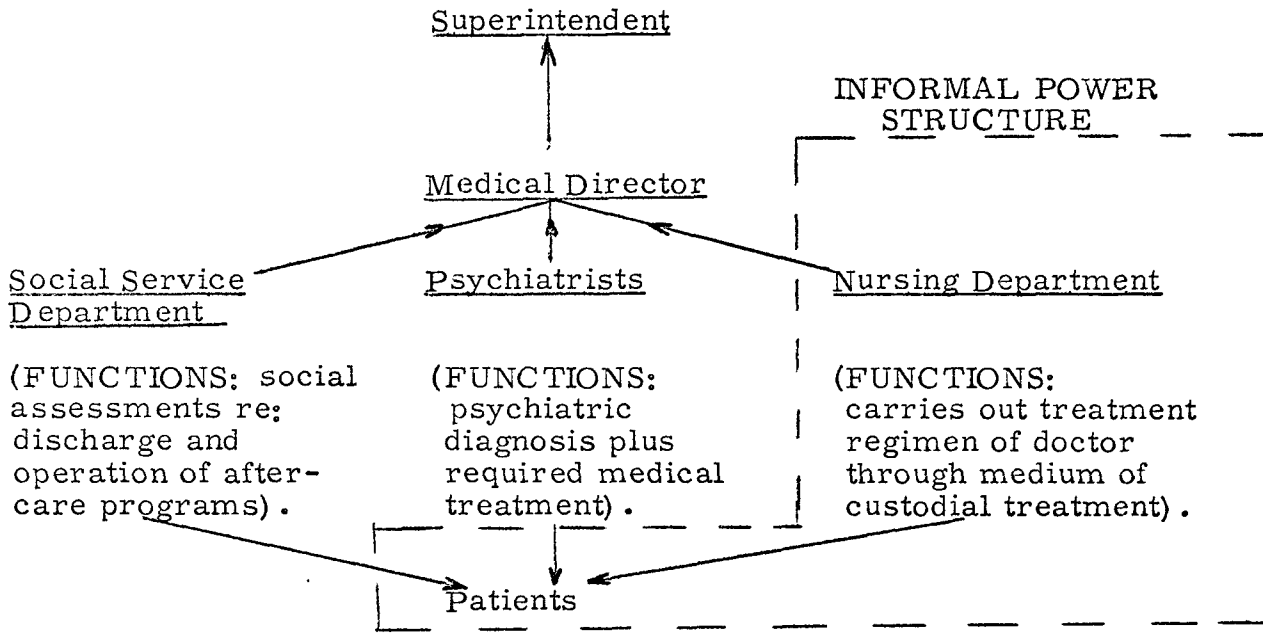
[1]D.B.Kandel & R.H. Williams, Psychiatric Rehabilitation - Some Problems of Research (New York: Prentice-Hall, Inc., 1964), p. 36.

hospital system, will highlight areas of conflict that must be dealt with as they are encountered, and these will be explained as they arise.

DIAGRAM # 1 FORMAL STRUCTURE

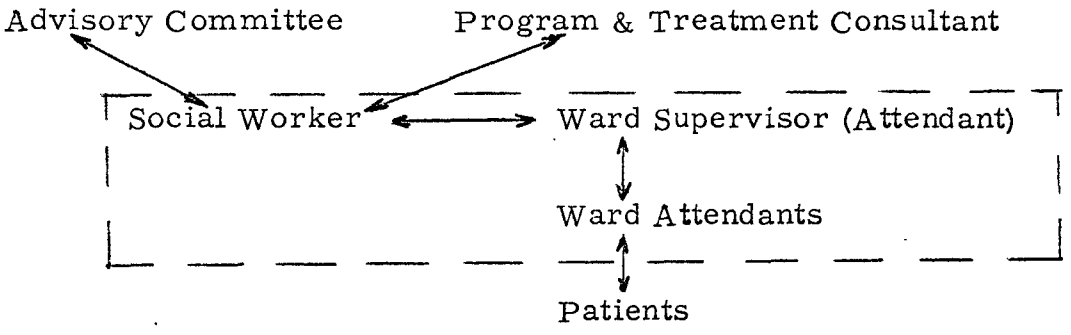


In this diagram the area enclosed by the dotted line indicates the actual system as it exists in this hospital. Nursing Office has the greatest power of any system in the hospital. This department is in 24 hour contact with patients through the ward staff (Aides and Attendants) and because of the power inherent in this department they are in a position either to sabotage or to reinforce any program that attempts to deal directly with patients. In actual practice they are the link between patients and other professional staff, as well as between patients and community, and it is because of this intermediary position that they derive their power. The formal structure, as outlined in the diagram,

