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A DESCRIPTIVE STUDY OF THE PRESENTATION OF PSYCHO-SOCIAL PROBLEMS IN THE EMERGENCY DEPARTMENT OF A SMALL GENERAL HOSPITAL

by

Maureen L. Leyland

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The undersigned certify that they have read, and recommend to the Faculty of Social Welfare for acceptance, the research project entitled "A Descriptive Study of the Presentation of Psycho-social Problems in the Emergency Department of a Small General Hospital" submitted by Maureen L. Leyland in partial fulfillment of the requirements for the Degree of Master of Social Work.

James Gripton

Dr. James Gripton,
Professor,
Faculty of Social Welfare

M. R. Rodway

Dr. M.R. Rodway,
Associate Dean,
Faculty of Social Welfare

Barbara Dobbie-McMillan

Mrs. Barbara Dobbie-McMillan,
Professor,
Faculty of Nursing

Barbara A. Jordan-Knox

Ms. Barbara Jordan-Knox,
Director of Social Work,
Rockyview Hospital

Date: December 10, 1980

ABSTRACT

The author considers 2 basic questions in this study: (i) whether there are more people presenting in the Emergency Department with psycho-social problems warranting referral to the Social Work Department than actual referrals to the Social Work Department indicate; (ii) whether the implementation of a social work service within the Emergency Department on an extended hours basis would lead to increased recognition and referral of patients with psycho-social problems.

Several procedures were developed to provide answers to these questions: reviews of medical charts, the implementation of a questionnaire to patients presenting in the Emergency Department and the development of a social work service on an extended hours basis within the Emergency Department.

The data obtained from these procedures lead the author to answer both questions in the affirmative and to conclude that a social work position should be developed within the Emergency Department of Rocky View Hospital.

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CHAPTER 1

INTRODUCTION

There has been a dramatic increase of between 350 to 400 percent in the number of admissions to hospital emergency wards since World War II (Bergman, 1976; Gwinn, 1979). Concomitantly, there has been a considerable increase in the presentation of problems in emergency wards which have a primary or secondary psycho-social component (Bennett, 1973; Satin, 1971; Gwinn, 1979). Such are the conclusions of several studies of Emergency Ward Utilization (the "Yale Studies" 1966; Krell, 1976; Grumett and Trachtman, 1976).

Although most of these studies were done in United States' hospitals, similar trends have been noticed in Canadian hospitals (Farber, 1978; Calvert et al. 1969). Calgary now has two hospitals where attention is paid to psycho-social problems through the development of psychiatric emergency assessment teams.

The research to be described here was carried out in a small 194 bed general hospital located in south-west Calgary. It attempts to describe the utilization pattern in Rocky View Hospital's Emergency Ward, focusing in particular on the presentation of problems with a primary or secondary psycho-social component.

Although the dramatic increases in utilization rates mentioned above are based on data from large city centre hospitals, similar trends have been reported at Rocky View Hospital. For example, a study in 1977 showed that there had been a 107 percent increase in total admissions to the Emergency Ward since 1971.

TABLE 1

To Show the Percentage Increase in Admissions to Rocky View Hospital's Emergency Department 1971-77

Year	Emergency Patients	Percentage Increase
1971	20,297	100
1972	23,846	117
1973	26,710	131
1974	32,152	158
1975	34,759	171
1976	39,731	196
1977	41,952	207

Several studies carried out by members of Rocky View Hospital's Social Work Department and by practicum students there have drawn attention to the expected number of patients presenting in the Emergency Ward with problems warranting the intervention of the Social Work Department (i.e. problems with a primary or secondary psycho-social component).

For example, a study in February and March 1979, in which medical records were reviewed daily, showed 22 and 27 patients in the respective months might have been referred to the Social Work Department, in addition to the 10 each month that were referred.

TABLE 2

To Show the Number of Patients Who Were Considered Potentially Socially Referable, Presenting in Rocky View Hospital's Emergency Ward During February & March 1979

Not Referred to Social Work

Month	Provisional Diagnosis	0700-1500 Days	1500-2300 Afternoons	2300-0700 Nights
Feb. 1979	Anxiety, emotional upsets	0	5	2
	Overdoses (sent home)	2	2	1
	Assaults	1	2	1
	Migraine headaches	0	3	3
	Totals	3	12	7 = 22
March 1979	Anxiety, emotional upsets	2	5	2
	Overdoses (sent home)	1	2	5
	Assaults	0	1	0
	Migraine headaches	2	2	5
	Totals	5	10	12 = 27

Referred to Social Work

February = 10

March = 10

Such preliminary studies set the scene for the research to be described in this project. It attempts to consolidate the more limited studies carried out previously at Rocky View Hospital. It is intended to provide the hospital administration, the Emergency Ward Staff and the Social Work Department with data on the demographic characteristics of the population using Rocky View Hospital's Emergency Ward and also to look at the presentation of psycho-social problems in that ward.

In Chapter 2 a review of the literature has been made, looking at utilization patterns and trends in emergency wards, the presentation of psycho-social problems in emergency wards and the role of the social worker in emergency wards.

Chapter 3 describes the methodology employed in this research project. The findings of the research are presented in Chapter 4 and the conclusions of these findings are presented in Chapter 5.

The project concludes with a summary of recommendations indicated by the research.

CHAPTER 2

LITERATURE REVIEW

A review of the relevant literature was undertaken. Social Work Abstracts, Sociological Abstracts, Psychological Abstracts and Index Medicus were all consulted. Searches of the card catalogues in both the University and Medical Libraries were made also. This review is in three parts:

a) general utilization patterns and trends in emergency wards
b) the presentation of psycho-social problems in emergency wards
c) the role of the social worker in emergency wards.

1. Utilization Patterns and Trends in Emergency Wards

As stated in the Introduction to this project, there has been a great increase in the last three decades in the number of people presenting in hospital emergency wards (Bergman 1976, p. 33; Gwinn 1979, p. 73; Kaufman and Klagsburn 1972, p. 231; Weinerman et al. 1966, p. 1037; White and O'Connor 1970, p. 163).

Other studies show that, in addition to this general increase, there has been a considerable increase in the

proportion of people presenting in emergency wards with "non-urgent" conditions (Grumett and Trachtman 1976, p. 115; Roth 1972, p. 846; Weinerman et al. 1966, p. 1037).

Gibson (1978) suggests that:

> "many patients presently treated in hospital emergency departments for non-urgent conditions could more appropriately be treated in other ambulatory care settings...the major single defect of the present emergency medical service system is seen as inappropriate utilization." (p. 94)

What is meant by the terms "non-urgent" and "inappropriate utilization"? Grumett and Trachtman (1976) suggest that patients' and doctors' opinions as to what constitutes an emergency differ. In the literature the classification of a case as appropriate/inappropriate, emergent/non-emergent, legitimate/illegitimate, is based on the perception of the caregiver - the physician and/or nurse.

Gibson (1978) asked emergency ward physicians what they considered the most appropriate place for treatment for a sample of 888 patients presenting at various emergency wards in Erie County, New York. In the physicians' judgement, only 51 percent of the sample required treatment in the emergency room. The physicians named hospital outpatient departments and general practitioners offices as the most appropriate treatment sources for most of the 49 percent of "inappropriate" emergency room users.

Roth (1972) offers an explanation for the universal complaint amongst those who operate emergency services being that of patient "abuse" of the emergency room facility. He contends that emergency room staff are trained to view the emergency room as a place where trauma work is carried out; a place where patients with life-threatening conditions or bodily dismemberment can be treated efficiently and effectively. Medical cases are more likely to be seen as illegitimate than are surgical cases. In their ratings of illegitimacy the highest ratings (i.e. the most illegitimate) were for cases classified as "gynaecology", "genito-urinary tract", "dental" and "other medical". Cases lowest on the scale were those classified as "pedaeatrics", "beatings and stabbings", "industrial injuries" and "automobile accidents". Roth claims that in the case of complaints such as abdominal pain, depression and digestive upset, where diagnosis is more subtle and complex, many cases were viewed as illegitimate because "no easy answers" could be offered.

Mannon (1976) substantiated Roth's findings concerning the process of classification of emergency cases in a study conducted in a 600 bed general hospital in the mid-Western United States. His conclusion was that:

> "legitimate work is associated with 'real' emergencies, including those that require heroic technical efforts or those that can be treated by means of 'cool speedy care'.

> The illegitimate cases are those that involve comprehensive and prolonged care. Patients whose problems are not amenable to quick diagnosis and treatment are not going to be successful cases in the emergency room and are therefore seen as inappropriate". (p. 1007)

However, it cannot be inferred that physicians' views about the legitimacy of the conditions of those presenting for emergency service determined whether or not they received treatment. Roth found some medical staff estimating the proportion of patients who were using the emergency service inappropriately as high as 70 to 90 percent. Yet the proportion of cases treated as illegitimate (i.e. made to wait an excessive time, referred elsewhere, treated contemptuously) ranged from 20 to 25 percent.

Several studies have focused on the demographic characteristics obtained on patients presenting in emergency wards (Baltzan 1972; Bauer and Baltzan 1971; Berman and Luck 1971; Davis 1973; Gwinn 1979; Huffine 1974; Mannon 1976; Matheson 1974; Weinerman et al. 1966). The general conclusions that can be drawn from these studies is that within urban areas, there is an over-representation of the lower socio-economic groups amongst the patient population.

Weinerman et al. in the "Yale Studies" (1966) concluded that the emergency ward of Yale - New Haven Hospital constituted "a major medical resource for the economically deprived 'core-city' minority populations". (p. 1054)

Gwinn (1972) suggests that "many patients are seeking emergency department care for a variety of non-emergency conditions; for many individuals, especially the urban poor and the parents of young children, this facility is the sole source of medical care". (p. 73)

Torrens and Yedvab (1970) have defined three major roles for emergency rooms, one of which is as family physicians to the poor.

Some studies have sought to explain this over-representation of the lower socio-economic groups. For example, Rowden (1973) suggests as one reason that care in the emergency ward offers the patient relative anonymity. He contends that a long-term, regular relationship with a private physician is not always appealing to the lower class patient who may fear social denigration by an upper class physician.

Rowden suggests as another reason that it can be difficult for the poor to make appointments with family physician and/or clinics. It is often difficult for those in blue collar occupations to take time off for medical appointments during the day. The emergency room, being open at all hours and not requiring an appointment, is a more convenient medical resource.

Baltzan (1972), in a study of an emergency department in Saskatoon, concluded that the ready availability of medical care in the emergency department was one of the

major reasons for its use by all classes of patients. Despite the fact that users often have to wait a considerable length of time for treatment in the emergency room, it was found that the waiting periods were often no longer than in clinics where appointments had been made.

The three common themes running throughout the literature on the utilization of emergency services are:

(i) the great increase in emergency ward utilization in the last 30 years

(ii) the increasing "inappropriate" use of the emergency ward in terms of increasing proportions of people presenting with non-urgent conditions

(iii) the over-representation of lower socio-economic groups in the patient population.

Most of the above mentioned studies were carried out in large city centre hospitals. White and O'Connor (1970) carried out a study of people presenting in the emergency ward of a smaller community hospital. They did not identify the same patterns of misuse, nor did they discover significant over-representation of any one socio-economic group. It might be important to remember that:

> "...emergency room service patterns will differ according to hospital size, the characteristics of the patients served by that hospital and the size and the characteristics of the community in which the hospital is located". (White and O'Connor, p. 168)

2. Presentation of Psycho-social Problems in Emergency Wards

The literature draws attention to the presentation of psycho-social problems in emergency wards and the frustration this arouses in the staff.

