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THE SOCIAL WORK PRACTICE OF DISCHARGE PLANNING:

AN EXPLORATORY STUDY

by

JACK PAUL GESINO

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

1988

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Abstract

THE SOCIAL WORK PRACTICE OF DISCHARGE PLANNING:
AN EXPLORATORY STUDY

by

Jack Paul Gesino

Adviser: Professor Mildred Mailick

The literature on how psychiatric social workers approach discharge planning is lacking. This study was undertaken to learn more about the helping process psychiatric social workers use, specifically if they use a problem-solving process and if they attend to the relationship component when helping clients, namely families, resolve discharge planning problems. Social workers' responses to resolving three hypothetical discharge cases were analyzed for problem-solving practice principles and relationship elements. Findings indicate that psychiatric social workers utilized a problem-solving process and relationship components when resolving discharge planning problems. The implications of the findings are discussed.

ACKNOWLEDGMENTS

I wish to thank Dr. Mildred Mailick, Dr. Kay Davidson and Dr. Michael Smith for their guidance, support and understanding throughout the dissertation process.

I wish to dedicate the dissertation to my daughters, Meaghan and Emily and my son Joshua, who will hopefully forgive me for too many absences, and to the woman for whom this whole endeavor would be but a dream, my wife, Dorothy.

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CHAPTER I

PROBLEM STATEMENT

With deinstitutionalization and the increased pressures for rapid discharge of psychiatric patients because of the various cost containment programs, the administrators of psychiatric hospitals are requesting social workers to assume primary responsibility for discharge planning (Lurie, Pinsky, and Tuzman, 1981; Rock, 1987; Thistel, 1987). Patients and families who are discharged from psychiatric hospitals may face problems similar to those patients and families who are discharged from general hospitals. For example, there is evidence that with the introduction of cost containment regulations, patients are being discharged in poorer health and therefore placing a greater burden on the family and community services (Easterbrook, 1987).

Psychiatric patients and their families are presented with additional burdens not experienced by patients discharged from general hospitals. The mentally ill have been identified as among the groups at high risk of receiving reduced services as the health care system undergoes rapid changes in the next few years (Rock, 1987). Community resources for mental health care are limited and shrinking.

Unlike a physical illness, a mental disorder frequently alienates the family and social support systems

on which recovery and discharge depend (Goldman, Pincus, Alan, Taube, and Regiver, 1984). Holden and Lewine (1979) found that families were severely stressed, experiencing aggravated health problems and a loss of leisure time and social contacts. They experienced a sense of frustration at the lack of information given by professionals, especially on coping strategies and community resources. Psychiatric patients and families, therefore, have many psychosocial needs that must be met at the time of discharge for successful post-hospital adjustment.

Even though discharge planning is becoming a major responsibility of social work, research has not explored the practice principles used by social workers in resolving discharge planning problems. The lack of research in studying the processes of discharge planning may reflect a general tendency in the field to view discharge planning as merely providing concrete services and not having any therapeutic value (Blazyk and Canavan, 1985; Lurie et al., 1981; Rock, 1987).

A number of social work theoreticians point out that much of social work practice involves elements of the problem-solving process (Siporin, 1975; Pincus and Minahan, 1973). In regard to discharge, Shulman and Tuzman (1980) view discharge planning as a series of problem-solving tasks designed to orchestrate the knowledge required to help the patient with his/her problem within the context of the health care facility.

The problem-solving process occurs within the context of a relationship between a client and worker (Siporin, 1983). The social work literature has consistently accorded the relationship between the worker and client a central role in practice (Proctor, 1982). The purpose of this study is to examine the extent to which social workers use a problem-solving process and attend to relationship issues during discharge planning. This information should be helpful in identifying the gaps in current discharge practice and in developing teaching models to fill these gaps.

OBJECTIVE

To develop more knowledge about the social work practice of discharge planning in a psychiatric hospital.

SPECIFIC AIMS

1. To identify the salient components of the social work practice of discharge planning in a psychiatric hospital and develop a protocol for teaching these components to psychiatric social workers.

2. To identify the problem-solving principles psychiatric social workers use when helping a patient and family with discharge planning.

3. To identify ways in which psychiatric social workers use the relationship component in discharge planning.

4. Based on the protocol developed in number one, to present an in-service program for the Institute of

Living's Department of Social Work for the purpose of enhancing the staff's understanding of the specific knowlege and practice principles required for discharge planning.

JUSTIFICATION OF THE STUDY

The role of discharge planning within social work is becoming increasingly important with the push toward shorter hospital stays and the emphasis on community-based care. Schools of Social Work are faced with the task of training professionals to meet this growing need for expertise in discharge planning. Educational programs must be based on a solid foundation of research.

Along with this is the demand for greater professional accountability. To the extent that we can define the practice principles of discharge planning, the better we will be able to evaluate the effectiveness of intervention.

The role of discharge planning has been undervalued in the field of social work. By specifying the knowledge base required in discharge planning, it is expected that social workers as well as other professionals will view discharge planning as a therapeutic process that is an integral part of treatment.

CHAPTER II

LITERATURE REVIEW

HEALTH CARE AND COST CONTAINMENT

Since 1965 the United States' expenditures for health care have risen from approximately 25 billion a year to 425 billion a year in 1987 (Easterbrook, 1987). In 1950 individuals paid 65 percent of health costs; government paid 22 percent; and private insurance 9 percent. In 1985 federal, state and local funds covered more than 40 percent of medical costs. Private insurance pays slightly more than 30 percent; individuals pay slightly less than 30 percent (Easterbrook, 1987). Care provided by hospitals accounted for 46.3 percent of all personal health care expenditures in the United States in 1981, with federal funds providing three-quarters of these payments. The federal contribution to hospital reimbursement has risen from 12.9 percent in 1966 to 41.2 percent in 1981, while contributions from state and local governments have remained under 15 percent (Caputi and Heiss, 1984). As a result of the increasing federal reimbursement to hospitals, the federal government initiated a number of regulatory programs to control costs. Prior to the introduction of federal regulations to control costs, the private sector of medicine established utilization review committees to control the use of medical services. The committees served two

functions: to monitor admissions and to establish hospital priorities. With the enactment of Medicare in 1965, the federal regulatory requirements adopted the concept of the utilization review plan as a condition of participation, with the formation of the utilization review committee as a requirement for receiving Medicare payments (Caputi and Heiss, 1984). The introduction of Utilization Review Committees within the context of a retrospective reimbursement system was the beginning of the federal government's involvement in containing hospital costs.

Hospital utilization review committees established norms for acceptable lengths of stay for the most common medical conditions. In addition, where cases exceeded the norm, the committees requested that the physician justify the extended stay. If the committee deemed the hospitalization justified, Medicare reimbursement was granted. When continued hospitalization was deemed unnecessary, financial sanctions were imposed on patients and hospitals through a denial of payment for all or part of the costs deemed unnecessary or not medically justified (Caputi and Heiss, 1984).

In 1972 there was the passage of amendments to the Social Security Act (P.L. 92-603) further refining the intent of the utilization review committees. The Professional Standards Review Organizations (PSROs) were developed. The intent of this new mechanism was

> . . . to control and monitor both the cost and quality of medical services provided to Medicare, Medicaid, and maternal and child and health program recipients. Like utilization review standards, PSRO provided for the review of contained hospital stays but expanded these reviews to encompass admission certification and evaluative studies of medical care. Reviews of the professional activities of physicians and other health professionals were to be conducted and were to be directed specifically toward the overutilization or underutilization of medical resources (Caputi and Heiss, 1984, p. 8).

The retrospective payment system was found insufficient to curb hospital costs. In 1982 Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This set the stage for a prospective payment system under Medicare.

> TEFRA included new limits on hospital costs (such as ancillary costs) that covered total inpatient operational costs, established limits on a per case rather than per diem basis, adjusted each hospital's reimbursement limit to reflect its mix of cases and clinical problems, and established an overall target rate or increase for each hospital's growth in total costs per discharge. It also provided hospitals with a financial incentive payment when a hospital did not spend up to its limit. Most significantly, it mandated that the federal government develop a legislative proposal for a prospective payment system for Medicare (Widem et al., 1984, p. 448).

In 1982 the Health Care Financing Administration (HCFA) of the Department of Health and Human Services issued a report on a prospective payment system for hospital reimbursement for Medicare (Public Law 92-21). The prospective payment system was developed out of 10 years experience with prospective rate-setting in a number of states. It was based upon the classification of patients by Diagnostic Related Groups (DRGs), which had

been formulated by researchers at Yale University in 1975 (Caputi and Heiss, 1984; Widem, Pincus, Goldman, and Jencks, 1984).

The DRG system classified all hospital discharges into one of 467 discharges into 23 major diagnostic categories (MDCs). The following clinical and medical criteria was used: principal diagnosis, secondary diagnosis, and whether a surgical procedure had been performed. These were applied in combination with the three other variables of age, sex, and the discharge status of the patient (Bentley and Butler, 1982). Caputi and Heiss (1984) state,

> The underlying assumption of this DRG classification system was that commonalities existed among patients' attributes and medical problems on the one hand and patterns of treatment, medical approaches, and levels of service on the other. The specification of these commonalities made it possible to establish the definition of a predictable length of stay in the hospital for each patient in a given DRG (p. 8).

Under the DRG system, hospitals retain the difference between the reimbursement rate and the actual cost of providing a patient's care if the discrepancy is in the hospital's favor; if the cost of care exceeds the reimbursement, the hospital absorbs the loss. This gives the hospital a substantial economic incentive to reduce the costs involved in treating each patient (Reamer, 1985). However, negative incentives have also been included. The prospective payment system legislation also required hospitals to contract with a peer review organization (PRO) in their geographic area. The PRO reviews patterns of admissions and discharges and assesses

the quality of care provided by hospitals. PROs operate on a contract to the Health Care Financing Administration and ". . . they score bureaucratic points by finding dubious claims" (Easterbrook, 1987, p. 51).

The prospective payment system has sharply reduced the length of hospital stays. The average length of hospital stays for Medicare patients has declined by about 20 percent in the last few years to 7.7 days from 9.5 days (Pear, 1985). Prior to the DRGs, voluntary hospitals in New York had an average occupancy rate of nearly 90 percent; 9 out of 10 beds were being used each day. In the last two years, that rate has fallen to 81.9 percent. In New York's municipally owned and operated hospitals, the occupancy rate has dropped to 80 percent, from a high of 84 percent in 1984.

Some authorities have suggested that this system of payment has pushed patients out of the hospital before they are ready to leave, and, as a result, patients are now "sicker" at the time of discharge ("Hill Panels Find," 1985; Easterbrook, 1987). In its preliminary report to the Senate Committee, the General Accounting Office said its investigators had visited hospitals, nursing homes and home health agencies in six cities and also conferred with administration officials and representatives of national health and medical associations. At each site, agency investigators were told that "patients are being discharged from hospitals after shorter lengths of stay

and in a poorer state of health" than was the case before the new payment system took effect (Freudenheim, 1985). This type of information has prompted consumer groups to urge the government to require hospitals to tell Medicare patients that they have a legal right to challenge their discharge from a hospital if they think they are being sent home prematurely (Pear, 1986). There are also Medicare "ombudsmen" to help patients file appeals against improper discharges (Easterbrook, 1987).

This system of payment has generated other areas of concern. Richard P. Kusserow, Inspector General of the Department of Health and Human Services, stated that, "Evidence is mounting to suggest abuse of the new Medicare payment system through the premature discharge and subsequent readmission of patient needing hospital care" (Pear, 1985, p. 11). This had resulted in increased profits for hospitals and in many hospitals treating a higher percentage of chronic patients. Hospitals are experiencing the 20/80 Phenomenon -- 20 percent of patients account for 80 percent of admissions. Hospitals have been treating chronic patients who are primarily poor patients for many years. However, the DRG system has both exacerbated this problem and made it more obvious due to the high cost of this care (Kotelchuck, 1985).

The DRG system has affected public hospitals that serve patients who are poor. Prior to the prospective payments system, hospitals would admit patients for short

stays on the basis of a "social admission" (Easterbrook, 1987). These patients were not in life threatening situations but were in a general state of decline as a result of being alone, little family support or a family requesting a respite from a demanding care situation. However, today PROs reject such admissions (Easterbrook, 1987). The social implications of this policy are not fully known at this time. Nevertheless, as Easterbrook states, "Poverty, loneliness and lack of family support are, of course, social problems that the Health Care Financing Administration cannot be expected to solve. But to the extent that moving people out of hospitals lessens one social problem (health care spending), we must be prepared for the possibility it will make others worse" (1987, p. 52).

The reimbursement rates have been noted to be disadvantageous to both the poor and the institutions that serve them (Kotelchuck, 1985). Kotelchuck (1985) notes that there are lengths of stay of poor patients which are not currently considered by DRGs. One of these variables is placement problems. Kotelchuck (1985) states,

> Undoubtedly, part of the reason for extreme lengths of stay is the unique placement problems facing many poor patients. Poor housing conditions, disorganized family situations, and lack of resources often make discharge of poor patients to their home difficult (p. 9).

PSYCHIATRIC HOSPITALS AND THE PROSPECTIVE PAYMENT SYSTEM

The DRG system did specify a category for mental diseases and disorders and a category for substance use

and abuse-induced organic mental disorders. The category for mental diseases, MDC 19, includes nine diagnostic subgroups derived from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The substance abuse category, MDC 20, includes six diagnostic subgroups (Widem et al., 1984). However, psychiatric hospitals who had already met conditions for participation in Medicare and psychiatric units in general hospitals who requested exemption were excluded from the prospective payment system. Psychiatric disorders were initially not included in PPS because of a lack of experience with the psychiatric DRGs (Goldman et al., 1984; Widem et al., 1984). There have been a number of factors cited as reasons for why psychiatric DRGs would not predict the length of stay and resource utilization accurately. Goldman et al., (1984) cite the following: many mental disorders are chronic; diagnosis in psychiatry are syndromic and descriptive, and the disorders are frequently of unknown etiology; standardized treatment has not yet been developed for a significant portion of disorders; and lastly, the current nosology does not fully characterize the reasons for hospitalization. In addition, the complexity of the mental health system also contributes to the problem of implementing DRG-based prospective payment system. The mental health system encompasses a wide variety of facility types (psychiatric hospitals and psychiatric units in general hospitals) and

provider groups (psychiatrists, psychologists, social workers, and nurses). Each has different practice patterns, case mix experiences, rates and charges (Goldman et al., 1984). In 1982, the American Psychiatric Association (APA) recommended further testing and validation of the DRG system for mental disorders before applying the prospective payment system to psychiatric patients. The APA argued that the DRG system would not adequately take into account severity of illness and coverage of liaison psychiatry, support services, and new technologies in psychiatry (Widem et al., 1984).

The PPS legislation authorized the Department of Health and Human Services to study the feasibility of a technology for bringing psychiatric facilities into the DRG system (Widem et al., 1984). In December, 1985, the Health Care Financing Administration recommended that Medicare's prospective payment system not be currently extended to include treatment in specialized psychiatric facilities and psychiatric units of general hospitals. Much of the concern about applying the DRGs to the alcohol, drug abuse and mental health (ADM) field emanated from the revenue distribution among different types of facilities that might result (McGuire et al., 1987). As McGuire et al., (1987) state,

> The PPS determines payment on the basis of length of stay and cost averaging. General hospitals with 'scatter beds,' general hospitals with distinct-part units, private and public psychiatric hospitals, and free-standing and hospital-based substance abuse facilities all

> treat ADM disorders. When DRG payment weight is based on an average length of stay for treatment occurring in all types of facilities, the resulting payment may be greater than cost for general hospitals with 'scatter beds' and less than the cost for specialized facilities. This is called the problem in 'fairness in PPS' (p. 616).

In addition, McGuire et al., (1987) cite the concern that specialized psychiatric facilities were at "systematic risk." McGuire et al., (1987) state,

> When there is systematic risk, a facility receives no protection from the law of large numbers, which is relied upon to equalize costs and revenues at a facility over time. If more costly patients are likely to be treated at specialized facilities, PPS payments based on an overall average will redistribute net revenues away from the specialty toward the non-specialty sector. Moreover, systematic risk presents problems for patients as well as facilities. Financial incentives associated with this redistribution may affect patients' access to care, the treatment offered to ADM patients, and the financial viability of distinct-parts units and specialized ADM facilities (p. 616).

Although psychiatric hospitals and psychiatric units of general hospitals are not included in the DRG-based prospective payment system, the philosophy of reducing lengths of stay and of monitoring appropriate admissions has intruded within the psychiatric system of care. Hospitalization of the mentally ill is no longer measured in terms of years but is now a matter of weeks (Avison, Speechley, and Nixon, 1987). In most states, the necessity and appropriateness of psychiatric hospitalization is being reviewed by Peer Review Organizations. As a result, psychiatric hospitals are

experiencing decreasing lengths of stay. The Group for the Advancement of Psychiatry state that there are

> . . . legal, social and economic forces in American society applying pressure for rapid discharge.

They go on to say that,

> The legal principle of 'least restrictive care' dictates one major impetus. Many social groups, including those which purport to represent psychiatric patients' rights, advocate reducing power of those in positions of social control (i.e., professionals, administrator). Economically, lengthy hospitalizations threaten their already tenuous cash flow. These varied pressures, in conjunction with advances in treatment, e.g., medications, have resulted in a precipitous drop in length of stay for psychiatric patients (1985, p. 42).

Psychiatric patients who are now being discharged earlier from hospitals face serious problems. A proportion of discharged psychiatric patients are lost to follow-up care because hospital discharge rates have outstripped the capacity of community-based services and there is little continuity in the services offered (Avison et al., 1987). Patients with psychiatric illnesses require specialized supports like board and care homes which are currently underfunded and are not covered by many insurance policies, including Medicare. Such supports are severely limited and their lack is likely to increase the recidivism rate of these patients (Goldman et al., 1984; Avison et al., 1987). Furthermore, rehospitalization of psychiatric patients is likely to occur when families are not actively involved in the

discharge planning (Avison et al., 1987). The Group for the Advancement of Psychiatry (1985) state,

> When patients are discharged without an adequate treatment plan that includes the family, they reappear to be processed and discharged again in a never-ending spiral which unfortunately tends toward chronicity, hopelessness, and increasing isolation from the community (p. 43).

Mental illness may frequently alienate the family and social supports on which recovery and hospital discharge depend and because of this, earlier discharges of psychiatric patients exacerbate an already precarious supportive system (Goldman et al., 1984).

At the present time there are a number of studies attempting to measure the reliability and feasibility of DRGs for psychiatric patients (Freiman, Mitchell, and Rosenbach, 1987; McGuire et al., 1987; Mitchell et al., 1987; Taube, Lee, and Forthofer, 1984. However, most studies report considerable difficulty in finding ways to adequately determine lengths of stay and for appropriately discriminating among psychiatric patients on the basis of their resource use (Mitchell et al., 1987). Some studies have indicated that under PPS, hospitals would be more likely to provide less definitive treatment and possibly engage in more selective admission policies in an attempt to screen out patients who are expected to have high treatment costs.

Lastly, there is concern that some psychiatric units in general hospitals might close because reimbursement fees would be lower than the actual cost of psychiatric

care. As a result of these problems, access for psychiatric patients who are in most need of care will be in peril (Freiman et al., 1987).

The real challenge of devising and implementing a DRG-based PPS for psychiatric patients is to conduct research studies in order to develop an effective and equitable classification system that will enable psychiatric hospitals to participate in prospective payment systems without serious threats to quality of care (Taube et al., 1984).

SOCIAL WORK, PROSPECTIVE PAYMENT SYSTEM AND DISCHARGE PLANNING

The prospective payment system and the climate of cost-containment in health care is shaping the nature of the delivery of social work services, affecting practice methodologies and role functions (Caputi and Heiss, 1984). PPS has generated concern around productivity and because of this there is the opinion within the profession that involvement in discharge planning is a mandate for social workers. Caputi and Heiss (1984) state:

> In order to maintain a position of power and influence within the DRG system, social work professionals will have to endorse this mandate and clearly establish their expertise in discharge planning (p. 3).

At the same time, there is also the concern that social workers will become "too managerial" in implementing the various components of discharge planning and that we risk

losing our unique clinical focus with the patient and family (Health and Social Work Editorial, 1984).

Discharge planning has a long history within the social work profession. Dr. Richard Cabot introduced social work into the hospital dispensary at Massachusetts General Hospital in 1905. Dr. Cabot believed that social work was a major link between medical and environmental resources. Since its introduction in 1905, discharge planning has been a primary function for hospital social workers (Berkman and Rehr, 1972). During the past few years, discharge planning has received considerable attention from many hospital social work departments and from the social work profession (Davidson, 1978; Mullaney and Andrews, 1983; Rock, 1987; Shulman and Tuzman, 1980). The involvement of social work in discharge planning has been described by some as the "key to the future of hospital social work" (Schreiber, 1981).

Since the 1970s, there has been a proliferation of articles concerning the role of social workers in discharge planning (Beallor, 1980; Caputi and Heiss, 1984; Davidson, 1978; Foster and Brown, 1978; Kulys, 1984; Reamer, 1985; Schreiber, 1981; Shulman and Tuzman, 1980); the ethical and legal dilemmas of discharge planning (Abramson, 1981; Brown, Conley and Widish, 1984; Mullaney and Andrews, 1983; Reamer, 1985); and the training of

social workers for the role of discharge planner (Lurie et al., 1984; Lurie et al., 1981; Rauch and Schreiber, 1985).

Much of the attention has resulted from the impact of the DRG-based prospective payment system. Social work's concern with discharge planning has centered around its own survival as a discipline in health care settings and on its concerns on the quality of care given to patients and families (Caputi and Heiss, 1984; Reamer, 1985; Rock, 1987; Shulman and Tuzman, 1980). This concern with discharge planning has been described by Barry Rock (1987) as ". . . one of the greatest slogans of our time: it is at once a methodology, a discipline, a function, a movement, and a panacea" (p. 529). Whatever way it is described, discharge planning, within the context of the DRG system, has posed special risks for social work clients and it is this concern for clients that has generated the profession's interest in discharge planning (Reamer, 1985). The DRG-based prospective payment system and the current atmosphere of cost containment in health care is affecting the delivery of care to patients and families.

