by a social agency in this manner is essentially sound. A study of 25 treatment cases carried in the agency during a 17-month period indicates that 5 of these cases were completely successful, 6 were partially successful, 5 were failures and 9 are in process at this point. The results shown during treatment in these 9 cases have been such as to make workers, supervisors and psychiatrists feel that it is very likely there will be successful outcome in a majority of these cases.

Perhaps it is unnecessary for us to say that we are reporting this experiment for whatever it might be worth. Certainly it is an insufficient experience to justify any kind of dogmatic recommendations as far as others are concerned. We are aware of the fact that other agencies have other types of psychiatric programs which have their own distinctive merits. In our case, the program which we have described arose out of a philosophy of case work combined with practical necessity. There would have been nothing antithetical to our philosophy of case work in setting up one of the other types of psychiatric service—to which we referred earlier in the paper. Certainly, a treatment program carried on within the agency itself would have many advantages, particularly if the agency's and the psychiatrist's treatment philosophy were in accord. Most psychiatrists in New York, however, have a rather different orientation to treatment from the time-limited one to which we hold. This does not mean that we cannot work with psychiatrists whose treatment philosophy differs from our own. All seven psychiatrists used by the agency at present have a treatment philosophy which differs in varying degrees from that of the agency. At least five of our present group of psychiatrists, however, have demonstrated both an interest and a willingness to adapt to what we consider agency necessities and some have expressed their own growing conviction that some of our agency requirements and procedures can be turned to therapeutic advantage. I think that Dr. Samuel Rosen, a member of our panel, may want to talk about this in the discussion which is to follow.

DISCUSSION OF MR. APTEKAR'S PAPER

By RUTH FIZDALE
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IT may surprise you to hear me say that I am grateful to Mr. Aptekar, and his staff, for their courageous contribution to two perplexing problems in our field. I know that we were gathered here, today, primarily to consider the relationship between social work and psychiatry in the treatment of the neuropsychiatric patient, but it seems to me that another problem has shown itself through the earlier discussion. This is the problem of how to keep a social agency fluid in its concept of services needed in a specific community. To this problem, and to the one of defining, in the midst of professional change and confusion the distinctive roles of psychiatrist and social worker, Mr. Aptekar has brought us a clearly defined and extremely valuable base from which our discussion can flow.

Although Mr. Aptekar is not apologetic in his tone, his need to trace exactly how the agency's psychiatric treatment service came into being, his stress on the freedom "to experiment," and to do away with "the traditional services" are related to what I feel is a need in our field: namely, to develop skills in keeping an agency's services as flexible and creative as we attempt to keep the skills of the workers who administer them. We would think little of a worker who approaches each cilent in the same manner, who in his attempt to help, cannot distinguish differences in persons, and cannot be creative in *the how* of his helping. Yet, when it comes to determining what services an agency should offer to its community, we see little incongruity in the fact that we do not apply the same scientific and flexible approach here that we demand of ourselves as case workers. When new agencies are set up we cling to the "traditional" and are rather accepting that that which works well in Brooklyn, New York, will be of equal value to the community in Paducah, Kentucky. We do little to study the composition of a community, its peculiar and particular problems and needs. Occasionally, an agency reaches the point where clients refuse to come and workers refuse to apply for positions with us. We then are frantic in our efforts to bring more useful services into existence. As often as not, we find ourselves up against a board of directors and a group of contributors who rightly ask "if the agency was so good in 1932, why are its services so bad now?" We are hard put to explain this and often seek comfort in a not-too convincing whistle that certain board members and contributors have "invested too much in the bricks of the building" or are hopelessly uneducable. However, if we are honest with ourselves, we must accept some responsibility for this state of affairs. We must admit that perhaps we have been less interested in the how of keeping our agency

related to community needs than we have in the how of administering the services.

A social agency is an organization, supported by a community, to meet such needs of its individuals as cannot be met through their own resources, and which can affect the health and welfare of the entire community. (I use the term community broadly to include the nation.) Our concept of services needed in a community has shifted with advances in community understanding of the interrelated nature of our lives, and with social and economic changes. However, changes in services have been achieved slowly and with great difficulty. We fail our client community equally if we do not accept as fully our responsibility for developing a flexible concept of community services, as we do when we fail to develop our skills in the giving of these services.

