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A Study of the Factors Involved in Re-Admission to the Hospital of Fifty-Eight Veterans Treated for Psychiatric Illness

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A STUDY OF THE FACTORS INVOLVED IN RE-ADMISSION TO THE HOSPITAL OF FIFTY-EIGHT VETERANS TREATED FOR PSYCHIATRIC ILLNESS

by

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Presented with the permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions or the conclusions deduced by the writer.[1]

1 In compliance with Section 3, VA Circular 214, 1946

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CHAPTER I

INTRODUCTION

The maintenance of hospital facilities for the patient needing psychiatric care is one of the major problems presently confronting the Veterans Administration. One aspect of this problem appears to revolve around available bed space and recruitment of hospital personnel. This same problem exists in civilian hospitals. The following statement quoted by Paul Haun from the Report of the Commission of Hospital Care further defines the problem:

> Better methods of diagnosis can reveal in the earlier stages cases of mental illness which previously went unnoticed until they were developed. Effective case-finding programs and public education concerning the nature of mental illness have resulted in the discovery of patients who otherwise would not have been found. Thus a combination of natural growth in the population coupled with better methods and greater efforts at case-finding has intensified the problem by greatly increasing the number of people who need care. . . . Physical facilities for the care of the nervous and mental patients are for the most part inadequate in capacity and outmoded as to effectiveness.[1]

At the close of the fiscal year, June 1953, the Veterans Administration was operating 162 hospitals with a functioning capacity of 109,056 beds.[2] The thirty-five neuro-psychiatric hospitals had the highest occupancy rates,

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1 Paul Haun, Psychiatric Sections in General Hospitals, New York, 1950, 4, 5.

2 Veterans Administration Annual Report for Fiscal Year Ending June 30, 1953, 9, 10.

averaging 95 per cent of operating capacity.[3] There was also the additional pressure of 15,000 applicants awaiting scheduling for hospital admissions at the end of June, 1953.[4] With this in mind, and with the anticipation of an increase in the number of new psychiatric cases, a study of the reasons for the return of the lapsed patient would appear significant at this time.

Purpose.

The purpose of this study was to determine what factors are involved in the patient's re-admission to the Psychiatric Service at Veterans Administration Hospital, Hines, Illinois. The investigation was limited to an evaluation of the reasons for the patient's return to the hospital. In this study, consideration was given to the types of treatment and services rendered on behalf of the patient during his hospitalization, his post-discharge adjustment in the community, and whether or not these affected his return to the hospital.

Method

The method was formulated on a research design. Factual material was obtained both from the Social Service records and from the clinical charts of the Psychiatric Service. The information from the records was transferred to schedules, which were later tabulated. The data were then studied and evaluated to form a basis for the conclusions.

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3 Veterans Administration Annual Report for Fiscal Year Ending June 30, 1953, 9, 10.

4 Ibid., 11.

Sources

The material for the study was obtained from a review of pertinent literature, including books, periodicals, and bulletins related to the fields of social work and psychiatry. Additional information was secured from personal interviews with members of the hospital staff.

The data selected for the study were obtained from records of those patients whose last re-admission to the Psychiatric Service occurred during the interval between January 1, 1950, and June 30, 1953. In those cases where there were more than one, or several re-admissions, the data covered only the hospitalization and the post-discharge adjustment preceding the readmission period under study.

The study group included only those patients who had been hospitalized on the Psychiatric Service and discharged from that service. Patients who had been hospitalized previously on other services and who were readmitted to the hospital on the Psychiatric Service were excluded from the study. However, if a patient was transferred from another ward to the Psychiatric Service, discharged from there and later re-admitted to the Psychiatric Service, he was included in the study.

During the period under study there were a total of 1,329 patients admitted to the Psychiatric Service.[5] Of this total, 58 patients were re-admitted. Of these, there were 48 patients who were readmitted once, six who were readmitted twice, two who had three readmissions, one patient with four

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5 The number of admissions was obtained from the records of the Psychiatric Service.

readmissions, and one patient who was readmitted seven times.

The 58 patients in the study were all adult male veterans of World Wars I and II. The term "veterans" in this study refers to male adults honorably discharged from service. Included in this category are veterans either service connected or not service connected for psychiatric illness. A veteran whose psychiatric illness had been adjudicated by the Veterans Administration as service connected may receive financial compensation in amounts set up by law, proportionate to the extent of his disability.[6] Patients in the study group were all eligible veterans accepted for hospitalization and treatment in accordance with the general policy of the Veterans Administration. Veterans eligible for hospitalization and treatment are admitted to the Psychiatric Service upon their own application or the request of their guardian, relatives, or representatives; or they may be accepted by court commitment through proceedings initiated by officials, relatives, or representatives.[7] They remain in the hospital only when this is desired by themselves or their guardian, relatives, or representatives, or when their immediate release is contraindicated in the interests of themselves or others.

Plan of Presentation

The study will present a description of the setting and functioning of the Psychiatric Service at Veterans Administration Hospital, Hines, Illinois,

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6 Red Cross Hand-Book, Section 1, Par. 1325 13-10A.

7 Veterans Administration Regulations and Procedures, "Psychotic Patients; Their Hospital Administration, Discharge, Trial Visit, Elopement, etc.", Par. 6155.

and an evluation of the treatment and services rendered. Consideration will be given to the socio-economic factors involved in the pst-discharge adjustment, and an analysis will be made of the expressions of both patients and relatives of the reasons for returning to the hospital.