> Given the paucity of appropriate resources in most communities the basic human right of choice is . . . being usurped and public policy is imposing an unintended tyranny over the most vulnerable in society -- elderly, ill, disabled, and poor people (Shulman and Tuzman, 1980, p. 12).

In this regard, there have been recent lawsuits against the City of New York seeking compliance with a law

requiring appropriate discharge planning and aftercare coming after the inappropriate discharge of a mentally ill homeless person (New York Times, 1987). There is concern that the urgencies of discharge planning may overshadow other psychosocial needs in medical care (Grossman, Harrell, and Melamed, 1979).

The DRG system has affected many patients and families in ways that directly relate to the profession's concern for human dignity and the right to self-determination. Low-income and minority groups may begin to be denied access to the hospitals of their choice. They will be treated at public-financed hospitals which already provide more than their share of care for low-income groups (Freiman et al., 1987; Kotelchuck, 1984; Reamer, 1985). The DRG system also has implications for influencing the quality of care provided to patients. Hospitals have a financial incentive to reduce the number of medical procedures and related services they provide. Social workers are in the position to see the pressure on hospital personnel to reduce the number of referrals to other specialists like occupational and physical therapy (Reamer, 1985). Situations like this bear directly on social work ethics including the right to self-determination and the concern for distributive justice in health care (Reamer, 1985). Hospital social workers are obligated to ensure that the implementation of

DRGs does not interfere with the patients' autonomy and wishes about care necessary to their well-being. Social workers must also be aware of the criteria used to allocate beds and services that may become more limited as a result of the DRGs (Reamer, 1985).

Even without the effects of DRGs, hospitalization invariably creates an emotional and social crisis for many patients and families. It is intrinsically disruptive for patients and families who frequently do not understand the illness. The lack of understanding on the part of the patient and family dramatically influences how they will manage the process of discharge (Blazyk and Canavan, 1985). Family roles change significantly when a member is ill and enters a hospital. Role changes affect the family's overall level of functioning. Hospitalization and discharge are crucial stages in a process of role definition and offer the patient and family many possibilities for change (Blazyk and Canavan, 1985).

Interestingly, patients and families may want to address issues related to discharge planning. In 1984 this author conducted a needs assessment of adult children whose elderly parent was admitted to a psychiatric hospital. The study was an attempt to have family members define specific problems they would like to have help with and the type of service they preferred. There was a total of fifty respondents. "Help in planning for my parent's

discharge" was cited by 80 percent of the adult children. In a second study of fifty families whose relative was admitted to a short-term unit of the same psychiatric hospital in 1986, "Help in planning for my relative's discharge" was cited by 74 percent of the respondents. Although the samples are small, the initial data suggested that families wanted social work services that would help them address problems related to discharge planning.

Given the disruptive nature of hospitalization and discharge and the premise that families want social workers to help them plan for discharge, then we must consider the psychosocial context of the discharge planning process and provide patients and families with a therapeutic and growth enhancing adaptation process to meet with the demands of discharge (Blazyk and Canavan, 1985). Namely, social workers must address the patient and family's understanding of the illness, its impact upon various family roles and family functioning and the life choices they must make when leaving the hospital (Rock, 1987).

Social workers, as a result of their education and training, are highly qualified to perform and oversee all aspects of the discharge planning process (Shulman and Tuzman, 1980). There have been numerous calls for the profession to take a leadership role in discharge planning.

Reamer (1985) states,

> Social workers must be especially careful to serve as watchdogs when large-scale policies with

> wide-spread popular appeal present risk for clients. To the extent possible, workers should promote the development of hospital-based procedures that will monitor carefully the effects of DRGs on admission criteria, inpatient care, and discharge planning and personnel standards (p. 89).

Caputi and Heiss (1984) state:

> A timely and strategic reaction to the DRG mandate offers the opportunity to make changes and adaptations that incorporate the clinical experience of social work and the profession's advocacy role to ensure the rights of patients to high-quality medical and psychosocial care (p. 11).

Shulman and Tuzman (1980) state:

> If social work does not take a consistent leadership and coordinating role in discharge planning, the risk to the profession and to patients is that discharge planning programs will become technologically efficient and value neutral and may run counter to the very idea of the service ethic, which is supposed to distinguish the professions from mere commerce (p. 8).

Since the inception of the Professional Standards Review Organization (PSRO) and now the DRG-based PPS, social workers are confronted with political, economic and social factors which are frustrating their efforts to provide a professional level of discharge planning and undermining the interests of social workers in engaging in this activity. Also, as Shulman and Tuzman (1980) state,

> Unfortunately, though, many social workers have abdicated their appropriate role in discharge planning, tending to see it as involving only technical skills rather than the professional levels of skill truly required (p. 3).

They go on to say that in order to counteract this, social workers must ". . . insist that certain value principles, operational principles, and areas of knowledge form the foundation of the discharge planning process" (p. 3).

To this end, certain leadership groups within the profession, most notably the Society for Hospital Social Work Directors of the American Hospital Association, have identified the specific components of the social work role in discharge planning (Appendix A). The ideology of the social work leadership is that discharge planning is an important social work function, involving a specific knowledge base and skills. However, a gap exists between the ideology of the leaders and that of front-line social workers who see discharge planning in less than ideal terms. Some social workers view discharge planning as a mechanical "shuttle service" requiring little skill or expertise (Blazyk and Canavan, 1985; Phillips, 1972; Ullman and Kassebaum, 1961). Acceptance of discharge planning as a therapeutic part of social work practice is still resisted by many front-line social workers who undervalue the professional skills required by this activity. Discharge planning carries the stigma still associated with the provision of concrete services, resource finding and financial help in the minds of many social workers. The results of a nationwide survey of social workers' roles in hospitals indicated that

respondents spent less time on discharge planning and rated it less important than they did family and individual therapy (Adelson and Leader, 1980). Blazyk and Canavan (1985) state,

> These attitudes also reflect discrepancies between the roles medical social workers perceive for themselves and the expectations other professional and administrative groups have of social workers (p. 489).

Not surprisingly, other professionals have been interested in securing the role of discharge planner. The nursing profession is one of the primary disciplines to seek discharge planning as a "nursing responsibility." The involvement of nurses in discharge planning has increased their autonomy within many settings. This has led to many nurses accepting discharge planning activities and the role of discharge planning coordinator (Kulys, 1983; Mundinger, 1984). Frequently, one now hears about the "turf" issues between nurses and social workers regarding who is the more qualified to perform the role of discharge planner (Kleyman, 1984). A 1974 survey of 128 hospitals in Virginia about discharge planning activities (61 responded) reported that nurses were cited more often than social workers as responsible for discharge planning activities (National League for Nursing, 1976). This trend is continuing in major health care settings throughout the United States.

SOCIAL WORKERS IN PSYCHIATRIC HOSPITALS AND DISCHARGE PLANNING

Much of the social work literature on discharge planning pertains to the medical settings of general hospitals. The literature on how social workers approach discharge planning in psychiatric hospitals is limited. The culture of psychiatric hospitals places considerable emphasis upon the "clinical" process and "therapy", while deemphasizing the concrete service component of professional responsibilities. Many social workers in psychiatric hospitals have primary treatment responsibilities for patients and families, similar to those of the psychologist and psychiatrist (Lurie et al., 1981). In one of the few articles written about psychiatric social workers and the role of discharge planning Lurie et al., (1981) reported that

> . . . the psychiatric social workers . . . were at first reluctant to take on the discharge planning role on a more formal and structured basis. They thought that formalizing this role would detract from the 'higher status' position of being a primary therapist (p. 15).

This perception continues to persist in many psychiatric hospitals. Rock (1987) states,

> Clinical social workers have a tendency to denigrate discharge planning as providing concrete services and filling out forms and thus not worthy of consideration in therapy sessions where only intrapsychic processes are of concern (p. 529).

Although this separation of intrapsychic and concrete services occurs among some social workers in general hospitals, discharge planning has been more formalized within their roles and thus further along in its acceptance as part of a psychosocial process. This has not been true for psychiatric social workers and, because of this, the integration and acceptance of a discharge planning function within their role is more problematic. Currently, there is little conceptualization of the social work practice of discharge planning in psychiatric hospitals. A telephone survey was conducted of thirteen private and public psychiatric hospitals in the country for the purpose of identifying those social work departments who took primary responsibility for discharge planning. Twelve social work departments reported having responsibility, but no specific social work policy and, interestingly, no conceptual model or disciplinary role function description (Thistel, 1987). This situation is no longer tenable or viable for psychiatric social workers or social work departments in psychiatric hospitals.

Social workers' response to cost containment measures is important for the profession and for the patients and families they serve. Although some social workers are resistant to assuming a greater role in discharge planning, the increased demand for discharge planning will necessitate that they assume a primary role in this area

(Caputi and Heiss, 1984). However, discharge planning is plagued by a number of misconceptions and bureaucratic factors which negatively influence social workers and contribute to their reluctance to become more involved in it.

FACTORS INFRINGING ON THE ACCEPTANCE OF THE DISCHARGE PLANNING ROLE BY SOCIAL WORKERS

A number of factors have been attributed to the reluctance of social workers to identify more closely with a discharge planning role. One of the major factors is the concern among social workers for maintaining a strong professional identity. Various aspects of the discharge planning process are seen by social workers as undermining their professional autonomy and status.

Davidson (1978) traces the early role of hospital social workers and considers how the dissatisfaction with various aspects of that role gave impetus to social workers' wishes to become involved in activities and roles which would provide a greater sense of "professional" identity. One aspect of the role that undermined the sense of professional identity was the lack of autonomy in selecting the patients to be served. The decision to refer patients and families resided primarily with the physician. This system of referral fostered a dependence upon physicians for both the selection of patients to be served and for the timing of intervention.

Furthering the erosion of social workers' independence in the selection of patients and the timing of intervention was the fact that the criteria for selecting patients to receive social work services was largely determined by the needs of the hospital. Most hospitals were confronted with the need to discharge patients. As a result, most referrals made for social work services were based upon helping the patient with discharge planning problems. These referrals led to an emphasis upon the mechanistic procedures associated with discharge planning and the apparent diminution of the casework process with hospitalized patients. Although procedures for admission and discharge were important to hospitals and the patients, Davidson (1978) states, ". . . they were ancillary and had low status in relationship to the central treatment purpose of the institution" (p. 44).

These factors contributed to the opinion that social work was not autonomous, and not a "true profession," but a "semi-profession" (Carr-Saunders, 1955; Etzioni, 1969). The characterization of social work as a semi, non-autonomous profession led social workers to assume tasks and roles which would give them greater professional prestige.

Discharge planning and its role within the practice of social work began a steady decline. Social work departments were facing a situation in which they were understaffed and unable to provide social work services to

all hospitalized patients. As social work services became accepted adjuncts of hospital care, the emphasis shifted from discharge planning to treatment-oriented services. The general trend in the 1960s toward the separation of clinical, treatment-oriented services from the delivery of concrete services paralleled and accelerated this pattern (Lurie et al., 1981).

Freudian theory gave impetus to this transition in social work practice. Freudian theory, ". . . provided a facade of scientific respectability. Internal conflict superceded external factors as a cause of personal and social breakdown" (Bracht, 1978, p. 10). The interest of social workers in dealing with the emotional aspects of clients was not only occurring because of the wish to secure a stronger professional identity, but from the recognition that internal factors also affected an individual or family's social functioning (Shulman and Tuzman, 1980). By embracing Freudian theory, social workers acquired an opportunity to surmount the opinion that social work was a non-autonomous, semi-profession. Services and tasks associated with discharge planning were now perceived as non-professional. For this reason, these services and tasks were abandoned, or, at a minimum, downplayed as being an important part of the social worker's repertoire of intervention skills. Social workers began to emphasize internal factors as causes for a client's behavior. Understanding and explaining

behavior from this perspective provided a base of scientific respectability and, importantly, gave social workers an opportunity to gain a sense of status and professional respect. Social workers began to value situations where they could utilize their clinical knowledge and skills in the service of their clients. However, the practice of discharge planning was not seen as an activity whereby one could use one's clinical knowledge and skills. This further detracted from the discharge planning role as a primary social work function.

The search for a strong professional identity and concomitantly the emphasis upon the "clinical process" in social work practice were and continue to be important factors underlying social workers' resistance to discharge planning. There are additional factors which affected the social workers' acceptance of a discharge planning role. One of these factors is related to the fact that discharge planning can be an extremely time-consuming, frustrating and discouraging experience (Kulys, 1983). For instance, a social worker may be confronted with a particular case where he or she must implement a discharge plan that does not necessarily meet the needs of the client and family due to the lack of adequate community services.

Another factor is related to the anger that the discharge planning process often engenders from patients and families and even the medical staff with whom the social worker is supposedly working collaboratively.

Patients and families see themselves as being forced out of the hospital by the social worker. They feel pressured by the social worker to make critical decisions regarding plans for discharge when they are feeling that continued hospitalization is still needed. Patients and families soon come to believe that the social worker is a mere agent of the hospital, whose sole purpose is to get them out of the hospital as soon as possible (Kulys, 1983).

Hospital policies aimed at discharging patients earlier have confronted social workers with numerous ethical and legal dilemmas which further undermines the acceptance of a discharge planning role (Abramson, 1981; Brown et al., 1984; Mullaney and Andrews, 1983; Reamer, 1985). It is recognized that professional social workers, as employees of the hospital, responsible for job performance in accord with the profession's code of ethics, are often pressed by the patient and health care system. They frequently find themselves between "a rock and a hard place" while trying to accomplish discharge planning (Mullaney and Andrews, 1983).

Ethical dilemmas are occurring for social workers in the areas of patients' right of self-determination, confidentiality, and access to optimal care. Brown et al., (1984) describe ethical dilemmas as ". . . the result of confrontation between morally incongruent internal values and system values and produce stress that hinders

one's abilities to cope on the job and in other social roles" (p. 7).

Social workers who are involved in discharge planning have ethical responsibilities to prepare patient care plans that are consistent with humane considerations and fundamental to social work objectives. Social workers must continue to (1) assist persons to identify and resolve problems between themselves and their environment, (2) ensure that social institutions remain responsive to people, and (3) enable individuals to utilize opportunities that maximize their potential (Brown et al., 1984; Gorden, 1962). However, as Abramson (1981) states, "Conflicting values inherent in social work, make discharge planning an activity of ethical conflict" (p. 33). Abramson recognizes a number of important questions arising from two of the following obligations imposed by the social work code of ethics. The first states that the social worker's primary responsibility is the client. The second states that the social worker should adhere to commitments made to the employing agency. The ethical questions involve the following: To whom does the social worker have primary obligation in discharge planning? The individual patient who is medically ready for discharge? The patient's family? The hospital that needs an acute bed for another patient and which will not be reimbursed for a patient who is not in

need of acute care? Society, which is allocating its scarce resources in a way that it considers most just?

Abramson (1981) also addresses two additional areas which are significant and where the social worker is likely to face some difficult ethical questions. These involve the social worker's concerns for client self-determination and with doing good for the client. In regard to self-determination, social workers are concerned with the individual's right to make his or her own decisions in matters affecting him or her. However, how does one address a situation where the doctor and family feel the patient should be discharged to a nursing home, but the patient, who is competent, wants to return home?

Furthermore, Reamer (1985) recognizes the serious possibility that social workers may be expected to explain to patients a hospital policy or decision conflicting with the right to self-determination. This would place the social worker's genuine concern for the patient's wishes and welfare in conflict with the duty to comply with hospital policy.

In regard to doing good, the social worker's concern is with contributing to the individual's health and welfare. However, how does one consider the situation where the patient wants to return home, but the social workers feels that this would not be in the best interest of the patient, so he or she pursues a nursing home placement for the patient. When does this paternalistic

involvement on behalf of the patient begin to interfere with the patient's exercise of his or her autonomy?

Both situations involve a patient's degree of autonomy and competency, along with a patient's right to privacy, particularly when making a referral to a nursing home. This raises such questions as can a patient be transferred to another facility against his/her wishes? Can the social worker sign release forms for medical information needed to prepare a transfer? They are areas protected under a federal mandated "Patient's Bill of Rights." For this reason, there are some important legal implications for social workers in discharge planning (Mullaney and Andrews, 1983).

The ethical and legal implications of the discharge planning process create a number of unknowns for the social worker. This can contribute additional stress to an already difficult process. Such considerations may have contributed to the overall ambivalence and reluctance social workers show toward discharge planning.

DEFINITIONS OF DISCHARGE PLANNING TASKS AND PROCESS

A number of authors provide definitions of discharge planning and of the various components associated with the process. These definitions and components serve as a basic foundation for social workers' understanding of discharge planning and guide their activity within the discharge planning process.

Discharge planning has been described as ". . . a systematic, organized and centralized approach to providing continuity of care from the time a patient is admitted to a health care facility through return to the community" (Lurie and Tuzman, 1980, p. 14). Further definitions are provided which attempt to outline the more specific tasks and functions and some of the skills claimed by social workers.

> Discharge planning is an interdisciplinary collaboration for the assessment and implementation of all elements of patient care that make it possible for the patient to complete treatment in the acute care hospital and return home or the community with whatever continuing care is required (Beallor, 1980, p. 2).

A further elaboration states,

> Discharge planning means a centralized, coordinated, interdisciplinary process in which members of a health care team collaborate with patients and their families to (1) anticipate patient needs after hospitalization; (2) develop a plan that will help patients function independently and will support gains they made during hospitalization; and (3) help patients implement that plan (American Hospital Association, Society for Hospital Social Workers, 1980, p. 5).

Additionally, discharge planning has been defined as the "professional service" that aids patients and families in coping with illness and its effects and in moving through the hospital system and experience a return to the community with all necessary supports (Rossen, 1984). Discharge planning is also explained as more than merely helping patients leave the hospital, but as a process that goes beyond the helping action to identify ". . . sources

of pressure for hospital discharge, assessing their nature, strength and legitimacy" and planning according to "societal as well as . . . social works' value system" (Fields, 1978, p. 5).

A model of case management or case coordination in social work practice has received increased attention during the last few years (Austin, 1983; Bertsche and Horejsi, 1980; John and Rubin, 1983). Lurie et al., (1981) describe case management as a principle role within the discharge planning process. The authors state,

> case management in discharge planning combines the traditional clinical responsibilities for assessing and treating the patient and family with responsibility for coordinating various health care services and community resources to achieve effective continuity of care. Inherent in this role therefore is the integration of clinical and administrative skills (p. 14).

The following have been identified as elements within a case management/discharge planning process:

- A form in intervention at the interface of systems (Bertsche and Horesji, 1980).
- Service integration.
- A process by which responsibility for implementation of the client's individual program plan is established.
- Direct rather than indirect service (Bertsche and Horejsi, 1980).
- Linking the client to a complex delivery service system and taking responsibility for insuring that the

client receives appropriate services in a timely fashion (Johnson and Rubin, 1983).

- Providing support to patients and families.

- Acting as a liaison between programs, minimizing conflict between subsystems (Bertsche and Horesji, 1980).

The discharge planning literature frequently includes the following four components as part of the discharge planning process:

A. Screening

This involves identifying the patients in greatest need of discharge planning and those who will need resources beyond the patient's and family's normal utilization patterns. Rehr, Berkman and Rosenberg (1970) and Christ (1984) have developed high risk screening tools for patients who are likely to experience problems with discharge planning.

B. Assessment

This involves ascertaining the patient's and family's needs, strengths, and weaknesses in relation to post-hospital care. Areas requiring assessment include the following: activities of daily living; family and environmental support, including social, emotional and financial consideration; mobility; communication; nutrition; special care needs, like physical therapy; medications; psychosocial functioning and behavioral problems; social interaction; and risk factors for further problems.

C. Planning

This component includes formulating a scheme for post-hospital care, again with the assistance of the patient and family. The discharge planner provides information to those involved and ensures that they understand the alternatives available. A good plan maximizes the independence of the patient at discharge and ensures that all arrangements hve been completed at that time.

D. Follow-up

This component is critical. It involves ensuring that the plan agreed upon is implemented. The discharge planner should be available to provide additional information or referrals if the needs of the patient change within a few days after discharge (Rossen, 1984).

The elements cited as existing within the discharge planning/case management process, and, to an extent, the four components above, are regarded as elements requiring competence in a number of areas identifed with the traning and practice of social work. These areas include brokerage, political skills, community work, clinical skills, and rehabilitation (Johnson and Rubin, 1983).

In June of 1985, the Society for Hospital Social Work Directors of the American Hospital Association issued a position statement on the role of social work in the coordination of a discharge planning program and various responsibilities entailed in this role. I have included

the position statement in its entirety for it provides the most comprehensive outline of the discharge process as it pertains to social workers. (See Appendix A).

The position statement and the literature on discharge planning identify the various parts and responsibilities of discharge planning, and state that social workers are especially qualified to perform this activity. However, much of the literature on discharge planning does not specify what the "process" is or should be between the client and social worker when engaged in working through problems around discharge planning. The literature frequently refers to the "clinical skills" as a necessary element in discharge planning. A number of authors state that discharge planning is a "social work process" involving 'casework" services (Schreiber, 1981). However, there is little clarity about what is meant by clinical skills, casework services or social work process as it relates to the specific process of discharge planning.

Fisher (1984) describes what kinds of clinical skills are needed for discharge planning. She states that discharge planning requires

> . . . an assessment of the capacity of individuals, families and communities to cope with a complex array of problems. Such an assessment must include ego strengths and deficits, the emotional, financial, and social situation of the immediate and extended family as well as neighbors and friends where appropriate, and the vast arena of community resources and services. The social worker . . . must be skillful at individual clinical assessment and family evaluation, short-term and long-term

> treatment, group work services, and resource evaluation to approach discharge planning needs (p. 20).

Although Fisher and others provide greater clarity about social work skills needed to assist patients and families with discharge planning, there is limited description of the clinical skills to address specific discharge planning concerns, or of what social workers should focus on and the knowledge and practice principles required.