places the nursing department in direct contact with patients but because there is no specific treatment program outlined by the psychiatrists that staff are to follow, an informal treatment culture is developed on the individual wards. It is the informal treatment culture that this proposal intends to replace, and at the same time it will involve a redistribution of power from the Nursing Office and the positioning of the proposed ward Social Worker in a buffer position between the ward and Nursing Office. This structure and orientation are outlined in Diagram # 2 and the subsequent philosophy.

DIAGRAM # 2

WARD STRUCTURE (PROPOSED)



Advisory Committee

1. Superintendent
2. Chief Social Worker
3. Director of Nursing

FUNCTIONS: to act as a coordinating body for in-patient services specifically related to operation of the ward and to deal with pending difficulties in the hospital system that arise from the new treatment program.

Program & Treatment Consultant
(Ward Psychiatrist)

FUNCTIONS: to act as consultant to and supervisor of ward Social Worker. Also to work in conjunction with Social Worker and ward staff in individualizing treatment plans within the program.

Treatment Team
consists of:

1. Social Worker
2. Ward Supervisor
3. Attendant Staff

FUNCTIONS: treatment regimen based on William Glasser's Reality Therapy (patients are not "sick," but irresponsible) to be worked out in conjunction with Treatment Team and Program and Treatment Consultant. Each team member, except Social Worker, to be assigned initially as observer to a specific number of patients in order to promote greater understanding and appreciation of patients as individuals. Treatment media to be peer group focused with Social Worker as group leader and assigned staff members as group observer-recorder.

Treatment Goals:

1. to help patients work toward accepting more responsibility, i.e. as individuals they must accept more responsibility

for their own behaviour. Patients to be rated according to "Self Care," "Area Care," "Productivity," and "Considerateness."

2. to work toward elimination of depersonalization and institutionalization.

3. to lessen the existing vertical distinction between staff and patients.

4. to give patients greater voice in ward operations and daily activities (replace assignment with choice).

5. to promote greater patient voice in ward operations.

6. to help orient patients toward potential discharge (make the transition to community less abrupt).

7. to decrease the stigma attached to hospitalization that patients encounter both in hospital and upon return to their communities.

III

THE EXISTING STRUCTURE AS BUREAUCRACY

As indicated in the above diagrams and their explications it is necessary to understand the existing structure as a bureaucracy and to be able to work with and through such a system in order to transform the "ends" of the organization.

> The chief merit of bureaucracy is its technical efficiency, with a premium placed on precision, speed, expert control, continuity, discretion, and optimal returns on input. The structure is one which approaches the complete elimination of personalized relationships and non-rational considerations.[2]

The elimination of personal involvement is important from a management standpoint, as it promotes the overall efficiency of the organization, however, management is divorced from treatment which necessitates involvement, and as a result they tend to deal with patients as statistics or case book numbers, that is, by categorization as they follow standardized procedures.

> This very emphasis leads to a transference of the sentiments from the aims of the organization onto the particular details of behavior required by the rules. Adherence to the rules, originally conceived as a means, becomes transformed into an end-in-itself; there occurs the familiar process of displacement of goals whereby 'an instrumental value becomes a terminal value.'[3]

Because of the objectivity required by the bureaucratic structure the social worker is challenging one of its prime modes of operation when he is

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[2] Robert K. Merton, "Bureaucratic Structure and Personality," edited by Herman D. Stein & Richard A. Gloward, Social Perspectives on Behavior, (New York: The Free Press, 1966), p. 578.

[3] Ibid., p. 580.

attempting to overcome the categorization tendency of management in order to have a patient dealt with as an individual with specific problems that cannot be categorized or pigeon-holed, but must be handled as specific issues.