Habeck and David (1978), describing the emergency room of a military medical centre, found that many people presenting in the emergency room had no substantial illness but seemed to require some form of social work intervention. They found:

> "...much nursing and physician frustration, due to lack of experience and knowledge regarding behavioral counselling and the availability of community social services and mental health resources". (p. 495)

Mannon (1976) in his analysis of how medical staff define cases as legitimate or illegitimate, found that the cases the staff found frustrating to deal with were "the helpless (child abuse victims), the drunk and drugged, and the 'regulars'." (p. 1007)

Blais and Georges (1969) in a description of the presentation of psychiatric emergencies in Ottawa General Hospital, found that:

> "...the emergency ward staff, constantly harassed with medical-surgical urgent situations, has little patience with a disturbed patient and his family or friends". (p. 124)

Some authors have found links between lower socio-economic class and the presentation of psycho-social problems (Mannon, 1976; Roth, 1972; Weinerman et al. 1966). Grumett and Trachtman (1976) state in reference to lower socio-economic status patients that:

> "...additional problems associated with poverty, unemployment, family disorganization and geographic shifts often accompany these visitors into the emergency room". (p. 115)

Blais and Georges (1969) found a high percentage of patients from lower socio-economic groups presenting with "psychiatric emergencies". They proposed the development of a walk-in clinic that could more readily offer help to such patients. They suggested that such a clinic should provide short-term therapeutic interventions rather than other methods of intervention:

> "...studies have led to an increasing awareness of the shortcomings of conventional long-term and so-called intensive psychotherapy, especially as it applies to the therapeutic expectations and needs of the patient of lower socio-educational level". (p. 130)

Satin (1971) examined the prevalence and disposition of psycho-social problems in the emergency unit of a large, urban general hospital. Two hundred and fifty-seven patients were selected for the study, without regard to the type of problem brought to the emergency room. Each patient was interviewed by one of three trained research psychiatrists.

Thirty-seven percent of the sample were viewed by the psychiatrists as having major psycho-social problems. A further 40 percent were seen as having an important psycho-social problem. Unfortunately no specification of criteria or procedures for the classification of a problem as psycho-social is given in the article.

However, Satin suggests that:

> "...judging by the patients and types of problems presenting there, the emergency unit clearly functions as a general community physician and not as a specialized surgical trauma facility". (p. 111)

Satin goes on to describe the way in which physicians deal with problems comprising a primary or secondary psycho-social component. He suggests that they usually focus on the physical symptom if possible. For example, a slashed wrist/suicide attempt allows the physician to focus purely on the surgical procedure of suturing the cut.

> "The evidence is that in practice (the emergency unit) selectively does not recognize or deal with the psycho-social problems brought to it...this may be based on a lack of skill on the part of the professional staff in recognizing or dealing with such problems, a refusal to accord them the status of a legitimate illness or an insistence on their inappropriateness to the emergency unit...In any case, there is here a sizeable and important body of patient need that is not responded to". (Satin 1971, p. 113)

Satin has raised what he feels is an important issue. He suggests that there seems to be a need for emergency ward staff to broaden their definition of the function of the ward. Those responsible for the emergency services must begin to recognize and accept its potential role as a preventive treatment centre for psycho-social problems. Satin goes on to suggest that emergency room medical staff should be better trained to deal with, or at least recognize and refer, people with psycho-social problems, particularly as they are usually presented in conjunction with physical complaints.

In another article, Satin (1972) describing the same study population, found a high prevalence of recent life-stresses among patients in the emergency unit:

> "Physical problems are much more likely to be presented as a 'ticket of admission' perhaps because of the physical illness treatment image of the emergency unit".
> (Satin 1972, p. 125)

He goes on to suggest that emergency room staff must be prepared to look beyond the acute physical symptoms/problem presented to precipitating factors both emotional, social and environmental.

Assuming continuation of the present organization of health care services the trends in the utilization of emergency services discussed above are likely to continue. This suggests that more effective ways of dealing with the

"illegitimate" patient who comes to the emergency room, must be found. One component of more effective services is a better understanding and utilization by all emergency service staff of knowledge of the sociological aspects of illness and the social psychological dynamics of illness behavior. (Koos, 1956; Mechanic and Volkart, 1961; Zborowski 1952; Zola, 1966). Over two decades ago Hinkle and Wolff (1958) made the assertion that:

> "...it is probable that an increasing proportion of therapeutic effort will have to be directed at the patient's relationship to his environment if we wish to make any significant improvement in his health". (p. 1387)

The literature on the psycho-social aspects of illness and treatment since that time, and the recent trends in utilization of emergency services would appear to support this view. Satin (1972) takes the position that:

> "...the emergency unit...must become more sensitive in recognizing the constellation of life experiences producing stress reactions and calling for therapeutic interventions if it is to fulfil its professional responsibilities". (p. 126)

3. The Role of Social Workers in the Emergency Ward

Recognition that many people using the Emergency Ward have psycho-social problems of a primary or secondary nature, has resulted in the development of psychiatric

emergency teams and walk-in clinics in some hospitals (Blais and Georges 1969; Errera, Wyshak and Jarecki 1963; Kaufman and Klagsburn 1972). Psychiatric emergency teams now exist in two large general hospitals in Calgary. These teams or clinics are staffed by a variety of mental health professionals - psychiatrists, social workers, nurses and psychologists. In this section of the report however, the author deals specifically with the role of social workers in the emergency ward.

The medical social work literature has stressed the importance of the social and emotional aspects of illness. Bartlett (1958, p. 19-20) notes that when social problems are significantly related to disease and its care, social casework has a contribution to make, both in helping toward better understanding of these problems and in assisting the patient to meet these problems as constructively as possible. Hemmy (1952, p. 98) sees the need to consider the physical, emotional and social aspects of illness together, as they are so interwoven that it is not possible to address them separately. Adcock (1968, p. 342) emphasizes the importance of seeing the patient as a whole person. Such concepts have become truisms for medical social workers. It is now being recognized that they have as much validity in the emergency ward as they do in the other hospital units in which social workers have more traditionally worked.

Several descriptions of social work programs in emergency wards can be found in the literature (Bennett, 1976; Bergman, 1976; Grumett and Trachtman, 1976; Habeck and David, 1978; Krell, 1976).

Bennett (1976) describes a program at Brooklyn Hospital, New York, in which social workers provide service to the emergency ward over extended hours, including evenings and weekends. She reports that this program resulted in a threefold increase in referrals from the emergency ward to the social service department over one year.

Farber (1978) describes a similar program at St. Boniface General Hospital in Winnipeg. The program was developed in 1973 after several factors pertaining to emergency ward utilization were observed by the social workers in that hospital. These were that:

> "1) psycho-social crises tended to occur after 5:00 p.m. - the traditional closing time for social work departments
>
> 2) few community resources were available after 5:00 p.m.
>
> 3) there was a tendency for people in crisis, whether medical, social or psychological, to expect a hospital emergency department to provide the range of services required
>
> 4) people other than the patient, may be affected when emergency treatment is required

5) there were many situations in which social work consultation should have been an essential adjunct to medical treatment

6) it was recognized that emergency staff, be they nurses or physicians, are often unable to provide the level of psychosocial care required by patients and/or their families, because of the volume of patients to be seen and the acute nature of medical treatment." (p. 8)

Farber then describes the functions and goals of the social work department, which began to offer extended coverage to the emergency ward.

Groner (1978) describes an extended coverage social work program established in 1977 at Northridge Hospital, Los Angeles. She lists seven categories for the classification of cases. These are:

(a) work with patients and/or families who are treated for non self-inflicted traumatic injury or illness requiring counselling and/or follow-up care e.g. attack, rape, coronary disease, accident

(b) death in the family, including unexpected deaths, anticipated deaths and deaths on arrival

(c) work with those patients and/or family with mental health problems requiring psychiatric consultation e.g. suicide attempts, alcohol abuse, family and marital problems

(d) work with patients and/or family who have minor medical disorders and present unusual anxiety because of them e.g. patients with physical symptoms veiling severe social and emotional problems

(e) work with those who have minor medical problems but significant social problems, including transportation, job or unemployment, financial and housing problems

(f) work with patients who present non-urgent medical problems and need assistance to utilize community medical resources e.g., people with colds, flu and sore throats

(g) work with child abuse victims and their families.

Groner expands on all these categories, illustrating each with actual case histories.

Crisis Intervention

The clientele in the emergency ward offers the social worker the opportunity to use many skills and therapeutic interventions. However one clear thread running throughout the literature is the emphasis on the opportunity that the emergency ward provides as a centre for crisis intervention work.

Farber (1978) links crisis intervention work with preventive health care:

> "...as health care costs continue to rise, new means are required to identify and alleviate those conditions that produce, precipitate and perpetuate poor physical and emotional health. Early identification of these conditions can often postpone or alleviate their deleterious effects. One way to achieve early identification and remediation is by crisis intervention and a hospital emergency department provides one obvious setting for the initiation of this type of service". (p. 18)

The concept of crisis intervention has developed from the work of Lindenmann (1956) and Caplan (1964), who began

to formalize the concept of a crisis and developed ideas on how people in crisis could best be helped. Caplan stated that a crisis ensues when:

> "...a person faces an obstacle to important life goals that is for a time, insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different attempts at resolutions are made". (p. 9)

The outcome of a crisis may be adaptive in terms of the enlargement of the individuals experience and coping mechanisms. It may also be maladaptive in terms of the development of a pathological state of avoidance and the development of displaced problems (such as physical illness) or the exhibition of symptoms of strain (emotional illness). As Satin (1972) notes in his discussion of life stresses and psycho-social problems,

> "...recent life stresses cause disequilibrium and strain in the lives they effect. In a certain proportion of cases this leads to dysfunction and symptoms or complaints of illness, and may result in application for help to medical resources". (p. 126)

The clue to the successful operation of a crisis intervention program in a hospital emergency department seems to be ready availability of the social worker. Crises do not limit themselves to regular office hours. Gwinn (1979) reports on a study that indicates that only if social workers

are present on the ward (even being on call is not enough) would the medical staff readily refer patients to them. It seems that the social worker must become an observable member of the emergency ward team.

Teamwork

Whitehouse (1957) suggests that:

> "...teamwork is a close co-operative, democratic, multi-professional union devoted to a common purpose - the best treatment for the fundamental need of the individual". (p. 148)

Idealistically this is so, but teamwork is not always attained, even amongst members of the same profession. For example, Marsh (1974) looked at teamwork amongst social workers and found considerable confusion and lack of agreement as to goals and purpose. If this happened amongst professionals from the same discipline, it seems likely that effective co-ordination of effort and utilization of different competences will be even more difficult with a team representing different disciplines. Compton and Galloway (1975) suggest that conflict is inherent because of:

> "...the way students in all fields are inculcated with a different conception of human nature, of human conduct and human relations". (p. 455)

Despite these pessimistic viewpoints, successful teams have been developed. Grumett and Trachtman (1976)

report that while there was initial concern amongst the social workers about the acceptance of non-medical practitioners in the emergency department, their effectiveness rapidly gained them credibility as demonstrated by increased referrals. Farber (1978) suggests that the essential components of successful teamwork are being readily available and providing feedback to the medical staff on referred patients. Groner (1978) stresses the educative function of the social worker and describes the organizing by social workers of an interdisciplinary discussion meeting. She states that:

> "...doctors, nurses, clerks and emergency room social workers can do much to enhance teamwork, co-operation and appreciation of each other's roles and contributions". (p. 28)

Naeman (1976) looks in depth at the social workers' educative function in a hospital setting. He reports that social workers' perception of their own role is often very different from that of the physicians. Citing studies on this subject, he states that while physicians refer sizeable numbers of patients for social work services, they often perceive the role of the social worker as primarily encompassing concrete, instrumental services to patients. Naeman then examines possible reasons for this difference in viewpoints and proposes how social workers can influence physicians perceptions of their role, for example by case discussions.

In developing an emergency ward team, there is agreement in the literature that the social worker should be prepared to work shifts. Social work service being offered on an extended hours basis seems to be the basis for development of an emergency ward team of which a social worker is an essential member.

CHAPTER 3

METHODOLOGY

The purpose of this study was to address the questions of how many persons were presenting in the emergency department of Rocky View Hospital with psycho-social problems warranting referral to the Social Work department and whether more would be referred for social work services if such services were more accessible to the Emergency Department.

Four procedures were used to help answer these questions:

1. a retroactive study of emergency medical charts for the months of March and April, 1980.
2. an ongoing study of emergency medical charts during the period June 1st to June 20th, 1980.
3. the administration of a questionnaire to a sample of patients in the Emergency Department during the study period.
4. the provision of social work services on an extended basis in the Emergency Department.

Before expanding on the methodology a description of the setting of the study is in order.