I am heartened by the advances that Mr. Aptekar and his agency have made in facing squarely the differences in their community, of throwing traditional attitudes away, and finding services to meet the needs of their particular community. I hope that his break with "the traditional" will stir us to an equally dynamic and careful study of other communities, and to the development of services directly related to their needs. We need to develop research skills in areas other than those pertaining to the effectiveness of treatment methods, so that we may speak authoritatively, and with leadership when we are helping a community develop services to meet its needs.

I find no problem in accepting Mr. Aptekar's assumption "that while psychiatric treatment as such does not have to be a social agency function, it can represent as valid a type of social service as any other." This service was developed upon evidence of community need and with the support of the community, hence, it falls within my definition of a social agency function. One could ask why the community did not develop a clinic or a specialized intake agency for referral to psychiatrists. However, since this community believes in a multiple-service agency, the question becomes one of whether or not we are in favor of multiple-service agencies.

Assuming that no community has funds sufficient to cover every pertinent request for service made upon it, I would like to ask how this agency determines allocation of funds for its psychiatric or analytic treatment service. Are funds allocated upon a comparative study between community needs for this service and for others, for example, housekeeping service, funds for rehabilitation, camp care for children, etc.? Is allocation determined merely by the number of requests that come into the agency on a first-come, first-served basis? I hope that there will be time for us to consider this question in our discussion, as well as the following two: How does this agency determine the number of interviews per week and the duration of treatment for a particular case? This is not clear in the paper. Does the physician determine this? Does the agency participate in the decision? If the person resists treatment or is not making constructive use of it, how is the case terminated, and by whom? I would also like to know whether the agency has found the need to define the type of case that falls within the scope of a social agency, that is, for which psychiatric treatment can be financed by a social agency. Although the cases cited in the paper leave little question as to the value of the service for the

people involved, it would be helpful to know whether there are other applicants for whom such service is not clearly within a social agency's scope.

I would like now to turn to Mr. Aptekar's definition of case work, counseling, and psychotherapy. I am assuming that I was invited to discuss this aspect of the paper because of my relation to the neuropsychiatric program in the VA. As Chief, Staff Development Section, Social Service Division, I would, of course, have a definite tie to any division. However, because of the smallness of our Central Office staff, I have also been serving as temporary liaison between our division and that of Neuropsychiatry.

The Veterans Administration has 52 mental hygiene clinics throughout the United States. In addition, there are 34 NP hospitals and about 57 NP units in the General Medical and Surgical hospitals. We are concerned with sound integration, not only of psychiatry and social work, but also of clinical psychology, psychiatric nursing, occupational therapy, and the attendant, etc., in treatment of the NP patient. You can, therefore, appreciate why I welcome the fact that this paper deals only with the relationship between a psychiatrist and a social worker in the treatment of a patient. I gratefully confine myself accordingly, and will deal only with this question as it arises in mental hygiene clinics.

Our mental hygiene clinics were developed within the past three years. The organizational structure and functions of the various professional members of the team were generally defined, but were more permissive in character than mandatory. Each clinic interpreted this material in defining specifically the roles of the various professional persons and what its team relationships would be. In some clinics case workers are responsible for the taking of history, and for *assigned* responsibilities to work with families "in helping them understand the patient." In other clinics, case workers carry an intake responsibility that is related to helping a patient decide whether he is interested in psychiatric treatment. Subsequent relationship is primarily with the family concerning problems they experience in living with a person who is ill. In some of our clinics there is almost no differentiation between the case worker and the psychiatrist. Because case workers brought something of particular value in the initial interviewing of clients, they were assigned intake responsibilities. Beyond that, there is very little difference. In these clinics, however, the psychiatrists in charge have taken responsibility for close supervision of the case work staff.