Lurie et al., (1981) have advocated for the development of a practice model for discharge planning. This is a critical issue for social work because a well-defined knowledge base and practice principles may better prepare social workers for addressing the complex issues associated with discharge planning and the problems presented by patients and families during this process. The development of a practice model for discharge planning has been identified as an important element for the training of social work students (Lurie et al., 1981; Rauch and Schreiber, 1985; Shulman and Tuzman, 1980). The problem-solving process is strongly identified with social work practice and advocated by some as the ideal process for social work in discharge planning (Bunston, 1985; Hallowitz, 1974; Hallowitz, 1970; Northern, 1969; Perlman, 1957; Pincus and Minahan, 1973; Reid, 1985; Reid, 1977; Shulman and Tuzman, 1980; Siporin, 1975).

THE PROBLEM-SOLVING PROCESS

The problem-solving process in casework is presented comprehensively by Helen Harris Perlman (1957) in her book, Social Casework: A Problem-Solving Process. In the model proposed by Perlman, social roles serve as the context within which problems in living occur and need to be resolved. The distinctiveness of social work's approach to problem-solving is

> . . . its focus on the client's social functioning and social relationships; its concern for consensual agreement involving the client and significant others, and for collaborative situational interventions; its emphasis on the provision of needed social resources; its stress on improving the client's competence and gratification in social task performance as a way of helping him to achieve productivity and self-realization (Siporin, 1975, p. 52).

Problem-solving has been defined as

> . . . a series of planning activity stages with the goal of achieving an effective solution to a problem. Problem-solving, particularly in relation to human problems, thus requires insightful solutions which have a good measure of formal logical thinking and a large dollop of creative thinking (Bunston, 1985, p. 227).

In accordance with the idea that problem-solving involves planned stages of activity, the problem-solving process is seen as containing five phases (Bunston, 1985).

Phase 1 -- Assessment: This involves the presentation of the problem by the client. The worker pursues a detailed exploration of the problem, clarifying it, and negotiating a preliminary contract with the client.

Phase 2 -- Setting Objectives: The social worker and client set goals.

Phase 3 -- Planning Interventions: This involves the formulation of possible solutions to the problem.

Phase 4 -- Evaluating and Implementing Interventions: The social worker monitors the effectiveness in resolving the client's problems.

Phase 5 -- Termination: The social worker summarizes and reviews the case with the client.

These five phases closely parallel the practice principles found within Perlman's problem-solving model. The practice principles include the following. The "will" preceding each statement signifies the "intention" underlying each of the following propositions. Lewis (1982) notes that such propositions in time can be specified operationally and subjected to empirical investigation. The "will" element in the proposition links the principle to its predictive assertion and that such propositions become the essential building blocks of knowledge claimed by our profession.

(1) The worker will help the client to identify their needs and problems.

(2) The worker will clarify the facts regarding the identified problem.

(3) The worker will seek to establish what psychological, social and physical factors are contributing to the client's problems.

(4) The worker will share with the client the significance of the problem.

(5) The worker will align his/her and the client's separate appraisals regarding the significance of the problem and select for joint consideration that which most clearly relates to the client's needs and goals.

(6) The worker will select some action in assisting the client to make some internal or overt behavioral change in relation to the problem.

(7) The worker will use the relationship with the client as the "catalyst" for problem-solving.

(8) The worker will make conscious use of time.

(9) The worker will assess with the client whether the problem-solving work is assisting the client.

(10) The worker will summarize and review the case with the client as part of termination.

The practice principles found within Perlman's method are sequential steps for guiding the problem-solving process. Its use, however, is very much a dynamic process (Bunston, 1985). One of the most important practice principles underpinning Perlman's problem-solving model is the worker's use of the "relationship" with the client as the "catalyst" for problem-solving. The dynamic process of problem-solving frequently involves the worker's use of the therapeutic relationship with the client. A problem-solving orientation on the part of the social worker requires that he or she help the client in ". . . the context of a positive therapeutic relationship" (Hallowitz, 1974, p. 137). A number of writers note that

the importance given to the relationship in the helping process has diminished in recent years despite the fact that the use of the relationship is the hallmark of social work practice (Biestek, 1957; Hamilton, 1951; Imre, 1984; Perlman, 1979; Proctor, 1982; Richmond, 1917; Siporin, 1983).

The term relationship has been used in casework since the early 1930s. It was first used by Virginia Robinson in her book, A Changing Psychology in Social Casework, published in 1930. Prior to the 1940s, there was little effort given to defining or analyzing the term conceptually. However, a number of writers attempted to describe the qualities of relationships which they considered important. The following is a list of the various descriptions of the term relationship taken from the early years of casework practice and outlined by Biestek (1957).

> 1929 The flesh and blood [in social casework] is the dynamic relationship between social caseworker and the client, child or foster parent; the interplay of personalities through which the individual is assisted to desire and achieve the fullest possible development of his personality (American Association of Social Workers, 1929, pp. 29-30).
>
> 1930 . . . a treatment relationship whose essential characteristic is dynamic interaction between client and worker. . . . the treatment relationship itself becomes the constructive new environment in which he [the client] is given an opportunity to strive for a better solution (Robinson, 1930, p. 150).
>
> 1935 In the process of both diagnosis and treatment the interview is in reality an interplay of dynamic personalities which

constantly act and react to each other's questions and answers, to each other's gestures, facial expressions, manners, and even dress. Generically an interview is a mutual view . . . of each other's thoughts, feelings, and actions.

Whether this process is designated as friendliness, rapport, identification, transfer, relations, sympathetic insight or empathy, it aims to establish a bridge across which an interviewer and interviewee can convey a sense of their mental and emotional nature to each other, whereby they can become 'we' in another form, winning across the void which separates man from man and gaining a feeling of kinship (Young, 1935, p. 2).

1940 At all times the case worker must offer a relationship free from prejudice and anxiety, an open table cleared for cooperative action in solving a certain problem . . . In the chemistry of the relationship between the case worker and the seeker of help, the resulting product depends upon the interaction of ingredients from both parties (Shafer, 1940, p. 180).

1941 It is the dynamic interaction which takes place between personalities, or better, between personality trends or drives . . . What happens depends upon the two individuals who, it should be remembered, are participating simultaneously in other relationships. In addition, much depends upon the situation in which people get together. Relationship, in other words, is the means for carrying out function. It must not be looked upon as an end in itself, but instead must remain incidental to function (Aptekar, 1941, pp. 48-49).

1948 The relationship is the medium through which the client is enable to state his problem and through which attention can be focused on reality problems, which may be full of conflict as emotional problems (Austin, 1948, p. 205).

1949 In its simplest form a relationship may be defined as a connection between two persons for common satisfactions or purposes. A casework relationship is the professional meeting of two persons for the purpose of assisting one of them, the client, to make a better, more acceptable adjustment to a personal problem. Within its limits is found the emotional exchange that makes

> treatment possible. The relationship is the sum total of all that happens between the participants -- all exchanged, the feelings, attitudes, actions, and thoughts expressed; everything, in fact, that the client and worker do whether open, overt or devious and hidden (Lyndon, 1948, p. 16).

> 1951 Within the democratic frame of reference the professional relationship involves a mutual process of shared responsibilities, recognition of the other's rights, acceptance of difference, with the goal, not of isolation, but of socialized attitudes and behavior stimulating growth through interaction (Hamilton, 1951, p. 18).

Throughout the years, other writers have contributed to the definition of the term relationship for social work practice. Taft (1949), speaking of social work process, states,

> In essence, all help, as we mean it, is psychological and depends upon a relationship process, whether it is expressed in the tangible form of relief, of foster home, of hospital service or is derived from interviews alone (p. 6).

Lewis (1982) includes the relationship as the key factor underlying a number of practice principles. For example, "The worker must continue to focus clearly on the reality of her current relationship with the recipient" and "The worker must offer through and within the helping relationship a new experience for the recipient" (p. 218).

Hollis (1972) states,

> Basic to all casework treatment is the relationship between worker and client. Three aspects of this relationship are of particular significance: it is a means of communication between client and worker; it is a set of attitudes; and it is a set of responses, expressed in behavior (p. 228).

Siporin (1975) states,

> A helping relationship is a state and process of mutual attraction and bond between two or more persons. It is a pattern of reciprocal expectations, interaction, and interdependence between a helper and person (or group) in need of help, in which the helper applies certain resources in the services of the other, and the other utilizes these resources to meet his needs (p. 202).

Perhaps no social worker has written more extensively on the term relationship, specifically within a problem-solving process, than Helen Harris Perlman (Perlman, 1957 and 1979). Beginning with Social Casework: A Problem-Solving Process, Perlman (1957) writes about the importance of the relationship between the social worker and the client during a problem-solving process. She reminds us that the client who needs help has invested a lot of feeling in the problem he or she presents and feels frustrated at finding him or herself helpless and uneasy at having to take help. Perlman (1957) states,

> Since some emotional involvement is inevitably a part of wanting and not wanting, striving and resisting, being able or being unable, the caseworker will continuously need to relate himself both to the objective difficulty and to the client's emotional involvement in it. By doing this the worker will be affecting the relationship bonds (p. 57).

In Relationship: The Heart of Helping People, Perlman (1979), provides a refinement of her earlier ideas and gives some important descriptions of the term relationship. This refinement is a reflection of the

change Perlman notes in her ideas about social work process and relationship which began with her initial focus on a structured process of conscious functioning and that of the structured problem-solving model of casework.

The relationship was viewed as being developed out of the problem-solving work between the client and worker. This was the "bud" of her problem-solving model of casework. However, she began to value the process and the relationship for "its enhancement of the human being and the human's becoming" as the profession's purpose (Perlman, 1971, pp. xix-xx).

> Relationship was now seen as . . . a catalyst, an enabling dynamism in the support, nurture, and freeing of people's energies and motivations toward problem-solving and the use of help. Thus, relationship is vital in the conveyance and utilization of any service given by one human being to another . . . the substance and dynamics of relationship within all or any of the human services deserves our recognition of its powers again -- or anew (Perlman, 1971, pp. xix-xx).

The idea that the relationship assists clients with problem-solving and that it does not have to be confined to a therapeutic process is significant for social work practice in discharge planning. Giving special attention to the relationship with the client, the social worker can affirm the client's self-worth and accept his or her presenting need. The relationship demonstrates to clients that they belong and that there is "compassionate concern" for them (Perlman, 1979). Focusing on relationship issues

during discharge planning may contribute to diminishing the widely-held belief among social workers that discharge planning is concrete and mechanistic. Relationship, in concert with a problem-solving process, should be what helping patients and families who have discharge planning problems is all about. Perlman (1979) states that the helping relationship

> is not at all a substitute for any of the things - aids, means, opportunities - that must be provided for people's well-being. It is an essential accompanying condition, because it is the nourisher and mover of the human being's wish and will to use the resources provided and the powers within himself to fulfill his personal and social well-being (p. 11).

It may be that the "aids and means" (telephoning and community referrals) came to be a substitute for the relationship component in some social workers' practice of discharge planning. Some authors have suggested that in recent times social work has given less attention to the concept of relationship as indicated by the dearth of references in the current literature (Imre, 1984; Perlman, 1979; Siporin, 1983). Although Perlman indicates that this may be due to a feeling that the topic has been exhausted by previous studies, there are others who feel that ". . . this trend mirrors the effort in the field to make the materials of social work conform to the criteria of positivist science" (Imre, 1984, p. 44). Siporin (1983) speaking of the helping relationship in social work practice states that

> The therapeutic process involves a relational process between the social worker and the individual, family, or group client and that also needs to be better understood and used. . . . The conception of the helping relationship and of the relational process remains incomplete (p. 197).

SUMMARY

Cost-containment measures in health care have produced many changes in general and psychiatric hospitals, the most notable being shorter lengths of stay for patients. As a result of the pressure to rapidly treat and discharge patients, many social work departments have taken a leadership role and assumed major responsibility for discharge planning. However, many social workers have viewed discharge planning as requiring little skill or expertise and as of lower status than other treatment responsibilities (Blazyk and Canavan, 1985; Davidson, 1978; Ullman and Kassebaum, 1961).

There is a particular need to conceptualize and develop practice models for the social work practice in discharge planning for social workers in psychiatric hospitals. Departments of psychiatric social work are struggling to identify and define the role of discharge planning within the other functions of psychiatric social workers (Thistel, 1987). The literature on social work in discharge planning has provided little information about the approach of psychiatric social workers to discharge planning. Many psychiatric social workers have roles that

are defined as "family treatment" and "individual treatment." They may value these functions because of the prestige accorded to them and many social workers may not view discharge planning as a therapeutic process (Lurie et al., 1981). Although many clinical social workers continue to view discharge planning as not "worthy of consideration," Rock (1987) states, "That attitude is most unfortunate and must be resisted. Discharge planning is a psychosocial process involving life choice for patients. It is thus at the core of a problem-solving approach to psychotherapy" (p. 530). Recent literature has begun to address the therapeutic value of discharge planning (Blazyk and Canavan, 1985; Rock, 1987). Blazyk and Canavan (1985) state,

> Referrals for both 'concrete' and interpersonal services are rich in symbolic meaning for the patient and for the family. Such referrals can be significant factors in addressing the social and emotional needs triggered by the illness and should be made with awareness of how each particular referral will influence these needs (p. 494).

Recently, increased attention has been given to psychiatric social workers and discharge planning but the discharge planning function remains an area in which the profession has little knowledge (Rock, 1987).

Social work must take a leadership role in developing comprehensive discharge planning systems including mechanisms for data collection, case finding, resource development, evaluation, and follow-up (Rock, 1987;

Shulman and Tuzman, 1984). In addition, social work must also take a leadership role in delineating the clinical expertise and the therapeutic components within the function of discharge planning. Many aspects of the discharge planning function have been discussed by social workers, but the therapeutic possibilities inherent in this task have been largely ignored (Blazyk and Canavan, 1985). There is an urgent need to do this within psychiatric hospitals. Ultimately, as Shulman and Tuzman (1980) state,

> It is the responsibilitiy of . . . social work . . . to devise and implement discharge planning programs that meet the increasingly restrictive regulatory requirements while not losing sight of patient's (families) physical and psychosocial needs (p. 6).

CHAPTER III

RESEARCH DESIGN AND DATA COLLECTION

INTRODUCTION

Shorter lengths of stay in psychiatric hospitals resulting from government cost-containment programs make it imperative that psychiatric social workers respond to the many psychosocial needs of patients and families, including discharge planning.

Psychiatric social workers lack the knowledge, techniques and resources to make discharge planning a therapeutic process for patients and families. Siporin (1975) notes that practice theory should be continuously checked, revised and validated periodically in relation to changing conditions and needs. This study of the helping process that psychiatric social workers use in assisting patients and families with discharge planning is an effort to examine an area of practice that is in the midst of significant change.

Discharge planning is a psychosocial process involving "life choices" for the patient and family and it is a "problem-solving" psychotherapeutic process (Rock, 1987). In order to conceptualize the therapeutic possibilities inherent in the helping process of assisting psychiatric patients and their families with discharge planning, it is important to understand how the social worker responds to

the patient and family as they experience the transition from hospitalization to discharge. A major task for achieving this understanding is to examine the helping process used by social workers when assisting patients and families with discharge planning. This entails exploring the problem-solving process and the relationship components psychiatric social workers use during the discharge planning process.

PURPOSE OF THE RESEARCH

The purpose of the research is to obtain information about the helping process social workers use to assist patients and families with discharge planning. Three research questions arising from this purpose are as follows:

1. What problem-solving principles do social workers use in discharge planning?

2. What problem-solving principles do social workers feel are most important or least important for resolving discharge planning cases?

3. Do social workers utilize the relationship component as one of the problem-solving principles in discharge planning?

DESIGN

The study follows an exploratory research design utilizing an experience survey (Atherton and Klemmack, 1982; Selltiz, Jahoda, Deutsch and Cook, 1959). Data collection consisted of (1) structured questionnaires on three hypothetical cases, (2) a card-sort ranking ten

problem-solving principles and (3) a questionnaire concerning the respondent's role and feelings about discharge planning (Appendix B).

During the card-sort the respondent was asked to rank order ten problem-solving principles from Most Important to Least Important. The purpose of this ranking was to get a picture of the individual's own view of, or attitude toward, the practice principle being considered (Atherton and Klemmack, 1982; Selltiz et al., 1959). A pretest of four interviews was conducted.

Respondents were asked to read three hypothetical cases based on actual clients and to answer five questions aimed at eliciting how they might actually intervene in a request for help around discharge planning. Case histories were edited to prevent identification of the clients. The questions included the following:

1. How would you proceed in the case?

2. What factors do you consider to be important in trying to resolve the case?

3. Are there any factors which you think might limit your ability to resolve the case?

4. How would you address these limitations?

5. How did you feel responding to the case?

Upon completion of the written responses to each case, the respondents were requested to rank ten problem-solving principles from the Most Important (1), to the Least Important (10), according to each case. The practice

principles were typewritten on three-by-five index cards. The respondents were requested to place each card upon a large chart which displayed a rating scale (Appendix B).

SAMPLE

A purposive sample of eighteen social workers, including two second-year students were selected. The social workers were employed at the Institute of Living, a 420-bed private, non-profit psychiatric hospital in Connecticut. The social workers were employed in various divisions throughout the hospital, and worked with different groups of patients and various ages. The work areas included the outpatient clinic (4, including the 2 students), the inpatient service (10), and the day treatment programs (4). There were sixteen female respondents and two male respondents. Except for the two students, respondents had a minimum of three years post-masters experience with a maximum of ten years experience. All but one of the respondents had prior experience with discharge planning and fourteen were currently involved with discharge planning. The primary responsibility of the social work respondents was family work, discharge planning and most recently for some of the workers, primary therapy. None of the respondents had taken a course in discharge planning.

The social workers in the outpatient clinic (excluding the students) had an average of 9 years experience in social work. The day hospital social workers had an average of 6.7 years of experience with a minimum of 4.5

years and a maximum of 11 years experience. The inpatient social workers had an average of 7.7 years of experience, with a minimum of 3 years and a maximum of 19 years of experience.

The respondents were asked ten general questions concerning their role and feelings about discharge planning (Appendix B). The outpatient social workers, whose principle role is that of a primary therapist for individual patients sixteen years of age and older, reported that they spent no time in discharge planning. They all felt that discharge planning was a critical part of treatment, specifically as it related to the termination process. However, they mostly related that it was "busy work" and were pleased that they did not have to be involved in it.

The outpatient social workers considered the following aspects to be the positive features of discharge planning: that it was part of overall treatment and as a result it could be challenging; it provided an opportunity to network with other professionals in the community. The following wre cited as negative aspects of discharge planning: there were limited resources; too much paperwork; the negative value attached to the process by colleagues; and the lack of time.

Lastly, the outpatient social workers felt that the role of the social worker in discharge planning should be

to help the patient and family adjust to discharge, to do a complete family assessment and to be a consultant to others around issues related to discharge planning.

The day hospital social workers' roles ranged from providing primary therapy (one worker to individual geriatric patients) to providing family therapy, group therapy and "concrete" assistance to the identified patient whose ages ranged from sixteen years of age to sixty (2 workers) and to patients sixty-five years and older (1 worker). They reported being "very involved" in discharge planning. The percentage of their time spent in discharge planning ranged from 20% to 50%. Although one worker stated that he spent "100%" of his time in discharge planning because he was always concerned with addressing issues of discharge with the patient and family throughout the patient's stay in the day hospital.

The day hospital social workers reported that they were involved in performing the following discharge planning tasks: telephoning community agencies, including federal and state government; coordinating interviews, transportation and financial resources; making recommendations to patients and families; assisting patients and families with gathering information, exploring barriers to programs and resources; collaboration with treatment team; working with the feelings of patients and families; and as one worker

stated, "making a series of therapeutic judgments along the way regarding how to tell them they have been rejected; how to explain delays; how much or little they should be involved vis-a-vis making calls."

The day hospital social workers related that discharge planning was essential to the treatment of the patient and family and that gains made in treatment could be lost without appropriate discharge planning. However, they also expressed feeling frustrated by the process when it either did not result in a successful outcome or when they were requested to become involved in discharge planning at "the last minute" so that little "clinical" involvement between themselves and the patient and family occurred.

They considered the following aspects to be positive features of discharge planning: when referrals for community services went smoothly; when the patient and family "properly" terminated with them; when discharge planning was integrated with treatment and there is the feeling that the patient and family will continue their improvement because of good discharge planning.

The following aspects were considered to be the negative features of discharge planning: too few resources; too long waiting lists; too many non-connecting telephone calls; lack of time to do a good job; when others interpret the social worker's role as a broker of services.

Lastly, the day hospital social workers reported that they felt that the role of the social worker in discharge planning should be one that is considered "central" to their overall function within the hospital. However, they related that the role had to be a part of "treatment" and not separate from it. They also reported that the consultant role in discharge planning was an appropriate role. Most of the day hospital social workers voiced much concern that they were often perceived of as "willing to pick up the pieces" and that they did not want a role in discharge planning that included this element.

The inpatient social workers whose primary role is family treatment (within adolescent units, short-term units, a geriatric unit and general adult units) reported they were all involved in discharge planning, specifically those cases in which they were already assigned to work with the family of the identified patient. The percentage of time spent in discharge planning was reported to be 20% to 65%. Most individuals reported that between 20% (4) and 50% (4) of their time was spent in discharge planning. The two social workers from the short-term units reported that 60% of their time was spent in discharge planning. The length of stay on the short-term units ranged from 10-35 days, with a mean of 25. The geriatric unit's average length of stay was 37 days, the adolescent unit was 100 days and the general adult unit was 80 days.

The inpatient social workers reported that they were involved in the following discharge planning tasks: assessing the patient and family needs; researching facilities (transitional living facilities and nursing homes); telephoning facilities; filling out forms; discussing with the patient and family and treatment team "clinicially and concretely"; giving information to the patient and family; helping patients and families come to a decision; helping families say "good-bye to the hospital"; helping families deal with chronic illness; collaborating with the treatment team; leading discharge planning groups for patients and coordinating services.

All of the inpatient social workers felt that discharge planning was an essential part of good treatment. However, many of them also expressed their dislike of the process. Some said that they did not like it at all, while others said that it was important, but it was the "least favorite" part of their job. The following comments were illustrative of their feelings: "I don't want to be the discharge planner for other therapists' cases." "Discharge planning is important, but I resent being summoned to perform miracles at the last minute." "I often feel that the work is dumped on me."