Rocky View Hospital Emergency Department

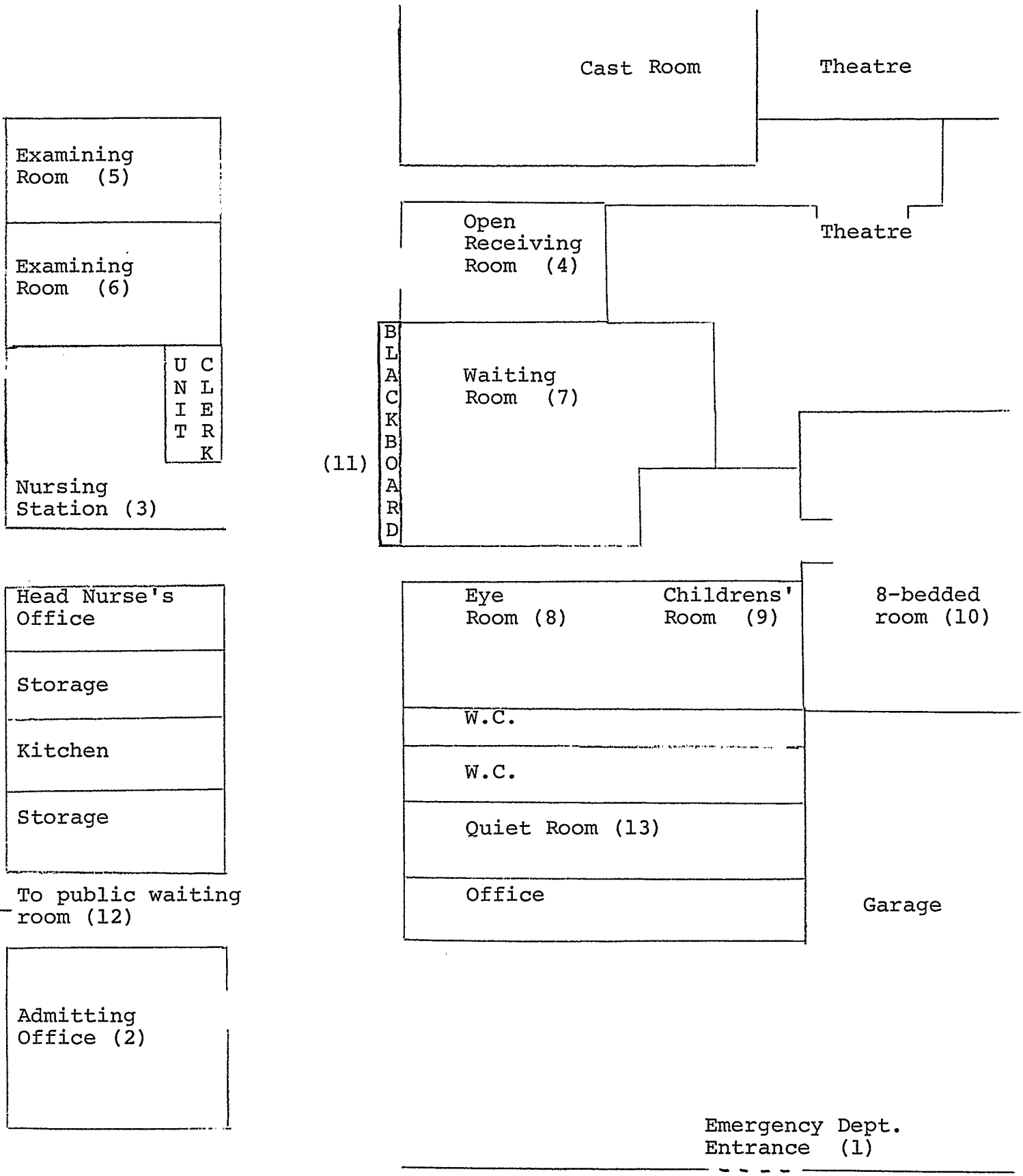
Rocky View Hospital is located in south-west Calgary. It is a 194 bed general hospital, most beds being devoted to medical or surgical treatment. There are eight paediatric beds and a six bed intensive care unit.

The hospital is a two-storey building built in the form of a cross. The Emergency Department is located on the first floor of the eastern wing and the floor plan is shown in Diagram 1 on the following page.

Patients usually enter through the Emergency Department entrance (1). To be admitted as a patient, personal information for the creation of a medical chart must first of all be given to the admitting clerk in the admitting office (2). The purpose of the Emergency Department admitting procedures are to obtain information to establish a person's status as a patient, and to allocate medical services to the patient on a system of priorities that takes into consideration the patients immediate physical status, the risks of postponing treatment, the competing claims of other emergency patients and the current medical resources of the facility. This system of assigning priorities and allocating services is intended to minimize the risk to patients and maximize the effective utilization of available resources and is called triage. This assessment process begins at the admitti office when a patient in severe pain or distress is sent directly to the nurses station (3), where the patient is triaged further by the nurses and placed in a room/bed appropriate to the patient's condition. In a case of such urgency information for the medical chart is then provided

DIAGRAM 1

Rocky View Hospital's Emergency Department: Floor Plan



by either the parademic, the escorting relative/friend or later by a relative/friend on their arrival at the hospital.

When the personal information section of the medical chart has been completed by the admitting clerk the patient is sent to the nurses station (3).There the chart is attached to a clipboard which is placed in the pigeon-hole assigned to the bed and room number in which the patient has been placed (4 to 10). The name of the patient and the presenting complaint are entered on the blackboard (11). When the physician has examined the patient he/she places his initials beside the patient's name on the blackboard.

Depending on the age of the patient and/or the nature of the complaint, relatives/friends are usually asked to wait in the Public Waiting Room (12) opposite the admitting office. If waiting friends and relatives are very anxious and distressed they may be taken to the Quiet Room (13) to wait.

Patients with less serious complaints are usually taken by the nurse to the Emergency Department Waiting Room (7). Patients with serious complaints (e.g. chest pains) are usually placed in the open receiving room (4), where they can be readily observed.

Having been appropriately triaged, the patient then waits to see a physician. Patients with serious complaints are, of course, seen before those with lesser complaints. During busy periods, queuing problems arise and must be

managed. Some patients will become frustrated with waiting and the nurses may have to spend much time placating anxious and irate patients.

During the period from 7:00 a.m. to 12:00 midnight, there are usually two physicians on duty at any one time. Only one physician is on duty during the night. During the 7:00 a.m. to 12:00 midnight period there are usually 6 nurses on duty; 3 nurses are on duty during the night.

Once having been seen by the physician, the patient is either admitted, transferred to another hospital, kept for observation or discharged.

Medical charts are sent to the medical records office for filing.

Estimating Social Referability

One component of this study involved estimating how many people presenting in the Emergency ward were potentially referable to the Social Work Department.

Four operational definitions of social referability were used:

1. if information on the medical chart indicated that the patient fell into any of the categories of social referability listed in a classification developed in an earlier study of emergency ward patients that was conducted at Holy Cross Hospital, Calgary (see Appendix A);

2. if the patient in the study sample to which a questionnaire was administered reported current psycho-social problems;

3. the assessment of the social worker on duty;

4. the assessment of the physician on duty.

1. Retroactive Study of March/April 1980 Emergency Ward Medical Charts

The Emergency Ward medical chart consists of a single self duplicating sheet. Personal information obtained by the admitting clerk, is entered at the top of the form. A nurse at the nursing station fills out the 'nursing observation' section. She reports the patient's statement of the complaint and adds her own observation on the patient's condition. Vital signs and allergies are also recorded by the nurses. The rest of the chart is completed by the attending physician after examining and treating the patient.

The retroactive study of medical charts applied the first operational definition of social referability. Charts were reviewed to see into which of 24 categories in a psycho-social classification (developed from a study done at Holy Cross Hospital, Calgary) they could be placed.

During March and April there were 7,245 admissions to the Emergency Ward. All records for each two month period are filed together in alphabetical order. It was decided

that a sample of one in seven would be sufficient for this part of the analysis. Beginning with the first chart filed, each seventh file thereafter was drawn. This yielded a sample of 1035 patients.

This review of medical charts employed the author's judgement rather than a set of explicit criteria and systematically developed judgement procedures. Severe time and staff constraints made any other procedure infeasible. Furthermore, the chart information was often incomplete or unspecific and physician's methods of reporting varied greatly. Consequently judgements by a single judge and an attempt to err on the conservative side (placing cases in the "medical only" category unless information clearly suggested otherwise) were considered as providing the most reliable and valid data under the circumstances.

2. On-going Study of Emergency Ward Medical Charts

During the period from June 1st to June 20th when the author was on duty as a social worker in the Emergency Ward, the review of medical charts described above was continued. This was done to determine whether there was any change in the frequency of reported psycho-social problems during this period. One explanation of such a change would have been the service demonstration effect of the presence

of a social worker on duty in the Emergency Ward. It was expected that the presence of a social worker and accessibility of her services might sensitize physicians and nurses to the presence of patients' psycho-social problems.

The author's work schedule during this period meant that she was not always in the hospital at a time when it was convenient for medical records staff to have her reviewing charts in their office. Consequently during this period, she was assisted by the secretary of the Social Work Department.

To enhance the reliability of judgements the author and the secretary spent five days each reviewing the same medical charts independently and then comparing results. Through this procedure it was possible to make more consistent interpretations of the information on the charts. Unfortunately the data that would have permitted computation of an interjudge reliability coefficient were not kept.

3. Administration of a Questionnaire to Patients Presenting at the Admitting Office

In order to obtain a more reliable estimate of the extent of presentation of psycho-social problems in the Emergency Ward and hence the number of potentially socially referable patients, a sample of patients were asked about their complaints; why they had come to Rocky View, and

whether they were experiencing any psycho-social problems at that time. Rowden (1973) states that:

> "...the most crying need in the area of the Emergency Room is for research about patients which involves the patients. This is particularly important if one wants to make first hand determination of why people use the Emergency Room...if we really want to be confident about our assertions concerning why these patients come to the Emergency Room we will have to ask those same people and not rely on staff opinions about patients records alone". (p. 185)

The administration of a questionnaire was an attempt to follow Rowden's suggestion and to operationalize definition 2 of social referability, the patients' identification of psycho-social problems. A schedule of the times when it was administered appears in Appendix B. Questionnaires were given out for four randomly chosen one hour periods during each 12 hour shift.

The Emergency Ward setting posed a major obstacle to obtaining information on all patients presenting during the one hour periods chosen for administration of the questionnaire. This was because it was unavoidable that some patients would not be able to complete a questionnaire on their own due to the painful and crisis nature of some complaints presented in the Emergency Ward. Thus two questionnaires asking similar information were developed and copies can be found in Appendix C and D. One form of the questionnaire

was designed to be completed by the patient if he or she was physically able to do so. The other was designed to be completed by the person accompanying the patient to the hospital if the patient was too ill or distressed to provide the information directly.

Arrangements were made with the admitting clerks to direct patients or those accompanying the patient to the investigator after they had obtained the personal information required for the medical chart. This was to be done during the hours designated for questionnaire administration. Most of the clerks did this by saying, "Before you go to the nursing station this lady would like to ask you something." This introduction gave the author the opportunity to explain the purpose of the study and to ask the patient or the person accompanying the patient if they would fill out the questionnaire. The questionnaire was completed whilst the patient was waiting to be seen by a physician. Completed questionnaires were returned to the Admitting Office.

The size of the admitting office meant that during busy periods, when up to 7 or 9 patients an hour were being admitted, the clerks were fully occupied and the atmosphere became harried and tense. The task of the Admitting Clerk is to obtain factual and personal information from people who are often anxious, in pain and distressed. The Admitting

Office is the first hurdle they must pass over before the hospital accords them the status of patient. Sometimes patients view admitting procedures as frustrating "red tape". Having to ask people in these conditions to undergo an additional administrative procedure required much tact.

Towards the end of the study some nurses and orderlies complained that some patients were leaving questionnaires in the waiting room and treatment rooms. Additional efforts were then made by the author to get patients to return completed questionnaires to the Admitting Office and to collect them herself from patients still awaiting treatment.

