A Multidisciplinary Social Casework Center With A Staff Psychiatrist

JOHN C. EBIE, M.B., D.P.M., M.Sc.

Dr. Ebie, while a Rockefeller Foundation Fellow, was with the medical research council unit for epidemiological studies in psychiatry, University Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh. Currently, he is lecturer in psychiatry, University of Ibadan. Tearsheet requests to John C. Ebie, Department of Psychiatry, University College Hospital, Ibadan, Western State, Nigeria.

Current thinking in social casework favors a multidisciplinary approach (*1, 2*). In Scotland, multidisciplinary social casework centers are being set up to implement the Social Work Scotland Act of 1968. In England and Wales, a multidisciplinary approach to social casework has been recommended (*2*) but has not yet been implemented. The Craigmillar Health, Welfare and Advice Centre in Edinburgh was the first multidisciplinary social casework center in Scotland and the only one known to have a psychiatrist on its staff. My study of the center was aimed at documenting the way this experimental multidisciplinary social casework center functioned, the characteristics of the center clients, and the contributions of the attached psychiatrist. The study yielded information of interest not only to social workers, administrators, policymakers, and others, but also to psychiatrists whose role in social casework agencies is still unclear.

For my study, Prof. G. M. Carstairs, director, and Dr. N. Kreitman, assistant director, of the Medical Research Council Unit for Epidemiological Studies in Psychiatry, University Department of Psychiatry, Royal Edinburgh Hospital, offered me the use of the unit's research facilities. The project was undertaken while I was a Rockefeller Foundation Fellow.

The Craigmillar Center

The Craigmillar center, opened in March 1968, serves the Cragmillar ward. The ward is one of the 23 electoral wards in the City of Edinburgh and has a population of 26,200. The residents of Craigmillar ward have a disproportionate share of the social and medicopsychological problems of the city. In 1966 the ward ranked first in four of the 18 variables studied by Philip and McCulloch (*3*): juvenile delinquency, children taken into care, overcrowding, and referrals to the Royal Scottish Society for the Prevention of Cruelty to Children. In 1968 it ranked first in number of attempted suicides (*4*).

The staff of the Craigmillar center consists of social workers and others from statutory, voluntary, and religious bodies involved in the area, and a psychiatrist, who attends the center on a part-time basis, takes on cases, and advises the staff on the psychological management of the clients. The center is in the charge of a senior social worker called the center coordinator. The social workers and the psychiatrist function as a team. Thus clients are regarded as center clients rather than clients of the individual agencies represented at the center.

Contact must be made by or on behalf of a prospective client before casework is offered. People have come to know about the center through posters and the mass information media. A new client, after an initial interview by the duty social worker and discussion by the social work staff and psychiatrist at one of the twice-weekly "intake" meetings, is allocated to a worker whom the staff think can best handle his case. The social worker assumes responsibility for the client but can refer him to a colleague or to a subsequent intake meet-

ing as the need arises. All the social workers except the marriage guidance counselors and members of the Citizens Advice Bureau carry out home visits, which constitute an essential part of their casework method.

At regular staff meetings, policy and administrative matters are discussed. Regular staff seminars led by a consultant psychiatrist are also held. From time to time, a "case conference" is convened to discuss a client with difficult problems. All persons, including social workers, physicians, and clergymen, involved with the client's family are invited to the conference, where a decision is made how best to handle the problems of the family.

Collection of Data

I did not interview any clients, but a social worker completed a pro forma for every new client (that is, a person making his or her first contact with the center) either at the first visit of the client to the center or shortly after. The data collected from January through March 1969 were card-punched. The cooperation of the social workers was sought before the pro forma was introduced. Each social worker was given explanatory notes about the pro forma, and I was available to clarify any missing points.

Results

During the 3-month period of my study, 128 new clients contacted the center.

Sex-age-marital status and social class. The client cohort consisted of 100 females and 28 males with a predominance of young and married people. By comparison with the population from which the clients were drawn, females, people aged 20 to 44 years, married or divorced people, and social class 5 (unskilled workers) were significantly over-represented (tables 1–3). Males, people aged 15 to 19 years or 45 years and over, single or widowed people, and social classes 1 to 4 were significantly under-represented. (The Registrar General's Classification of Occupations issued in 1966 was used in determining the social classes of clients.)