A study of the re-admission problem was conducted at Veterans Administration Hospital, Bedford, Massachusetts, during 1950 and 1951. The purpose was the same as that of this study. The main difference between the two studies was in method and time interval. The Bedford study covered a period of one year, 1949, and used two groups, one as a control. Comparable data on the two groups were then collected and studied.

With this background of purpose, method, and plan of presentation, the study will continue to present a description of the setting and function of the Psychiatric Service at Veterans Administration Hospital, Hines, Illinois.

CHAPTER II

SETTING AND FUNCTION

The Veterans Administration Hospital, Hines, Illinois, is classified as a general medical and surgical unit operating under regulations of the Veterans Administration. The hospital is located on the outlying boundaries of a large metropolitan center and is surrounded by several suburban areas. As of May, 1954, when this study was completed, the operating bed capacity was 2,630.[1]

In addition to the services of the medical and surgical units, there are specialized services consisting of Tuberculous, Neurology, and Psychiatric Serives, and the Paraplegia, the Blind Rehabilitation, and the Diagnostic Centers. The Neurology Service and the Psychiatric functioned as a single unit prior to March, 1953. At that time, there was a separation of the Neuropsychiatric Service into a Neurology Service and a Psychiatric Service with a separate Chief for each service.[2]

The Psychiatric Service is located in a separate building from all of the other services. It has an operating capacity of 138 beds. At the time of

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1 Bed capacity from Registrar's Office, Veterans Administration Hospital, Hines, Illinois.

2 Peter Volpe, Memorandum from Manager of the Hospital to Neuropsychiatric Staff, Veterans Administration Hospital, Hines, Illinois, March 11, 1953.

the study, there were five wards, one of which was used as a bed ward. The remaining four wards allow for separation of patients according to the degree of disturbance. There are four closed wards and an open ward, which is used by patients who have made sufficient recovery from their illnesses to be given some self direction. These patients have freedom of the hospital grounds and activities and are usually in the process of completing plans for return to the community. On each ward is a large dormitory, a day room, and several smaller rooms used for examinations and interviews. In addition, there are facilities for physical treatment, group and ancillary therapies, general staff meetings and other administrative functions of the service. The Psychiatric Service utilizes all aspects of modern therapeutic techniques in the care of its patients. Services within the hospital are therapeutically structured in terms of available activities and in the attitudes and behavior of the total staff.

The Psychiatric Service functions primarily as a short term, in-patient facility for psychiatric patients and secondarily as a teaching unit. Patients requiring long term service are transferred to Neuropsychiatric Hospitals located in surrounding areas, providing this type of care.[3] The staff of the Psychiatric Service consists of the Chief, the Assistant Chief Consulting Psychiatrists, Staff Psychiatrists, Psychiatric Residents, Clinical Psychologists, Clinical Psychology Trainees, Social Workers, Social Work Students, Nurses and Aides, and any other disciplines as indicated.

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3 Letter from E. C. Andreassen, Area Medical Director, December 4, 1952.

In order to help the patient make the most constructive use of his period of hospitalization, services are established on the multi-discipline or team approach. This approach results in a more effective utilization of the specific skills and knowledge contributed by the various members of the team to the total treatment plans for the patients.

The professional and personal capacities essential for participation in a teamwork situation are cited by Eleanor Cockerill as:

> Preparation in one's own field through a fundamental knowledge of principles and concepts which can be clearly communicated to others.
>
> The ability to see oneself in relation to the contributions of others. . . . A general knowledge of other fields and also some capacity to think within their conceptual schemes. Recognition of the instances that require a different kind of knowledge and competence and knowledge about where that competence is to be found.[4]

It is impossible to rigidly define the boundaries of function for each service. A certain amount of overlapping is inevitable and in fact seems feasible in order to insure a smooth continuing treatment atmosphere. Each team is organized around a Resident Psychiatrist with representative members of the various services. For example, a team is usually composed of the Resident Psychiatrist, the Consulting Psychiatrist, Staff Psychiatrist, Staff Clinical Psychologist, Social Worker and Nurse. In addition, the Psychology Trainees and Social Work students attend the Service team under supervision of the respective supervisors assigned to each team.

Each team holds weekly meetings relative to the responsibilities delegated to it. This includes the establishment of diagnosis and prescription

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4 Eleanor Cockerill, "The Interdependence of the Professions in Helping People," Social Casework, XXXIV, November, 1953, 376.

for the patient, plans for Trail Visit or discharge, arrangements for passes, and preparation and evaluation of material pertinent to treatment planning. It is also necessary for team members to keep abreast of new developments relative to their teams: new patients, transfers, discharges, elopements, changes in behavior, and re-interpretation of patients' symptoms. There is usually a formal or informal presentation of a case which aids the members in securing a clearer understanding of the patient and his illness. This atmosphere also presents an ideal setting for the free exchange of ideas and information. The number of patients assigned to each team varies, but the average number ranges from twenty-two to twenty-four.