Turning now from an overview of the hospital to the more specific area of dealing with patients on the wards, the above mentioned difficulties are again encountered in varying degrees. As Goffman states,

> the handling of many human needs by the bureaucratic organization of whole blocks of people - whether or not this is a necessary or effective means of social organization in the circumstances - is the key fact of total institutions...
>
> When people are moved in blocks, they can be supervised by personnel whose chief activity is not guidance or periodic assessment but rather surveillance...[4]

In like manner Vinter writes that:

> to some extent every organization must bring about certain changes in those who participate in it; newcomers must be socialized into appropriate behavior patterns, proper loyalities and attitudes must be enduced, persons must be changed, their attitudes coordinated, and so on.[5]

In this respect, there is great similarity between Goffman's "total institution" and Vinter's "treatment agency" and such organizational patterns are best handled through bureaucratic structures which necessitate categorization if its functions are to be maintained within manageable limits.

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[4]Erving Goffman, Asylums, (New York: Double Day & Company Inc., 1961), p. 6.

[5]Robert D. Vinter, "Analysis of Treatment Organizations," Edited by Edwin J. Thomas, Behavioral Science for Social Workers (New York: The Free Press, 1967), p. 207.

It is in the form of treatment that the professional runs into the barriers erected by such a bureaucratic structure. The social worker's focus on treating each person as a "unique" individual is the antithesis of the tendency toward segregation and categorization that is so prevalent in these settings. By individualizing the client, the social worker is, in actuality, applying a counter-force to the rational impersonal methods of social control in custodial settings.

On the wards the patients are not involved, in any manner, with the treatment plans designed for them by the staff. This is partly due to the public attitude that such persons are not responsible for their behavior, while also to involve a patient in this process would contradict the principle of efficiency since it would overtax a scarce resource, the professional's time.

> The obligation of staff to maintain certain humane standards of treatment for inmates presents problems in itself, but a further set of characteristic problems is found in the constant conflict between humane standards on one hand and institutional efficiency on the other.[6]

In a custodial hospital then the social worker and the bureaucratic structure are at cross purposes. The structure promotes rationality and efficiency whereas the social worker promotes involvement and the maximum of humane treatment. In this type of setting then, the structure is not condusive to the therapeutic involvement as envisaged by the social worker.

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[6]Goffman, p. 78.

As implied earlier in this paper, it was because of the frustration involved in working within such a system that this writer was spurred to appraise the situation in a more objective fashion. Comparative studies conducted in other institutions showed that it was not an impossible situation.

> In social work, virtually all professional work is done in and through a welfare organization and these agencies have rules by which the services are provided. Moreover, a social agency is itself typically a large organization, part of an extended, complex, organization system.[7]

A knowledge of bureaucracy is thus essential for all practitioners, because of the extent that social work falls under bureaucratic jurisdiction, and if the social worker is to utilize fully the services available for his client.

The formal structure of the hospital as well as the informal structure that developed to carry out hospital objectives, once understood, have helped to point the way for innovation and structural changes. Since social work draws heavily upon sociological theory and research and, in this instance, especially systems theory this writer was able to utilize sociological studies done on mental hospitals to point out operational and methodological problems that must be addressed if one is to make changes in the existing structure.

Background reading for this paper has drawn heavily on both systems theory and role theory, both of which are compatible when

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[7]Edwin, J. Thomas, Behavioral Science for Social Workers, (New York: The Free Press, 1967), p. 189.

working in a large psychiatric setting. Systems theory emphasizes the interrelatedness of the various parts of the total structure, and the structure combined with its operational philosophy determines the role relationships of all persons within the system, whether employees or patients. "Rational - legal authority has its source in role specifications. It is a rational authority legitimized by the rules governing admission to roles."[8] These two theories must be addressed by the researcher when introducing a new program as the setting can determine the reaction to the program. One must be prepared to deal with the structured and individual reactions to change that accompany innovation whose effects radiate throughout the total system.

Social work as a form of therapy emphasizes individualization and to make it a functional profession in an in-patient facility, as outlined above, some structural changes in the system must be attempted. These changes must be tailored to the specific program, in order to be relevant and, in this instance, the changes can be included under lines of accountability as seen from the perspective of a single ward. It is in making these changes in the structure for the benefit of patients that this paper is addressed. At the time that such changes are being made the transition is to be a gradual one that, while phasing out the existing structure, offers a replacement in order to minimize disequilibrium.

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[8]John Cumming & Elaine Cumming, Ego and Milieu, (New York: Atherton Press, 1967), p. 109.