Information Sought in the Questionnaire

Copies of the questionnaire appear in Appendix C and D. There were two forms of the questionnaire; one to be completed by the patient, and the other to be completed by a person accompanying the patient to the hospital (relative, friend, fellow employee, parademic) in the event that the patient was incapable of doing so. Except for a question asking the relationship of the respondent to the patient (if the patient was not able to complete a questionnaire himself) the information sought on the two forms was identical.

The following information was sought:

1. Date and time of visit.

2. Description of condition that brought the patient to the Emergency Department for treatment.

3. Previous visits to Rocky View Emergency Department during the previous 12 months.

4. Presence of psycho-social problems and expectations of help with such problems during this visit.

5. Reasons for coming to Rocky View Emergency Department rather than an alternative source of medical treatment.

6. Demographic and social characteristics, including age, sex, marital status, employment status, occupation, education and length of residence in Calgary.

Analysis of the foregoing information was intended to shed light on the following questions and issues:

1. Differences in social and demographic characteristics, types of injuries and complaints and reasons for coming to the Emergency Ward of patients presenting to the ward during the study period.

2. How representative are persons coming to Rocky View Emergency Department of the Calgary population?

3. Association of types of injuries or physical complaints, time of day or week, frequency of attendance at Rocky View Emergency Department and patient demographic or social characteristics, with social referability.

4. The expectations of patients acknowledging psychosocial problems with respect to desiring help for such problems.

4. Social Work Service in the Emergency Ward

The fourth procedure involved in this study was offering social work service to those patients who appeared to be in need of it. This involved application of the third and fourth definitions of social referability (i.e. the professional opinion and assessment of the social worker and of the physician).

The professional judgement of the social worker as to what constituted social referability was based on guidelines laid down by Rocky View Hospital Social Work Department for services to be offered (see Appendix E). It was also based on a previous study which concluded that assessment, counselling, discharge planning and immediate service were the four services to be offered by the hospital social work department (Calvert et al, 1970).

Prior to the implementation of this social service component, referrals from the Emergency Department were made either by direct contact with the Social Work Department during the daytime or by the Director of Social Work collecting referrals made during after hours periods, each weekday morning at 8:30.

During the period May 5th to June 20th the nurses and physicians on duty were informed that a social worker was available in the Emergency Ward to see patients should

a referral be made. A schedule of the times the author/ social worker was available can be found in Appendix F. A procedure whereby the author could identify patients as being potentially socially referable was developed as follows.

Whenever the author was on duty as a social worker in the Emergency Ward, she read at two-hourly intervals the blackboard on which patients' names and provisional diagnoses are entered. If a patient had a complaint such as abdominal pain or headache she then read the medical chart. On the basis of her understanding of the information charted, she then approached the examining physician to see if this patient could be interviewed.

It took time and effort to build up relationships with the nurses and physicians to a point where it could be said that credibility had been established and trust created.

There were 12 physicians on rotation in the Emergency Ward and many nurses, several of whom are part-time workers. Thus each shift meant explaining the availability for service of the social worker to a different doctor and different set of nurses. The author's impression is that she did gain credibility and build up trust during the limited period during which this service was offered. An A-B-A single system design will be used to provide some empirical data

for this impression. This is presented in chapter four, section four.

A major difficulty was encountered in determining potential referrals from the abbreviated blackboard diagnoses. For example, when patients came in with obvious physical injuries (e.g. cuts) it was this obvious injury that would be entered on the blackboard. Additional information concerning how the patient had received the injury, which might indicate a referral for social service was not entered on the blackboard. A thorough study of potential referrals would have necessitated reviewing all medical charts on all patients in the Emergency Ward. This was not possible due to the author being involved in other research activities during each shift. Also, especially during busy periods, the space in the nurses station was limited and charts were in demand by many other hospital personnel including X-ray and laboratory technicians, nurses, physicians, clerks.

Despite these difficulties in establishing the service component, several patients were interviewed by the author. Brief case histories are presented in chapter four, section four.

In addition to the four procedures described above the author also acted as a participant observer during her

time in the Emergency Department. Various procedures and incidents were witnessed and recorded in a daily log. These will be discussed in chapter four, section five.

CHAPTER 4

FINDINGS

1. The Retroactive Study of March/April 1980 Medical Records

A total of 7,245 patients were admitted to the Emergency Ward during March/April, 1980. A retroactive review of a one in seven sample of all their medical charts yielded a total of 1,035 cases.

Of these 1,035 cases, 971 or 93.8 percent were classified by the author as "medical only" cases; 39 or 3.8 percent were classified as "identified psycho-social" cases and 25 or 2.4 percent were classified as "medical-possible psycho-social" cases. Hence a total of 6.2 percent of the sample were classed as potentially socially referable.

Of the 39 cases where psycho-social problems were reported on the medical chart, only 3 were actually referred to the Social Work Department. This is less than 8 percent of this category and only 0.3 percent of the total sample.

A statistical analysis was done to establish the limits of prediction from a random sample of 1,035 to the population of 7,245 cases.

With repeated samples of 1,035, the probability of there being more than 49 or less than 29 cases of identified psycho-social problems was 0.05.

Likewise with repeated samples of 1,035, the probability of there being more than 35 or less than 15 cases falling in the category of "medical-possible psycho-social" was 0.05.

On the basis of this analysis it was decided that the one-seventh sample provided an acceptable level of prediction for the purposes of this study.

If the classification procedure employed provides a reasonable estimate, then approximately 6 percent of all Emergency Ward admissions are potentially socially referable. This is at least 20 times the percentage of actual referrals to the Social Work Department. Of the 7,245 patients seen in the Emergency Ward during March/April only 19 were referred to the Social Work Department. This is 0.3 percent of the total. It is reasonable on the basis of these statistics to say that the number of referrals from the Emergency Ward to the Social Work Department may reflect an under-utilization of this service.

2. The On-going Review of Medical Records

During the period June 1st to June 20th, 2,606 medical charts were reviewed by the author and the Social Work Department's secretary. Of these 2,606 cases, 2,480 or 95.2 percent were classified as "medical only" cases, 60 or 2.3

were classified as "identified psycho-social" cases and 66 or 2.5 percent were classified as "medical-possible psycho-social" cases.

A total of 5.2 percent of cases were potentially socially referable. There was no significant difference in the distribution of these cases and of those in the March/April sample of 1,035 cases. Referrals for social service are shown in Table 3.

Of the 60 cases identified as psycho-social problems the medical charts indicated that 11 or 0.4 percent of the total had been referred for social service. Six had been referred to the Social Work Department in the hospital; five to other agencies.

The medical records may not always record referrals for social service and this review may understate actual practice. For example, 6 cases were reported as having been referred to the Social Work Department but the author herself, in her role as a social worker, saw 11 patients during this period and only one of these was amongst the six reported cases of referral. As referral to the author/social worker, when she was available in the Emergency Ward, was often verbal it is possible that the physician then did not record this referral on the medical chart.

During the study period a total of 16 referrals were made to the Social Work Department from the Emergency Ward.

TABLE 3

Referrals for Social Service from the Emergency Dept. of Rocky View Hospital from June 1st to June 20th 1980

Type of case	Total Cases		Referrals to S.W. Dept.		Recorded on medical charts to other Agency		Referrals S.W. Dept. Records	
	#	%	#	%	#	%	#	%
Medical only	2480	95.2	-		-		-	
Psycho-social	60	2.3	6	0.2	5	0.2	16	0.6
Possible psycho-social	66	2.5						
	2606	100						

This is 0.6 of total admissions. Consequently even if all 16 cases had been identified as referrals on the medical charts this would have represented one-eighth of the 126 cases that the author and Social Work Department secretary considered potentially referrable.

Again, these statistics seem to indicate an under-utilization of the services of the Social Work Department.

3. Findings from the Questionnaire Administered to Patients Presenting in the Emergency Ward

Two hundred and ten people were asked to complete the questionnaire. Five were unable to do so; three because of language barriers and two because of pain.

Of the total of 205 completed questionnaires, 92 were completed by the patients themselves and 113 were completed on the patient's behalf by someone accompanying the patient. Of these 113 questionnaires, 52 percent were completed by a parent and 20 percent by a spouse.

A computer analysis of the information obtained from the questionnaires was done using the Statistical Package for the Social Sciences (S.P.S.S.). The findings are presented below.

Time of Emergency Admissions

The days of the visits were divided into two categories; weekday and week-end. Weekdays were Monday through Friday; week-ends were Saturday and Sunday.

Likewise the time of the visit was divided into workday and after hour periods. Workday visits fell between 8:00 and 17:00 hours, Monday to Friday; after hours visits fell between 17:00 and 8:00 hours, Monday to Friday, and all day Saturday and Sunday.

Of the 205 completed questionnaires 64 percent came to the Emergency Department on a weekday and 54 percent were after hours visits.

The percentage of Emergency Ward admissions during periods when the Social Work Department was open (i.e. between 8:00 and 17:00 hours, Monday to Friday) was 18 percent.

A Chi square test was applied to determine if there were significant differences between observed and expected occurrences of weekday and week-end and of workday and after hours visits.

Table 4 indicates that the probability of being admitted on a weekend was significantly greater than a weekday. The difference, though statistically significant is modest. Further analysis of the relationship of time of week to different kinds of presenting injuries and illness, or to non-availability of other services did not yield any explanations for the observed difference.

Table 5 shows admissions during working hours and after hours. The differences here were much greater than those between weekdays and weekends. Patients coming to the Department after working hours were more likely to give as a reason "It was the only place open" than those attending during working hours ($p \leq .05$).

TABLE 4

Differences in Weekday and Weekend Admissions to the Emergency Department

	Weekday	Weekend	Total
Observed	131 (64%)	74 (36%)	205
Expected	146.43 (71%)	58.57 (29%)	205

$\chi^2 = 5.69$ $p \leq .05$ two-tailed

TABLE 5

Differences in Working Hours and After-hour Admissions to the Emergency Department

	Working Hours	After-hours	Total
Observed	94 (46%)	111 (54%)	205
Expected	54.91 (27%)	150.09 (73%)	205

$\chi^2 = 38.00$ $p \leq .001$

Reasons for Coming to the Emergency Department

Sixty-seven percent of all the patients admitted to Emergency during administration of the questionnaire stated that they had injuries of one kind or another.

Cuts and sprains form the largest categories of injuries, being reported 26 percent and 37 percent of the time respectively.

The circumstances under which the injuries happened were: sport, 32 percent; at home, 17 percent; at work, 12 percent and vehicular (motor vehicles and bicycle) accidents, 11 percent.

The main kinds of physical complaints presented were: fever, 15 percent; rashes and allergies, 17 percent; and stomach problems, 23 percent. For classification of injuries and physical complaints see Appendix G.

Of those patients presenting with physical complaints, 75 percent said that they had never presented with this complaint before.

Seventy-seven percent of all patients reported never having been to the Emergency Department in the last 12 months. These two figures indicate that the questionnaire sample consisted mostly of first-time attenders to the Emergency Department and that there was a low rate of hospital recidivism for the group .

Seventy percent of all injuries and physical complaints had been troublesome for less than 24 hours and 16 percent for less than a week, indicating that most of the sample were presenting 'acute' problems in terms of the length of time that their problem had been troubling them.

Ten percent of the total sample reported "worry" as a problem; six percent reported "depression"; five percent reported "difficulties with friends and family"; three percent reported "loneliness"; five percent reported "financial concerns" and two percent reported "job worries".

Given that only one patient who completed a questionnaire was referred to the author in her role as social worker, these figures suggest that a number of patients warranting referral to the Social Work Department may not have been referred.

Of the patients reporting psycho-social problems, 69 percent said that they did not expect help with this/ these problems during their visit to the Emergency Department, and 31 percent said that they did. While this indicates that most people do not expect help with their non-medical problems and see Emergency Department as an inappropriate place for other than medical treatment, almost one-third would have seen help with such problems as appropriate. Furthermore, it is reasonable to suppose that some

of those not expecting such help may have assumed that help for non-medical problems would not be available to them in the Emergency Department.

The three main reported reasons as to why people came to Rocky View Emergency were:

(a) it was the closest place 52 percent

(b) it was the only place open 36 percent

(c) the family doctor was not available 25 percent

These figures indicate that the Emergency Department serves as a convenient general medical facility.

Demographic and Social Characteristics

The demographic sections of the questionnaire yielded the following results.