The Chief of the Service has final responsibility for the over-all treatment program for the patient as well as specific plans for hospital program. He holds regularly scheduled conferences with staff and Resident Psychiatrists, consulting psychiatrists, and with members of the various services. The consulting psychiatrist has special qualifications and functions in the capacity of a teacher and a professional consultant in supervision. He is available on a part-time basis. The staff psychiatrist has responsibility for the services of the team to which he is assigned. He delegates to the resident psychiatrist responsibilities in the operational area for care and treatment of the patients on his team, but assumes final responsibility for treatment plans. He also has responsibility for tutoring the resident in matters of diagnosis and treatment, medical and legal problems pertaining to the Psychiatric Service, and in the art and ethics of medicine. In addition, the staff psychiatrist has responsibility for the operation of a ward which is assigned to him.[5]

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5 Personal interview with Dr. W. David Steed, Chief of Psychiatric

The clinical psychologist contributes to the service in the administration of tests which aid in the establishment of accurate diagnosis. He may also under supervision of the staff psychiatrist carry cases for intensive psychotherapy.

The general function of the psychiatric social worker is to help the patient make effective use of the treatment given in the hospital. As a member of the team she contributes pertinent social information and evaluations relative to the patient's background, intra-familial and other inter-personal relationships. In addition, she offers help to patients and their families in giving adequate interpretation concerning the patient's illness and hospitalization, and extends help to both patient and family with problems emerging out of or contributing to the illness. She further is responsible for making available to the patient and his family the resources of the community. According to the recommendations of the team, she may be responsible for direct psychotherapy with the patient. Supervision and guidance in direct treatment depends upon the goals and focus of treatment. When the main problem is modification of environmental pressures, the patient usually is carried in a supportive casework relationship. Otherwise, when attempts are made to modify deep-seated behavior patterns or conflicts, invariably the supervision and guidance of one of the staff psychiatrists is sought with arrangements for joint conferences between casework supervisor, caseworker, and the supervisor of therapy.[6]

The nurse as a member of the team is able to make important contri-

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6 Personal interview with Mrs. Rachel Calloway, Casework Supervisor, Social Service Department, Psychiatric Service, Veterans Administration Hospital, Hines, Illinois.

butions because of her continuous contact and observations of the patient on the ward.

The treatment program of the Psychiatric Service is further supplemented by Diagnostic Staffs in which help is given with particularly difficult problems. Similarly, the Admitting Staff where all hospital personnel become acquainted with new patients contributes to the program.

The function of the Psychiatric Staff, the Service team, and the roles of the various members of the team have been described for purposes of understanding the framework within which the patient is treated. However, the boundaries of professional roles become flexible when efforts are concentrated on the illness and the needs of the patient. Constant interchange of information between the members of the Service prevent duplication of effort and offer a broad base for continued treatment planning.

CHAPTER III

PERIOD OF HOSPITALIZATION

An attempt will be made in this chapter to describe the study group with reference to identifying information: the diagnosis, the kind of treatment received, the duration of hospitalization, and the type of discharge. The social services rendered on behalf of the patient will also be presented.

Thirty of the fifty-eight patients in the study group had had one or several re-admissions exclusive of the period under investigation. This would seem to indicate that a specific group within the study group had formed a pattern of returning to the hospital. The findings regarding age and marital status of patients in the study group show that the majority were married and the bulk of patients were between the ages of twenty-five and forty. This span of years covers what is usually considered the most active and productive period of an individual's life.

The age and marital status of the patients are given in Table I.

TABLE I

AGE AND MARITAL STATUS

Age	Number of Patients	Married	Single	Separated	Divorced
Under 25	5	2	2	1	
25-30	14	6	6	1	1
31-35	15	6	3	4	2
36-40	13	9	2	2	
41-45	3	3			
46-50	3	3			
Over 50	5	3	1		1
Total	58	32	14	8	4

The majority of the patients were affiliated with a religious group. Denomination did not appear to be an important factor as there was an equal distribution of patients found in the two major religious sects.

TABLE II

RELIGIOUS AFFILIATION

Religion	Number of Patients
Catholic	25
Protestant	27
Other	6
Total	58

Of the fifty-eight patients in the group, there were four Negroes. Although this number seems to be small, this figure corresponds to the ratio of Negroes generally admitted to Veterans Administration neuro-psychiatric hospitals.[1]

Thirty-six of the patients were service-connected for psychiatric illness; twenty-one were not service-connected, and there was no information available in one case. The service-connected patients are entitled to receive out-patient care as well as compensation and other benefits through the Veterans Administration. A non service-connected veteran may become eligible for pension if Veterans Administration determines he is permanently and totally incapacitated by his illness.

The large proportion of patients in the study group receiving compensation would seem to indicate that these veterans, before their induction into service, may have been among those persons in the population who were making a precarious or marginal adjustment. With the onset of the war, they were affected by a situational process which may have tended to activate dormant conflicts.

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1 Veterans Administration, Annual Report for 1953, 162.

TABLE III

COMPENSATION STATUS

Status	Number of Patients
Service-connected	38
Non-service connected	21
Unknown	1
Total	58

The majority of patients in the study group were of the age group eligible for military service during World War II. Consequently the largest number of patients were in this classification. Fifty-one were veterans of World War II and seven of World War I.

After admission to the Psychiatric Service, patients are examined and evaluated as soon as possible in order that treatment plans can be initiated. The goal of treatment is to help the patient to make a satisfactory adjustment to his immediate surroundings and subsequently, if possible, an effective adjustment in the community. The efforts of all services in the hospital are directed towards this objective.

Upon admission the patient is given a tentative diagnosis. This is subject to change or modification in the light of clinical developments. Establishment of diagnosis is a flexible matter because of the varied physiological and psychological factors inherent in each individual situation.