The inpatient social workers considered the following aspects to be the positive features of discharge planning: it lends focus to treatment; the patient and

family can work together to gain a sense of control; you get tangible results; it is helpful to families; the clinical aspects of termination; working with the family; knowing that the patient and family may sustain their improvement because of good discharge planning; becoming knowledgeable about community resources and developing relationships with other professionals in the community.

The following aspects were considered to be the negative features of discharge planning: insufficient time; insufficient resources; insufficient knowledge about resources; time-consuming process; being blamed for the discharge plan not working; having an unclear role; the separation of discharge planning from family treatment; when the family does not follow through with the discharge plan that the social workers developed.

Lastly, the inpatient social workers felt that the role of the social worker in discharge planning should be one that involved working closely with the family. They felt that discharge planning should be considered part of treatment and that the social worker should work on discharge planning with the patient and family on the day of admission. They also felt that the social worker should not be involved in discharge planning cases when they are not actively involved in working with the family. The inpatient social workers also felt that they could have a consultative role in discharge planning.

In summary, the sample represented a varied group of psychiatric social workers both in experience and practice settings. Most of the respondents were actually involved in discharge planning. There was a general consensus that discharge planning was essential to good treatment and of significant therapeutic value. However, there was also considerable ambivalence expressed about its place within their practice. For a breakdown of the social workers' attitudes and roles in discharge planning, please refer to Appendix F.

DATA ANALYSIS

The five questions to the hypothetical cases were intended to probe the respondents' reflective thinking about the case. A reflective focus for this segment of the study is based upon the ideas presented by Donald A. Schon (1983) in his book, The Reflective Practitioner. Schon observes that the aforementioned questions assist individuals with engaging in a reflective process and that thinking about specific problem situations their reflectiveness is generally focused around the following areas:

1. The reasons underlying a specific judgment the individual made about the problem situation.

2. Strategies and theories used to understand a pattern of behavior found in the problem situation.

3. The feeling for the problem situation which has led the individual to adopt a particular course of action.

4. The way the individual has framed the problem he or she is trying to resolve.

5. The role the individual has constructed for himself or herself within the larger institutional context and its influence on the individual's work with the problem situation.

The framework allowed for the utilization of the five questions following the hypothetical cases and it was intended to elicit the types of problem-solving principles and possibly theories social workers use when requested to help patients and families with discharge planning.

Originally, the responses were to be categorized and analyzed for the specific references that related closely to the practice principles found with Helen Harris Perlman's problem-solving model (Perlman, 1957). The analysis of the content was based on the assumption that most social workers would use principles found in the problem-solving process (Bunston, 1985; Siporin, 1983 and 1975) and especially when resolving discharge planning cases (Shulman and Tuzman, 1980). It was felt that Perlman's problem-solving principles led themselves as a classification system for recording basic units of the social workers' responses to the hypothetical cases (Selltiz et al., 1959). The practice principles are located in Appendix C.

Although many of the social workers' responses included references to specific problem-solving principles, the responses were not always clearly related to a problem-solving method, therefore, they were not easily categorized for the purpose of analysis. The responses to the five questions did not allow for a clear differentiation of practice principles for use as a classification system for the recording of responses. However, the nature of the responses did allow for them to be grouped for the purpose of categorization. As a result, the responses were first categorized according to each of the five questions and then the responses were further categorized according to the specific answer provided. For example, the responses to the question, "How would you proceed in this case?" revealed that the social workers intervened in a number of ways, including the following: (1) meeting with the patient and family; (2) consultation with the team; (3) locating available resources. Because most of the responses were similar, they could be utilized as separate groupings for the purpose of categorization. In this way it was possible to analyze the content and also to determine numerically how many social workers reported the same type of activity. Sentences were chosen as the basic unit for the classificiation of the responses. Selecting one or two sentence responses allowed for the categorizing of the

responses and for a detailed comparison of the responses (Holsti, 1969; Weber, 1985).

The reliability of this form of content analysis is usually achieved through intercoder reliability. However, because this is an exploratory study, the reliability of the analysis resided with the "stability" of the content classification over time (Weber, 1985). I followed the same procedure for classifying all the responses for each of the hypothetical cases.

Upon completion of their written responses to the hypothetical cases the social workers were requested to rank ten problem-solving practice principles from the Most Important (1) to the Least Important (10) for resolving each of the cases (Appendix D). Because only thirteen of the eighteen social workers fulfilled this segment of the study, the rank order scale of 1 to 10 was collapsed into the Most Important (1, 2, 3); Moderately Important (4, 5, 6, 7); and Least Important (8, 9, 10) in an effort to derive some meaningful conclusions. If a principle was ranked within any of these categories more than 30% of the time, it was considered important and thus reported.

The results were tabulated by hand. They were analyzed statistically by the means of a frequency distribution, which allowed for the summarizing of the findings. Based upon the small sample (13) and the number of practice principles (10), both the absolute (actual

numbers) and the relative frequencies (percentages) are reported. The simple ranking technique and the statistical analysis used allowed for a clear and concise reporting of the problem-solving practice principles that social workers felt were most, moderately, and least important for resolving discharge planning cases.

Qualitative data are used throughout the analysis to illustrate the directions or principles that social workers actually used and in an effort to provide a clear understanding of the phenomenon the social workers attended to in their attempts to resolve the discharge planning cases.

LIMITATION OF THE RESEARCH

There are a number of limitations associated with the study. First is the sample size of eighteen. This is a small number from which to draw any major conclusions regarding the problem-solving process and the attendant helping patterns social workers use in discharge planning in psychiatric settings. Therefore, the study is exploratory, designed to collect some preliminary information regarding the helping process social workers use with patients and families in discharge planning. The data are limited in terms of broad generalizability but may be important or have relevance for the social work staff at the Institute of Living.

A second limitation restricting generalization of the study's findings concerns the characteristics of the

social workers participating. Social workers at the Insititute of Living are a selected group, who have chosen to work within a psychiatric "treatment" facility. Their responses will be heavily influenced by this factor.

The third limitation is related to the validity and reliability of the instrument used to collect the data. The hypothetical cases, the follow-up questions to the cases and the ranking of the problem-solving principles may not elicit the type of information that is intended.

The fourth limitation is related to the procedures for analyzing the data. A content analysis of the findings from the responses to the hypothetical cases is used. The problem with this method of analysis is in devising a sufficiently specific descriptive or quantitative instrument for measuring the data. I have attempted to address this limitation by providing numerous quotations from the social workers.

The last limitation was related to my administrative role within the social work department. At the time of the study I was the social work coordinator for one of the hospital divisions and supervised a number of the respondents. Because of my position, the social workers may have provided responses to please me or provided responses that were consistent with some of my own beliefs regarding discharge planning. I attempted to address this limitation by informing the social workers that their participation was voluntary and anonymous.

CHAPTER IV

FINDINGS

INTRODUCTION

The study was undertaken to learn more about how psychiatric social workers use a helping process when resolving discharge planning problems.

The results suggest that the respondents used a helping process that was characterized by a person-in-situation focus and the workers' use of a problem-solving method. They proceeded to resolve the discharge planning problems by focusing on five primary tasks. The responses to the five questions closely correspond to that aspect of a problem-solving process that focuses on the client's social functioning and social relationships, concern for consensual agreement involving the client and significant others, concern for collaborative situational interventions and the provision of needed social resources (Siporin, 1975).

However, the findings from the five questions and from the ranking order of the problem-solving practice principles indicated that the social workers stopped their problem-solving work at Phase III - Planning Interventions. The respondents tended to use the same problem-solving practice principles throughout each case, while appearing to disregard a number of other practice

principles. They did not address issues related to termination. The findings did indicate that respondents used relationship components. However, they made few explicit comments with regard to using the worker-client relationship as a "catalyst" for the problem-solving work.

Lastly, the findings indicated that the respondents felt that there were a number of factors which would limit their ability to resolve the cases and frequently contributed to their negative feelings regarding their involvement with the case.

The findings from the three hypothetical cases and from the ranking of the ten problem-solving practice principles are presented below.

CASE NUMBER 1

A 76 year old white widow, Mrs. W, was admitted to the geriatric unit of a psychiatric hospital with a diagnosis of depression. Prior to her admission, Mrs. W was living with her 50 year old mentally retarded daughter in public housing. Mrs. W was found living in squalid conditions and appeared malnourished.

The State Department of Protective Services became involved in the case. The agency became conservator of person for Mrs. W and sought her admission to the hospital.

Mrs. W's level of depression began to improve after a few weeks of hospitalization. She managed well on the unit. However, her appetite remained poor and she

interacted minimally with other patients and staff. Because of the improvement in her level of independent functioning, the Utilization Review Committee informed Mrs. W and her doctor that her condition no longer warranted hospitalization. She had three days left in her insurance coverage. The staff, Mrs. W's doctor, and the Department of Protective Services did not feel the patient should return home. Mrs. W stated that she wanted to return home. The social worker was requested to help Mrs. W plan her discharge within this three day period.

Case 1 Question 1: How would you proceed in the case?

The responses of the 18 social workers revealed that in trying to resolve Case Number One they would pursue an approach that involved a variety of tasks. Fifteen of the 18 social workers identified a minimum of 5 tasks, with the remaining workers citing 3 tasks. The following are illustrative of the tasks mentioned by the workers.

TASKS

1. To explore or "investigate" whether there were other family members who could be involved in helping the patient.

2. To meet with the patient to "assess" her feelings about hospitalization and discharge options. Also, exploring ways of involving the daughter.

3. To "consult" and "collaborate" with the team to find out their recommedations, and also involve the conservator in this process.

4. To investigate and telephone community resources to determine what services were available at home and what nursing homes were appropriate.

5. To help the patient apply for specific entitlements like Medicaid, Meals-on-Wheels and homemaker services.

The responses demonstrated that the social workers used a sequential pattern in trying to implement a discharge plan. It generally began with some type of assessment of the problem, then consultation with the treatment team or outside agency, and then locating a nursing home or home care services. Concomitantly, the responses indicated that the social workers attended to the client's feelings about hospitalization and planning for discharge.

1. ASSESSMENT

One of the first tasks the social workers frequently mentioned they would attend to was to "assess" the circumstances surrounding the case (15 of the 18 respondents). They used the word "assess" or substituted similar words including "investigate", "explore" or "find out". Assessment was pursued for purposes of either trying to understand the client's feelings about discharge, trying to understand other situational variables including the impact of discharge upon the patient's daughter, insurance, financial and legal

problems or seeking others for some assistance in understanding various aspects of the case. As noted above, most of the responses included at least three tasks for resolving the case, many of which included assessing these numerous variables.

The following responses illustrate those variables the respondents stated they would assess.

"I would investigate whether the patient has any other family members that could be involved in her care."

"Explore whether the patient could reside at home if it was possible for such follow-up as visiting nurse, etc."

"Assess what treatment was necessary to maintain patient's recovery (ex: use of medication)."

2. MEETING WITH THE DAUGHTER

The respondents frequently stated that they would meet with the daughter in an effort to fully assess the case and to implement the most appropriate discharge plan.

The respondents indicated they would involve the daughter. Some of their responses were as follows:

"I would find out about the patient's retarded daughter and plan for her care."

"I would explore the circumstances regarding her retarded daughter and try to provide supports for her."

3. MEETING WITH THE PATIENT

Nine of the respondents indicated that they would involve the patient in their assessment of discharge options. Some of their comments were as follows:

"I would also want to speak with Mrs. W to find out her concerns about home, hospitalization and placement."

"I would meet with Mrs. W to do my own assessment of her functioning and her feelings about her hospitalization and post-discharge options."

The respondents' statement regarding seeing the patient and her daughter appear to closely correspond to the first five problem-solving practice principles in Appendix C.

4. COMMUNITY RESOURCES

The last task that the respondents included was locating available community resources for the patient and daughter (fourteen of the social workers gave this response). These resources included assistance from formal and informal systems. The formal systems included the welfare department, day care centers, nursing homes, visiting nurse services and mental health services.

However, the most frequently mentioned resource was the informal system, namely other family members. Eight respondents cited this as an important resource to locate.

Case 1 Question 2: What factors do you consider to be important in trying to resolve this case?

The respondents pointed to a number of factors which they thought were important for resolving the case. They are listed in the descending order of reported frequency.

IMPORTANT FACTORS

1. Financial and insurance issues (8)
2. The relationship with the daughter (7)
3. The wishes of the patient (7)
4. Housing/placement (7)
5. Time (6)
6. Teaming (4)

1. FINANCIAL/INSURANCE

Responses concerning these factors were primarily centered around the social workers mentioning "finances" or "limited insurance" as possible factors for helping the patient with discharge or as buying additional time in the hospital so that an appropriate discharge plan could be formulated.

2. RELATIONSHIP WITH DAUGHTER

The social workers expressed much concern about the daughter.

"How a discharge plan will affect the relationship between the patient and child."

"Concern for daughter and the patient's guilt if she were separated from her."

"Consideration of traumatic effect of separating patient and daughter."

3. THE WISHES OF THE PATIENT

Many social workers related the concern that the patient be allowed to express her feelings about discharge.

"The patient's desires."

"Her needs and wants."

4. HOUSING/PLACEMENT

Where the patient and daughter would live was also another concern expressed by the social workers.

"Finding realistic living arrangements."

"Finding residential care for the patient."

5. TIME

Time or lack of it was an important element for the social workers.

"Three day time period."

"The time factor of three days is the most critical element of the situation."

6. TEAMING

The ability to work with the team was another important issue for the social workers.

"Flexibility, empathy on part of co-workers."

"Staff feelings."

"Helping patient and staff reach an acceptable plan together."

The respondents' statement concerning the discharge plan's effect on the relationship between the patient and her daughter and with the patient's wishes and needs appear to reflect problem-solving principles one and two (See Appendix C).

As part of a problem-solving process the respondents were assessing the impact of various possible discharge

plans on the patient, the daughter and the relationship between the two.

Case 1 Question 3: Are there any factors which you think might limit your ability to resolve this case?

The respondents cited six key factors which they felt would limit their ability to resolve the case. They are listed below in the descending order of reported frequency.

LIMITING FACTORS

1. Time (13)
2. Family issues, including lack of family supports (10)
3. Lack of community supports, including housing, appropriate nursing homes (9)
4. Lack of agreement with the discharge plan (6)
5. Finances (4)
6. Lack of experience in working with the elderly (4)

1. TIME/FAMILY ISSUES

Clearly, the respondents felt that three days was an insufficient period of time to resolve the case in view of the complexity of the family situation. There was much concern over the lack of family supports and the effect of the mother-daughter relationship upon implementing the most appropriate discharge plan. Some of the respondents' statements concerning this were as follows:

"It is important to view the case in a systematic fashion, in other words, plans for mother cannot be made unless daughter's situation and mother-daughter are taken into serious consideration."

"Lack of supportive others and family means that discharge planning has to be coordinated by hospital."

"Lack of availability of other family members to assist in patient's care."

2. LACK OF COMMUNITY SUPPORTS

Many social workers commented on the apparent lack of community resources for the patient and/or daughter.

"Availability of placement."

"Lack of community resources."

3. LACK OF CONSENSUS ABOUT THE AGREEMENT WITH PLAN

The respondents felt that it might be difficult to get agreement for the plan from the patient, staff and other community representatives, and this was a limiting factor for resolving the case. The respondents' statements included the following:

"Attitudes of co-workers not willing to help or be flexible in planning."

"Mrs. W's resistance to a placement outside the home."

"Patient has conservator of person and patient does not agree with treatment team."

4. LACK OF EXPERIENCE WITH AGE GROUP

Respondents related that inexperience with resolving a discharge plan for patients in an age group with which they had little experience generated additional stress. Their comments included the following:

"Lack of expertise in working with geriatric patients."

"General discomfort and fear working with elderly people."

"My unfamiliarity with the resources for the elderly."

Case 1 Question 4: How would you address these limitations?

The responses indicated that the social workers would pursue four basic approaches in addressing the limitations of the case. They include the following, and are listed in the descending order of reported frequency.

BASIC APPROACHES

1. Contacting community resources (10)
2. Receiving assistance from the treatment team (8)
3. Contacting Hospital's Utilization Review Committee or the patient's insurance company (6)
4. Dealing with the patient's feelings (5)

Some of the respondents' comments on how they would address each of the four basic approaches or tasks is presented below.

1. CONTACTING COMMUNITY AGENCIES

The social workers were concerned with making appropriate community referrals.

"Help patient and daughter qualify for financial assistance."

"I would arrange VNA, Meals-On-Wheels and daycare assistance."

"Seek funds and assistance for nutrition and household problems. Contact public housing authorities."

"Request that Protective Services follow Mrs. W."

2. TREATMENT TEAM

The social workers expressed the need to work with the team.

"Consultation with other staff."

"Elicit help from the MD on case and other treatment team supports."

"Networking and gathering information via other staff members and supervision."

"Request assistance from other staff."

3. CONTACTING HOSPITAL'S UTILIZATION REVIEW COMMITTEE OR THE PATIENT'S INSURANCE COMPANY

The social workers expressed the need to extend the patient's hospitalization.

"I would try to talk with the Utilization Review Committee to buy Mrs. W some more time to make a discharge plan whereby Mrs. W has a chance to maintain her gains -- pointing out the likelihood of her returning soon if this isn't done."

"Try to see if any extension can be made with the insurance."

4. DEALING WITH THE PATIENT'S FEELINGS

The social workers were again concerned with addressing the identified patient's feelings.

"I would explore the patient's concerns about the daughter."

"Keep the patient's feelings and thoughts prominent in all planning."

The respondents' comments appear to represent the use of the first five problem-solving principles in Appendix C.

Case 1 Question 5: How did you feel responding to the case?

The feelings of the respondents mainly centered around being "frustrated", "angry" and "discouraged". These reactions were generated by the time constraint, lack of control and/or inexperience and the inability to meet the patient's needs.

Time constraints were cited most frequently by the respondents (8) as contributing to their negative feelings. Their comments about time indicate the negative influence of having to implement a discharge plan quickly. The following statements by the respondents demonstrate the intensity of feelings generated by time constraints in resolving a discharge plan.

"I feel discouraged and angry, particularly because of the time problem."

"I feel very angry and helpless because it is impossible to do a good clinical job without sufficient time. I would hate to be in this situation very often.

"Frustrated and angry, given the complexity of the case and the limited time in which to plan, it is practically impossible to do good discharge planning."

There was also a finding that negative feelings were generated for some of the respondents (6) by their limited control over the case and/or lack of experience. Not having sufficient time would seem to contribute to the feeling of limited control. The following statements were reflective of this concern.

"It seems like one of those very frustrating cases where the initial tendency is to experience one's self as impotent."

"I would have little power or control over the situation and I could see feeling quite helpless although rationally, I would have done my best."

"I find the process frustrating and often feel limited as where to seek help and/or what types of agencies can be most helpful. I have often felt that this area in my profession (personally) is limited and I need much more education and experience."

The last element which generated similar negative feelings was the respondents' (2) concern for the patient's needs. The following statements were concerned with this issue.

"I have great empathy for the patient who now faces an abrupt discharge, is in conflict with her treatment team

about the appropriateness of returning home, and is at the mercy of whatever options can be explored and secured within 72 hours."

"Discouraged and angry because of the apparent conflict between patient needs and wishes."

Time constraints, lack of control and/or inexperience and the inability to meet the patient's needs together created an intense degree of negative feeling about assuming a discharge planning role in this case.

CASE SUMMARY

The findings from case number one revealed that psychiatric social workers will attempt to resolve a discharge planning problem by attending to a number of sequential, interrelated tasks. The primary tasks included the assessment of the patient and family, collaboration with the treatment team, integrating the needs of the patient with the available resources and intervention with the patient and daughter around their feelings about discharge and its impact upon their relationship.

These factors, and in addition, time, were cited throughout the responses to the five questions as limiting factors needing to be addressed or as contributing to such feelings as anger, discouragement and frustration of the social worker.

CASE NUMBER 2

A 16 year old male, J, was admitted to the short-team unit of a private psychiatric hospital at the request of

his parents. The parents reported that their son had exhibited much acting-out behavior. He was consistently smoking marijuana and drinking. He missed an excessive number of days at school and had been suspended for fighting.

The parents reported having numerous violent confrontations with the patient over his behavior. The parents related that they did not want the son to return home upon discharge. They requested that J be transferred to a supervised residential setting from the hospital.

Initially, J was angry and negative with the staff and other patients. He refused to see his doctor or the social worker or to become involved in any of the unit's therapeutic groups. However, after the first week, J appeared to become more comfortable and began to join unit activities and see his therapist.

J had two weeks remaining in his hospitalization when a family meeting was scheduled. The parents remained adamant about their desire to have J discharged to a residential treatment setting. J stated that he did not want to live in a residential treatment setting and wanted to return home.

One week before J's insurance benefits were to run out, J informed the doctor and social worker that his father had abused him. J related his feeling that it was his father who did not want him to return home. J related

this information in confidence and requested that it not be shared with his parents.

The social worker was requested to meet with the parents and J and to arrange final discharge plans.

Case 2 Question 1: How would you proceed in the case?

The respondents indicated that they would address this case by pursuing a number of tasks. Ten of the respondents specified 5 tasks, 5 respondents 4 tasks, 3 respondents 3 tasks and 1 respondent specified just 1 task.

The five steps cited most frequently by the social workers included the following:

TASKS

1. Report the abuse to Department of Children and Youth Services (DCYS), or "Explore legal requirements of reporting suspected abuse to DCYS".

2. "Meet with the family" for purposes of "assessment", "exploration of situation" and "to discuss family situation."

3. "Investigate" or "explore" other options for placement or aftercare services.

4. "Involve" other agencies, including the school where ongoing treatment or financial assistance could be secured.

5. Meet with the patient to "review" the situation, to "explain" the need to report the abuse and to "find" out his perception of the problem.

1. FAMILY ASSESSMENT

The following statements illustrate how the respondents would proceed with the task of assessing the family.

"Do family assessment to determine specifically what the parents' concerns are."

"Family assessment to be done in order to understand family dynamics and their ability to benefit from treatment."

The social workers' responses revealed that they used a number of problem-solving practice principles which corresponded closely to principles 1, 2, 3, 5, and 6 found in Appendix C.