IV

REVIEW OF EXISTING LITERATURE

A base line that is evident in reviewing the literature, is the concept of moral treatment as espoused and practiced by Phillipe Pinel in France during the 19th century. He was instrumental in removing the shackles and chains from patients since he felt that when,

> treated with dignity, humanity and understanding, they responded in a more socially acceptable manner. Conversation, reading aloud, games and useful and interesting activities of all kinds were shown to have benificial effects. This type of program was called 'moral treatment.' It resembled in many ways the programs now used in most mental hospitals - milieu theory, remotivation therapy, activity programs.[9]

Herein lies the confusion when reading the literature since different terminology is used in describing the form of treatment that takes place on a ward through the medium of peer group interaction. Such names as milieu therapy, psychiatric rehabilitation and therapeutic community are used and, in essence, their philosophies are similar since all activity is utilized that is felt to be therapeutically affective in working toward relieving symptomatology and reintegrating the patient back into the community. However, each author has his own interpretation of the form of treatment that he employs - some emphasize social rehabilitation whereas others state that insight therapy is the form of treatment. Therefore, the specific forms of treatment are disguised under names like

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[9]More for the Mind, The Canadian Mental Health Association, (Toronto: 1963), p. 2.

therapeutic-milieu, which is becoming a household word with as many interpretations as there are authors writing about it.

The emphasis is however on utilizing the hospital environment with the patients as therapists in the sense that they set limits for behaviour and support the efforts of their peers. Staff in such an on-going program act as supplementary therapists to the patients and throughout the program the emphasis is placed on the individual to accept increased responsibility for his behaviour and actions, oriented toward his discharge and return to his community.

The treatment focus for these programs can be plotted on a continuum at one extreme of which behaviour and symptoms are explained in psychodynamic terms with the emphasis based on the development of insight, while at the other extreme, role theory is used to explain behaviour and the therapeutic emphasis is placed on socialization through teaching the patient more appropriate roles, that is, roles that are more appropriate to the outside world. Depending on the degree of sophistication the literature indicates that all programs could be placed somewhere on this continuum.

Milieu type treatment can be either the prime mode of therapy or it can be used as an adjunct to individual psychotherapy. Most of the literature reviewed however, placed it as the prime mode since there is a scarcity of professionals in the field that restrict the use of individual psychotherapy. Mulieu programs can be adjusted to the individual setting and can utilize the therapeutic potential of all available staff in the hospital

from the psychiatrists to the floor cleaners.

A recurrent theme in the literature on treatment points out that there are very restricting limitations and inadequencies in theory and knowledge related both to the etiology of mental disorders as well as the effectiveness of different treatment modalities for psychiatric disorders. In this light more sense can be made of the fact that different milieu programs overlap and yet are individualized to their specific setting. No single theory and treatment program is offered for psychiatric settings. Therefore, because of the confusion, programs are tailored for the individual hospital and are influenced by the capital and, staff available for the program. The orientation of the hospital is also important since it reflects the community values regarding mental disorders, which determines whether the hospital is custodial or treatment oriented, as well as how patients are accepted by the community.

A serious drawback to milieu treatment is the fact that no universally accepted scales have been established for rating the effectiveness of such treatment programs. It is continually pointed out that increased patient exposure to staff may have a strong influence on the remission of symptoms and therefore improved behaviour may not be a direct result of the treatment program.

Another theme is the fact that public attitudes toward mental illness restrict financial support for health programs and thus limit the funds available for research into both etiology and treatment. Several research studies have had their programs altered because of the split between

research and practice, that is the hospitals emphasized treatment to the detriment of research.

There are numerous publications that have expanded on the understanding of mental hospitals as social systems however, these studies emphasize systems and neglect treatment. One major attempt to link systems and treatment is outlined in the Cummings book, Ego and Milieu, in which they define milieu therapy as "a scientific management of the environment aimed at producing changes in the personality of the patient."[10] Their theory includes social structure, culture and personality.

> Many of the new approaches are experimental insofar as no scientific proof of their effect on the recovery rate goes but there can be little doubt that all are consistent with moral and social values and therefore worthwhile in improving the human condition of the patients.[11]

From this standpoint more research is required in the mental health field to evaluate treatment and maximize the funds that are available for treatment. Chronic staff shortages, in all probability, will continue and therefore treatment must be geared to full utilization of available staff.