Of the total number of patients, there were forty whose re-admitting diagnosis remained the same as the original diagnosis and eighteen whose

diagnosis changed upon re-admission. The re-admitting diagnosis will be discussed in Chapter IV.

TABLE IV

DIAGNOSES AT INITIAL HOSPITALIZATION

Diagnoses	Number of Patients
Anxiety with chronic alcoholism	5
Alcoholism chronic	9
Anxiety Reaction	11
Character Disorder	1
Character Neurosis	1
Conversion Hysteria	1
Depressive Reaction	2
Emotional Immaturity	1
Epilepsy Idiopathic	1
Inadequate Personality	1
Involutional Melancholia	2
Psychoneurosis	2
Schizophrenia	21
Total	58

The largest diagnostic classification was Schizophrenia, which constituted 36 per cent of the total number. However, the larger number of patients with this diagnosis is anticipated since its incidence is higher among all patients hospitalized for psychiatric disorders.[2]

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2 Eugene B. Brody and Frederick C. Redlich, eds. Psychotherapy with

The fact that the majority of patients in the group were diagnosed as Schizophrenics appears to have some significance for the study, for it is generally recognized that this group of psychiatric disorders have difficulty in maintaining social and economic adjustments.

Within the last twenty years there has been a great deal of progress made in the treatment of mental disorders. These advances have been achieved primarily through an increased understanding of the psycho-dynamics of human behavior and the development of clinical methods having an influence on mental states. Important contributions to the treatment of the psychoses had their origins in the early 1930's with the development of insulin coma and electric shock treatment.[3]

Both of these treatments are utilized for the treatment of patients in the Psychiatric Service. Certain beneficial results observed from the use of electric shock treatment have been described by Alexander as helping the person to "strengthen certain defenses and replace poor or non-efficient ones with better ones."[4] He further describes insulin coma treatment as one where "the patient is enabled to lower his defenses and come to grips with his real problem and reorganize himself on a more realistic basis."[5]

The aim of psychotherapy, individual or group, is to help the individual to achieve a more balanced emotional outlook on life. An important

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3 Leo Alexander, Treatment of Mental Disorder, Philadelphia and London, 1953, 41.

4 Ibid., 77.

5 Ibid., 78.

aspect of individual psychotherapy is the attitude and actions of the therapist. The patient more frequently responds to how the therapist acts towards him and the manner in which he talks to him than in what he tells him. In talking with a skilled person about his problems, the patient often comes to view his feelings and action in their true perspective and to develop more adequate means of handling them.

As participant of the group, the patient is given opportunity through the dynamics of the group process to lessen isolative tendencies and to experience feelings of personal security; to test the validity of his own concepts against those of others and to release rivalrous and hostile feelings.[6]

Other important aspects of treatment are the daily activities of the ward program, which include occupational therapy, sports, and socialization. The extent of the patient's participation in these activities depends upon his interests and whether or not he will be a hazard to himself or others. These activities also frequently help the patient to break down barriers to make friends by diminishing sensitivity, or to help the patient work at something he is interested in, which may increase his self-respect and lessen his problem of dependency.

In addition to the various types of treatment described, other drugs and medication may be used, as in cases of alcoholism to sedate and build the patient up physically, or in other cases to bring endocrine changes necessary for continued treatment.

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6 Robert G. Hinckley, "Psychotherapy with Chronic Psychiatric Patients," Veterans Administration, Information Bulletin, TB 10-53, 16.

TABLE V

DIAGNOSIS AND TYPE OF TREATMENT

Diagnosis	Number of Patients	Kinds of Treatment: Convulsive Therapy	Psycho-therapy	Combination	Drugs & Medication	Unknown
Anxiety with Chronic Alcoholism	5		3		2	
Alcoholism Chronic	9			1	8	
Anxiety Reaction	11		4		3	4
Character Neurosis	1				1	
Conversion Hysteria	1		1			
Character Disorder	1		1			
Depressive Reaction	2		1		1	
Emotional Immaturity	1		1			
Epilepsy Idiopathic	1					1
Inadequate Personality	1			1		
Involutional Melancholia	2			1		1
Psychoneurosis	2					2
Schizophrenia	21	1	5	5	1	9
Total	58	1	16	8	16	17

In this setting it can be presumed that every patient receives some form of psychotherapy, whether or not this is specifically recorded in the clinical record. The patient is seen at least daily on the ward, and these interviews with the doctor can be regarded as achieving therapeutic benefits in various degrees. In the above table, however, the patient was considered

to have received psychotherapy beyond thesuperficial variety described, and this additional psychotherapeutic effort was specifically recorded in the clinical record. The term "combination" in the above table refers to the use of psychotherapy combined with either shock treatment or with drugs and medications.

Duration of Hospitalization

Since the Psychiatric Service functions as a short term treatment hospital, the majority of the patients remained in the hospital less than three months. Fourteen of the Schizophrenics, the major diagnostic category, were in the hospital for less than three months, two remained less than six months and five stayed from six months to one year. Nine of the patients with the diagnoses of anxiety reaction were there for less than three months and two were in less than six months. All patients with diagnoses of alcoholism remained in the hospital for less than three months.

TABLE VI

DURATION OF HOSPITALIZATION

Duration of Hospitalization	Number of Patients
Less than three months	46
Less than six months	5
Six months to one year	5
One year to two years	1
Unknown	1
Total	58

Type of Discharge

The patient's readjustment in his family and the community is the ultimate goal of the treatment program. Consequently, discharge becomes a part of the total treatment planning when the patient is admitted to the hospital. Patients are discharged from the hospital under four general classifications: against medical advice, trial visit, maximum hospital benefits, and elopement.