That our clinics developed so, was partially due to the rapidity of their growth. However, it was also due to the state of affairs in the fields of psychiatry and social work. Psychiatry is in the process of finding new approaches and re-defining itself. I doubt if one would find that all psychiatrists agree with Mr. Aptekar's delegation to them of only the somatic and psychopathological. Social work is developing confidence in its psychological skills and thus feels prepared to work with emotionally disturbed individuals. When we were faced with the need of setting down some central policy or definition, we were confronted with all the variations in both fields. In providing services on a national public scale, we cannot ignore any particular school of practice unless its profession has determined that school of practice to be invalid. For this reason, each clinic was permitted to de-

velop as it saw best. The only limitation set upon them was that where social workers or psychologists were assigned treatment possibilities, it would be at the discretion of the psychiatrist, and under his direct supervision. We felt that once our clinics were established and had developed some clarity as to their own program and relationships, we could then review what they had worked out and compare it with the effectiveness of their treatment. We hope that such review would be made jointly with the various professional groups (both inside and outside of VA) involved in the treatment of NP patients. We hope that out of this study will come some guidance to our clinics. This is a problem with which we are now planning to become engaged, and I can assure you that it is far easier to consider than to do.

Whether one agrees with Mr. Aptekar or not, one can welcome wholeheartedly the clarity of his own definition. I feel that all case workers must face squarely what their responsibility can be in the treatment of an NP patient. Psychiatrists faced with overwhelming requests for their service turn naturally to case workers and psychologists, because they see that these disciplines have something valuable to offer. However, just what it is, is not entirely clear to them. Since they cannot at the same time delegate to us their legal responsibility for what we do with their patients, it is not surprising that their sharing has had all the frustration of "Indian-giving." It is no small dilemma for the physician to be in the position of having to delegate treatment responsibility, while retaining legal responsibility. As case workers, we are inclined to overlook the physician's dilemma and see only its symptom. I believe, as case workers, we owe the physician the reponsibility of helping him consider what within our training qualifies us to carry, what kind, if any, treatment responsibility for the NP patient. We must examine this in the light of our training and our experience, and with full awareness of what NP patients need. We should not base our decisions merely upon the conviction that in a particular setting, a particular psychiatrist is so poor that any social worker can do better than he does. Lack of skill on the part of any physician is the responsibility of his medical profession and does not give us the right to take over. Only training and experience can give us such a right.

Mr. Aptekar bases his differentiations between case work and psychiatry upon qualifications for treatment. He says that illness is the realm of the physician. Perhaps I am attributing my own lines of demarcation to him, but I believe he says that counseling is in the area of normal problems that can arise in the process of maturation of any person. Normal growth and the need to make certain changes and adjustments can create problems for individuals. These problems can become aggravated into illness. Perhaps counseling, then, is more in the area of prevention than treatment. Before moving on from this point, I should like to throw out for consideration whether we are moving in the direction of a new professional group; the psychiatrists' pull towards greater use of psychologists and social workers in treatment (along with our push); the increasing demands for treatment; the physician's inability to delegate with free conscience, all *may* be the ferment for a new professional group. The psychiatrist is realistic when he finds it difficult to delegate

treatment responsibilities to a person whose training did not include more than medical and psychiatric information, and whose experience with the psychotic is usually minimal. He knows how easy it is to miss the physical component in an emotional problem; how difficult it is to understand the language of the psychotic. At the same time he knows that he himself does not use all of his medical professional training in his treatment of patients. It may well be that if pressures continue, a new professional group with a different kind of training will evolve. Perhaps this training will include training in the medical field and in the psychiatric, much as a physician gets. Hopefully it will include case work techniques in interviewing and supervision, along with some of the unique skills of the psychologist. If such a group is needed and emerges, I hope that all the professional groups now engaged in the treatment of NP patients will jointly set up the standards for training. I hope they will insist that such persons be licensed, and given legal responsibility for what happens to their patients.

I would like to comment briefly on one of the most valuable aspects of the psychiatric treatment service described by Mr. Aptekar. One of the greatest problems besetting the NP field is what Mrs. Elizabeth Ross (consultant to VA Social Service Division) terms as "a technique of communication" between psychiatrist and social worker. Though we can sympathize with the psychiatrists who removed themselves from the panel in the face of these forms, we nonetheless must admire what is an outstanding experiment in devising a method of communication between psychiatrist and social worker. This report form responsibly tries to define what out of the mass of material each deals with, is pertinent to share with the other. It takes the sharing out of the personal area. It is what the agency and the psychiatrist see as essential. It is not related to a case worker's desire to show a psychiatrist up, or a psychiatrist's desire to get through as quickly as possible with a burdensome conference. We hope that the Jewish Community Services of Queens-Nassau will continue to experiment with these forms, to see their pertinence to case work practice and share their experience with the field.