In summary, although there have been many studies done on milieu treatment, more are required and of a type that involves rigorous controls in order that such studies can be made applicable to other settings and it is hoped that the following research proposal will be one that can be

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[10]Cummings, p. 5.

[11]Action for Mental Health, Joint Commission on Mental Illness and Health, (New York: Basic Books, 1961), p. 178.

generalized. This proposal although drawing heavily on sociological theory and various milieu programs is unique in that initially it is being geared to one specific setting, and is being directed by a social worker, whereas most of the programs reviewed were led by psychiatrists, psychologists or research personnel. This project will utilize existing personnel and will not involve any substantial capital outlay and will focus on both treatment and research.

IV

ADMINISTRATIVE PROBLEMS

If change in the administrative hierarchy is a necessity for the ward to have the flexibility required for the operation of a social rehabilitation program, then certain conditions must be accepted.

> Adequate structuring ensures that one of the two prerequisites of a stable social system is fulfilled: namely, that individuals in the system share a set of well-defined norms about the behavior that is expected of them. Several mechanisms promote these goals: 1. specification of the roles of individuals participating in the project; 2. specification of the goals of the program and the values on which it is based; 3. better communication and; 4. a more adequate authority structure.[12]

The other prerequisite requires that individuals be adequately motivated to serve in the project and are in agreement with its goals and values.

In order for the above conditions to be met, in the writer's opinion, a form of administrative structure is required that sets the particular ward up as a semi-autonomous unit within the hospital system, but which nevertheless must abide by the general rules and regulations in operation for the entire hospital. Decentralized administration, that is administration of the ward on the ward, would comply with the rules governing the total system, but would guarantee the necessary flexibility that is required for the program. Within the administrative structure, as it exists, one change must be made and that change places the social worker

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[12]Kandel O. Williams, p. 69.

in charge of the ward in a buffer position between the ward and the rest of the administration, and he would be in a position to mediate with the various departments and services that affect the ward. He would act as a funnel for communication, and would be responsible for the implementation of policies on the ward, and would have recourse to the Advisory Committee in situations that required further clarification or alteration.

On the ward itself, he would have total administrative authority, legitimized by the appropriate hospital administration to implement the program, and the phasing of the program, as deemed appropriate. All personnel on the ward would be responsible to the ward social worker and would be on loan from the appropriate department, e.g. attendant staff from Nursing Department, for the specific project, unless other arrangements could be made. This would negate the effects of dual lines of authority and accountability.

In-service training would play an integral part in the program and would be considered as Phase I of the operation. The philosophy and goals would include the following and would be expanded as required.

> ...increased interaction, particularly between staff and patients, which is often directed to opening previously blocked channels of communication; democratic insistence on giving a greater voice in decisions to those traditionally of low status in the hospital, including the patients; emphasis on groups rather than individuals, as the focus of study and action; and, finally, an associated atmosphere of movement, excitement and reform.[13]

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[13]M.S.Schwartz & C.G.Schwartz, Social Approaches to Mental Patient Care, (New York: Columbia University Press, 1964), p. 182.

This program would be geared toward achieving a commitment of the staff as a team, to decrease the hierarchical distinction between patients and staff, to gain commitment of the staff to the project, to clarify roles and expectations of individual members with emphasis on colleague relationships among staff. Under role clarification, I have included the following job analyses for staff, as guidelines that can later be refined into job descriptions. In-service training would be carried out in weekly staff meetings with more or less sessions scheduled as felt to be beneficial.

Social Worker

1. to act as Ward Manager and in such capacity submit progress reports on ward operations in writing to departments and offices in contact with the ward;
2. to be supervised by Program and Treatment Consultant (Psychiatrist);
3. to coordinate and initiate ward programming and to be instrumental in expanding hospital services for benefits of patients on the ward;
4. to conduct weekly staff meetings and to supervise staff, primarily through a group focus and secondarily on an individual basis;
5. to promote awareness of proposed ward philosophy through in-service training programs for staff, as required;
6. to act as group worker in charge of patient group sessions (weekly or as scheduled);
7. to coordinate statistical records for total patient population;
8. to consult with Advisory Committee in relation to systems problems and in planning expansion to make all hospital facilities available

to patients;

9. to be responsible for assessing effectiveness of the social rehabilitation program;

10. to be responsible for initiating phasing operations of the program;

11. to act as "buffer" between ward and other departments and personnel in hospital;

12. to assess staff members' (attendants) suitability for the program and to have option of choosing staff if necessary;

13. to be responsible for overall administration of rating scales except where authority to do so is delegated to others (attendants and patients).