Patients who have improved during their period of hospitalization but whose adjustment after discharge is anticipated to be precarious are placed on trial visit. Extensive planning is usually necessary with the patient, his relatives, and the psychiatric staff before he is ready to leave the hospital. The patient who goes home on trial visit should have active support in re-establishing family and community adjustments. Decision as to whether trial visit supervision should be provided by a VA out-patientelinic or by the hospital is based on an evaluation as to which plan will be most helpful to the patient. The patient is formally discharged when it is certain from reports during his period of supervision that he has made an adequate community adjustment.

A discharge of maximum hospital benefits is given to those patients who have made a satisfactory adjustment within the hospital setting and appear unable to benefit from further hospitalization. Eloped patients are those who leave the hospital without permission. Those patients who leave the hospital against medical advice are persons who have not received the full benefit of treatment and for whom continued hospitalization is the recommendation of the medical staff.

TABLE VII

TYPES OF DISCHARGE

Discharge	Number of Patients
Maximum hospital benefits	36
Against medical advice	12
Trial visit	6
Elopement	3
Unknown	1
Total	58

Thirty-six of the patients in the study group were discharged as having received maximum hospital benefits, six were discharged on trial visit, and twelve against medical advice. Three patients eloped, and the type of discharge for one patient is unknown. The fact that over twenty-five per cent of the group left the hospital through other than desirable channels appears significant. These fifteen patients might be expected to require re-admission to the hospital in view of their not having received as extensive treatment as would have been recommended.

Social Service Contact with Relatives

The general function of the psychiatric social worker as a member of the team has been previously described in Chapter II. Only a brief description will be given in this paragraph concerning her role in working with relatives. The worker usually contacts relatives of the patient within a week after his admission to the hospital for the purpose of (1) securing social data relevant to diagnosis and social planning, (2) giving interpretation of the illness

in such a manner as to enlist the relative's cooperation in helping the patient to receive maximum hospital benefits, (3) explaining hospital procedures and tentative treatment plans, and (4) extending help with personal or family problems which stem from and contribute to the patient's illness.

Patients whose families are unable to come to the hospital because of distance are contacted as early as possible through correspondence. In some instances, relatives were seen only at the time of the patient's admission and discharge; in others continuous contact was maintained during the period of hospitalization.

Where indicated, the social worker may undertake the treatment of relatives for modification of attitudes detrimental to the patient's recovery. In other instances, the worker may continue to work with the patient under supervision.

In reviewing these records there was evidence that relatives had been seen by the social worker during periods of hospitalization not covered by this period of study. In addition, there remains the possibility that there was insufficient time to interview relatives, particularly in those instances where the patient left the hospital against medical advice or elopement.

Of the twenty-one records where there was one interview, the content of two were relevant to discharge. In four records of two interviews, one concerned discharge. In nine records where there were three or more interviews, the content of two concerned discharge and one modification of attitude. The content of the remainder of the interviews is unknown.

TABLE VIII

SOCIAL SERVICE CONTACTS WITH RELATIVES

Diagnoses	No. of Patients	One Inter-View	Two Interviews	Three	Other	Unknown
Anxiety with Chronic Alcoholism	5	3				2
Alcoholism	9	3		1	1	4
Anxiety Reaction	11	6				5
Character Neurosis	1					1
Conversion Hysteria	1					1
CharacterDisorder	1					1
Depressive Reaction	2		1			1
Emotional Immaturity	1					1
Epilepsy Idiopathic	1					1
Inadequate Personality	1	1				
Involutional Melancholia	2		2			
Psychoneurosis	2	2				
Schizophrenia	21	6	1	8	3	3
Total	58	21	4	9	4	20

Social Service Contact with Patient

The social worker usually contacts each patient soon after admission. Help is given in interpretation of the hospital and of his own status as a patient; aid with problems arising from his inability to handle practical matters and keeping him in contact with his family. As part of the treatment

plan, the social worker helps in preparing the patient for adjustment in the community after discharge or trial visit. Frequently patients will seek out the social worker to discuss a specific problem after they have become familiar with her role. The worker may undertake supportive or intensive treatment with the patient if such a recommendation is made by the team. In the fourteen records where there was one interview, eight were relevant to discharge planning, while the content of the remainder is unknown. Of the ten patients who had two interviews, the content of three involved discharge planning. Of the eighteen patients who had two or more interviews, the content of nine interviews was concerned with discharge plans. In addition, one patient was carried on an intensive treatment level.

At the time the patient is ready to leave the hospital, either through discharge or trial visit, treatment plans may indicate continued support in emotional areas or practical situations, such as vocational counseling or financial assistance. Service-connected veterans may be referred to the Veterans Administration regional office for further psychiatric care. The non-service connected patient may be referred to other agencies in the community giving this kind of care.

There were forty-two cases where no referral was made. Of the sixteen remaining, eleven were for psychiatric care; the remaining referrals involved financial assistance, employment, and alcoholics anonymous.