Previous contact with social and other agencies. Most clients had contacted other social work agencies before coming to the center; frequently, they had contacted more than one. The three agencies with the largest number of clients visiting the center were the Ministry of Social Security (81), the Children's Department (29), and psychiatric hospitals (28).

Problems of clients. The clients' problems were examined in three ways; namely (*a*) help specifically asked for by the client, (*b*) problems noted by the social workers within the first 2 weeks of the client's contact with the center, and

Table 1. Distribution of clients and Craigmillar population, by age

Age group (years)	Number of clients [1]	Percentage of clients	Percentage of Craigmillar population aged 15 and over	x^2
15–19.....	3	2.4	15.4	13.86
20–24.....	28	22.2	10.0	18.82
25–34.....	32	25.4	19.4	2.29
35–44.....	30	23.8	17.0	3.46
45–54.....	15	11.9	16.3	1.47
55–64.....	12	9.5	12.6	.96
65 and over..	6	4.8	9.3	2.78
Total....	126	100.0	100.0	43.64

[1] Ages of 2 clients were not known.
NOTE: $x^2 = 43.64$, degrees of freedom $= 6$, $P < 0.001$.

Table 2. Distribution of clients and Craigmillar population, by marital status

Marital status	Number of clients	Percentage of clients	Percentage of Craigmillar population aged 15 and over	x^2
Single.....	8	6.2	25.4	18.47
Married [1]....	108	84.4	65.1	7.32
Widowed....	7	5.5	8.3	1.22
Divorced....	5	3.9	1.2	7.22
Total....	128	100.0	100.0	34.23

[1] Separated but not divorced is categorized as married.
NOTE: $x^2 = 34.23$, degrees of freedom $= 3$, $P < 0.001$.

Table 3. Percentage distribution of clients and Craigmillar population, by social class

Social class	Number of clients [1]	Percentage of clients	Percentage of Craigmillar population aged 15 and over	x^2
1..... 2.....	0	0	4.0	4.30
3.....	32	29.4	44.0	5.33
4.....	29	26.6	28.8	.18
5.....	48	44.0	23.2	20.37
Total....	109	100.0	100.0	30.18

[1] Social class of 19 clients unknown.
NOTE: $x^2 = 30.18$, degrees of feedom $= 3$, $P < 0.001$.

(*c*) allocation of the clients to workers at the center.

Ninety-four clients requested material help (that is, help with money, food, clothing, and housing), 10 requested psychological help, four requested material and psychological help, and 18 requested other types of help. Two clients did not request help but were referred because they had neglected their children.

Social workers found the following categories of problems in the first 2 weeks of contacts with clients:

Category	*Number with problem*
Temporary relief (for example, looking after children while mother was in hospital)	32
Family relationship	5
Relationship outside of family	4
Housing	16
Housing crisis	5
Emotional	40
Financial	78
Marital	22
Legal and special	12
Other	37

Clients frequently had more than one category of problem and tended to ask for material help irrespective of any psychological problems that were found (table 4).

Table 4. Relationship between presence or absence of psychological, marital, or interpersonal problems and help requested by client

Help requested by clients	Problems present	Problems absent	Total
Material	28	66	94
Psychological [1]	10	0	10
Material and psychological	4	0	4
Other	9	11	20
Total	51	77	128

[1] Includes marital problems.

The psychiatrist, mental health officers—employed by local authorities and responsible for psychiatric patients in the community—and marriage guidance counselors, whose clients predominantly would be those with psychological or emotional problems, received 42 percent of the allocated cases, with the psychiatrist receiving the largest number of allocations to any one person (table 5). No client who requested psychological help only or both material and psychological help was unallocated; all such clients were allocated to the psychiatrist, mental health officers, and marriage guidance counselors. Clients who were found by social workers to have emotional and related problems were allocated mainly to the psychiatrist, marriage guidance counselors, and mental health officers (table 5). The 66 unallocated cases consisted predominantly of those that were satisfactorily dealt with by the duty officer at the initial interview and closed at the next intake meeting.