Attendant Staff

1. permanent assignment to ward (no rotation to other wards) unless transfer is requested by attendant or Social Worker. Transfer to be discussed between Social Worker and attendant to determine reasons thereof and the effect of such change on the individual, the ward and his assigned patient group;

2. must attend weekly staff meetings to discuss ward operation, areas of difficulty in working with patients, requested program changes for patient groups, and to promote an awareness of the philosophy of the particular ward and its benefits to patients, staff and the entire hospital;

3. each member of attendant staff assigned initially as observer to a specific number of patients (8-10);

4. attends patient group sessions weekly, or as scheduled, as observer-recorder and submits written record of meeting to Social Worker in advance of staff meeting;
5. to be supervised by ward Social Worker (minimal individual supervision except as required; emphasis on supervision in staff meetings);
6. to offer suggestion and support to patient's initiative with emphasis on patients acquiring more responsibility as determined by treatment regimen;
7. to acquire familiarity with proposed rating scales and their administration;
8. to keep up-to-date statistical records on patient's progress as determined by rating scales;
9. to encourage patient activities and contacts outside of hospital;
10. to cooperate in submitting required reports to Nursing Office.

Psychiatric Consultant

1. to act as consultant to and supervisor of ward Social Worker;
2. to work out treatment programs for patients in conjunction with Social Worker and ward staff (Treatment Team);
3. to focus treatment program on patient peer group interaction;
4. to be available for staff meetings, as required, for rating of patient progress and subsequently to revise treatment plans;
5. to alter medication perscriptions as requested and agreed upon by staff and patients.

Area Supervisor (Nursing Office)

At present this position entails supervision of four male wards and is a form of liason between Nursing Office and these wards. This individual is responsible for overseeing all medical treatment that requires nursing procedures. The following will serve as guidelines for this position in relation to the social rehabilitation ward:

1. to have minimal authority on ward, limited to situations requiring nursing care and procedures;
2. to be integrated into ward activities on a colleague basis wherever possible (e.g. ward staff meetings, in-service training);
3. to consult with Social Worker as required in relation to the specific ward and its operation, programming, etc.

Since heavy emphasis would be placed on role theory in relation to both patients and staff several staff sessions would deal exclusively with role theory, group interaction and analysis as well as theoretical understanding of the rating scales to be used in assessing change, so that communication between staff members would not be hampered by technical misunderstanding. Staff must become familiar with the theory involved and its application in order to increase the flow of communication.

Phase II of the program would commence at the point where staff felt comfortable with the theory and philosophy of the program and were able to apply the rating scale accurately. This phase could consist of the resocialization of patients through peer interaction. Emphasis would be on the small patient groups.

> The type of programs that are oriented toward changing the patient's role share an assumption that the most significant sociocultural differences between the hospital and the community lie in the withdrawal from the patient of the normal rights and obligations of adults. All of the programs attempt in some measure to give responsibility back to the patient.[14]

Patients will be given scaled responsibility and privileges in accordance with their degree of disability and will be expected to assume more direction in solving their own problems and setting up their own programs, but will not be involved in deciding hospital policy which is strictly an administrative function. Patients will be expected to assume leadership roles for their groups on a rotation basis. The program "defines the patient as actor, initiator, cooperator, and manager of his own affairs and everyone else as assistants in this process."[15] Every task that can be organized and performed by patients should be considered for allocation to them - this is the grist for the mill of problem solution. Only when patients must seek help in planning or facilitating should they turn to the (staff member).[16]

Phases III and IV would consist of establishing representative small groups composed of one member from each group and it would function as an interim patient government and the last phase would begin with the establishment of patient government for the ward.

The object of group life is that it is felt to be the most appropriate

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[14] Ibid., p. 148.

[15] Cummings, p. 139.

[16] Ibid., P. 137.

medium for patient resocialization and affords individuals the opportunity to test themselves in various roles and situations while at the same time group culture sets limits on deviant behaviour and supports the patients in their efforts.