TABLE IX

SOCIAL SERVICE CONTACT WITH PATIENT

	Number of Patients	One Interview	Two Interviews	Three or More Interviews	Other	Unknown
Anxiety with Chronic Alcoholism	6	1	3			1
Alcoholism Chronic	9	6	1			2
Anxiety Reaction	11	1	3	2		5
Character Neurosis	1	1				
Conversion Hysteria	1					1
Character Disorder	1	1				
Depressive Reaction	2			1	1	
Emotional Immaturity	1					1
Epilepsy Idiopathic	1					1
Inadequate Personality	1			1		
Involutional Melancholia	2	1				1
Psychoneurosis	2				1	1
Schizophrenia	21	3	3	13		2
Total	58	14	10	18	1	15

TABLE X

REFERRALS

Type of Referral	Number of Patients
Financial assistance	2
Vocational Counselling	1
Psychiatric Care	11
Other	2
No Referrals	42
Total	58

Summary

The patient group was described in relation to the statistical data obtained from their social service records. Material was presented relative to age, marital status, religion, race, compensation status, and classification of military service.

Services rendered on behalf of the patient group during their period of hospitalization were described and statistically presented.

The major diagnosis of the patient group was representative of highest incidence of psychiatric disorders found in the majority of neuro-psychiatric hospitals. Recognised methods of treatment were available for use of the patient group. The services offered by the social worker in her contacts with patients and their relatives were defined.

CHAPTER IV

LIVING ARRANGEMENTS AND EMPLOYMENT

The data presented in this chapter will be focused on the living arrangements and employment situation of patients in the study group after discharge from the hospital. Material from the records will be presented to discern, if possible, whether or not the patient was subjected to different factors in his post-discharge adjustment than those he encountered prior to his hospitalization.

The question of whether or not a patient can continue to benefit from his period of hospitalization would depend to a significant degree upon the kind of family situation in which he is placed. A patient who lives with family members who are hostile or reject him, overtly or unconsciously, would seem to have a real obstacle to maintaining progress made during hospitalization. However, those families who are sincerely interested in the patient and who make every effort to deal with disturbed behavior should be viewed as a valuable resource in post-hospital adjustment.

Some difficulty was encountered in determining the approximate living arrangements for the majority of the patients because of their frequent moves and lack of recorded information concerning their living arrangements. Many patients planned to return to their old neighborhood, but expressed an intention to move to a new community. In other instances some patients lived in

both old and new communities. The following case illustrates the type of mobility characteristic of many patients in the group.

James M. a twenty-three year old veteran of World War II, was admitted to the Psychiatric Service in January, 1950. He was given a diagnosis of anxiety reaction and was discharged with maximum hospital benefits in April, 1950. After his discharge he returned home to Indiana to live with his mother. He became involved in a quarrel with his mother after a period of one week and left home to enroll in school in Kentucky. He left school after a three-week interval and returned home. During July he sought re-hospitalization at a Veterans Administration hospital in Indiana and was referred to a Veterans Administration hospital in Danville, Illinois. He was re-admitted to the Psychiatric Service at Hines as a transfer from Danville on August 11, 1950. Upon re-admission, the patient complained of irritability, nervousness, jitteriness, and spells of depression. The patient stated that he felt he left the hospital too soon. The admitting statement obtained from the clinical record described the patient as having made a poor social and work adjustment after his first period of hospitalization.

Of the fifty-eight patients in the study group, twenty seven returned to their old neighborhoods. Five patients went to live in new communities, and six returned to other accommodations which in this study include rooming houses, hotels, and temporary living arrangements. There was no recorded information concerning twenty patients. However, it seems somewhat significant for the study that twenty-seven, or 46 per cent, of the patients, returned to their old neighborhoods. This would imply that these patients may have again been exposed to the same community experiences they encountered before

hospitalisation.

TABLE XI

LIVING ARRANGEMENTS AFTER DISCHARGE

Living Arrangements	Number of Patients
Old neighborhood	27
New neighborhood	5
Hotels, rooming houses, etc.	6
Neighborhood unknown	20
Total	58

A larger number of patients in the study group lived with family members after discharge from the hospital. Twenty-two patients returned to their wives, twelve went to live with parents, and three lived with other relatives. Since six patients lived in hotels and rooming houses, it was difficult to determine with whom they lived or if they had close ties with family members. There was no information available concerning fifteen patients.

TABLE XII

PERSONS WITH WHOM PATIENT LIVED

Person	Number of Patients
Wife	22
Parents	12
Other relatives	3
Unknown	21
Total	58

Employment

The ability of a patient to maintain employment after discharge is usually regarded as one indication of favorable post-hospital adjustment. But this assumption appears to be contingent upon a number of variables in the employment situation plus specific individual differences of patients to adjust to various types of employment. Some occupations would tend to elicit symptomatic behavior in some patients whereas in others there would be no difficulty encountered in adjusting to the job. A patient whose psychiatric illness is of such a nature that he cannot withstand pressure situations would not adjust to an employment situation which presented pressures for him in terms of production or competition. Similarly, a patient who had difficulty in meeting people would tend to become disturbed if his job required that he make numerous contacts with people.

Questions concerning previous employment, types of occupation, and stability of work habits were included in the schedule to determine work patterns of patients in the study group. There was not enough information in the records to make a valid interpretation concerning each specific area. In forty cases there was no record as to whether or not the patient returned to previous employment or secured new employment. Of the remaining eighteen, eleven patients returned to previous employment and seven secured new employment.

In the area of occupational activities, four patients were classified as professional workers, ten as business or white-collar workers, sixteen as skilled laborers, one was semi-skilled, and eleven were laborers. Five of the patients were either full or part-time students. There was no information

concerning eleven. Of the forty-seven remaining patients, the larger proportion were found to be classified in occupations ranging from casual laborers to skilled laborers.