Table 5. Relationship between presence or absence of emotional, marital, or interpersonal problems and case allocation

Case allocated to—	Problems present	Problems absent	Total
Child care officers	3	5	8
Probation officers	0	2	2
Mental health officers	5	2	7
Psychiatrist	10	0	[1] 10
Welfare officers	0	5	5
Health visitors	1	1	2
Citizens Advice Bureau officers	1	5	6
Officers of the Royal Scottish Society for the Prevention of Cruelty to Children	2	8	10
Marriage guidance counselors	8	1	9
Little Sisters of Assumption	0	3	[1] 3
Unallocated	21	45	66
Total	51	77	128

[1] Allocated to 1 person.

A significant difference was found in social class only between clients allocated to the psychiatrist and those allocated to other workers. Clients allocated to the psychiatrist were predominantly in social classes 3 and 4, whereas clients allocated to other workers were predominantly in social class 5 (table 6).

Discussion

The methodological aspects of this study have been discussed elsewhere (*5*). One limitation of

Table 6. Comparison of social class distribution of clients allocated to psychiatrist and to others

Cases allocated to—	Client's social class		
	3 and 4	5	Total
Psychiatrist	9	1	10
Other workers	21	24	45
Total	30	25	[1] 55

[1] Social class of 7 allocated clients unknown.

NOTE: x^2 (corrected for continuity) = 4.57, degrees of freedom = 2, $P < 0.05$.

this study is that no objective psychological instruments were used to demonstrate psychological or emotional problems in clients. Thus the relevant findings reflect the opinions of the social workers. The study is useful, however, because it highlights the way a forerunner of the multidisciplinary social casework centers in Scotland functions.

Why certain groups were over-represented in the client cohort is not known as there was no selection of clients. The excess of married women in the client cohort may have occurred because women come to the center in their capacity as mothers of households with the responsibility of running the home. Teenagers, on the other hand, may think that the center has nothing to offer them. And diminished mobility may be responsible for the under-representation of the elderly since contact by or on behalf of the client must be made before casework is offered.

Previous contacts of clients, problems of clients, and allocations of cases show that a substantial proportion of clients (20 to 40 percent) had or were thought by social workers to have psychological problems. This supports the findings of Bemmels (*6*) of the high incidence of clients with psychiatric disorders in social agency caseloads. Social workers found psychological problems even when clients requested material help; the reason is not known. Perhaps material problems masked the psychological ones or the psychological problems resulted from material ones. Other possibilities are that the client's psychological problems may have received attention elsewhere, hence the client did not mention them; or it may be that the client did not expect the center to handle his psychological problems.

Why some of the clients but not others were allocated to the psychiatrist, mental health officers, and marriage guidance counselors is not known. The clients allocated were probably those whose emotional problems were thought by social workers to require intervention. Why clients in a higher social class were mainly allocated to the psychiatrist also is not known. The system of allocating clients needs further study.

The functions of the psychiatrist, who has been available at the Craigmillar center since July 1968, fall into two broad categories; namely, diagnostic and therapeutic service to clients allocated to him and guidance to social workers in the management of their clients. He makes diagnoses of conditions and treats some clients that are allocated to him and refers the others to psychiatric hospitals. The psychiatrist also follows up patients from the area who attempt suicide. The center, with its social work facilities, appears to be an appropriate place to follow up persons who have attempted suicide; most have a background of serious social problems.

At intake meetings, the psychiatrist helps in defining the psychological problems of the clients and sometimes in deciding whether or not a psychological problem is present. The psychiatrist also systematically lectures and has informal discussions with the social workers to acquaint them with common emotional and psychiatric disorders.

This centralized facility appears to be an efficient way of providing social casework service for a community, since it cuts away duplication of services. It also affords a means of assessing the total problems of a defined geographic area since all these problems would be referred to the centralized facility.

Social workers found a high incidence of psychological problems in clients using the center; the results emphasize the need for an objective assessment of the psychiatric status of the clients and guidance to social workers in the psychological management of their clients.

During the period studied, some clients who were thought to require psychiatric help were managed at the center instead of being referred to psychiatric hospitals. This type of center could provide outpatient psychiatric facilities for the community that it serves.

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