> An ego-damaged paitnet is in a sense deculturated; the goal is to bring him back into sufficient relationship with social life to allow him to work at his own unique compromises between individuality and conformity. The restoration of acceptable behavior is particularly import- and for a mentally ill patient because it helps to restore to him the label 'normal' that leads to social acceptability.[17]

This in effect is the purpose of the program, to restore the patient to a level of social functioning that is either more self-gratifying to the patient if he remains under the hospital's control or to return to his community as a more productive member of society with the ability to function in several roles.

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[17] Ibid., pages 180-1.

VI

RESEARCH DESIGN

This research proposal is to follow the design of a Demonstration Experimental Study. Its intent is to study the effectiveness of a social rehabilitation program under controlled conditions and to be used as a means of deriving further hypotheses related to treatment that could either be integrated into this program or in separate programs at a later date. It is experimental in that it is designed to test the effectiveness of services and through the analysis of the results lead to the refinement of theory related to services for mentally ill patients in psychiatric hospitals. "The very word 'demonstration' suggests a research study in which one objective is to influence others by showing that something can be done."[18] Its intent is to influence system changes congruent with the philosophy and aims of the program as well as to influence changes indirectly in the hospital philosophy and objectives, that is from being a custodial to a therapeutic institution. The changes in the system however, will not be measured empirically but are hoped for results of the study.

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[18]Edwin J. Thomas, "Field Experiments and Demonstrations," Edited by Norman A. Polansky, Social Work Research, (Chicago: University of Chicago Press, 1967), p. 291.

VII

RESEARCH METHODOLOGY

Theoretical Hypothesis: The social rehabilitation program results in improved social functioning within the hospital and facilitates better preparation for adjustment into the community than has previously existed.

Independent Variable: The social rehabilitation program.

Dependent Variables: 1. Improved social functioning within the hospital;
2. facilitates better preparation for adjustment into the community than has previously existed.

Explication of Terms

Social Rehabilitation: is a form of teritary prevention in that its focus is on the reduction of the prevalence of disabilities, in this instance, antisocial behaviour that arise from mental illness. As a therapy it is concerned with assisting the patient to achieve an optimal role compatable with his capacity and potentialities. In this program rehabilitation is focused on the patient's social functioning within the hospital although in most studies the in-hospital rehabilitation is linked with post-hospital rehabilitation. An assumption of this program is that if patients are assisted through peer group interaction within the hospital that they will be able to expand this level of functioning upon returning to the community even where post-hospital facilities are lacking or non-existent. A further assumption is that social isolation is a strong contributor in the etiology of mental illness and that this illness can be seen as a denial by the patient of the reality of the world around him (Glasser) which can be counteracted by social interaction. Peer group activities are to be the medium of

treatment through which teaching the patient to share responsibility for his own management and finally to assume this responsibility is to be an integral part of ward life. The stress on interaction is intended to counteract institutionalization and disocialization which is engendered by forced passivity and dependency in custodial hospitals. Patient opportunity is to be provided within the hospital structure for work and constructive activity that approximate as far as possible normal living and social performance consistent with the patient's background, interest and potential.

Improved Social Functioning: the empirical referents for this variable include increased capacity for self-direction, the assumption of responsibility for his own behaviour, increased interaction on a social level with others, increased acceptance and respect for others as individuals all of which can be empirically measured by the Behavior Rating Scales*.

Better Preparation for Adjustment into the Community Than Has Previously Existed.

The present intent is to utilize limited indices in determining the effects of the program on this variable. The actual preparation for return to community can be determined by interviewing staff on the control ward as to the type of preparation they feel that patients have received from them as well as the number and type of contacts that patients have had

*Developed at the Veterans Administration Hospital, Palo Alto, California - summarized in an article that appeared in Psychiatric Quarterly, Volume 41, 1968, pages 46-55.

with both the Social Service and Vocational Rehabilitation Departments. This information could then be cross-indexed with similar categories from the experimental ward.

The rating scales would be administered on both wards just prior to discharge giving a composite score. This score would then be correlated with the length of stay in the community (before re-admission to like facilities) in order to determine an index of adjustment into community life.

The indices outlined preclude other than limited follow-up upon the patient's return to community. It is felt that although these indices are limited, that they will give a farily accurate picture of re-adjustment. However, other determinants could be included, such as an additional Community Social Adjustment Scale, to be administered approximately six months after discharge. This second scale could be the focus of an interrelated research study.

Assumptions.

Several explicit assumptions have been stated earlier in this paper, and will not be repeated in this section which will supplement those already listed.