TABLE XIII

TYPES OF EMPLOYMENT

Employment	Number of Patients
Professional	4
Business or white collar	10
Skilled	16
Semi-skilled	1
Laborer	11
Other (school)	5
Unknown	11
Total	58

There were twenty-one patients in the study group who were employed full time and five part time. Six were listed as casual laborers, which in the study group refers to those patients whose records indicated they were never steadily employed for any length of time. The typical work history of one patient in the classification revealed that he would secure a job which he held for about three or four days. He would refuse to return to the job, going back to the employment office to secure a new job. In other instances, patients in this classification would receive jobs which they held for one or two weeks; they would remain unemployed for a period of time and then secure another job.

Five of the patients were enrolled as students and seven were unemployed. There was no recorded information concerning fourteen. The larger proportion of the forty-four patients where information was available were not steadily employed. This would appear significant for the study inasmuch as there is some indication that the majority of the patients were unable to maintain steady employment. It is difficult to assess whether the unemployment was caused by negative factors in the job situation or by inherent qualities in the psychiatric illness of the patients. However, there is a slight indication that the larger number of patients were unable to maintain steady employment.

TABLE XIV

STABILITY OF EMPLOYMENT

Employment	Number of Patients
Full time	21
Part time	5
Casual	6
Unemployed	7
Other (school, etc.)	5
Unknown	14
Total	58

CHAPTER V

FACTORS INVOLVED IN RE-ADMISSION

This chapter will present material as to reasons for return to the hospital. The response of both patient and his relatives regarding contributing factors of relapse will be presented.

The majority of the patients retained their initial diagnoses upon re-admission to the hospital. This would seem to indicate that the larger proportion of patients returned because of exacerbation of symptoms. Eighteen patients received a new diagnosis, which does not seem significant for the study.

There was no correlation between the patient's initial period of hospitalization and the period of time he remained out of the hospital.

TABLE XV

DURATION OF HOSPITALIZATION AND COMMUNITY ADJUSTMENT

Duration of Hospitalization	Number of Patients	Interval Between Discharge and Re-Admission
Less than three months	46	16
Less than six months	5	8
Six months to one year	5	11
One year to two years	1	8
Over two years	0	15
Unknown	1	
Total	58	58

Almost 80 per cent of the group was hospitalised for less than three months. The fact that nearly 40 per cent remained out of the hospital for over a year seems to indicate that an encouragingly large proportion of patients were able to adjust outside a hospital setting for an extended period of time.

Patients' Expression of Difficulty

Complete information was not found in all of the records regarding the patients' responses upon re-admission. However, themajority of the patients were admitted for emotional and somatic complaints which appeared to be mainly re-activation of the previous psychiatric illnesses. Upon re-admission many patients, in addition to their emotional or somatic complaints, admitted difficulties in relations with close family members. Other patients admitted difficulties in the community or with employment.

Some difficulty was encountered in making an evaluation as to the precipitating social factors in re-admission because many patients expressed difficulty in the area of employment, as well as in family and community relations. This would seem to indicate that re-admission of some patients stemmed from internal factors inherent in their psychiatric illness rather than external social causes. The patients' responses upon re-admission are indicated in Table XVI.

TABLE XVI

PATIENTS' RESPONSES UPON RE-ADMISSION

Problem Presented	Number of Patients
Emotional and somatic complaints	20
Somatic complaints and problem in community	7
Somatic complaints, problem with wife	5
Somatic complaints, problem with employment	7
Somatic complaint, problem with parents, children	3
Somatic complaints, wife, employment	9
Other--medical check-up, separation from son	7
Total	58

The term "Other" in Table XVI refers to those patients whose re-admission involved precipitating factors other than those of family, employment, or community. The following case is an example of such a situation: John S, a twenty-six year old veteran of World War II was admitted to the hospital in March, 1953, with a diagnosis of Schizophrenia. He was discharged in May, 1953, with maximum hospital benefits. The social history revealed that the patient had some difficulty in his relationship with his mother, but after discharge he moved into a trailer next to the one in which his mother and step-father lived. He appeared to be making a marginal work adjustment as he was never steadily employed, receiving new employment every three or four days. The precipitating factor in his return to the hospital was the burning of his trailer home. The patient became disturbed when his home caught fire and burned to the ground.

Another patient in this classification returned to the hospital for medical reasons with no manifestation of psychiatric disturbances. The responses of two more patients in this category revealed that these were lonely and unable to make friends. The precipitating factor in another's return was separation from his son, who had been inducted into service. This patient also expressed difficulty with employment. One patient who was having an affair with a married woman became upset when she went back to her husband. His social and economic adjustment was described in the clinical record as satisfactory.

Relatives' Expression of Patients' Difficulties

There was insufficient information in the records of patients in the study to give a valid interpretation of relations' expression of the patients' difficulties. There was no recorded information in thirty-eight cases. Of the remaining twenty, there were twelve cases where the wife gave some expression of the patient's difficulties. Eight wives stated they had difficulty in their own relationships with patients. Four wives complained of additional difficulty with patients in other areas: one patient was unable to get along in the community, three had difficulty with employment, and one had difficulty in the community.

Three parents complained of the patients' lack of adjustment in the home. One mother stated that the son became disturbed when his home was burned. The child of another patient remarked about his inability to get along in the community, and the sister of another patient made the same complaint. One brother stated that the patient was unable to get along with relatives.