2. REPORTING ABUSE

3. EXPLORING AFTERCARE RESOURCES

4. COLLABORATING WITH COMMUNITY AGENCIES

A majority of the respondents reported that resolution of this case involved these tasks. Reporting the suspected abuse to the State Department of Children and Youth Services, investigating aftercare placement services, and involving other agencies were all mentioned. This finding represents that they were responding to the most immediate needs of the case by clarifying the legal obligations related to an allegation of child abuse, by securing some type of living arrangement for the patient, and by identifying other

helpful programs. The respondents provided the following statements regarding these three interrelated tasks.

"I would explore the legal requirements of reporting suspected child abuse."

"I would investigate temporary shelter."

"I would explore residential treatment, financial resources, application for Title 19 is necessary."

"Either way I would also involve the school system as well as other agencies to have the boy involved in on-going treatment with and without his family."

5. MEETING WITH THE PATIENT

Meeting with the identified patient was the last of the five tasks frequently cited by the respondents.

The following statements reflect how the respondents would proceed with this task of meeting with the patient.

"Discuss with J the reasons for not wanting the therapist to discuss the abuse with the parents; his refusal to live in a residential setting; issues which led to the family violence; and discuss the law about reporting abuse."

"Tell patient of my need to report information and tell him he could bring it up with my support in family session."

"Meet with J alone to find out the reasons why he wants to go home in light of previous abuse and assess if there are any extended family or responsible others with whom he could live."

"I think I'd put much effort to gaining the patient's trust with the hope that I could weaken the patient's defenses enough to allow for his wish for confidentiality to be waived."

The above statements appear to reflect that the respondents would use the first six problem-solving practice principles found in Appendix C.

Case 2 Question 2: What factors do you consider to be important in trying to resolve this case?

The respondents indicated that there were a number of important factors. They are listed in the descending order of reported frequency:

IMPORTANT FACTORS

1. Continued abuse (12)
2. Family issues (12)
3. Identified patient (9)
4. Placement (8)
5. Need for further assessment (4)
6. Time (3)
7. Reporting abuse (3)
8 Finances (3)

Some of the respondents' comments are presented below.

1. CONTINUED ABUSE

The social workers expressed much concern about the risk of abuse to the patient.

"Question of abuse is central."

"Risk for future abuse."

"Alleged history of abuse and violent confrontations."

2. FAMILY ISSUES

"Try and help family recognize issues, if possible, and see if they can give him some support and stay involved in some positive way."

"Parents' feelings about patient residing at home and possibility for there to be some working out of conflicts."

"Underlying family dynamics, including evidence of intergenerational abuse and/or alcohol abuse."

"I would also try and help the family deal with bombshell effect of a last-minute disclosure/allegations."

3. IDENTIFIED PATIENT

Again, social workers related various concerns about the identified patient.

"Patient does not seem motivated to change behavior at home or to live elsewhere."

"His needs for independence and support."

"The patient's well-being. Helping him work through father's abuse, not blame himself and try to help him build a positive life for himself."

"Patient's response to hospialization -- improve behavior, development of trusting relationship."

4. PLACEMENT

Where the patient was going to live was also among the social workers' concerns.

"Waiting lists complicate the problem."

"Suitability of other placements."

"Alternative living situations which would enhance patient's separation/individualization and ego development."

"Whether home is an option."

5. FURTHER ASSESSMENT

The social workers expressed the need for more assessment.

"Understanding why the patient would make such an allegation toward the father if in fact the abuse had not taken place. Establishing a better understanding as to the patient's resistance to a residential setting and his wish to return home."

"Clarification of the nature of the problem."

6. TIME

"Time limits are, again, the biggest pressure."

7. REPORTING ABUSE

"Disclosing abuse to Department of Children and Youth Services."

8. FINANCES

"Financial support for alternative living arrangement."

"Limited funds to pay for hospitalization."

A number of the respondents' statements with regard to the patient and family contained references to the first four problem-solving practice principles in Appendix C.

Case 2 Question 3: Are there any factors which you think might limit your ability to resolve this case?

The respondents cited six key factors which they felt would limit their ability to resolve the case. They are listed below in the descending order of reported frequency.

LIMITING FACTORS

1. Time (13)
2. Family situation/family dynamics (10)
3. Finances/insurance/limited resources (7)
4. Placement problems (4)
5. Confidentiality (4)

1. TIME

Although time was not cited frequently as being an important factor for resolving the case, it was cited as a factor for limiting the respondents in resolving the case. Time was not only a limiting factor in the sense that the social worker would be unable to resolve a discharge problem, but it was viewed as limiting the respondents' ability to intervene with the family, and was seen as being restrictive because of other caseload responsibilities. For example, some workers felt this case would require all their time and that as a result they could not attend to other cases.

Some of the respondents' concerns were as follows:

"Brief period of time in which to work with this family."

"Lack of time for addressing very major problems in relationships with the family."

"Time limit -- on inpatient stay at hospital (also other caseload responsibilities too)."

"The limited amount of time to work out these issues and greater limitations than necessary of being called in one week prior to discharge."

2. FAMILY SITUATION/FAMILY DYNAMICS

In Case Number Two some of the respondents' comments were as follows:

"Lack of effective strategizing with the boy and family."

"Family uncooperativeness."

"Family's inability or refusal to become involved in treatment and work towards solution/resolution."

"Lack of on-going relationships with the family and/or patient."

"Trust issues between the patient and family about abuse alleged by patient and conflict between patient and parents about returning home."

"Parents refusal to view situation with open mind."

3. FINANCES/INSURANCE/LIMITED RESOURCES

4. PLACEMENT PROBLEMS

Respondents were concerned that "finances, insurance, resources" and "placement" impinge upon their ability to implement a discharge plan within one week. Comments regarding these factors were as follows:

"Don't know about family's financial situation and whether more time can be bought."

"Financial restriction and questionable resources to find placement/treatment."

"Lack of available resources."

5. CONFIDENTIALITY

Confidentiality was also cited by some of the respondents as a limiting factor. Respondents either felt they were in a dilemma about reporting the abuse or that it was difficult to develop a therapeutic relationship with the patient and family.

Some of the respondents' comments were as follows:

"Patient's insistence on confidentiality regarding alleged abuse puts the social worker in a dilemma."

"The fact that one had to keep the abuse in strict confidence would limit flexibility, also possibility of working with the parents on the issue."

Case 2 Question 4: How would you address these limitations?

The responses indicated that the social workers would pursue three basic approaches for addressing the limitations of the case. They include the following and are listed in the descending order of reported frequency.

BASIC APPROACHES

1. Working with the family (12)
2. Contacting community agencies (11)
3. Consultation (5)

1. WORKING WITH THE FAMILY

Some of the respondents' comments regarding the work with the family were as follows:

"Enlist the family in locating resources if possible."

"By involving the patient and family in a process of self-disclosure, minimizing punitive nature of intervention."

"Educate family in a beginning way regarding abusive relationship."

"Be as open and honest with the family as possible."

"Do the best I can in helping parents and son (siblings) define the problem and to discuss issues together. Try to establish a working together atmosphere in addressing the problems."

2. CONTACTING COMMUNITY AGENCIES

"Work effectively with DCYS to develop appropriate interventions and funding."

"Enlist support and assistance of DCYS to aid in assessment and the possibility of needing out-of-home placement."

"Make decision regarding other agency involvement."

"Check out community resources."

Some of the statements appear to represent the use of the first four problem-solving principles found in Appendix C.

3. CONSULTATION

One last task chosen by the respondents for addressing the limitations was seeking consultation with others. Their comments were as follows:

"Seek consultation and supervision to resolve conflicts on whether to report abuse to DCYS."

"Discuss with staff."

"Consult with team."

"Involve as many people as possible."

Case 2 Question 5: How did you feel responding to the case?

The feelings of the respondents mainly centered around being "frustrated", "discouraged" and "angry". These reactions were generated by the time constraint, the family situation (the complexity of family issues) and lack of control. These findings were similar to those found in Case One.

A small number of the respondents indicated that they felt more comfortable in working with this case than they did with Case Number One.

1. TIME

Time constraints were cited most frequently (by eight respondents) as contributing to feelings of anger and frustration. The social worker had little time to implement a discharge plan and felt that there would be

little impact on changing the family. Some of their comments were as follows:

"Terrible. When there is limited time I am left feeling angry, frustrated and burnt out."

"Time limitations with the complexity of problems presented again, cause me to feel frustrated."

"Very little time to make an impact."

"Discouraged about being called in at last minute and angry about that, too."

"Frustrated again by time limitations restricting in this case amount of family work that could be done prior to discharge and to resolve conflicts between parents and patient."

2. THE FAMILY SITUATION

3. LACK OF CONTROL

Negative feelings were also generated by the family situation and the lack of control or inexperience with this type of client population. Six respondents cited each of these factors. Some of their comments were as follows:

"I felt frustrated by resistant parents."

"This case seems to differ from the first in that the family put the social worker in a difficult situation, rather than the social worker's peers."

"The patient and his parents might have not been so polarized if family therapy had been integrated with the patient's treatment from the start."

The respondents' comments regarding the lack of control or inexperience were as follows:

"Overwhelmed, especially as working with adolescents is not my area of expertise. While you can apply general knowledge and universal social work principles, I felt it is important to have specific knowledge about the population one is working with."

"I would find it difficult because I'm not familiar with laws regarding juveniles nor am I familiar with working with this age group in general."

4. TEAMING ISSUES

Two respondents cited problems related to teaming. Their comments were as follows:

"It's a pain in the ass because it causes a great deal of confusion regarding the nature of the problem and respective responsibility."

"It is a difficult case, which requires good team work and treatment -- and in this situation it wasn't really done."

5. COMFORT WITH THE CASE

Four of the respondents indicated that they felt "comfortable" in working with this case. It should be noted that these workers were assigned to adolescent units and were experienced in working with adolescent cases. Some of their comments included the following:

"I felt glad that I knew the procedures, guidelines and options."

"Fairly familiar to me. I am comfortable."

"I think I feel more hopeful about this sort of case because the patient has shown the ability to adjust to a treatment setting and open up to his therapist. Overall, I find this to be a very challenging and very classic kind of social work case."

CASE SUMMARY

The findings from Case Number Two revealed that this group of psychiatric social workers attempts to resolve a discharge planning problem by attending to a number of sequential, interrelated tasks. The primary tasks included the assessment of the patient and family, finding appropriate community resources and working with the patient and family for purposes of addressing feelings and relational patterns.

Time, the family situation and lack of control or inexperience, contributed to the respondents' negative feelings with regard to resolving Case Number Two. All three issues appear to be related to the respondents' concern that they would have little influence or impact on changing the family's pattern of relating and the underlying family problems. Respondents not affected by these factors felt more positive about the case because of prior experience and knowledge of client population and ability to see some of the client's strengths.

Many of the social workers' statements indicate the use of a problem-solving process in addressing the various issues associated with the case.

CASE NUMBER 3

A 77 year old married, white male, Mr. D, was admitted to a psychiatric unit for the second time in the last six months with a primary diagnosis of depression. Mr. D was readmitted from home. While at home he essentially remained in bed twenty-four hours a day. He become extremely demanding with his wife. Mrs. D had become extremely stressed emotionally and physically in caring for her husband. The couple's six children sought their father's readmission because of Mrs. D's own deteriorating condition.

Mr. D was readmitted to the hospital with only forty days remaining in his Medicare coverage. The family agreed to use some of their savings to pay privately when and if Medicare coverage stopped.

Mr. D was treated with a number of antidepressent medications. However, there was little improvement in Mr. D's level of depression or independent functioning. He continually reported numerous somatic complaints, wanted to die, and infrequently participated in the unit's therapeutic groups.

In his individual sessions, Mr. D was extremely negativistic and frequently spoke of his intentions to remain in bed when he returned home.

Mr. D was beginning to stay beyond the forty days of Medicare coverage. Mr. D's full recovery appeared slight and there was considerable concern about using all of the family's resources. The team felt that Mr. D required so much assistance that he should be transferred to a nursing home. The children also spoke of this possibility. Mrs. D was extremely ambivalent and experienced much difficulty in making a decision.

The social worker was requested to assist the patient and family in making final discharge plans. It was agreed that Mr. D would be discharged four weeks from the time of the referral to the social worker.

Case 3 Question 1: How would you proceed in the case?

The respondents indicated that they would address this case by pursuing a number of tasks. Ten of the respondents cited 5 tasks; 3 cited 4 tasks; 5 cited 3 tasks. The primary tasks included the following:

TASKS

1. Meeting with the entire family for purposes of exploring feelings with regard to the circumstances underlying the case; meeting with the patient's wife to explore her feelings; meeting with the family to assist them in securing supportive services and meeting the family for the purpose of assessment.

2. Exploring the possibility of nursing home placement, placing the patient's name on waiting lists.

3. Securing services for the wife.

4. Securing additional information about the patient's condition and involving the patient in the discharge process.

5. Exploring financial resources.

The tasks are presented below in the descending order of reported frequency, along with some of the respondents' comments regarding them.

1. FAMILY INTERVENTION

Sixteen of the eighteen respondents indicated they would have some type of involvement with the family. Meeting with the wife in order to explore her feelings and provide support was cited the most frequently, by nine of the respondents. Some of their comments included the following:

Meeting with the wife

"Meeting with the patient's wife to clarify her feelings and discuss preferred options."

"I'd try to work with wife by helping to instigate a productive mourning process."

"See spouse alone to offer support."

"Separate sessions with wife who may be torn and pulled in many directions. Focus on trying to help her look at how she wants to spend the rest of her life while recognizing her husband's illness and limitations."

"I would meet weekly with the patient's wife to clarify her concerns and work towards resolving her ambivalence."

Family feelings

Following the task of meeting with the wife, the two most frequently cited purposes of meeting with the family within the overall task of "Family Intervention" was to explore the family's feelings and to assist them in securing supportive services. Seven of the respondents cited each of these tasks.

"Meet with the patient's extended family to assess their feelings and help them work through issues."

"I'd try to engage as many family members as possible to begin working through their feelings of loss, separation, death and old age issues."

"Help family to address emotional issues related to placement, how it will be for them."

Securing supportive services

The respondents expressed the need to obtain community resources.

"Enlist the help of family members to find an appropriate nursing home. Help them look at financial and practical issues."

"Explore potential resources immediately and have the family assist in the process also."

"I would also discuss the financial situation with the family and see if Mr. D qualified for other assistance."

"I would recommend to family to check out volunteer services (e.g., church) and see if help could be arranged for Mr. D's care at home to help his wife."

Family assessment

Four of the respondents stated that they would proceed with some type of family assessment.

"Family assessment including the whole family (husband, wife, children and spouses)."

"Evaluate family as a source of help."

2. EXPLORING NURSING HOME PLACEMENT

The second task cited by a majority of the respondents for proceeding in the case was exploring the possibility of nursing home placement. Eleven of the eighteen respondents cited this task. Some of their comments were as follows:

"Identify appropriate skilled nursing facility in area preferred by the patient and family. Coordinate referral process."

"Assist the family in locating appropriate nursing homes."

"Contact nursing homes that family could visit which might be appropriate for patient. Investigate other living arrangements which might be possible for placement of patient."

"I might pursue looking into a facility which would provide care for both where she would get assistance with him and also have support herself."

3. THE IDENTIFIED PATIENT

Seven respondents would involve the patient for the purposes of securing additional information about his condition and including him in the discharge planning process. Some of their comments were as follows:

"Involve Mr. D in the discharge planning process (he may have previous thoughts that it was acceptable by family for him to stay in bed all the time at home)."

"Meet with the patient and do a brief assessment and ask the patient his preferences."

"I'd try to understand why the patient is treatment resistant."

4. EXPLORING FINANCIAL RESOURCES AND SERVICES FOR THE WIFE

The last two tasks cited frequently by the respondents were exploring financial resources and securing some type of assistance for the patient's wife. Five respondents cited each of these tasks.

"Look at financial/practical issues."

"Research for further financial resources."

"I would certainly make sure there was some support and coverage for Mrs. D."

"To have the spouse involved in some type of outpatient treatment for herself."

"Provide individual medical/psychiatric services for Mrs. D if necessary."

The responses of the social workers indicated their concern with the emotional components of the case and concomitantly a concern with the "concrete" dimension of securing placement.

The responses represent the use of the first seven problem-solving practice principles found in Appendix C.

As in Case One and Two, many respondents would meet with the identified patient to complete their assessment of his needs.

Their comments with regard to working with the patient also revealed the use of the first five problem-solving practice principles found in Appendix C.

The findings from all three cases indicate that meeting with the patient is an important task for discharge planning.

Case 3 Question 2: What factors do you consider to be important in trying to resolve this case?

The respondents indicated the following factors as important for resolving the case. They are listed in the descending order of reported frequency:

IMPORTANT FACTORS

1. Family (15)
2. Husband (14)

3. Wife (12)

4. Finances (7)

5. Nursing home (5)

6. Time (3)

Some of the respondents' comments regarding these factors is presented below.

1. FAMILY

The respondents expressed various concerns regarding the family situation.

"Family's ability and willingness to help wife with Mr. D."

"Effect of patient's illness on adult children."

"Help children accept their changing role with their parents and mourn the loss of their parents as caretakers."

"Realistic expectation of the children."

"Family guilt, unrecognized anger and guilt."

"Children's input."

"Helping family to grieve the loss."

"Family's willingness to be involved in decision-making process -- family level of maturity/use of denial."

2. HUSBAND

The respondents related a number of concerns with regard to the identified patient.

"Factors involved in Mr. D's depression and lethargy."

"Poor prognosis for the patient."

"Include patient so that self-determinatin is not ignored."

"Needs of the patient, desire of patient."

"Patient's strengths, weaknesses, goals."

"Mr. D's lack of motivation to change."

3. WIFE

The respondents expressed various concerns surrounding the wife.

"The stress level of Mrs. D. Mrs. D's feelings about her husband's condition and need for nursing home placement."

"Effect of patient's illness on wife."

"Helping Mrs. D with ambivalence, guilt and grief."

"Important to help Mrs. D so that she does not become exhausted."

"Needs of wife."

"Mrs. D's ability to cope with him at home."

"Wife's prognosis."

4. FINANCES

The respondents voiced concern over available funds.

"Funding availability."

"Cost of care: nursing home; VNA."

"Financial limitations."

5. NURSING HOME

Where the patient was to reside was another concern expressed by the respondents.

"Availability of an appropriate nursing home."

"Work needs to be done to see that a nursing home placement is successful."

"Waiting lists."

6. TIME

Lastly, time was another issue of concern to some of the respondents.

"There is more time than in other examples -- but still not enough!"

"Time constraints -- four weeks is not a significant period of time to accomplish goals."

Respondents' comments included references to the first three problem-solving practice principles found in Appendix C.

Case 3 Question 3: Are there any factors which you think might limit your ability to resolve this case?

The respondents cited nine key issues which they felt would limit their ability to resolve the case. They are listed below in the descending order of reported frequency.

LIMITING FACTORS

1. Finances (8)
2. Wife (7)
3. Husband (the identified patient) (7)
4. Waiting lists/finding appropriate placement (6)
5. Family (5)
6. Time (5)

7. Timing of intervention (3)

8. Working with the elderly (3)

9. Insurance (3)

Some of the respondents' comments regarding these factors is presented below.

1. FINANCES

Concern with financial matters was voiced by many of the respondents.

"Financial limitation may affect referral to SNF."

"Financial problems."

2. WIFE

The respondents expressed concern about a number of factors related to the wife.

"Patient's wife's ambivalence about placement."

"Mrs. D's resistance to separation from her husband."

"Mrs. D's ambivalence can immobilize her and make decision-making difficult and she needs the help of her children and/or friends at this time."

3. HUSBAND

The respondents made numerous statements about the patient.

"Guarded prognosis for patient. Poor response to medications and little noted behavioral improvement."

"Health status of the patient. Physical condition could deteriorate unexpectantly which might make a nursing home undesirable."

"Patient's lack of support and level of depression not allowing him to effectively participate in discharge planning."

"Patient's resistance to discharge planning."

4. WAITING LISTS/FINDING APPROPRIATE PLACEMENT

The respondents were again concerned about placement issues.

"Availability of appropriate facility within adequate proximity of patient's wife for visitation."

"Availability of nursing home beds may set limits on the case's resolution."

"Waiting lists exceeding a month. Facilities unwilling to take the patient due to depression and/or other prevailing problems."

5. FAMILY

A number of the respondents expressed concern about the entire family.

"The family's ambivalence complicates treatment somewhat."

"Family resources will undoubtedly limit options."

"Conflictual family relationships."

"The children may need help in backing off from patient's wife while she mourns and comes to terms with her loss."

"Need to mobilize family supports if he had to go home to wait for nursing home placement."

6. TIME

Again, the respondents continue to relate time as a limiting factor.

"Time constraints."

"Time (in relation to long waiting lists at nursing homes)."

7. TIMING OF INTERVENTION

The respondents stated their concern about the late referral of the case.

"Late referral may make working with relatives more difficult."

"Not being involved with the family from the start when the family was first involved with the hospital to develop an alliance with the family and to complete as extensive family evaluation as possible."

"Again, beginning intervention at the time of admission would have been helpful. It's not unrealistic to do some good work in a month."

8. WORK WITH THE ELDERLY

Some respondents again related their concern in working with the elderly.

"Lack of expertise with geriatric patients and resources."

"Again, my general reluctance to work with the elderly and over-identification with the needs of the children."

"My unfamiliarity with resources for this population."

9. INSURANCE

Insurance was another concern noted by some of the respondents.

Case 3 Question 4: How would you address these limitations?

The responses revealed that social workers would pursue four basic approaches or tasks for addressing the limitations of the case. They included the following and are listed in the descending order of reported frequency.

BASIC APPROACHES

1. Family intervention (13)
2. Assisting family with financial concerns (5)
3. Team consultation/education (5)
4. Nursing home placement/home care (4)

The respondents' comments contain references to a number of problem-solving practice principles. Some of the respondents' comments are listed below.

1. FAMILY INTERVENTION

The comments represent the selection of specific tasks to be addressed with the family.

"Be up front with the family from the beginning and ask children to check-out nursing homes. I would also give them list, including cost."

"I would also explore possibility of children taking turns staying with parents or the parents staying with them occasionally."

"Give information to wife and children."