1. Evaluation of progress is to be made mainly in terms of social and interpersonal criteria.
2. The service outlined is felt to be beneficial to patients.
3. Sufficient controls can be established to determine the effectiveness of service.

4. The service can be carried out by the staff available.

5. There will be no or minimal contamination of the control ward as a result of staff interaction that will be statistically significant in evaluating the study.

6. The nature and number of community services available to patients after discharge from the hospital will have minimal effects on the degree of community adjustment. Because the hospital serves both rural and urban populations, the services available in the communities vary greatly.

Research Population.

The research population is the total universe available for study, that is the total ward population of approximately 45-50 males of various ages, psychiatric diagnoses, and socioeconomic backgrounds. All patients on the ward are to be included in groups, the compositions of which are to be similar. All patients will be administered the Rating Scales at the beginning of Phase II of the program and subsequently at pre-determined intervals of approximately 1-2 months with the final rating undertaken just prior to discharge from the hospital. Rating scores will be charted for each individual patient and responsibilities and privileges will be scaled according to the latest composite score.

The control group consists of another male ward of equal size, patient composition and a ward philosophy similar to that in existence in the entire hospital at the present time, that is a custodial orientation to patient treatment. Patients on this ward will also be administered the

Rating Scales at the beginning of Phase II of the experimental ward program, as well as just prior to discharge. The major difference between the two wards will be that only the experimental ward will have an active rehabilitation program, the presence of which it is felt will reflect directly in the composite rating scores of the two wards.

Reliability

This program can be assessed for reliability in three ways - inter-rater, intra-rater and by having a person, not connected with the project, but aware of the rating scales and their application, administer the scales for comparison purposes with the results achieved by the other raters.

The reliability of the Behavior Rating Scales will be constant when the rating is done for all patients, on both the experimental and control wards, by one person, however, it will have to be tested for reliability on the experimental ward when the rating is done by all staff members. Re-tests will have to be used to compute inter-rater reliability scores, that is certain staff members will all rate a pre-determined number of patients to determine the degree of error involved in having several raters administering the scales.

Validity

At this time of writing the complete Behavior Rating Scales are not available. Also it is not known whether validity tests have been used in testing these scales in relation to more well-known rating scales to determine a validity coefficient. This information is forthcoming however,

but the question of validity cannot be satisfactorily answered at this point in time.

An additional factor that must be mentioned is that without complete knowledge of this specific Behavior Rating Scale, it is not known whether it will be applicable in toto or have to undergo minor revisions to make it more applicable to this research study.

Analysis of Data

Similarly the final form to be utilized in analyzing the data cannot presently be determined, however, the present intent is to use interval scales in determing the results of the Behavior Rating Scales for each individual in order to determine his progress or regression as well as areas of competence and disability as these factors show up in the program. Each patient will have a chart listing his composite rating score, and, if available, the factors reflecting his community adjustment. All of this information will be correlated for the individual patients on the experimental ward and cross-indexed with the control ward.

Conclusions

It is expected that the results of this research will indicate that this social rehabilitation program will result in improved social functioning of patients both within the hospital and also in reintegration back into the community. It is felt that as a result of the program the transition to community will be less severe than for those patients who have not experienced a period of resocialization and who must make the change from hospital to community culture with little or no preparation.

The results of the research program should also indicate the types of patients and the corresponding disabilities that best respond to such a program. A potential factor could be that ward composition changes will take place within the overall hospital so that programs can be initiated that correspond to a more homogeneous patient population.

Because of its demonstration value this program may have an effect on the hospital's orientation to treatment. It will arouse staff interest in treatment, both negatively and positively, and the effectiveness of the program could determine whether more active treatment will be encouraged within the hospital. Ward composition could also be altered in another fashion, that is, they could be determined on a geographic basis, indicative of the patient's home community, so that follow-up could be integrated by the treatment team into their overall program.

In relation to Social Work practice, it is felt that this program will stimulate interest in the Social Service Department both in the on-going evaluation of the program, and as well a re-evaluation of the Department's functions. It could result in a more viable role for Social Workers in both research and treatment within this setting. Program analysis can lead to a synthesis of knowledge regarding treatment as well as further refinement of the practices followed in this research. It can stimulate further research both within and outside the hospital and can be instrumental in integrating the use of manpower of different educational levels and orientations in both research and practice.

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