The Emergency Department serves a predominantly young, male population. Forty-seven percent of all patients were under 20 and 80 percent were under 35. The 1976 Calgary Census reveals that 36 percent of the general population of Calgary were under 20 and 64 percent were under 35 years old.

Sixty-one percent of all patients were male, 39 percent female. In contrast the 1976 Census shows that of the general population of Calgary 49 percent were male and 51 percent were female.

Sixty percent of all patients completing the questionnaire stated that they had never been married; 33 percent said

they were married. Three percent reported being divorced, one percent separated and two percent living with a partner. The 1976 Census shows that 46 percent of the Calgary population were not married, 47 percent were married (this category includes people who are separated), 3 percent were divorced and 4 percent were widowed.

Of the total sample 48 percent reported that they were working, 49 percent said they were not and 3 percent did not answer this question. The 1976 Calgary Census shows that 48 percent of the Calgary population were actively employed.

In an analysis of occupations Blishen's* occupational index was used. Although the index was revised in 1967, the 1961 scale was used as Blishen also included in 1961 an analysis of occupational rank by province which has not been repeated since. This index seemed to be the most appropriate tool for analysis as it applies specifically to Canadian occupations. It was also useful because the wording of the occupation question on the questionnaire was such that the replies could only be classified using a scale made up of many categories. (Blishen's scale lists 330 occupations).

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*Blishen, B.R., "A Socio-economic Index for Occupations in Canada," Canadian Review of Sociology and Anthropology, February 1967, 4 (1), pp. 41-53.

The fewer occupational categories used in the Census require much more information than was obtained on the questionnaire for classification.

Table 6 indicates that in the sample there was an over-representation of the higher level occupations.

TABLE 6

Occupations of Sample of Emergency Ward Patients Compared with Alberta Population in 1961

Socio-economic rank of Occupations	Observed	Expected
60:00 +	16	8.79
50:99 - 59:99	18	9.70
40:99 - 49:99	14	19.40
30:99 - 39:99	26	28.19
< 30:00	23	30.92
	97	*97.00

$\chi^2 = 16.71$ $p \leq .01$ two tailed

*percentages for 1961 study prorated to 97.

Likewise Table 7, an analysis of the occupations of patients' parents indicates that there was an over-representation of the higher socio-economically ranked occupations. These findings are in contrast to other studies of emergency ward patients that report an over-representation of lower

TABLE 7

Occupations of Parents of Emergency Ward Patients Compared with Alberta Population in 1961

Socio-economic rank of Occupations	Observed	Expected
60:00 +	33	7.60
50:99 - 59:99	7	6.00
40:99 - 49:99	14	12.20
30:99 - 39:99	5	17.70
<30:00	2	19.50
	61	*61.00

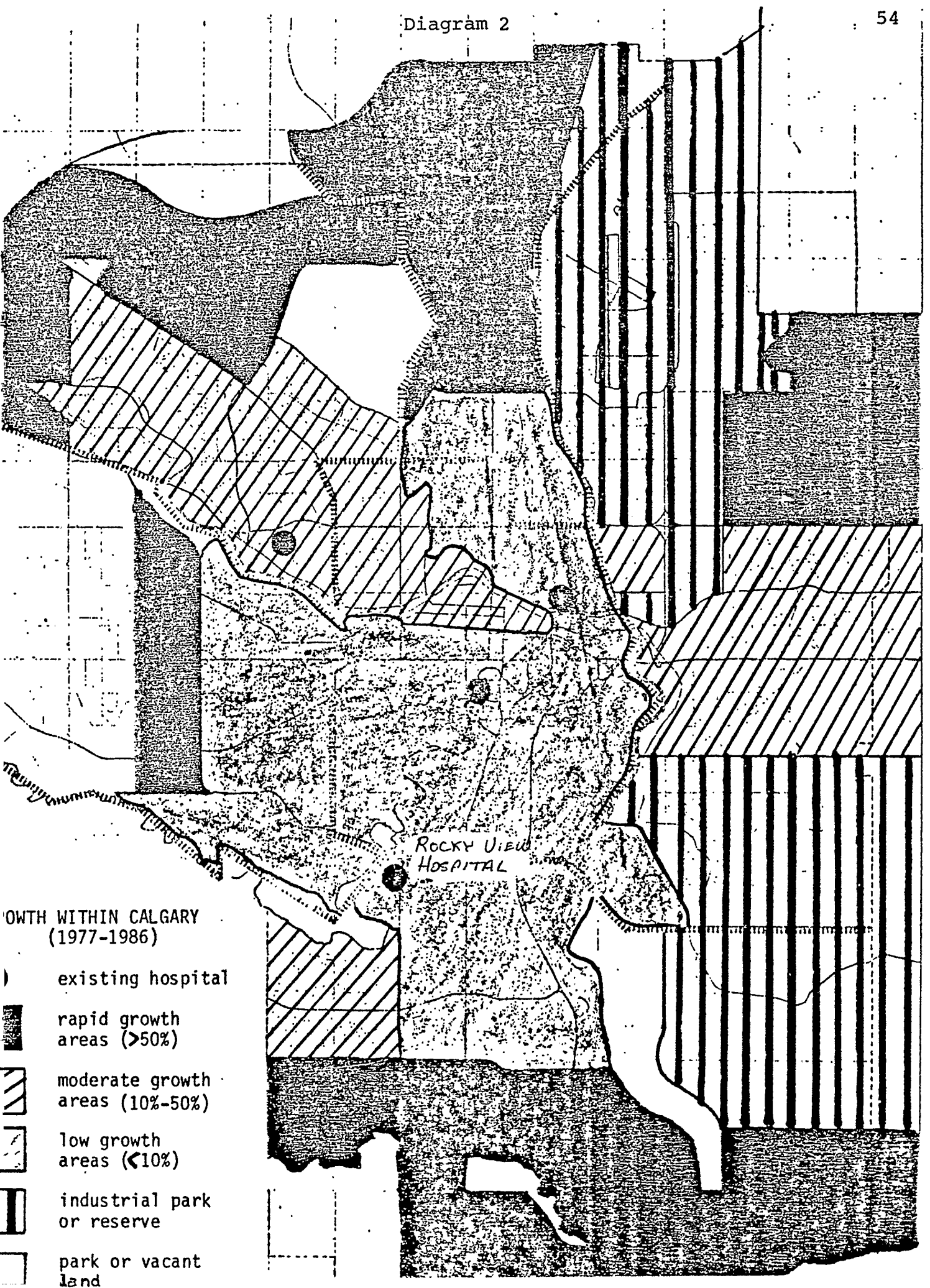
$\chi^2 = 110.129$ $p \leq .001$ two tailed

*percentages for 1961 study prorated to 97.

socio-economic groups (for example Grumett-Trachman 1976, Weineman et al, 1966). An alternative explanation for the results reported in Tables 6 and 7 is that there has been a major shift in the occupational composition of the Alberta population, and of the Calgary population in particular, since 1961 and that this accounts for the observed differences. A comparison of the educational levels of the questionnaire respondents with those of the Calgary population, indicates that there are real differences between the occupational level of Rocky View Emergency Department patients and those of the Calgary population as a whole, since

education correlates highly with occupational level. Of those questionnaire respondents aged over 18, 88 percent had completed grade 12 (27 percent also had a university degree or college diploma). In the Calgary population in 1976, 61 percent of those aged over 18 had completed grade 12 (15 percent also had a university degree or college diploma). These differences are significant ($p \leq .01$). Therefore it can be concluded that the population frequenting Rocky View Emergency Department tend to be from higher socio-economic groups.

The data concerning length of residence in Calgary show that 67 percent of the sample have lived in Calgary for over 5 years. In the general Calgary population in 1976, 93 percent had lived in Calgary for over 5 years. The population frequenting Rocky View Emergency Department has a lower length of residence than is found in the total Calgary population. A difference of proportions test showed that the differences in length of residence of the sample population and of the Calgary population was significant ($p \leq .01$). This may be accounted for by the fact that much recent Calgary population growth has been in the south, southwest and southeast of the city - areas within ease of access to Rocky View Hospital. Diagram 2 shows the projected growth areas in Calgary 1977-86. It can be seen that whilst Rocky View


ROCKY VIEW HOSPITAL
OWTH WITHIN CALGARY
(1977-1986)
existing hospital
rapid growth areas (>50%)
moderate growth areas (10%-50%)
low growth areas (<10%)
industrial park or reserve
park or vacant land

Hospital is now located in a low growth area it is within eacy access of several moderate and rapid growth areas. It can be expected that the average length of residence in Calgary of Rocky View Emergency Department patients will fluctuate with the development of new subdivisions in the moderate and rapid growth areas of the city and will likely remain below the average length of residence of the total Calgary population. An alternative explanation might be that Emergency Department patients would include a substantial number of people who had come to Calgary recently, had not yet connected to a physician or other medical resource, and would therefore tend to use the Emergency Department for general medical care.

Variable Relationships

Cross-tabulations were run in order to identify significant relationships between variables. Those few relationships that were significant at the .05 level, two-tailed are reported below.

Age appears to be a major factor in the reporting of psycho-social problems. Those aged 35 years or over reported more worry, depression and difficulties with friends and family than those under age 35. People who were married or who had been married reported worry more than those who had

never been married. However it was found that age was the significant variable as more people over 35 years old are likely to be married or have been married than are those under 35.

There was also a significant relationship between length of residence in Calgary and reports of worry. Those who had lived in Calgary for at least five years were more likely to report worry than were those who had not lived in Calgary so long.

Sports accidents were not found to be sex-related. However all fights were reported by males and 86 percent of all vehicular accident victims were male. All reports of headaches were made by females.

Other cross-tabulations, such as those between day and time of the visit and the kind of injury and how it occurred, yielded no significant findings.

A much more extensive study, involving a larger sample of patients, data on a wider range of variables, more sophisticated measurements, and more elaborate data analysis would be required to develop profiles of Rocky View Emergency Department patients, and particularly of those presenting with psycho-social problems. The differences found in this study, however, indicate that such a larger study would yield findings that would be useful in the future planning of emergency services.

4. (a) Patients Seen in the Emergency Ward During the Period When Social Service Was Being Offered on an Extended Hours Basis

The author was available in the Emergency Department in her role as a social worker for 5 day shifts (7:00 a.m. to 3:00 p.m.) and 5 evening shifts (3:00 p.m. to 11:00 p.m.) during the preliminary period May 5th to June 1st.

During this time the social worker saw 5 patients in the Emergency Department, 4 of whom were referred to the social worker by the physician. Other potentially socially referrable cases were noted by the social worker during her two-hourly review of the Emergency Department blackboard. However her comfort in initiating referrals was limited at this point. The social worker initiated one referral during this preliminary period. Brief case descriptions appear below, indicating the source of referral, the time of the referral, the problem and the kind of service offered.

Case 1:

Physician referred. 10:30 p.m. May 12th. Young woman with hyperventilation. She reported a long history of psychiatric treatment "back East". Current episode of hyperventilation began after an argument with her boyfriend. Follow-up done by Social Work Department.

Case 2:

Physician referred. 11:00 p.m. May 12th. Sixteen year old girl overdosed for first time. A meeting was arranged between mother, daughter and social worker for the next day.

Case 3:

Social Worker initiated. 8:30 p.m. May 13th. Mother of 5 had brought her baby into the Emergency Department after the baby had had an apparent seizure. Mother was distraught and crying heavily in the middle of the corridor. Social worker escorted mother, child and grand-parents into the Quiet Room whilst a transfer to Holy Cross was made. A follow-up phone call was made to determine that all was well.

Case 4:

Physician referred. May 20th - the day after the patient had been seen in the Emergency Department. Eighteen year old girl severely beaten up by her boyfriend. No family in town. Referral to the Womens' Emergency Shelter.

Case 5:

Physician referred. 8:30. May 23rd. Male patient complaining of insomnia. Physician suggested to social worker that he was a psychopath. Patient was given the Social Work Department's number should he decide to seek

counselling. Follow-up found all the information the patient had given to be false.

The Study Period June 1st to June 20th

During this time the social worker was present in the Emergency Department for a total of 168 hours. Ten patients were seen, one on two occasions.