"I would meet with the children in a psychoeducational and supportive way to help them understand some of their mother's issues and to also offer them support around their own issues."

"Meeting regularly with Mr. and Mrs. D, if not also to include the children, to explain current functioning, inform them of possible resources, pros and cons of the situation (placement or no placement)."

"Family ambivalence and feelings need to be addressed and worked through."

"Family therapy. Have family involved in selecting a home and exploring this with the patient."

The comments appear to represent elements associated with the first five problem-solving practice principles.

2. ASSISTING FAMILY WITH FINANCIAL CONCERNS

The respondents were concerned with helping the family secure financial assistance.

"Elicit aid from Medicare and/or other State Aid."

"Advise family on procedures to apply for Title 19 or other available funds."

"Place patient within the family budget."

3. TEAMING

Working with the team was another area of concern for the respondents.

"Long-term I would attempt to educate team regarding the importance of planning for discharge right from the time of admission."

"Consult with the treatment team."

"Again, consultation and collaboration with other staff, particularly patient's therapist."

4. NURSING HOME PLACEMENT/HOME CARE

Respondents related their concern for where the patient was going to live.

"Check into options of visiting nurse and nursing homes."

"Put Mr. D on waiting lists."

"Contact any persons in the community who might be helpful in suggesting appropriate facility/placement for treatment."

Case 3 Question 5: How did you feel responding to this type of case?

The responses to this question indicated that the respondents either felt more positive about responding to the case or felt frustrated, angry and helpless.

Eight social workers stated they felt more positive about responding to this case because there was more time, a workable family situation and a clearer role within the case.

Comments regarding positive feelings to the case include the following:

"I guess I feel a mix of hopefulness and sadness/frustration in responding to this case. At least family members (overall) seem willing to take necessary steps toward helping their father. It's sad that antidepressent meds don't help the patient."

"I feel reasonably good responding to this case. I felt competent and I felt the issue the family was facing was one which could be addressed and resolved with commitment and work. I also felt good that 4 weeks was allowed to formulate the discharge plan."

"Good because the family was so responsive, the burden of care did not seem to be exclusively on the social worker."

"More helpful than other two cases. More time to plan, more options and more family that may be able to provide support."

"This was presented with a little more time so I did not feel as pressed. Because it also seemed to be the type of case where the discharge plan had some definite constraints it seemed in some ways that there was more work to be done with family which I would like."

"In comparison to the other cases this was the least complicated (i.e., no legal issues to consider, sufficient time to do a good job). I felt like I would have more control and that my role was clear."

"Better than the last two, mainly because, while limited, there was more time to work out discharge and

because family was available to be involved from the beginning."

Eight respondents related that they felt frustrated, angry and helpless in responding to the case. They cited reasons such as the lack of time, the situation or type of case and personal issues with the case.

Some of the respondents' comments regarding these concerns were as follows:

"I object to the late involvement of the social worker (Medicare was already exhausted) in a case where placement decisions and family working through of guilt and acceptance of patient's condition require coordination with early treatment."

"Discharge date of four week hence seems arbitrary and I feel message to patient and family is that treatment has entered a status quo. Discharge planning phase with the social worker not taking an active role."

"Frustrated and left in the dark. Not feeling comfortable as I would if I had been able to develop an alliance with them from the beginning - rather than feeling like I'm running around crazy at the last minute."

"Sad, helpless, aware of my own aging prospects."

"Frustrated and aggravated with lack of time."

"Emotional difficulty of these decisions and my lack of knowledge about these systems. I also have a hard time with taking too much responsibility for wanting the patient and family to have a smooth discharge plan."

"I felt a little helpless and I'm sure if I were working with the couple I would feel sad that they would be facing a possible separation or leaving a home that meant a great deal to them. It is a difficult case to resolve and keep everyone happy, healthy and financially solvent!"

CASE SUMMARY

Responses to Case Number Three revealed that the respondents used a number of problem-solving practice principles in trying to resolve the case. In addition, they demonstrated a concern for psychotherapeutic variables like the family's response and adjustment to the patient's illness, role changes in the family and the family's response and adjustment to discharge planning. Concomitantly, the respondents were also concerned with situational variables like finances, appropriate nursing homes, and outpatient follow-up. The findings from Case Three were illustrative of the problem-solving phases of assessment, setting objectives and planning interventions (Bunston, 1985) and of the respondents' use of collaborative and community resource knowledge and skills identified by Lurie et al., (1981).

CARD-SORT OF THE TEN PROBLEM-SOLVING PRACTICE PRINCIPLES

After the respondents completed their written reactions to the hypothetical cases, they were asked to rank ten problem-solving practice principles from the Most Important (1) to the Least Important (10) for resolving each case. Each principle was typed on a 3 x 5 card. On the back of each card the letters A through J were assigned to each of the principles. The ten problem-solving principles are found in Appendix D.

Because there were few social workers ranking the principles, I collapsed the rank order scale of 1 to 10 into the Most Important (1, 2, 3); Moderately Important (4, 5, 6, 7) and Least Important (8, 9, 10).

CASE ONE

Most Important

Card	Frequency	Percentage
A	9	69.2
B	12	92.0
F	5	38.5

Moderately Important

Card	Frequency	Percentage
C	8	61.5
D	9	69.2
E	6	46.2
G	8	61.5
H	6	46.2

Least Important

Card	Frequency	Percentage
E	7	53.8
I	6	46.2
J	10	76.9

Principles (A) and (B) were ranked as the two Most Important for Case Number One. The only other principle to be considered Most Important was Principle (F). Principle (F) was ranked as Most Important by 38.5% of the respondents.

The following principles were considered Least Important in Case One: Principles (E), (I), and (J).

CASE TWO

Most Important

Card	Frequency	Percentage
A	10	76.9
B	10	76.9
G	5	38.5

Moderately Important

Card	Frequency	Percentage
C	7	53.8
D	6	46.2
E	5	38.5
F	6	46.2
G	7	53.8
H	5	38.5
I	9	69.2

Least Important

Card	Frequency	Percentage
E	7	53.8
I	6	46.2
J	10	76.9

As in Case One, Principle (A) and Principle (B) were ranked as the Most Important for resolving Case Number Two. The only other principle to receive a degree of relative importance was Principle (G). Principle (G) was

ranked as Most Important by 38.5% of the respondents.

The same principles were ranked Least Important for resolving Cases One and Two. They were Principle (E), Principle (I), and Principle (J).

CASE THREE

Most Important

Card	Frequency	Percentage
A	11	84.6
B	10	76.9
F	6	46.2
I	5	38.5

Moderately Important

Card	Frequency	Percentage
C	8	61.5
D	9	69.2
E	8	61.5
G	7	53.8
H	7	53.8
I	6	46.2

Least Important

Card	Frequency	Percentage
E	5	38.5
H	6	46.2
J	10	76.9

As in the first two cases, Principles (A) and (B) were ranked as the Most Important for resolving Case Number Three. Two additional principles achieved a degree of relative importance. They were Principles (F) and (I). Principle (F) was ranked as Most Important by 46.2% of the respondents and Principle (I) by 38.5%.

As in Case One and Case Two, Principles (E) and (J) were ranked as the Least Important principles for resolving Case Number Three. One other principle achieved a degree of relative importance within the category of Least Important and that was Principle (H). Principle (H) was ranked Least Important by 46.2% of the respondents.

SUMMARY OF CARD-SORT

The ranking of the problem-solving practice principles revealed that the respondents found the following principles to be the Most Important for resolving the discharge planning cases: helping the patient and family identify their discharge planning needs and other problems associated with discharge planning and establishing whether there are psychological, social and physical problems which may contribute to their discharge planning concerns.

The following practice principles were considered Least Important for resolving the discharge planning cases: selecting a task that will have the patient and family make some internal/external behavioral change in relation to the identified planning problem and addressing termination issues with them when the discharge planning process is completed.

SUMMARY OF FINDINGS

QUESTION ONE

Responses to Question Number One (How would you proceed in the case?) revealed that the respondents

pursued a sequence of integrated activities or tasks for resolving the three discharge planning cases. Most respondents provided a minimum of three integrated activities for resolving the cases. However, the majority of the respondents provided a sequence of five integrated activities. The five primary activities selected by the respondents for resolving the three cases included meeting with the identified patient and family to explore feelings and to do an assessment; exploring community resources for the patient; exploring community resources for the family; securing financial resources and consulting and collaborating with the treatment team.

The number of integrated activities the respondents selected for each case is illustrated in Table 1.

TABLE 1

SEQUENCE OF TASKS

CASE ONE

Number of Tasks	Frequency	Percentage of Respondents
7	1	5.5
5	15	83.5
4	1	5.5
3	1	5.5

CASE TWO

Number of Tasks	Frequency	Percentage of Respondents
5	10	55.5
4	5	27.5
3	3	16.5
1	1	0.5

CASE THREE

Number of Tasks	Frequency	Percentage of Respondents
7	10	55.5
4	3	16.5
3	5	27.5

Overall 64% of the responses to the three cases indicated that the respondents would proceed to resolve the discharge planning problems by selecting a sequence of five integrated activities. The specific activities selected by the respondents and their comments with regard to most of the questions revealed a set of findings that appear to correlate closely with a helping process that is characterized by a problem-solving approach, utilizing particular relationship components.

QUESTION TWO

Responses to Question Number Two (What factors do you consider important for resolving this case?) identified a number of important factors, some of which were pertinent to the specific characteristics of each case. Factors related to the family, housing, and/or placement were cited as important in all three cases. Except for the first case, involving the elderly female patient who had a limited family system, family was mentioned as an important factor by most respondents. In the case of the adolescent patient and in the case of an elderly male patient, the family was considered by 83% of the respondents as an important variable.

Housing and/or placement was the only other factor mentioned with some degree of frequency in all three cases. Thirty-eight percent of the respondents mentioned this factor for the elderly female patient whose adult daughter was retarded, 44% in the abused adolescent case and 27% in the elderly male patient case. Finances were mentioned with some frequency in two of the cases. In the case of the elderly female patient and the elderly male patient they were cited by 44% of the respondents.

The breakdown of those factors considered important for resolving the three cases is illustrated in Table Two.

TABLE TWO

IMPORTANT FACTORS FOR RESOLVING THE CASE

CASE ONE

Important Factors	Frequency	Percentage of Respondents
1. Financial/Insurance	8	44
2. Seeking involvement w/daughter	7	38
3. The patient's desires	7	38
4. Housing	7	38
5. Time	6	33
6. Team Issues	4	22

CASE TWO

Important Factors	Frequency	Percentage of Respondents
1. Family issues	12	83
2. Continued abuse	12	83
3. Identified patient	9	50
4. Placement	8	44
5. Further assessment	4	22
6. Time	3	16
7. Reporting abuse	3	16

CASE THREE

Important Factors	Frequency	Percentage of Respondents
1. Family issues	15	83
2. Issues regarding husband	14	77
3. Issues regarding wife	12	66
4. Finances	7	38
5. Placement	5	27
6. Time	3	16

QUESTION THREE

The responses to Question Number Three (Are there any factors which you feel might limit your ability to resolve this case?) revealed that there was an average of four factors per case. Again, the specific characteristics of each case influenced the factors selected by the respondents. The principal differences of each case revolved around the time allowed for the case and the age of the identified patient. In the case of the elderly female patient when there was a three day limit for resolving the case, 72% of the respondents indicated that time was a primary limiting factor. Family issues were the next factor cited, mentioned by 55% of the respondents.

In the case of the adolescent patient which allowed for a two week period for resolving the discharge plan, 72% of the respondents gave time as the primary limiting factor. The next factor receiving the most responses was family issues, cited by 55% of the respondents.

In the case of the elderly male patient which allowed for 4 weeks' time to resolve the discharge plan, time was

not cited with the same degree of frequency as it was in the two previous cases. Twenty-seven percent of the respondents indicated that time was a limiting factor. The primary limiting factor in Case Number Three was issues involving the entire family, cited by 61% of the respondents. This was followed by finances, mentioned by 44% of the respondents.

There were a number of factors cited less frequently, which nonetheless provided some important information regarding areas of concern which may influence the respondent's role in discharge planning.

In the case of the elderly female patient, 16% of the respondents cited the lack of agreement with the staff over the discharge plan they may arrange as a limiting factor for resolving the case. In addition to this factor, 22% mentioned the unfamiliarity in working with the elderly as a limiting factor.

In the case of the adolescent patient, 22% of the respondents mentioned the confidentiality of the patient as a limiting factor. In Case Number Three, 16% of the respondents cited the unfamiliarity in working with the elderly as a limiting factor.

Table Three illustrates the breakdown of those factors identified as limiting the respondent's ability to resolve each of the three cases.

QUESTION FOUR

Question Number Four (How would you address these limitations?) revealed that the respondents would again use a sequence of integrated activities previously found in the responses from Question Number One. Three principal approaches emerged for addressing the limitations of each case. They are as follows:

1. Working with the patient and family.
2. Contact with community agencies.
3. Consultation with the team and/or supervisor.

Table Four illustrates the sequence of activities for addressing the limitations cited in each of the three cases.

TABLE THREE

Limiting Factors

CASE ONE

Limiting Factors	Frequency	Percentage of Respondents
1. Time	13	72
2. Family issues	10	55
3. Lack of agreement with the discharge plan by staff, patient and/or patient's conservator	6	33
4. Unfamiliarity in working with the elderly	4	22

CASE TWO

Limiting Factors	Frequency	Percentage of Respondents
1. Time	13	72
2. Family issues	10	55
3. Finances/community resources	7	38
4. Patient confidentiality	4	22

CASE THREE

Limiting Factors	Frequency	Percentage of Respondents
1. Family issues	11	61
2. Finances	8	44
3. Issues related to wife	7	38
4. Issues related to husband	7	38
5. Placement concerns	6	33
6. Time	5	27
7. Unfamiliarity in working with the elderly	3	16

TABLE FOUR

Tasks for Addressing Limitations

CASE ONE

Sequence of Tasks	Frequency	Percentage of Respondents
1. Contact with community agencies	10	55
2. Consultation with the team	8	44
3. Working with the patient and family	4	22
4. Working with the Utilization Review Committee or insurance company	3	20

CASE TWO

Sequence of Tasks	Frequency	Percentage of Respondents
1. Working with the family	12	66
2. Contact with community agencies	11	61
3. Consultation with the team	4	22
4. Working with Utilization Review Committee	1	.5

CASE THREE

Sequence of Tasks	Frequency	Percentage of Respondents
1. Working with the family	13	72
2. Assisting with the financial concerns	4	22
3. Consultation with team	4	22
4. Addressing placement issues	3	20

QUESTION FIVE

The last question, Number Five, asked how the respondents felt about the cases. Overall, the responses indicated that they felt angry, frustrated and discouraged most of the time. The respondents related these feelings to time constraints, lack of control within the case, inexperience in working with a specific patient population and not being able to meet the needs of the patient and family.

In the case of the elderly female patient, the primary reason contributing to such feelings was the issue of time, cited by 44% of the respondents. The next reason, cited by 36% of the respondents, was the feeling of limited control and/or inexperience with the case situation.

In the case of the adolescent patient, time was, again, cited by 44% of the respondents as contributing to their negative feelings regarding the case. The family situation and inexperience in working with adolescents was cited by 33% of the respondents.

Interestingly, 22% of the respondents stated that they felt comfortable with this case and attributed their feelings to experience with adolescent cases.

In the case of the elderly male patient, the respondents indicated that they either felt positive about the case or frustrated and discouraged. More respondents

felt positive about working with this case than the first two cases. The positive feelings were attributed to having more time, a workable family situation, and a clear role within the case. The respondents who felt frustrated by the case cited the lack of time and the patient's poor prognosis as contributing to their negative feelings. One individual stated that fears of aging made the case a frustrating experience.

SUMMARY OF THE RANK ORDER OF PRACTICE PRINCIPLES

Responses to the ranking of the ten practice principles from the Most Important to the Least Important revealed that for all three cases Principles (A) and (B) were consistently ranked as the Most Important for resolving the discharge planning problem (See Appendix D).

For all three cases, Principles (A) and (B) were ranked as Most Important 76.1%. This closely corresponds to the first two activities selected by the respondents for resolving the discharge planning problem in all three cases. These were to meet with the identified patient and family to explore their feelings regarding the current status of discharge planning and to assess for themselves the nature of the discharge planning problem and other areas related to discharge.

The ranking of Principles (A) and (B) as Most Important for the three cases and the strong relationship to the first activities for resolving the discharge

planning problem suggests that the two primary practice principles for resolving discharge planning problems are including the patient and family in identifying their discharge concerns and assessing the case.

There were additional principles that achieved a level of relative importance during the ranking of the practice principles. In the case of the elderly female patient, Principle (F) was ranked as Most Important by 38.5% of the respondents (See Appendix D).

For the case of the adolescent patient, Principle (G) was ranked as Most Important by 38.5% of the respondents (See Appendix D).

In the case of the elderly male patient, Principles (F) and (I) were respectively ranked Most Important 46.2% and 38.5% of the time (See Appendix D).

The fact that these principles were not consistently ranked as Most Important for all the cases can be attributed to the different characteristics of each case. There were dissimilar problems, age groups and time periods for each case. For example, in the case of the elderly male patient the ranking of two additional practice principles as important may be accounted for by the fact that the respondent had more time to resolve the discharge plan (four weeks compared to three days in Case One and two weeks in Case Two). As such, the respondents could have the family focus on the use of time. The

family also appeared more cooperative in helping their relative, thereby allowing the respondent to feel more comfortable utilizing the relationship component during the discharge planning process.

There were two principles ranked as Least Important for the three cases. They included Principles (E) and (J). Principle (E) was ranked as Least Important by 48.7% and Principle (J) 76.9% (See Appendix D).

In the case of the elderly female patient and the adolescent patient, Principle (I) was ranked as Least Important by 46.2% of the respondents for both cases (See Appendix D).

Principle (H) was the only other principle ranked as Least Important -- 46.2% in all three cases (See Appendix D).

The ranking of Principles (I) and (H) as Least Important for resolving the respective cases may again be accounted for by the different characteristics found in each of the three cases. Principle (I) may have been less important in the case of the elderly female patient and the adolescent patient because the allotted time to resolve the case was so short that "the use of time" was apparent and in everyone's conscious awareness.

The findings from the ranking order of the problem-solving practice principles suggests that social workers are more likely to find some practice principles to be helpful in resolving discharge planning, while others are perceived to be less helpful.

CHAPTER V

DISCUSSION

The study was undertaken to learn more about how psychiatric social workers use a helping process when resolving discharge planning problems. Due to the small sample size and the low completion rate in the ranking order of the problem-solving practice principles, the findings should be regarded as provisional.

The results suggest that the respondents would use a helping process characterized by a person-in-situation focus and use of a problem-solving approach. The findings suggest that the key elements of a problem-solving method for psychiatric discharge planning are assessment, meeting with the identified patient, family, work, client-worker relationship and the provision of social resources. This finding appears to support those who have called for a problem-solving model in discharge planning (Rock, 1987; Shulman and Tuzman, 1981).

The findings also indicate that there are key problem-solving practice principles used by psychiatric social workers. In addition, the findings indicate that the problem-solving work stopped at Phase III of the problem-solving stages proposed by Bunston (1985) (See Chapter Two, p. 42), termination issues were not addressed and some problem-solving practice principles were not used.

Lastly, there were numerous variables which contributed to the respondents' negative feelings for the discharge work. The three principal elements were the lack of time, inexperience with specific client populations, and lack of community resources. To a lesser extent, collaborating with the treatment team was seen as negatively influencing the respondents' attitude toward the discharge process.

CLIENT-WORKER RELATIONSHIP

The findings indicate that the respondents used relationship components such as encouraging the expression of the client's feelings within a supportive environment, encouraging the client (family members) in a discussion of problems and providing a sense of warmth and acceptance when trying to resolve the discharge planning problems. However, the respondents made few explicit comments with regard to using the worker-client relationship as a "catalyst" for the problem-solving work.

The finding that respondents emphasized the feelings of the patient and family in resolving the cases reflects another aspect of the problem-solving process, namely, the relationship component (Perlman, 1957). By giving attention to the patient and family's feelings the respondents were dealing with that part of the helping relationship which is "need meeting" for the clients (Siporin, 1975). An essential task of the helping

relationship is to allow the individual to express his or her feelings (Smalley, 1967). Through the expression of feelings, the relationship can then develop between the client and the social worker.

> Facilitating the expression of the client's feelings may allow for the articulation of what is wanted and allows for a mutual understanding of problems, choices for solution and a mutual affirmed purpose (Smalley, 1967, p. 172).

These elements represent that aspect of the problem-solving process of relationship building where the worker attempts to clarify the problem situation by actively involving the client to think about him or herself and his or her situation and then to arrive at an agreed joint effort to resolve the problem (Bunston, 1985; Hallowitz, 1974).

Respondents' concern to allow the patient and family to discuss their feelings demonstrates themselves to be a ". . . receptive, responsive, empathic, helpful relater" (Perlman, 1957, p. 189). "One of the chief aids to releasing the client is the caseworker's relating consistently to his feelings" (Perlman, 1957, p. 143). This is a critical element for the relationship because as Perlman (1957) states,

> It contain[s] elements of acceptance and expectation, support and stimulation . . . to be cared for is a sign of one's worth. To be cared about by someone for whom one has respect and liking enhances the personality. [When the other's] eyes reflect an image that is likable, respectable, understandable, then our self-esteem is raised and served (pp. 73-74).

This is what is meant by "need meeting".

Sensitivity to the client's feelings, a core component of effective helping within a problem-solving process, was reflected in the respondents' general responses (Bunston, 1985). This finding is consistent with the original premise that the respondents would give attention to the relationship component when resolving discharge planning cases. However, the respondents never made direct reference to using the "relationship" as part of the problem-solving work. This omission may be accounted for by the fact that

> . . . much of the problem-solving work is on an unconscious or only partly conscious basis; that is, it happens spontaneously in the empathic interaction between case worker and client (Perlman, 1957, p. 87).