An evaluation of the responses of this small number of cases reveals that these patients were having difficulties in more than one area of social relations. This seems significant because of the similarity of both patients' and relatives' responses regarding contributing factors of relapse.

Valid interpretations could not be drawn in the area of employment as there were twenty-eight cases where there was no record concerning response about work. Of this number three patients were enrolled in school. Seventeen patients voiced no complaint about employment; thirteen expressed dissatisfaction with employment.

Of the thirteen patients who expressed dissatisfaction with employment, one was employed in a professional capacity, two were white collar workers, two were skilled workers, and one in semi-skilled employment. One patient expressed dissatisfaction with labor work, and the type of occupation in six cases was unknown.

Summary

The patient group was described in relation to the reasons for their re-admission to the Psychiatric Service. The responses of both patients and relatives were presented along with the contributing social factors of relapse.

Case material was presented to illustrate some of the factors involved in patients' re-admission. There were thirty-one records where patients voiced some expression concerning social factors of relapse. In twenty cases there were expressions from relatives concerning patients' difficulties.

CHAPTER VI

CONCLUSIONS

This study was presented in an attempt to discover reasons for the return of veterans to the Psychiatric Service at Veterans Administration Hospital, Hines, Illinois, from January 1, 1950, through June 30, 1953. The scope of the inquiry was limited to an evaluation of the types of treatment and services received by the patients during their period of hospitalization, factors involved in his post-discharge adjustment in the community, and whether or not these affected his return to the hospital.

The major diagnostic classification of the study group was Schizophrenia. This fact seems to have special significance as persons with the diagnosis are considered to have poorer potential for maintaining social and economic adjustments.

Thirty patients, or 51 per cent of the study group, had one or several re-admissions exclusive of the period covered by the study. This would seem to indicate that a specific group within the study group had formed a pattern of returning to the hospital upon encountering difficulty in adjustment outside of the hospital. The fact that 25 per cent of the patients left the hospital under other than desirable conditions indicates that they had benefited from maximum treatment and would be among those patients most likely to return to the hospital.

With the exception of the 25 per cent mentioned, the majority of the patients were discharged from the hospital by the recommendation of the medical staff. Veterans Administration had no control over those patients who leave the hospital before treatment is complete, and at the present time there have been no plans formulated as to how these patients can be helped.

The role and activities of the social worker in her contacts with relatives was focused mainly in areas of interpretation and discharge planning and with the patient in the area of discharge.

Those cases where there was no indication of referral might imply that the resources of the community were not available or that there had been a lack of opportunity to plan with the patients.

Since the records of the Psychiatric Service were not set up with respect to this specific study, records regarding social factors in post-discharge adjustment were not full enough to warrant valid conclusions.

The return of the larger number of patients to their previous living arrangements may indicate that their return to the hospital was influenced by the same precipitating factors as were involved in their initial admission.

There was insufficient information in the records to assess the work patterns of the total study group.

The majority of patients were re-admitted to the Psychiatric Service for emotional and somatic complaints which appeared to be mainly re-activation of their previous symptoms. An evaluation of the patients' responses upon re-admission revealed that the majority of them expressed difficulty in several areas of social adjustments. Those areas of difficulty were related to

relationships with relatives along with problems of employment and adjustment in the community.

APPENDIX

SCHEDULE

1. Identifying Information:

Name _____ Age _____ Marital Status _____

Religion _____ Racial Origin _____ Service connected for emotional illness _____

Veteran of W.W.I. _____ W.W. II _____

2. Period of Hospitalization

Diagnosis _____

Treatment: _____

Convulsive Therapy _____
Psychotherapy _____
Combination _____
Other _____

Duration of Hospitalization: Less than three months_____less than six months_____ 6 months to one year _____ one year to two years _____ over two years _____

Type of Discharge

Against medical advice _____
Trial Visit _____
Maximum hospital benefits _____
Elopement _____

Social Service contact with patient's relatives

Modification of attitude _____
Interpretation _____
Discharge plans _____
Number of interviews with relatives _____
Other _____

Social Service contact with patient

Services relative to administrative procedures _____
Continued service with patient as therapist _____
Discharge _____
Number of interviews _____

Waspatient referred for service to the community

Financial assistance _____
Vocational Counselling _____
Psychiatric care _____
Other _____

3. Living and Economic arrangements available to patient after discharge

Was patient returned to previous living arrangements _____

Old neighborhood _____
New neighborhood _____
With wife _____
With children _____
With parents _____
Other _____

Did patient return to previous employment

Professional _____
Business or white collar _____
Skilled _____
Semi-skilled _____
Labor _____

Was patient employed: Full time _____ Part time _____ Unemployed _____

4. Factors involved in patient's re-admission to the Neuropsychiatric Ward

Length of time involved between periods of hospitalization: Less than three months _____ Less than six months _____ Six months to one year_____ One year to two years_____ Over two years _____

Upon re-admission did patient express inability to get along

Old neighborhood _____
New neighborhood _____
With wife _____

With children _____
With parents _____
Other _____

Did patients' relatives express their inability to get along with patient _____ in neighborhood _____ with wife _____ parents _____ children _____ other relatives _____

Did patient express dissatisfaction with employment _____ professional _____ business and white collar _____ skilled _____ semi-skilled _____ labor _____

Did patient follow up on referral

Financial assistance _____ Vocational Counselling _____ Psychiatric care_____ Other _____

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