Case 1:

Social Worker initiated. 10:15 a.m. June 1st. A 33 yr. old mother of two children who was experiencing anxiety attacks. She was in therapy at Holy Cross.

Case 2:

Physician referred. June 4th. The patient was admitted at 3:00 a.m. with alcoholic ingestion. The physician asked the social worker to see the patient during her day shift. Patient was seen at 14:00 and the social worker was able to contact his worker at Holy Cross.

Case 3:

Physician referred. 8:45 p.m. June 7th. Twenty-seven year old female, in Calgary for 11 months. Currently in the process of a divorce/custody battle. Medical problem - abdominal pain. Social problems - (immediate) financial; (long-term) housing, relationship problems. Follow-up done by the Social Work Department.

Case 4:

Social worker initiated. 8:15 p.m. June 7th. Twenty-nine year old mother of three children returning once again to the Emergency Department with a migraine attack She was under treatment by a neurologist for hormonal/hereditary migraine attacks. No further intervention.

Case 5:

Social worker initiated. 8:30 p.m. June 8th. Seventy year old female in Emergency with vertigo. Her husband was with her and expressed concern as to how he would manage at home with a sick wife to look after too. Follow-up by Social Work Department.

Case 6:

Physician referred. 10:00 p.m. June 8th. Twenty-five year old mother of twins, currently in the throes of a divorce. In Emergency on two consecutive nights with chest pains and headache. She was already seeing a fellow social worker for counselling.

Case 7:

Physician referred. 10:30 p.m. June 10th. Seventy-eight year old lady in Emergency with medical complaints of general malaise/depression. She was already known to the Social Work Department and follow-up was done by them.

Case 8:

Social worker initiated. 11:30 p.m. June 11th. Nineteen year old young woman with a severely cut foot. Recently separated from her husband of 3 years. She had a 3 year old son. Follow-up by the Social Work Department.

Case 9:

Physician referred. 2:00 a.m. June 11th. Twenty-two year old male came in to Emergency with complaints of dizziness. Expressed suicidal ideation. Severe depression. Referred to Holy Cross for admission.

Case 10:

Physician referred. 12:30 p.m. June 12th. Fifty year old lady beaten up by her husband. Known to the Social Work Department. Referral to legal guidance and follow-up done through the Social Work Department.

Case 11:

Physician referred. 11:15 p.m. June 19th. The same lady as in case description number 7. Again follow-up was done by the Social Work Department.

In addition to these cases the social worker was able to do some incidental supportive counselling of families sitting in the waiting room. On this basis 4 relatives/ families were seen:

(a) the wife of a man in his thirties who was admitted to Emergency with chest pains and later taken to the Intensive Care Unit.

(b) the girlfriend of a man in his late twenties who was admitted with chest pains and later sent home.

(c) the mother of a teenage girl who was drunk, but also under treatment for anorexia nervosa.

(d) additional support to the family of a young girl seriously injured in a motor vehicle accident.

The above case descriptions serve as an indicator of the wide range of problems being presented in the Emergency Ward and warranting the intervention of the Social Work Department.

4. (b) Evaluation of the Service Component

The service component described in Chapter 3, section 4, was evaluated using the problem-oriented evaluation procedure (single system design) described by Bloom (1975, ch. 17).

This procedure enables one to establish scientifically the effectiveness of one's intervention with a system (an individual, group, organization) by making comparisons between the pre-intervention period and the intervention period and then between the intervention period and the post-intervention period.

In the case at hand the system under study was Rocky View Hospital Emergency Team. The procedure was used to determine the effectiveness of having a social worker readily available on an extended basis in the Emergency Department. The measure of effectiveness was whether there was a significant increase in referrals from the Emergency Ward to the Social Work Department during the period when the author (in her role as a social worker) was offering social work service on an extended basis in the Emergency Department.

The intervention period was May 5th to June 20th - the time period during which the service component was offered. The pre-intervention period was April 1st to May 4th when there was no social worker offering service to the Emergency Department on a readily available and/or extended basis. The post-intervention period was from June 21st to August 31st when there was a return to the pre-intervention state of affairs. "Desired behavior" was at least one referral from the Emergency Department to the Social Work Department (see Graph 1 in Appendix H).

The evaluation sought to determine the effectiveness of demonstration, availability and initiation of referrals as factors influencing the rate of referral from the Emergency Ward to the Social Work Department.

5.(i) Comparison Between Occurrences of the Desired Behavior in the Pre-intervention and Intervention Periods

During the pre-intervention period the desired behavior occured 7 times in the 34 twenty-four hour observation periods. During the intervention period the desired behavior occured 16 times in the 47 twenty-four hour observation periods. This represents a significant increase in the referral rate at the .05 level (see Table 8).

TABLE 8

To Compare Referral Rates Between the Pre-intervention and Intervention Periods

Pre-intervention Period	Observation Periods	Occurences of Desired Behavior
April 1st to May 4th	34	7
Intervention Period		
May 5th to June 20th	47	16

Proportion of occurences of desired behavior (referral) in pre-intervention period = 0.20.

Using tables (Bloom p. 203-205) at least fifteen occurences of the desired behavior need to occur for there to be a significant increase in desired behavior at the 0.05 level during the intervention period.

Sixteen occurences were recorded ∴ there was a significant increase at the 0.05 level in the referral rate during the intervention period.

This indicates that the combined effect of the demonstration factor (the process by which Emergency Ward Staff became more aware of the role of the Social Work Department), the availability factor (the author was readily available to accept referrals) and the initiation factor (the author was able to initiate some referrals) led to an increase in desired behavior (referral).

6.(ii) Comparison Between Occurrences of the Desired Behavior Between the Pre-intervention and Intervention Periods: Excluding the Referrals Made to the Author and Including Only Those Referrals Made to Other Members of the Social Work Department

During the pre-intervention period the desired behavior occured 7 times. During the intervention period there were 10 occasions during the 23 days when the author was not available to offer service to the Emergency Ward and referrals were made to the Social Work Department as a whole. This represents a significant increase in the referral rate at the .05 level (see Table 9).

This indicates that the demonstration factor alone did influence the rate of referral from the Emergency Department to the Social Work Department during the intervention period.

TABLE 9

To Compare Referral Rates Between the Pre-intervention and Intervention Periods to the Social Workers Other Than the Author

Pre-intervention Period	Observation Periods	Occurences of Desired Behavior
April 1st to May 4th	34	7
Intervention Period		
May 5th to June 20th	23 (days when the Emergency Ward social worker was not available)	10

Proportion of occurences of desired behavior in pre-intervention period = 0.20.

Using tables (Bloom p. 203-205) nine occurences of the desired behavior are required to represent a significant increase in desired behavior at the .05 level.

Ten occurences of desired behavior were recorded ∴ there was a significant increase at the 0.05 level in the referral rate during the intervention period to workers other than the "Emergency Ward" social worker.

7.(iii) Comparison Between Occurrences of the Desired Behavior in the Intervention and Post-Intervention Periods

During the post-intervention period there were 9 occasions when referrals were made. This represents a significant decrease in the referral rate between the intervention and post-intervention period at the .002 level (see Table 10).

TABLE 10

To Compare Referral Rates Between the Intervention and Post-Intervention Periods

Intervention Period	Observation Periods	Occurences of Undesired Behavior
May 5th to June 20th	47	31
Post-Intervention Period		
June 21st to August 31st	71	62

Proportion of undesired behavior occurring in intervention period = 0.65.

Sixty occurences are required to represent a significant increase in the occurence of undesired behavior at the .002 level of significance (Bloom, p. 203-205).

Sixty-two occurences of undesired behavior were recorded there was a significant increase at the .002 level in the number of times no referrals were made during the post-intervention period.

This indicates that the residual effects of the demonstration factor were not sufficient to maintain the intervention period level of referrals. The low rate of referral in the post-intervention period might also be accounted for by the following factors. The Director of the Social Work Department who had had primary responsibility for referrals from the Emergency Department during the pre-intervention period left the hospital in July shortly after the end of the intervention period. The Social Work Department was

then short-staffed and this became general knowledge throughout the hospital. There was also a new Head Nurse in the Emergency Department who had not been involved in the planning for this research project and had not been there during the implementation of the research design.

The evidence supports the conclusion that the provision of social work service on a readily available and extended basis within the Emergency Department was effective in bringing about a significant increase in the referral rate from the Emergency Department to the Social Work Department. The evidence also suggests that a short-term demonstration of the service through location of a social worker in the Emergency Department has little residual effect on the referrals made by physicians. The availability of a social worker in the Department may be necessary to effect more extensive utilization of social work services.

8. Other Findings as Recorded in a Daily Log

This study did not classify the presenting problems of the Emergency Department patients on the basis of whether they were emergent or non-emergent; urgent or non-urgent. However from conversations with the staff in the Department the author is able to report that there was a feeling of frustration amongst the staff in regard to the number of

patients whom they perceive as coming to the Emergency Department with non-urgent conditions. A focus for further study might be an analysis of presenting complaints on continuums of emergent - non-emergent; deserving - non-deserving.

Of 205 completed questionnaires, 45 percent were completed by the patient him/herself which indicates that almost a half of all Emergency Department admissions during the administration of the questionnaire were not suffering from severe, traumatic, painful injuries or complaints that the medical personnel would label emergent conditions.

Again, an observation made by the author was that during periods when the Emergency Department was busy and patients had to wait for long periods, an indeterminate number of patients left. This seems to indicate that such patients found the discomforts of waiting greater than the discomforts of the presumed medical condition. They were not suffering from injuries/complaints that the medical personnel would label emergent.

The author feels that there is a wide range of individual interpretation or response to the presence of illness. Studies of the sociological aspects of illness and the social psychological dynamics of illness behavior (Koos, 1956; Mechanic and Volkart, 1961; Zola, 1964) show that many factors lead people to perceive themselves as 'sick' or as in need of medical help. If further study of presenting

complaints in the Emergency Department was carried out in the future, the author feels it would be important to consider both lay and medical opinions of what constitutes a condition warranting admission to the Emergency Department. This would increase our understanding of differences in perceptions between the users of the service and the providers of that service. Such a study would have implications for the future planning of Emergency medical services, family practitioner services and public health education.

From conversations with some of the physicians in the Emergency Department the author is able to report that the role of emergency department physicians is seen primarily as that of medical resource in a serious, traumatic life and death situation. To consider the psycho-social context of a patient's complaint is seen as part of the role of a family practitioner but not an emergency department physician. There seems to be some disparity between the physicians' perception of their role and the role they are being placed into by their patient population (i.e. that of general medical practitioner). Satin (1972) suggests that even though physicians might wish otherwise the Emergency Department is no longer a medical trauma facility but a general walk-in clinic for people with a vast array of problems, many with a psycho-social component. He suggests that:

"...the emergency unit provides a great opportunity for identifying people with important needs and fulfilling the healers' obligation to introduce helping influences into their lives. Any argument as to whether the presenting illnesses are 'genuine' and pathological consequences of life stresses, or only indirect signs of antecedent problems which serve as conscious or unconscious ways of attracting helping authorities, seems academic; there is a large reservoir of need to be met."

(Satin 1972, p. 126)

CHAPTER 5

CONCLUSIONS

This research project was developed to determine

(i) whether there were more people presenting in the Emergency Department with problems of a psycho-social nature than referrals to the Social Work Department indicated;

(ii) whether the presence of a social worker offering service within the Emergency Department on an extended hours basis would increase the number of referrals from the Emergency Department to the Social Work Department.

The Presentation of Psycho-social Problems in the Emergency Department

Both the retroactive and on-going reviews of the Emergency Department medical charts indicate that between 4 to 6 percent of all Emergency Department admissions are potentially socially referrable. Yet only 0.3 percent of the retroactive and 0.4 percent of the on-going samples were actually referred. This may reflect underutilization of the services of the Social Work Department by the Emergency Department.

The administration of a questionnaire to a sample of people presenting in the Emergency Department during certain

one hour periods yielded the following results on the presentation of psycho-social problems:

Psycho-social problem	% of Total Sample
worry	10
depression	6
difficulties with friends or families	5
loneliness	3
financial concerns	5
job worries	2

The fact that only one person who completed a questionnaire, or 0.48 percent of the total sample was referred for social service is further indication of possible under-utilization of the services of the Social Work Department.