The findings regarding the concept of relationship provide some preliminary answers to questions raised earlier about the relationship component in discharge planning, including: What kind of relationship is most helpful and at what particular points in time? What changes in the patient/family should the relationship accomplish? What must the social worker do to accomplish the desired outcome of the relationship? The kind of worker-client relationship that appears most helpful is where there is a "partnership" throughout the problem-solving work in discharge planning. The relationship should be utilized to help the patient and

family accept a greater role in the decision-making about the final discharge disposition. To achieve this outcome the social worker must attend to feelings and allow the patient and family to share their varied concerns.

No qualitative differences could be discerned from the responses in the use of the relationship in terms of the various time periods of 3, 14 and 28 days for resolving the cases. However, the findings also suggest that further research is needed to learn more about how the relationship is used by social workers when resolving discharge planning problems. Siporin (1983) has stated that ". . . the conception of the helping relationship and relational process remains incomplete" (p. 197). In addition, Proctor (1982) states,

> . . . workers know that clients, their situations, and their problems vary widely, and they know that many different kinds of treatment relationships are possible and, at different times, desirable. Thus, the notion of a uniform invariant therapeutic relationship so prevalent in the literature is challenged by the multifaceted and varying nature of actual practice (p. 431).

This is especially true for the use of the relationship in discharge planning. With regard to discharge planning, perhaps Proctor (1982) is correct when she states that:

> Rather than attempting to achieve the ideal treatment relationship, practitioners need to consider for a particular client which conditions or outcomes their relationship will facilitate the larger purposes of treatment, and they must then identify the necessary interventive behaviors and responses to reach those ends (p. 433).

The respondents' attention to the feelings of the patient and family not only represented a concern with the relationship element in the helping process, but also with that part of the relationship which is concerned with the clients' right to self-determination (Perlman, 1957).

MEETING WITH THE IDENTIFIED PATIENT

The respondents' comments with regard to addressing the needs and wishes of the identified patients in the three cases, meeting with them separately and actively involving them in the problem-solving work of discharge planning, corresponds closely with Perlman's statement that part of fact finding in the problem-solving process is to "measure the client's capacities and needs" (Perlman, 1957, p. 191).

Within the context of meeting with the identified patient, the respondents attempted to determine the facts of the case. This represented the beginning of a problem-solving process. Perlman (1957) states,

> The first part of the casework process as in all problem-solving, is to assert and clarify the facts of the problem. The second aspect of casework problem-solving grows out of and is interwoven with the ongoing eliciting of facts: it is thinking through the facts (p. 89).

The social worker has his or her own problem-solving task to perform which consists of collecting the facts regarding the identified patient, family, problem(s), discharge options and then analyzing and organizing these facts, reflecting upon them and coming to some judgment of

their meaning and what is to be done about it and how to do it. Perlman (1957) states,

> The work of problem solving in the caseworker's mind must . . . be a systematically organized process. He will hardly play it out in its logical outline because he will measure it to the client's capacities and needs. But he must be clear as to what must happen in order to move from dilemma to solution or from statement to decision; the facts that constitute the problem must be known, thought and feeling must be brought to play upon them and choices and means for dealing with them must be considered and decided upon (p. 88).

The respondents' responses illustrated this aspect of the problem-solving process of eliciting and clarifying the facts of the case, attending to feelings and thoughts, and the consideration of the means to resolve the problems. The responses reflected strong commitment to social work values. Respondents were attentive to the patient's and family's right to self-determination, the right to receive adequate information about their illness and discharge plan, their right to alternate types of care and what Lurie et al. (1984) call the "recognition that continuity of care planning has as its major goal the achievement of as high a quality of life as possible" (p. 6).

The respondents' comments reflected basic ethical practice principles including: "To esteem and facilitate client participation"; "Individualization of the client as a unique person"; "Respect for the inherent worth and dignity of the individual"; "Respect for confidentiality";

"Empathy"; and a "Respect for colleagues, as persons, and for the worth of their contribution to helping tasks" (Siporin, 1975, p. 75).

The respondents' comments appeared to convey a sense that these principles would be utilized in resolving the cases. The enactment of these principles constitutes the respondent's use of self as a helping person within a problem-solving process (Siporin, 1975).

ASSESSMENT

A by-product of having the patient and family share their feelings is that it can become an experience in adaptation for the client and it is part of the assessment process (Perlman, 1957). Findings about respondents' concerns with the nature of the discharge problem and the patient's and family's functioning as it related to the discharge plan represented another aspect of the problem-solving process. An important element of the problem-solving process is to determine how best to help the client. The respondents stated they would help the patient and family by "assessing" the circumstances surrounding the case in an effort to understand their feelings about discharge and how situational variables impacted on the discharge plan and the patient and family. The respondent was attempting to create a "diagnostic product". They accomplished this by determining what the problem is, how it is related to the

client's goals, and what means the agency, the worker and client can bring to resolve the problem (Bunston, 1985; Perlman, 1957).

Problem-solving work begins with an assessment (Bunston, 1985). Assessment has been described as ". . . both a process and a product of understanding, upon which action is based. Assessment is an ongoing affair, continuous with the helping process itself" (Siporin, 1975, p. 219). Lewis (1982) states that the ". . . most critical and difficult intellectual task is . . . accurate assessment of the nature of the need and the appropriate action to meet it" (p. 15).

Lewis (1982) outlines the following assessment scheme: (1) identify the key elements in the problematic situation; (2) relate these elements in propositional statements that explain the specific problem condition to be altered; (3) suggest the appropriate intervention procedures and program of action for achieving the desired changes in the problem conditions; and (4) explicitly or implicitly designate the desired consequences of the service. Many of the respondents' comments about how they would pursue an assessment of the cases reflect a number of these elements. However, as Lewis (1982) states, "Such a scheme is an ideal not readily achieved in social work practice" (p. 194). Respondents made numerous references to trying to clarify the facts of the case and determine

the problem. The workers appeared to be engaged in their own problem-solving work which involves

> . . . examining the parts of the problem for the import of their particular nature and origin, for the interrelationships among them, for the relationship between them and the means for their solution -- this is the diagnostic [assessment] process within the problem-solving work (Perlman, 1957, p. 164).

FAMILY WORK

An underlying theme repeatedly presented by the respondents was the importance of meeting with the family for the purpose of addressing "their feelings". This finding implies that, at least for this group of respondents, discharge planning not only involves the investigation and/or securing of services for the identified patient, but a concern for the family. Throughout the discharge planning process the social worker must also simultaneously attend to and have an understanding of the patient's and family's feelings regarding the discharge and the presenting problem which brought them to the hospital.

Intervention with family was a significant psychotherapeutic variable frequently identified by the respondents. Concern with the family and the identified patient's role within the family appear to reflect the systems orientation of many of the respondents. A systems framework is an orientation

> . . . where the approach to helping grows out of the basic premise that human beings can be

> understood and helped only in the context of the intimate and powerful human systems of which they are a part. One of those powerful systems is the family of origin which has developed through the generations over time and which has deep and far-reaching effects on all its members (Hartman and Laird, 1983, p. 4).

Perlman (1957) also recognized the importance of the family in the problem-solving work. She states:

> Our ideas of what we need and want, our standards of behavior and our valuations of status, achievement, and even security, our sense of psychological well-being or imbalance -- all of these are fashioned by what we absorb from interaction with the attitudes and ideas of the people whom we grow and live moreover, the channels and opportunities through our physical and psychological selves can be both enhanced and expressed within our environment [family] (p. 18).

Various components of those problem-solving processes have been used in family therapy, and some of these components were reflected in the responses pertaining to the family (Hallowitz, 1970 and 1974). The respondents' comments illustrated their attempts to help the family develop a better understanding and feeling of family relationships that could generate more productive problem-solving work around discharge planning. They did this by stimulating family members to develop their own solutions to address the reality problems associated with their situation and to develop their own solutions when possible (Hallowitz, 1970).

For example, the respondents' concern in Case Three with helping the adult children understand their mother's

experiences, and need to mourn, and with exploring new roles for the adult children appeared to illustrate these problem-solving components. This focus was intended to help the family resolve their ambivalence and decide who would take responsibility for finding placement or caring for the patient, in the event that a placement could not be found. The problem-solving process associated with psychotherapeutic work with the family was directed toward the primary task of finalizing a discharge plan for the patient.

PROVISION OF SOCIAL RESOURCES

The respondents expressed concern for addressing a number of situational variables including housing and/or placement and securing financial assistance. A problem-solving process is used not only to address psychotherapeutic factors but is used in the provision or securing of services (Hallowitz, 1974; Siporin, 1975). The problem-solving components used when handling situational concerns of clients include the following: The worker determines in his or her mind, as well as a discussion with the client, whether or not it is within the client's power to do anything with regard to securing their own services (Hallowitz, 1974). The worker explores possible options, specifically including the client in this process and helping them to understand the implications of various solutions and involving others

when appropriate. Lastly, the worker can enhance problem-solving and the general treatment process when dealing with situational concerns by bringing in other professional persons (Hallowitz, 1974). The findings indicated that the respondents consulted and collaborated with supervisors and the treatment team when trying to address the limitations of the cases.

Variations of the problem-solving components used for addressing situational variables in the three cases could be found in many of the responses of the respondents. For example, the respondents' concern in Case One with meeting with the elderly female patient for the purpose of exploring where she wanted to live, reviewing the possibilities, exploring her feelings as to whether any of the options were feasible and also seeking the assistance of other team members illustrated the use of the above problem-solving components. Perlman (1957) recognized that part of the problem-solving work was to find "material means" and "environmental means" which the client can be helped to use. In each case the respondents attended to this problem-solving task.

As noted previously, psychiatric social workers are thought to focus more on the emotional aspects of a psychiatric illness, sometimes at the expense of environmental factors. The respondents' concern in this study with situational factors suggests that when such

factors need to be addressed, psychiatric social workers will attend to them and will make attempts to include the patient and family. In fact, many of the comments indicated that the situational factors in discharge planning, an important role of the psychiatric social worker is that of "locator of resource" (Hollis, 1972).

> The role of locator of a resource is an extremely important one. Success in it depends not only on thorough knowledge of the local community but also on imaginative assessment of the client's needs. The worker must display ingenuity in finding the resource in unexpected places and skill in interesting particular individuals in making special provisions for the client's special needs. Patience and much phone work and some footwork may be required (Hollis, 1972, p. 156).

Hollis (1972) concludes:

> It is part of the total treatment process and in some cases it plays a decisive role. Any worker who is inept in applying his basic understanding and skills to work in the environment is seriously handicapped in his efforts to help clients with intra or interpersonal problems (p. 161).

The respondents' concern with the provision of social resources suggests that even though psychiatric social workers may be thought to focus primarily on the emotional factors of a psychiatric illness, they also possess the expertise and knowledge to assume responsibility for the "tangible" aspects of discharge planning. The concern expressed by the respondents for using environmental resources in a manner that would enhance the patient and family's social functioning is clearly a representation of

a problem-solving process. A distinctive part of social work's approach to problem-solving is its focus on the client's social functioning and social relationships (Siporin, 1975). The respondents would consistently seek resources to meet the social and psychological needs of the patients and families.

LIMITATIONS OF PSYCHIATRIC DISCHARGE PLANNING

The findings indicated that the respondents felt that there were a number of factors which would limit their ability to resolve the cases and contribute to their negative feelings regarding involvement with the case. Some of the major limiting factors included the following: limited community resources, time, collaboration with treatment team, the late referral of the cases, an unworkable family situation and the lack of experience in working with a specific client population (i.e., adolescents or elderly). These limitations were reported to create feelings of anger, disappointment and frustration.

Social workers are uniquely skilled to assist patients and families therapeutically and to confront issues related to discharge but the above factors are known to severely hinder their ability to help patients and families (Blazyk and Canavan, 1985; Rock, 1987; Shulman and Tuzman, 1981).

Time, the lack of community resources, and inexperience in working with specific client populations were the three principal factors contributing to the respondents' negative feelings.

TIME

Time was a critical element both as a limiting factor in resolving the cases and in evoking many of the respondents' negative comments about their involvement. Obviously, for some of the case examples there was not sufficient time to do what the respondents considered to be the "best possible job". However, when the time period was extended as in the case of the elderly male patient, time became somewhat less of an issue. Time is an extremely important variable in social work practice. It ". . . intervenes between treatment and the ideal objective modifying or removing the casual factors in the client's difficulty" (Hollis, 1972, p. 296). Time is also a significant ecological dimension and its use in helping must be congruent with the ". . . client's individual needs, abilities, interests, situations, and life style" (Germain, 1973, p. 329). Time is the "medium of the helping process" (Taft, 1949, p. 1).

Social workers' use of time has been described as a dimension of style, which is one of the elements of skill underlying the intellectual base of social work practice (Lewis, 1982). Style, which facilitates the social

worker's work ". . . exhibits the manner in which each person arranges what she apprehends in her actions and their product" (Lewis, 1982, p. 147). Style has a distinct influence on work patterns and the perception of time. In addition, the institutions in which social workers work also influence style and use of time. Lewis (1982) notes, "Any professional working for an institution quickly learns that institution's time expectations" (p. 158). The worker's style and the hospital's time expectations may be significant issues affecting the social workers' perception of time and thus their negative feelings regarding the time element for resolving the discharge planning cases.

The respondents work in a hospital setting that has an extensive tradition of long-term treatment. Although the hospital is experiencing shorter lengths of stay, it maintains a culture based on long-term care. In addition to the reality based problems encountered in planning discharge services in a short period of time, the respondents also appear to be influenced by their own particular style and the hospital's style, both of which are based on principles of long-term treatment. For this reason, any time constraints may be seen as inhibiting the style of the respondent, thus contributing to his or her negative feelings about time limits.

Limited time is a critical dimension in discharge planning. Social workers may frequently find themselves with inadequate time and energy to form the necessary therapeutic alliance, to adequately complete a psychosocial assessment and to help the patient and family adjust to an illness and the final discharge transition.

COMMUNITY RESOURCES

The respondents became frustrated and discouraged knowing that in order for their patients and families to sustain the gains made from hospitalization, community resources and supports need to be available. However, given the current socioeconomic climate, such resources are scarce and are not adequately available (Blazyk and Canavan, 1985; Shulman and Turzman, 1981). Thus, social workers may consistently feel discouraged by this facet of the discharge planning work.

INEXPERIENCE WITH SPECIFIC PATIENT POPULATION

The respondents who reported feeling negatively about the cases cited unfamiliarity in working with adolescent or the elderly as reasons for their feelings. Those respondents who reported these feelings did not work with these populations.

The respondents may have lacked "assessment typologies" and "analogs" for dealing with the discharge planning issues confronting those specific client populations (Lewis, 1982). This suggestion is based on

the idea that when the social worker has sufficient experience in working with a specific client population he or she has assessment typologies and knowledge of appropriate services through which the worker can draw on. The worker possesses analogs in his or her memory from which he or she can recover rules and principles for the selection and application of interventive procedures (Lewis, 1982). For example, when the worker is requested to help arrange a discharge plan for an elderly patient, and has experience with that client population, the worker can retrieve analogs to guide assessment and help determine the most appropriate services to meet the client's needs. However, when a social worker has little or no such experience then the presence of analogs for purposes of assessment is lacking, and the worker may feel angry, disappointed and frustrated. Lewis (1982) states,

> A professional practice that lacks assessment typologies leaves the practitioner confronting an almost insurmountable task -- she must continuously master these complex materials and form them into compositions, a requirement that can quickly exhaust her intellectual and emotional energies (p. 196).

TEAMING

The respondents felt that collaborating with the treatment team contributed to their frustration and at times anger. They felt the team held them responsible for the successful outcome of the discharge plan. However the respondents collaborated with the team because they felt

the team could be helpful in arranging the best discharge plan. Respondents considered collaboration essential to resolving the discharge cases. Collaboration is one element found within the problem-solving method (Hallowitz, 1974; Siporin, 1975).

PROBLEM-SOLVING PRACTICE PRINCIPLES

As indicated by their responses and the ranking order, the respondents tended to use the same problem-solving practice principles for each case, while appearing to disregard a number of other practice principles. The problem-solving practice principles that the respondents were more likely to use included the first four found in Appendix C.

The respondents rarely made any explicit references to "consciously" using the relationship with the client as a "catalyst" for problem-solving.

Those principles not used or used sparingly included the last five found in Appendix C.

Lewis (1982) states, "Principles must be seen as governing the interaction of the worker and recipient through a process that continues and develops as it moves toward some kind of closure or culmination" (p. 215). The findings would seem to imply that this group of psychiatric social workers may be eliminating two important practice principles for discharge planning, that principle which addresses termination and that which makes

conscious use of time. Both principles are critical for moving toward the closure in the service or process between worker and client as described by Lewis.

As noted previously, time is an extremely important element in the helping relationship. Taft (1949) describes the importance of time in the helping relationship. Although writing about traditional casework treatment, her comments are relevant for the relationship and time components between the social worker and client within the context of discharge planning. Taft (1949) states:

> The basic task of helping then, provided the helper himself is in some possession of the solution is to provide a unique relationship experience in which the time medium is heightened or exaggerated by limits deliberately utilized, so that the one who needs help may overcome his own unrealized capacity for using and leaving the helper, for yielding deeply to the need of the other and as a consequence finding the self that can go on without him. In such an experience it is possible to affirm the passing moment as right, to feel it as the very reflection of the self, to bear more or less courageously its pain, its fear, its guilt, as well as its fulfillment and its ongoing (p. 12).

Lewis (1982) adds to the importance of using time in social work practice. He states:

> Process implies a sequence that orders time. To the extent that time is the medium of the helping process, the aim of the worker is to provide a unique experience in relationship in which time is heightened by limits deliberately utilized on the assumption that the recipient has his own ends, one goal of the process is to assure him the opportunity to utilize his own experience in arriving at his own conclusions within the time available to him (p. 216).

By not consciously making use of time with the patient and family in resolving discharge planning cases the social worker may be inhibiting the helping process and possibly denying them the "unique experience in relationship" (Lewis, 1982, p. 216).

TERMINATION

The practice principle related to addressing termination is also important for the helping process and the relationship experience between the worker and client. Termination is the final transition point in the helping process. There needs to be some preparation of the client for termination, with some agreement on a termination time for a testing of the client's reaction to it (Siporin, 1975). Termination is an extremely important part of the problem-solving process (Bunston, 1985). It should include the following tasks

> . . . evaluating the service program and the progress made in relation to the helping contract; stabilizing and generalizing the gains made beyond the helping situation; disengaging from the helping relationship; and terminating the intervention system (Siporin, 1975, p. 337).

Siporin (1975) states:

> For social worker and client, it also means exploring the meanings of the reactions to termination; facing and coming to terms with the feelings involved; and facing up to the emergence of new problems and tasks that go beyond the period of service (p. 337).

Termination as part of the problem-solving process involves an evaluative component and is an indispensable

part of the process (Bunston, 1985; Spitzer and Welsh, 1969). What accounts for the finding that the respondents are less likely to use the practice principle related to addressing termination and the practice principle related to the conscious use of time is unclear. I will venture two possible explanations. The first is related to treatment ideology. Social workers are ". . . inevitably influenced by the peculiarities of their practice context, which in turn affect their choice of practice principles" (Lewis, 1982, p. 252).

With regard to the use of time, the treatment ideology of the Institute of Living remains based on long-term treatment principles so that the use of a practice principle making conscious use of time would not fit the ideology of the hospital. Social workers assume ideological positions in their choice of practice principle. These choices are influenced by the preferences of the organization in which they work (Lewis, 1982).

Another possible explanation for not focusing on termination is that

> . . . much of the termination difficulty may be in reaction to the expectations of the social worker and to some tendency to hold on to clients. One aspect of this tendency appears to be the need of social workers to try to accomplish more extensive changes than are desired by clients (Siporin, 1975, p. 338).

The responses of the respondents in fact may support this explanation. They reported feeling discouraged in trying to resolve the cases because they could not make any "significant changes" in the family's patterns of relating, even though the referrals were made within the context of providing service around discharge planning. Lastly, the respondents currently practice in a setting that has not performed any outcome studies to demonstrate the effectiveness or ineffectiveness of treatment. As such, there is no ideology for evaluating effectiveness in serving clients, particularly as part of the termination process.

ADDITIONAL EVIDENCE SUPPORTING THE SOCIAL WORKERS' USE OF A PROBLEM-SOLVING MODEL IN DISCHARGE PLANNING

I conducted a two hour in-service program for the social work staff on the problem-solving process in discharge planning. I was hoping to promote a positive attitude toward discharge planning and to highlight the integration of the concrete and therapeutic aspects of this activity. The contents of the presentation essentially parallel the various sections of the study. It included the following components.

A. A review of the Prospective Payment System, Diagnostic Related Groups and social work.

B. A historical overview of discharge planning and social work.

C. The current role of social work and discharge planning at the Institute of Living.

D. A review and summary of the key findings of the study.

When the presentation was finished I requested the staff to complete a brief questionnaire (Appendix E). This was followed by an hour-long discussion period regarding social work and discharge planning, specifically as it related to practice at the Institute of Living. The total number of respondents was seventeen.

The findings revealed similar results about the social workers' use of problem-solving in discharge planning and in terms of their feelings about the role of discharge planner.

Findings to Question Number One (Was the material on the Prospective Payment System, DRG's and social work useful?) revealed that thirteen of the respondents said "yes" but four said "no".

Question Number Two (Was the review of discharge planning and social work role useful?) revealed that all seventeen of the respondents said "yes".

Question Number Three (Was the presentation helpful in understanding the role of social work and discharge planning at the Institute of Living?) revealed that all seventeen of the respondents said "yes".

Question Number Four (Did the presentation influence the way you may approach discharge planning cases in the future?) revealed that eleven of the respondents said "yes" and six said "no".

Those social workers who stated that the presentation had influenced the way they would approach discharge planning in the future indicated two key areas they found useful. One was that the content related using a problem-solving model to the psychotherapeutic skills and the value of discharge planning. Additionally, the concept that the activity was being addressed as a professional issue was influential.

Some of their comments included the following:

"Reinforced the therapeutic nature of discharge planning. Better helped to integrate psychotherapy skills into the formulation and implementation of discharge plans."

"Helped me to appreciate that the dilemma I experience in relation to discharge planning at this hospital are, in general, a systems problem. I'm glad it is being addressed as a professional issue."

"It emphasized the importance of discharge planning."

"Helped by being more assertive in relating to non-social workers that discharge planning is part of family work."

"Reinforced feelings around responsibilities and accountability around discharge planning."

"Provided problem-solving model and idea of termination and follow-up."

"Validated my problem-solving approach and encourages me to continue to teach this approach to other disciplines."

There were only a few comments by those social workers who said that the presentation did not influence the way they would approach discharge planning cases. The workers comments were generally positive and related to their feeling that the presentation confirmed their use of a problem-solving approach to discharge planning and the use of the worker-client relationship. Some of the comments were as follows:

"It confirms what I already practice."

"It confirmed my approach."

The content related to the use of specific social work interventions used in discharge planning was found by the social workers to be extremely useful. The findings from the questionnaire and the subsequent discussion appear to suggest that the importance of the presentation rested with that fact that it validated the important work that the social workers were doing in regard to discharge planning. It was as though someone was finally

recognizing and appreciating their professional skills and expertise in this area.

The discussion which followed the presentation revealed that many social workers felt that they did use a problem-solving approach in resolving discharge planning problems and that they valued their role in discharge planning. They strongly emphasized that this function should occur within the process of helping the family. Considerable passion was expressed with regard to their feeling that it was other disciplines, like nursing and medicine, who did not value the importance of discharge planning and the psychotherapeutic value of the discharge process.

The results of the questionnaire and the follow-up discussion left me with the impression that perhaps the profession has spent too much time focusing on how to get social workers to value the role of discharge planning and how to integrate the concrete and therapeutic elements of this activity. I was beginning to wonder if we were not "blaming the victim." Is the profession preferring to blame social workers for their lack of interest in discharge planning, for the failure to integrate the concrete and therapeutic elements of the activity rather than on those professions who undervalue the therapeutic importance of discharge and perhaps the role of social work? Is there an ideology that has developed from the

collective unconscious of groups like doctors, nurses and hospital administrators that is rooted in an interest to maintain the status quo of their institutions? (Ryan, 1971). Are social workers being maintained as "semi-professionals" in hospital settings by this ideology? I do not have answers to these questions, but they are questions which need to be addressed. The social workers expressed much discouragement that other disciplines did not fully value their professional skills in resolving discharge planning problems.

IMPLICATIONS

Based on the findings presented in the study, psychiatric social workers may wish to incorporate into their discharge planning a problem-solving model. If the model is to be accepted by psychiatric social workers and the social work profession, then Schools of Social Work and Hospital Social Work Departments will need to provide education and training.

The findings suggest that the hospital (Institute of Living) establish a comprehensive discharge planning system for attending to those factors which impacted negatively on the social worker's attitude about discharge planning. These factors included the late referral of discharge planning cases and inexperience working with specific client populations. A coordinated discharge planning program may reduce late referrals and allow for

some flexibility in case assignment (Blazyk and Canavan, 1985; Rock, 1987).

A coordinated discharge planning system within the hospital could allow for the establishment of a central data base on available community resources. This may help to reduce the stress workers reported because they did not know what resources were available for patients and families. A data base will do little to locate services which are needed but not available. Social workers will need to advocate for the hospital to begin developing a comprehensive network of community care. These networks should include case management, day treatment, transitional employment, socialization, and residential programs (Rock, 1987).

In addition, there is the need to design better and more integrated consultation with peers and supervisors for workers who are assigned difficult discharge planning cases or assigned to work with unfamiliar client populations around discharge planning. Peer and supervisory guidance and support is an essential component for addressing some of the limitations of discharge planning and the negative feelings associated with the process. This may also help reduce the pressures which result from teaming.

Hospital administrators may be less concerned over changing those factors which negatively influence social

workers' attitudes about discharge planning or whether we have the necessary expertise to make the discharge process therapeutic for patients and families. Their concerns may rest with cost containment and shorter lengths of stay. There is the risk that social work skills may be utilized but become subject to productivity statistics and shorter lengths of stay rates. The social work practice of discharge planning in psychiatric hospitals could become focused on managerial tasks.

Psychiatric social workers will be confronted with the administrative demands of discharge planning as well as the clinical and practical demands. Discharge planning with patients and families is a quality of care issue and a major concern to many hospital administrators. The problem-solving practice principles utilized by the workers in this study are part of a sound and humanistic practice and should not ". . . be sacrificed to the demands of efficient technocracy and unstrained regulatory accountability," but used to meet the highest quality of care for patients and families (Shulman and Tuzman, 1981, p. 8).

EDUCATION AND TRAINING

Based on the findings, the educational and training needs of social workers who would use a problem-solving model for psychiatric discharge planning includes assisting them to make conscious use of time, the

relationship, termination and other problem-solving principles. Of critical importance is that social workers will have to be trained to extend problem-solving beyond the third phase; they need to engage in Evaluation and Termination phases of the problem-solving process.

FORMAL EDUCATION AND IN-SERVICE TRAINING

A number of authors have developed programs to train social work students in the role of discharge planning and as part of continuing education programs for professional social workers (Lurie et al., 1984; Lurie et al., 1981; Rauch and Schreiber, 1985). Schools of Social Work should develop a curriculum around discharge planning, incorporating a problem-solving model and teaching the specific practice principles used during the discharge planning process. If one of the purposes of social work is to enhance the problem-solving capacities of people and that much of social work practice is a problem-solving process, then Schools of Social Work may be prepared to address this need (Bunston, 1985; Perlman, 1957; Pincus and Minahan, 1973; Siporin, 1975). By offering formal courses in a problem-solving model for discharge planning, Schools of Social Work can lend some legitimacy to a discharge planning role for social workers. Student placements specifically designed to train students in this model should be considered by the profession.

This implies a further specialization in social work education. This may be seen by social work educators who are generalists as too restrictive for the educational needs of most social work students.

As the findings from the in-service I conducted indicate, on-going in-service training which reviews the problem-solving model, the psychotherapeutic skills for discharge planning and how to use the model most effectively in working with the patient and family is essential. The profession must begin to redirect its energies from defending the importance of discharge planning for social work to exploring differential practice models for specific clients and specific problems associated with discharge planning, and then to educate others about what we have learned (Thomlison, 1984).

Again, as the findings suggest, there is a critical need to educate other disciplines about the therapeutic importance the discharge planning process has for patients and families. There is an urgent need for research in the field of discharge planning. We need to demonstrate which social work interventions have been helpful to patients and families during discharge planning. Social work practice must begin to rely on empirically supported practice methods (Ivanoff, Blythe, and Briar, 1987).

Lastly, the findings suggest that the word "discharge planning" does not adequately convey the true process that

occurs between the social worker and client and that it implies numerous negative connotations, thereby detracting from its importance.

The Random House Dictionary definition of "discharge" is to relieve of a load or burden, to relieve of an obligation, or to release or let go.

Much of discharge planning is seen as a burden. This may well negatively influence the provider of service and the recipient of the service.

Framing relevant constructs is an area often neglected in the social work field (Eisenhuth, 1981). Nonetheless, social work should consider implementing the concept of "Family Care Planning". The definition of care implies a very different meaning and feeling to the process. The Random House Dictionary definition of "care" is protection, charge, supervision; to watch over; to have an inclination, liking, fondness or affection; or to feel concern about.

This definition appears to approach the ideology of social work practice. Although a number of patients may not have families, the construct has much applicability. For those patients who have no family or limited family involvement, many will substitute other caregivers as surrogate family supports wherever they live. There are many kinds of situations which give us the "imagination" of family life whether it be a nursing home or

transitional living facility. A relationship with a professional caregiver may not be like that with a patient's mother or father but may feel very significant (Thomas, 1987). A sense of self is achieved by interaction with many others who frequently represent the idealized image of the parent(s) (Eisenhuth, 1981).

Helping patients and families leave the hospital based on the construct of "Family Care Planning" may well prove to enhance the status of the activity and the social worker and ultimately promote the social functioning of patients and families.

CONCLUSION

The results of the study provide some preliminary data supporting the hypothesis that social workers use a problem-solving process for resolving discharge planning problems. The process was characterized by a concern for the relationship between the social worker, patient and family and guided by social work values. A problem-solving model can serve as a framework for guiding one's practice and for evaluating empirically supported practice methods. Shulman and Tuzman (1980) state that:

> To develop the most effective, acceptable plan for all concerned, a problem-solving process must be established. Indeed, discharge planning can be seen as a series of problem-solving tasks designed to orchestrate the knowledge required to help the person (i.e. patient) with his or her problem within the context of the place (i.e. health care facility) (p. 4).

Hopps (1985) noted that the climate in health care, with its emphasis upon mechanistic cost cutting may be dehumanizing the patient (family) and provider while actually increasing the long range costs to the individual (family) and to society. She states that, "Consolidation of genuine knowledge building and research-informed practice ultimately should be directed to the needs of our clientele" (p. 467).

This study was undertaken in an effort to build an empirical foundation for social work practice in discharge planning, with the primary goal of better serving patients and their families. It is hoped that the study will contribute to this goal, and that social workers will take advantage of the practice suggestions offered and adapt them to meet client needs during the process of discharge planning.

Discharge planning is an integral part of the comprehensive health care of all patients admitted to the hospital. It may be defined as any activity or set of activities which facilitates the transition of the patient from one environment to another. The complexity of discharge plans varies and may be described by four levels of outcome. These are 1) patient and family understanding of the diagnosis, anticipated level of functioning, discharge medications, and anticipated medical follow-up, 2) specialized instruction or training so that the patient or family can provide post-hospital care, 3) coordination of community support systems which enable the patient to return home, and 4) relocation of the patient and coordination of support systems or transfer to another health care facility.

Each member of the health care team brings an important perspective to the discharge planning process. Although involved at all levels of discharge planning, social workers have the primary responsibility for assuring successful outcomes at levels three and four. They have a central coordinating role because of their assessment and counseling expertise, knowledge of systems and resources, and organizational skills.

The specific components of the social work role are:

- **Development of systems which ensure timely and efficient identification of patients who require discharge planning.**
  A critical part of the central coordinating role of social work is the early identification of patients who require discharge planning. This may be accomplished by case-finding through utilization of high risk screening instruments, initiation of criteria-based record reviews, or participation in patient-care rounds. Open referral and consultation procedures augment these mechanisms.
- **Assessment of the psychological, social, environmental, and financial impact of illness on patients and families.**
  The essential base for building a realistic discharge plan is a clear understanding of the impact of illness on patients and families including psychological, social, environmental, and financial aspects of their life situations. This is the comprehensive orientation that social workers incorporate into their assessments and the resulting plans.
- **Provision of psychosocial services to patients and families.**
  Social workers provide psychosocial services to patients and their families which enable adaptation to the illness and facilitate post-hospitalization planning. These services include individual and group counseling as well as family therapy. Such intervention is often necessary before patients and/or their families are able to make appropriate, realistic decisions related to the need for continuing care.
- **Coordination of the contributions of the health care team.**
  Social workers coordinate the contributions of physicians, nurses, and other health care providers. Achieving a cohesive and comprehensive discharge plan requires the counseling, negotiating, mediating, and advocating skills of the professional social worker in collaboration with all members of the health care team, the patient and family, and appropriate community resources. Social workers recognize the importance of timely and concise communication, both written and verbal.
- **Development and maintenance of liaisons with local, state, and federal resources.**
  Social workers are very adept at locating, assessing, and utilizing community support systems which meet the post-hospitalization needs of patients and families. Social workers are often the link between the hospital and numerous agencies in the community. These linkages afford many opportunities to build support for and to enhance the hospital's image as a vital community resource.
- **Establishment of systems to monitor and evaluate the effectiveness of the discharge planning process.**
  In order to ensure effective discharge planning, social workers utilize a variety of accountability measures. These may include telephone follow-up contacts with patients or families, questionnaires sent to continuing care providers, or home visitations. These programs may utilize volunteers who are trained and supervised by social workers.
- **Identification of services which are not available to meet the post-hospital needs of patients and families.**
  Social workers are aware of and can document gaps in community services which are needed by patients and families. Documentation may take the form of monthly statistical reports, quality assurance studies, follow-up interviews, or routine contacts with agencies. Social workers may effect the development of these resources by heightening community awareness, securing grants, forming coalitions, or advocating for new services to local, state or federal agencies. Additionally, information can be extremely valuable to health planners, whether hospital or community-based.

Effective and efficient discharge planning is critical to the health and safety of patients and is important to the hospital from a fiscal point of view. If the planning process is not adequate, the length of stay may increase. The patient may be released to an inappropriate level of care, require re-admission to the hospital, or suffer the loss of gains made during the initial hospitalization. In addition, the hospital may increase its risk of liability if discharge planning is not appropriate.

The role of the social worker in discharge planning is a complex one. It encompasses timely and efficient identification of patients who need discharge planning, assessment of the psychosocial impact of illness, provision of direct services, coordination of the development of the discharge plan, liaison with community resources, evaluation of the effectiveness of the planning process, and identification of gaps in services. While the emphasis on any one of these components will vary from case-to-case and from hospital-to-hospital, the basic concepts are essential for effective, high quality patient care.

Approved by the Board of Directors, Society for Hospital Social Work Directors of the American Hospital Association
June 1985.

APPENDIX B

STUDY PROTOCOL

Dear_____:

Thank you for participating in the study. Enclosed you will find three hypothetical cases. After reading each case, please answer the five questions following the case presentation. Feel free to include any information you think would be useful.

Again, thank you for your cooperation.

Jack Paul Gesino, ACSW

APPENDIX B

STUDY PROTOCOL

CASE NUMBER ONE

A 76 year old white widow, Mrs. W, was admitted to the geriatric unit of a psychiatric hospital with a diagnosis of depression. Prior to her admission Mrs. W. was living with her 50 year old mentally retarded daughter in public housing. Mrs. W was found living in squalid conditions and appeared malnourished.

The State Department of Protective Services became involved in the case. The agency became conservator of person for Mrs. W and sought her admission to the hospital.

Mrs. W's level of depression began to improve after a few weeks of hospitalization. She managed well on the unit. However, her appetite remained poor and interacted minimally with other patients and staff. Because of the improvement in her level of independent functioning, the Utilization Review Committee informed Mrs. W and her doctor that her condition no longer warranted hospitalization. As such, she had three days left in her insurance coverage. The staff, Mrs. W's doctor, and the Department of Protective Services did not feel the patient should return home. Mrs. W stated that she wanted to return home. The social worker was requested to help Mrs. W plan her discharge within this three day period.

APPENDIX B

STUDY PROTOCOL

CASE NUMBER TWO

A 16 year old male, J, was admitted to the short-term unit of a private psychiatric hospital at the request of his parents. The parents reported that their son had exhibited much acting-out behavior. He was consistently smoking marijuana and drinking. He missed an excessive number of days at school and had been suspended for fighting.

The parents reported having numerous violent confrontations with the patient over his behavior. The parents related that they did not want the son to return home upon discharge. They requested that J be transferred to a supervised residential setting from the hospital.

Initially, J was angry and negative with the staff and other patients. He refused to see his doctor or the social worker or to become involved in any of the unit's therapeutic groups. However, after the first week, J appeared to become more comfortable and began to join unit activities to see his therapist.

J had two weeks remaining in his hospitalization when a family meeting was scheduled. The parents remained adamant about their desire to have J discharged to a residential setting. J stated that he did not want to

live in a residential treatment setting and wanted to return home.

One week before J's insurance benefits were to run out, he informed the doctor and social worker that his father had abused him. J related his feeling that it was his father who did not want him to return home. J related this information in confidence and requested that it not be shared with his parents.

The social worker was requested to meet with the parents and J and to arrange final discharge plans.

APPENDIX B

STUDY PROTOCOL

CASE NUMBER THREE

A 77 year old married, white male, Mr. D, was admitted to a psychiatric unit for the second time in the last six months with a primary diagnosis of depression. Mr. D was readmitted from home. While at home he essentially remained in bed twenty-four hours a day. He became extremely demanding with his wife. Mrs. D had become extremely stressed emotionally and physically in caring for her husband. The couple's six children sought their father's readmission because of Mrs. D's own deteriorating condition.

Mr. D was readmitted to the hospital with only forty days remaining in his Medicare coverage. The family agreed to use some of their savings to pay privately when and if Medicare coverage stopped.

Mr. D was treated with a number of antidepressant medications. However, there was little improvement in Mr. D's level of depression or independent functioning. He continually reported numerous somatic complaints, wanted to die, and infrequently participated in the unit's therapeutic groups.

In his individual sessions, Mr. D was extremely negativistic and frequently spoke of his intentions to remain in bed when he returned home.

Mr. D was beginning to stay beyond the forty days of Medicare coverage. Mr. D's full recovery appeared slight and there was considerable concern about using all of the family's resources. The team felt that Mr. D required so much assistance that he should be transferred to a nursing home. The children also spoke of this possibility. Mrs. D was extremely ambivalent and experienced much difficulty in making a decision.

The social worker was requested to assist the patient and the family in making final discharge plans. It was agreed that Mr. D would be discharged four weeks from the time of the referral to the social worker.

APPENDIX B

STUDY PROTOCOL

1. How would you proceed in the case?
2. What factors do you consider to be important in trying to resolve this case?
3. Are there any factors which you think might limit your ability to resolve this case?
4. How would you address these limitations?
5. How did you feel responding to this type of case?

APPENDIX B

STUDY PROTOCOL

MOST IMPORTANT _____1

_____2

_____3

_____4

MODERATELY IMPORTANT _____5

_____6

_____7

_____8

_____9

LEAST IMPORTANT _____10

APPENDIX B

STUDY PROTOCOL

Age:

Male/Female:

Years of social work experience:

Have you taken any courses in Discharge Planning:

Area of the Hospital in which you work:

Primary age group you work with:

1. How involved are you in discharge planning with your present cases?
2. What percentage of your time do you spend doing discharge planning?
3. What types of tasks do you engage in when involved in discharge planning?
4. What do you think of discharge planning?
5. How do you feel about being involved in discharge planning?
6. What would you consider the positive features in being involved with discharge planning?
7. What would you consider the negative features in being involved with discharge planning?
8. Have you had any previous experience in doing discharge planning?

9. What and where was your previous experience in doing discharge planning?

10. What do you think the role of the social worker should be with regard to discharge planning?

APPENDIX C

PROBLEM-SOLVING PRINCIPLES

1. The worker will help the client to identify their needs and problems.

2. The worker will clarify the facts regarding the identified problem.

3. The worker will seek to establish what psychological, social, and physical factors are contributing to the client's problem.

4. The worker will share with the client the significance of the problem.

5. The worker will align his or her and the client's separate appraisals regarding the significance of the problem and select for joint consideration that which most clearly relates to the client's needs and goals.

6. The worker will select some action in assisting the client to make some internal or overt behavioral change in relation to the problem.

7. The worker will use the relationship with the client as the "catalyst" for problem-solving.

8. The worker will make conscious use of time.

9. The worker will assess with the client whether the problem-solving work is assisting the client.

10. The worker will summarize and review the case with the client as part of termination.

APPENDIX D

CARD-SORT OF PROBLEM-SOLVING PRINCIPLES

A. The social worker should help the patient and family identify their discharge planning needs and other problems associated with discharge planning.

B. The social worker should establish whether there are psychological, social and physical problems which may contribute to the patient and family's discharge planning concerns.

C. Once the social worker determines the nature of the discharge planning problem, he or she should share this with the patient and family.

D. If the social worker determines that there are additional problems which are impinging upon the discharge plan, but the patient and family are unaware of these problems, the social worker should relate and integrate this information with the patient and family's statement of the discharge problem.

E. The social worker should select a task that will have the patient and family make some internal/external behavioral change in relation to the identified discharge planning problem.

F. The social worker should use the worker/client relationship in arriving at a decision around how to proceed with resolving the discharge planning problem.

G. If in resolving the discharge planning problem other problems surface, the social worker should address these concerns.

H. The social worker should assess with the patient and family whether the help he or she is providing is helping the patient and family in coping to the changes brought about by planning for the discharge.

I. The social worker should help the patient and family make conscious use of time in working through the discharge planning problem.

J. The social worker should address termination issues with the patient and family when the discharge planning process is completed.

APPENDIX E

FOLLOW-UP QUESTIONNAIRE

Dear Colleague:

Please complete this short questionnaire. All responses are confidential. Thank you for all your support.

1. Was the material on the Perspective Payment System, DRGs and Social Work useful?

Yes No

2. Was the review of discharge planning and social work role useful?

Yes No

3. Was the presentation helpful in understanding the role of social work and discharge planning at the Institute of Living?

Yes No

4. Did the presentation influence the way you may approach discharge planning cases in the future.

Yes No

5. If yes, please briefly describe what part of the presentation contributed to this change and how.

Thank you.

Jack Paul Gesino, ACSW

APPENDIX F

SIMILARITIES AND DIFFERENCES AMONG WORKERS' ATTITUDES AND ROLES TOWARD DISCHARGE PLANNING

Number of Workers Assigned to Program	Age of Patients	Time Spent in Discharge Planning	Tasks	Roles of Workers in Discharge Planning	Positive Features	Negative Features
OUTPATIENT						
4 staff social workers 2 students	16 and older	0-1%	Busy work	Help patient and family make adjustment Consultant	Opportunity to network	Limited resources Paperwork Low status Lack of time
DAY HOSPITAL (Geriatric and Adult Programs)						
4 staff social workers	16-60 65 and older	20-50%	Telephone interviews Transportation and financial resources Consulting Family work	Consulting role Part of treatment plan	Central to post-hospital success Successful referral Good termination Integral part of treatment	Few resources Waiting lists too long Lack of time Feeling dumped on

APPENDIX F

SIMILARITIES AND DIFFERENCES AMONG WORKERS' ATTITUDES AND ROLES TOWARD DISCHARGE PLANNING
(Continued)

Number of Workers Assigned to Program	Age of Patients	Time Spent in Discharge Planning	Tasks	Roles of Workers in Discharge Planning	Positive Features	Negative Features
INPATIENT						
10	16 and older	20-65%	Assessing patient and family needs Researching resources Telephoning Filling out forms Talking to family and staff Decision-making Termination work	Working with family Part of treatment Consultative role	Part of treatment Sense of control for patient Working with family Good termination work Observing patient and family improvement Opportunity for networking	Lack of time Lack of resources and knowledge about resources Blamed when discharge plan does not work Unclear role Separated from treatment Lack of follow-through

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