The questionnaire in particular establishes that Rocky View Hospital's Emergency Department does have a significant proportion of its admissions presenting complaints with a primary or secondary psycho-social component. It is also possible that there was some under-reporting amongst questionnaire respondents on the question concerning psycho-social problems. Those persons who completed a questionnaire on behalf of the patient may not have been aware of the patient's psycho-social problems or may have been reluctant to disclose any without the patient's permission. The author concludes that there are more people presenting

in the Emergency Department who could be referred for social service than the actual number of referrals indicates.

Several implications can be drawn from this conclusion. Firstly, as Satin (1972) suggests, the failure to recognize and refer emergency department patients for social service means that a large reservoir of need is being overlooked. Satin suggests that if emergency department medical personnel concentrate purely on physical symptomatology and treatment it is likely that psycho-social problems will remain, sometimes prolonging physical symptoms, sometimes causing them to recur and sometimes leading to hospitalization. Given the cost of hospital care, it is important to address the financial implications of the presentation of psycho-social problems in emergency departments. In the interests of preventive medicine and public health, it is important to develop a mechanism for dealing with psycho-social problems in emergency departments. This study tested one such mechanism: the availability on an extended hours basis of a social worker within the Emergency Department.

The Role of a Social Worker in the Emergency Department

The case descriptions in Chapter 4 indicate the wide variety of cases that social workers might serve in their work within the Emergency Department. Crisis intervention

would likely be the main focus of social work within the Emergency Department although opportunities for other social work interventions such as marital and family counselling, bereavement counselling, stress-management training and behavioral work are available.

Gwinn (1979) suggests that there are four aspects of the emergency ward social worker's role:

"1. problem identification and effective referral
2. collaboration in the medical treatment
3. crisis counselling
4. sensitizing staff to psycho-social aspects of illness" (p. 74)

Other authors describe similar dimensions of the emergency ward social work role (Groner, 1978; Grumett and Trachtman, 1976; Krell, 1976). Bennett (1973) provides a comprehensive breakdown of the role which the author found useful in preparing herself for work in the Emergency Department. She lists six groupings of patients with whom the social worker might work:

"1. Persons who inappropriately ask for help in the emergency department.
2. Patients who need psychiatric help.
3. Patients or relatives who behave inappropriately.
4. Patients who have minor medical problems but major social problems.

5. Patients who need supportive help at home following emergency department treatment.

6. Relatives of patients who are admitted to the hospital because of traumatic injury or illness". (p. 111)

The effectiveness of the service component of this study is described in Chapter 4, Section 4 using a single-subject design. The author feels the overriding factor leading to the increase in referral rate during the study period was the availability on an extended hours basis of a social worker. Gwinn (1979) contends that being on call is not enough; it is the presence of the social worker within the emergency department that is the key factor in referral from physicians to the social worker. In her study at the University of Kansas Medical Centre, Gwinn found that the emergency department staff were aware of the high percentage (14 percent) of all emergency admissions presenting with concerns that would warrant referral for social service but did not make referrals because no social worker was readily available within the emergency department.

In the case of this research, the author contends that the significant decrease in the referral rate after the extended hours service component ended confirms the importance of availability in securing referrals from the physicians in the Emergency Department.

The development of a social work position within the Emergency Department is indicated. Models for developing this position are available in the literature (Bennett, 1973; Groner, 1978; Gwinn, 1979; Farber, 1978). All models provide for social work coverage to the emergency department on an extended hours basis. Given the nature of emergency department social work and of the setting, the author proposes that any position developed within the Emergency Department should be filled by a professionally qualified and competent social worker. The author also proposes that the hospital administration consider developing an Emergency Department social work position as soon as possible. For as Bergman says:

> "...to wait for an invitation to introduce such a service is to guarantee that either there will be no invitation or by the time the invitation is forthcoming, the social service role will already have been defined by people who are not trained to recognize a patient's psycho-social needs".
> (1976, p. 42)

Other Conclusions

Demographic data from the questionnaire indicate that the Emergency Ward has a predominantly young, male population. Some implications from this are that:

(a) it might be possible to direct public education leaflets and posters in the waiting room towards topics pertinent

to a young age-group - e.g. leaflets on drug abuse, alcohol from A.A.D.A.C.; work-related literature e.g. welders wearing goggles; sport-related literature - e.g. warm-up exercises before embarking on sport-activity.

(b) more facilities for parents to sit with their younger children; maybe toys in the waiting-room.

The information on the relationships between such variables as sex, age and presentation of psycho-social problems is limited because of the size of the sample. However it seems that from this information and from the patients seen by the author in the Emergency Department that no age group or sex group is excluded from the presentation of such problems. A social worker in the Emergency Department should be aware of the opportunities for intervention with all age groups and both sexes.

The information on the socio-economic rankings of Emergency Department users indicates that the population tends to come from the higher socio-economic occupations. The data on the socio-economic rank of people presenting with psycho-social problems does not indicate over-representation of any socio-economic group. However, further data collection and analysis on a larger scale would be needed to discover if there are any trends. The literature indicates that the presentation of psycho-social problems is linked with lower socio-economic class. (Bergman, 1976;

Grumett and Trachtman, 1976; Weinerman et al, 1969). If this seems to be so it would be necessary to look at the attitudes surrounding the referral as it is likely that middle-class physicians, nurses and social workers do not perceive the middle-classes as having psycho-social problems as readily as they do those in the lower classes. Value judgements are an important part of any labelling and referral process.

During the reviews of medical charts the author became aware of wide variations in recording practice. Interpretation of the information on the charts would have been easier if some systematic procedure for recording had been used. This might prove to be a useful area for further study.

Recommendations

1. Rocky View Hospital should initiate discussions between administration, the Social Work Department and the Emergency Department regarding the establishment of a social work position in the Emergency Department Team.
2. The system whereby daily contact was made by the Director of the Social Work Department with the Emergency Department, should be resumed prior to development of a full-time Emergency social work position.

3. Further research is indicated in the following areas:
   (a) social and demographic characteristics of those presenting psycho-social problems in the Emergency Department;
   (b) staff attitudes towards patients with psycho-social problems and/or non-emergent complaints;
   (c) staff attitudes towards the role of a social worker in the Emergency Department;
   (d) reasons why people choose to go to the Emergency Department and factors influencing that decision;
   (e) seasonal variations in admissions to the Emergency Department and the presentation of psycho-social problems;
   (f) a review of recording procedures within the Emergency Department in order to improve the completeness and usefulness of records.

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Appendix A (i)

Classification* of Medical Charts March/April 1980

1.	Ingestion	2	13.	Other psycho-social	
2.	Cut wrists		14.	Child abuse	
3.	Other suicide attempts		15.	Assault-aggressor	
4.	Alcohol abuse	3	16.	Assault-victim	4
5.	Prescription drug abuse	1	17.	Fighting/ drinking	8
6.	Street drug abuse	1	18.	Grief reaction	1
7.	Anxiety	12	19.	Family problems	2
8.	Depression	3	20.	Marital problems	1
9.	Hysteria		21.	Financial stress	
10.	Psychosis		22.	Transportation	
11.	Psychosomatic		23.	Medical only	971
12.	Behavior disorder	1	24.	Medical possible psycho-social	25

Medical only	971
Medical possibly psycho-social	25
Identified psycho-social problems	39
Total	1035

3 of 39 identified psycho-social problems referred

3 referred to Social Work Department

*Classification developed for a previous study of Emergency Ward Patients at Holy Cross Hospital.

Appendix A (ii)

Classification of Medical Charts

June 1st to June 20th 1980

1.	Ingestion	6	13.	Other psycho-social	
2.	Cut wrists		14.	Child abuse	
3.	Other suicide attempts		15.	Assault-aggressor	
4.	Alcohol abuse	10	16.	Assault-victim	11
5.	Prescription drug abuse	1	17.	Fighting/ drinking	12
6.	Street drug abuse	1	18.	Grief reaction	
7.	Anxiety	9	19.	Family problems	1
8.	Depression	5	20.	Marital problems	1
9.	Hysteria		21.	Financial stress	
10.	Psychosis		22.	Transportation	
11.	Psychosomatic	1	23.	Medical only	2,480
12.	Behavior disorder		24.	Medical possible psycho-social	66

Medical only	2,480
Possible psycho-social	66
Identified psycho-social	60
Total	2,606

11 of 60 identified psycho-social problems referred

6 to Social Work
5 to other agencies
11 total

Appendix B

Hourly Periods During Which the Questionnaire was Administered to Patients Presenting in the Admitting Office of the Emergency Department

	Hour 1	Hour 2	Hour 3	Hour 4
June 1st	08:00 - 09:00	10:00 - 11:00	13:00 - 14:00	19:00 - 20:00
June 2nd	08:00 - 09:00	09:00 - 10:00	17:00 - 18:00	18:00 - 19:00
June 3rd	11:00 - 12:00	12:00 - 13:00	14:00 - 15:00	16:00 - 17:00
June 4th	12:00 - 13:00	13:00 - 14:00	17:00 - 18:00	19:00 - 20:00
June 7th	21:00 - 22:00	24:00 - 01:00	03:00 - 04:00	07:00 - 08:00
June 8th	21:00 - 22:00	23:00 - 24:00	03:00 - 04:00	06:00 - 07:00
June 9th	20:00 - 21:00	23:00 - 24:00	05:00 - 06:00	07:00 - 08:00
June 10th	23:00 - 24:00	24:00 - 01:00	03:00 - 04:00	05:00 - 06:00
June 12th	08:00 - 09:00	09:00 - 10:00	16:00 - 17:00	18:00 - 19:00
June 13th	09:00 - 10:00	10:00 - 11:00	14:00 - 15:00	16:00 - 17:00
June 18th	20:00 - 21:00	22:00 - 23:00	03:00 - 04:00	06:00 - 07:00
June 19th	22:00 - 23:00	24:00 - 01:00	02:00 - 03:00	04:00 - 05:00
June 20th	20:00 - 21:00	21:00 - 22:00	03:00 - 04:00	06:00 - 07:00

Appendix C - Copy of Questionnaire No. 1

ROCKY VIEW HOSPITAL EMERGENCY SERVICES STUDY

Col.No.

Please answer the following questions. The information will be used to plan for better Emergency Services.

INFORMATION IS CONFIDENTIAL. YOU WILL NOT BE IDENTIFIED IN THE STUDY NOR WILL ANY INFORMATION GIVEN GO ON YOUR MEDICAL RECORD.

Date of visit ____ ____ (4-5, 6-7) Time of visit ____ ____ (8-9, 10-11) 6-13

PLEASE CHECK THE BOX WHICH APPLIES.

1. Do you have EITHER (a) an injury/accident (e.g. cuts, sprains, burns, bruising) 14

☐ 1

If YES, please skip on to QUESTION 2.

OR

(b) a physical complaint/illness (e.g. fever, headache, stomach pains, asthma)

☐ 2

If YES, please skip on to QUESTION 4.

OR

(c) another problem ☐ 3

INJURY/ACCIDENT

2. What kind of injury do you have? _____ 15

_____

3. How did the injury/accident happen? _____

_____ 16

PLEASE SKIP ON TO QUESTION 8.

PHYSICAL COMPLAINTS/ILLNESS

4. What kind of physical complaint/illness do you have? _____

_____ 17

5. How many times in the last 12 months have you been to Rocky View Emergency with this complaint/ illness?

_____ times 18

PLEASE SKIP ON TO QUESTION 8.

OTHER PROBLEMS

6. What kind of problem do you have? _____

_____ 19

7. How many times in the last 12 months have you been to Rocky View Emergency with THIS problem?

_____ times 20

8. How many times have you been to Rocky View Emergency in the last 12 months with:

(a) other accidents/injuries _____ 1 21

(b) other physical complaints/ illnesses _____ 2 22

(c) other problems _____ 3 23

9. How long has your current injury/complaint problem been bothering you?

less than 24 hours	☐	1	24
less than a week	☐	2	
more than a week	☐	3	
it comes and goes over time	☐	4	

10. Do you have any of the following problems that are also bothering you today? PLEASE CHECK ALL THAT APPLY.

worry/nervousness	☐	1	25
depression	☐	2	26
difficulties with friends/family	☐	3	27
loneliness	☐	4	28
financial concerns	☐	5	29
job worries/unemployment	☐	6	30

11. If you checked any of the above did you expect or get help with this/these problems during your visit to Emergency today?

Yes ☐ No ☐ 31

12. Did you come to Rocky View Emergency today because: PLEASE CHECK ALL THAT APPLY.

(a)	you did not have a family doctor to go to	☐ 1	32
(b)	your family doctor was not available	☐ 2	33
(c)	Emergency was the only place open	☐ 3	34
(d)	someone suggested you come here (please say who) _____	☐ 4	35
(e)	someone else brought you here (please say who) _____	☐ 5	36
(f)	it was the closest place to come	☐ 6	37
(g)	other reason _____	☐ 7	38

13. What is your age? _____ 39

14. Are you MALE ☐ (1) FEMALE ☐ (2) 40

15. Is your marital status:

(a)	never married	☐ 1	41
(b)	married	☐ 2	
(c)	divorced	☐ 3	
(d)	separated	☐ 4	

15. continued

(e) widowed ☐ 5

(f) living with partner ☐ 6

16. How long have you had this marital status?

(a) all my life ☐ 1 42

(b) over 5 years ☐ 2

(c) 2 to 5 years ☐ 3

(d) 1 to 2 years ☐ 4

(e) less than a year ☐ 5

(f) less than 6 months ☐ 6

(g) less than 3 months ☐ 7

17. Are you working at this time? YES No 43

If YES what is your occupation?

_____ 44-45

18. If you are a homemaker what is the occupation of your partner?

_____ 46-47

19. If you are in school, what is/are the occupation(s) of your parent(s)/guardian(s)?

_____ 48-49

_____ 50-51

20. What is the highest educational level you have completed?

Post graduate University studies	☐ 1	50
University/college	☐ 2	
Grade 12	☐ 3	
Grade 10	☐ 4	
Grade 8	☐ 5	
Less than grade 8	☐ 6	

21. How long have you lived in Calgary?

All my life	☐ 1	51
Over 10 years	☐ 2	
5 - 10 years	☐ 3	
2 - 5 years	☐ 4	
Less than 2 years	☐ 5	

THANK YOU FOR ANSWERING THESE QUESTIONS. YOUR HELP IS GREATLY APPRECIATED.

Appendix D - Copy of Questionnaire No. 2

No. 1-5

ROCKY VIEW HOSPITAL: EMERGENCY SERVICES STUDY

Col. No.

Please answer the following questions. This information will be used to plan for better Emergency Service.

INFORMATION IS CONFIDENTIAL. YOU OR THE PATIENT WILL NOT BE IDENTIFIED IN THE STUDY. THE INFORMATION WILL NOT GO ON THE PATIENT'S MEDICAL RECORD.

Date of visit ____ ____ (4-5, 6-7) Time of visit ____ ____ (8-9, 10-11) 6-13

PLEASE CHECK THE BOX WHICH APPLIES.

1. Are you the patient's:

(a)	spouse	☐ 1	14
(b)	parent/guardian	☐ 2	
(c)	friend	☐ 3	
(d)	brother/sister	☐ 4	
(e)	doctor	☐ 5	
(f)	a paramedic	☐ 6	
(g)	other	☐ 7	

2. Does the patient have: EITHER (a) an injury/accident (e.g. sprains, cuts, burns)

☐ 1 15

If YES, please skip to QUESTION 3.

2. continued

OR

(b) a physical complaint/illness (e.g. fever, headache, stomach pains, asthma) ☐ 2

If YES, please skip to QUESTION 5.

OR

(c) another problem ☐ 3

If YES, please move to QUESTION 7.

INJURY/ACCIDENT

3. What kind of injury does the patient have? _____ 16

_____

4. How did the injury/accident happen? _____ 17

_____

PLEASE SKIP ON TO QUESTION 9.

PHYSICAL COMPLAINTS/ILLNESSES

5. What kind of physical complaint/illness does the patient have? _____ 18

_____

6. How many times has the patient been to Rocky View Emergency with THIS complaint/illness in the last 12 months?

_____ times 19

PLEASE SKIP TO QUESTION 9.

OTHER PROBLEMS

7. What kind of problem does the patient have?

_____ 20

8. How many times has the patient been to Rocky View Emergency with THIS problem in the last 12 months?

_____ times 21

PLEASE MOVE ON TO QUESTION 9.

9. How many times has the patient been to Rocky View Emergency in the last 12 months with:

(a) other accidents/injuries _____ times 1 22

(b) other complaints/illnesses _____ times 2 23

(c) other problems _____ times 3 24

10. How long has the current injury/illness/complaint/problem been bothering the patient?
CHECK THE ONE THAT APPLIES.

(a) less than 24 hours ☐ 1 25

(b) less than a week ☐ 2

(c) more than a week ☐ 3

(d) it comes and goes over time ☐ 4

11. Does the patient have any of the following problems that are also bothering him/her today?
PLEASE CHECK ALL THAT APPLY.

worry/nervousness	☐ 1	26
depression	☐ 2	27
difficulties with friends & family	☐ 3	28
loneliness	☐ 4	29
financial concerns	☐ 5	30
job worries/unemployment	☐ 6	31

12. If you checked any of the above did you or the patient expect the patient to get help with this/these problem(s) during this visit to Emergency?

Yes	☐ 1	32
No	☐ 2	

13. Did the patient come to Rocky View Emergency because:
PLEASE CHECK ALL THAT APPLY

(a) the patient did not have a family	☐ 1	33
(b) the patient's family doctor was not available	☐ 2	34
(c) Emergency was the only place open	☐ 3	35
(d) someone suggested the patient come here please say who _____	☐ 4	36
(e) someone else brought the patient her please say who _____	☐ 5	37

13. continued

(f) it was the closest place to come to ☐ 6 38

(g) other reason _____ ☐ 7 39

_____

14. What is the patient's age? _____ 40

15. Is the patient MALE ☐ 1 or FEMALE ☐ 2 41

16. Is the patient's marital status:

never married ☐ 1 42

married ☐ 2

divorced ☐ 3

separated ☐ 4

widowed ☐ 5

living with partner ☐ 6

17. How long has the patient had this marital status?

all his/her life ☐ 1 43

over 5 years ☐ 2

2 to 5 years ☐ 3

1 to 2 years ☐ 4

17. continued

less than a year	☐	5
less than 6 months	☐	6
less than 3 months	☐	7

18. Is the patient working at this time?

Yes ☐ No ☐ 44

If YES, what is the patient's occupation?

_____ 45-46

19. If the patient is a homemaker what is the occupation of his/her partner?

_____ 47-48

20. If the patient is a preschooler or in school what is the occupation of his/her parent/guardian(s)?

49-50
_____ 51-52

21. What is the highest educational level the patient has completed?

post graduate study (University)	☐	1
university/college	☐	2
grade 12	☐	3
grade 10	☐	4
grade 8	☐	5
less than grade 8	☐	6

53

22. How long has the patient lived in Calgary?

all his/her life	☐ 1	54
over 10 years	☐ 2	
5 to 10 years	☐ 3	
2 to 5 years	☐ 4	
less than 2 years	☐ 5	

THANK YOU FOR ANSWERING THESE QUESTIONS. YOUR HELP IS GREATLY APPRECIATED.

Appendix E

THE ROLE OF THE SOCIAL WORKER

I Consultation:

1. Working with the health team on a daily/weekly basis to differentiate between those patients who need social work - community resource intervention and those who do not.

2. Providing staff with information regarding the community resources available and helping them to appropriately utilize these resources.

3. Joining with the health care team in a collaborative effort to utilize the social worker's special knowledge and professional judgement in the best interests of patients and their families.

4. Communicating regarding significant social, emotional, and cultural factors that may affect illness, recovery, rehabilitation or maintenance of health.

5. Assisting staff in identifying and selecting special interests and concerns and developing them into research considerations.

6. Providing staff with the assistance in proposal writing, co-ordination and decision-making necessary to plan and implement projects concerning patient care, needs assessment, or innovative approaches to intervention.

7. Discussing with staff special area problems re patient care and assisting in the planning of programs to meet these needs.

8. Informing re methods of community development and community action as related to health care.

9. Assisting in developing methods of improving the environment in which patients are treated.

10. Giving staff support regarding the philosophical concerns of patient care and attempting to provide a forum in which these concerns can be discussed.

11. Offering staff the opportunity to share conflicts and reactions to patients i.e. grieving, etc.

II Direct Service to Clients:

1. Service to patients and their families considered as "complex psycho-social situations" includes the following:

   a) assessment: focusing on

      1. an evaluation of the problem and precipitating events as perceived by the patient/family.
      2. collection of significant background information.
      3. attitudes and feelings of patient and significant others, including reaction to patient's illness or disability.
      4. observation of patient/family dynamics and interactions.
      5. identification of resources of patients and family
      6. assessment of problem solving ability of patient/family including ability to cope with stress and adapt to change.
      7. determination of problem by the social work consultant and assessment of need for the various services available.

   b) planning - identify appropriate intervention

   c) provision of services re intervention

      1. counselling or therapy services - individual, marital, family, group and crisis intervention.
      2. community resource/hospital resource liaison - referral to appropriate source.
      3. advocacy on behalf of clients.

Services re direct intervention is provided to a) inpatients and collaterals, b) outpatients on a limited basis and c) hospital staff as appropriate.

III Community Liaison - working with agencies for better service to patients involves the following:

1. Social worker serving as a link between the hospital and community social service agencies. Social worker must develop a knowledge of resources, services offered and how to utilize them.

2. Improving the accessibility of outside hospital resources for staff and patients.

3. Assisting staff in determining which agency is the most appropriate resource to use in a case.

4. Familiarizing staff with existing resources by arranging for agency visits to hospital.

5. Attempting to monitor and to provide feedback to agencies re their response to patient needs.

6. Involving community resource people in on-going planning and co-ordination of patient care and discharge planning - encouraging better understanding of medical implications.

7. Encouraging more involvement of community resources in hospital setting where appropriate.

8. Informing administration about the structure and function of community agencies and any changes having relevance for the hospital, particularly, changes in federal and provincial social welfare policies that have direct or indirect implications for hospital services.

9. Identifying gaps or inadequacies in community health and social services, documenting the problems and calling them to the attention of the appropriate authorities within the hospital and the community promoting action to remedy these problems.

10. Assisting community agencies to understand the hospital milieu, its policies and procedures.

IV Education:

The social worker should contribute to the educational programs of the hospital. Educational input can be offered to staff, volunteers and members of the community on an informal or formal basis where they have expressed a lack of knowledge or an interest in developing specific skills.

Within limits of resources, the social worker may contribute to the training of students, particularly those in a social service or health science program.

V Research:

Social work research in the health care field should be practice oriented and focus on such areas as the psychosocial aspects of illness, evaluation of social work interventions, social service needs of patients, manpower utilization, and measurement of program effectiveness. Within limits of resources the social worker may conduct research and studies, implement findings into daily practice and share the knowledge gained with other hospital staff.

Appendix F

Extended Time Periods When the Social Worker Was Offering for Service in the Emergency Department

Date	Hours
June 1st, 2nd, 3rd, 4th	8:00 - 20:00
June 7th, 8th, 9th, 10th	20:00 - 8:00
June 12th, 13th	8:00 - 20:00
June 18th, 19th, 20th	20:00 - 8:00

Appendix G

Classification of the variable: kind of injury

1. Infections
2. Bites
3. Cuts
4. Sprains
5. Burns
6. Bruising & swelling
7. Foreign body (e.g. metal in eye)
8. Other (where person reported part of body, e.g. arm)

Classification of the variable: how injured

1. Sports
2. Work
3. Fights
4. At home/garden
5. Environment (e.g. falling off curb; bee sting)
6. Vehicular (including bikes)
7. Not sure
8. Other

Classification of the variable: physical complaint

1. Fever & temperature
2. Allergies & rashes
3. Heart
4. Chest
5. Headache
6. Stomach
7. Asthma
8. Ear, nose, throat
9. Dizziness
10. Other

Appendix H

Graph to show the referral rates between pre-intervention, intervention and post-intervention periods.