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A survey of readmissions to the Veterans Administration Hospital, Bedford, Massachusetts: Part III - A study of selected social and medical factors associated with seventy readmissions at the Bedford Veterans Administration Hospital from July to September, 1949.

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BOSTON UNIVERSITY  
SCHOOL OF SOCIAL WORK

A SURVEY OF READMISSIONS  
TO THE VETERANS ADMINISTRATION HOSPITAL  
BEDFORD, MASSACHUSETTS

Part III

A STUDY OF SELECTED SOCIAL AND MEDICAL FACTORS  
ASSOCIATED WITH SEVENTY READMISSIONS AT THE  
BEDFORD VETERANS ADMINISTRATION HOSPITAL FROM  
JULY TO SEPTEMBER, 1949

A Thesis

Submitted by

Harriet Charlotte Belson

(B.S., Simmons College, 1949)

In Partial Fulfillment of Requirements for  
The Degree of Master of Science in Social Service

1951

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## CHAPTER I

## INTRODUCTION

Scope of the Problem of Readmissions

The problem of readmissions is related to the larger problem of the need for more public facilities for psychiatric patients. This need is shown in the fact that in 1949 there were only 680,913 neuropsychiatric beds for an estimated 8,500,000 psychiatric cases in the United States.<sup>1</sup> And despite the fact that the Veterans Administration is constantly expanding its hospital facilities for treating psychiatric disorders, despite the fact that in 1947, out of approximately 18,000,000 veterans of both World Wars in the United States there were more than 50,000 being treated in Veterans Administration Hospitals for psychiatric conditions,<sup>2</sup> there still remain many more veterans in need of psychiatric care than there are facilities to meet these needs.

One approach to the alleviation of this problem is the attempt to reduce the number of readmissions to neuropsychiatric hospitals. The extent of the general problem of readmissions in the United States and the specific problem of readmissions at the Bedford Veterans Administration Hospital may

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<sup>1</sup>Group For The Advancement of Psychiatry, Statistics Pertinent to Psychiatry in the United States, Report No. 7, March, 1949.

<sup>2</sup>Veterans Administration, Review of the Month, Branch Office No. 1 Monthly Progress Report, p. 2.

be highlighted by a few pertinent facts. In 1947, out of 25,666 admissions to public mental hospitals in Massachusetts, 14,376 were first admissions, 11,290 were readmissions.<sup>3</sup> Of the eleven hospitals whose patients contributed to these admissions, four had a patient population consisting of more readmitted than newly admitted patients. Bedford was included among these four.

In 1949, the year in which the patients in this study were readmitted, Bedford had a total of 389 admissions. Of these, 227 were new admissions and 162 were readmissions. If to the number of readmissions, the 131 patients who were returned from trial visit in the community are added, it is seen that there were in Bedford during this year 293 instances of rehospitalization of patients, more than the number of first admissions to the hospital.

#### The Group Study of Readmissions: Parts I and II

This study is Part III of a group study of the problem of readmissions at Bedford Veterans Administration Hospital. In Parts I and II, A. Loring Macalaster<sup>4</sup> and Robert A. Redding<sup>5</sup>

<sup>3</sup>Figures in the files of The Massachusetts Department of Mental Health.

<sup>4</sup>Macalaster, A. Loring, A Survey of Readmissions to the Veterans Administration Hospital Bedford, Massachusetts, Part I, Unpublished Master's Thesis of Simmons College School of Social Work, 1950.

<sup>5</sup>Redding, Robert A., A Survey of Readmissions to the Veterans Administration Hospital, Bedford, Massachusetts, Part II, Unpublished Master's Thesis of Simmons College School of Social Work, 1950.

undertook as their purpose

to evaluate selected medical and social factors involved in the readmissions of patients to Bedford Veterans Administration Hospital...also ...to shed light on the general problem of re-admissions and to serve as the basis for more focalized studies of readmitted patients.<sup>6</sup>

For their studies, Mr. Redding and Mr. Macalaster used all the patients who were readmitted to Bedford from either discharge or trial visit status from January 1, to June 30, 1949. Mr. Macalaster studied the first seventy-five cases, Mr. Redding the last seventy-four. They made a primarily quantitative study of the following factors associated with the readmissions:

- a) identifying data about the readmitted patients including age, war of service, pension status, competency, and diagnosis;
- b) medical factors concerning the patients including length of illness, number of previous hospitalizations, and treatment received from the various hospital services;
- c) social factors associated with the readmissions including the kinds of pre-release preparation by Social Service, the services given by the social worker in trial visit supervision, the nature of the patients' adjustment while in the community; and
- d) factors immediately associated with the readmissions seen in terms of precipitating factors in the breakdown and immediate reasons for rehospitalization.

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<sup>6</sup>Ibid., p. 2.

A compilation of the findings of Parts I and II prepared by Mr. Charles L. Rose of the Bedford Hospital Social Service Staff is included in the appendix of this study.

The Group Study of Readmissions: Parts III and IV

Parts III and IV of the group study have been undertaken by Nelson Woodfork<sup>7</sup> and this writer. The cases selected for Parts III and IV include all of the patients readmitted to Bedford from July 1 to December 31, 1949. This writer has studied the readmissions from July through September--seventy readmissions--and Mr. Woodfork has studied the readmissions for October, November, and December--seventy-four readmissions. The 144 readmissions during this six month period actually includes only 132 patients, since ten patients were admitted twice during the six month period and one, three times. Ten patients were readmitted once during the first three months studied and once during the second three months; one was readmitted twice during the first three months and once during the second three months; one was admitted twice in the first three months. Thus the seventy readmissions studied by this writer includes only sixty-eight patients.

It should be noted that although officially, readmitted patients are defined as patients who have previously been

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<sup>7</sup>Woodfork, Nelson C, A Survey of Readmissions to the Veterans Administration Hospital, Bedford, Massachusetts, Part IV, Unpublished Master's Thesis of Boston University School of Social Work, 1951.

discharged from Bedford, in keeping with Parts I and II this study includes as readmissions patients who returned to the hospital from trial visit status. For the purposes of this study a readmitted patient is defined as a patient who, having been considered improved in his illness by the medical staff, had been given an opportunity to live in the community on trial visit or discharge status and was later returned to the hospital. In the light of this definition, patients returned from elopement status were not included in this study, since these patients were not judged by the medical staff as well enough to reside in the community.

The material used here has been gathered from clinical records, nurses' notes, registrar's records, records of the Physical Medicine Rehabilitation Service, records of the Vocational Rehabilitation and Education Service, and Social Service records.

The clinical records were used to find information about the patient's previous hospitalizations, medical treatment, diagnosis, and reports on the patient's adjustment in the hospital. The nurses' notes in most cases yielded a further and occasionally more detailed picture of how the patient adjusted on the wards. From the registrar's records, such identifying data as the patient's age, war of service, religion, marital status, pension status was obtained. The Physical

Medicine Rehabilitation Service records indicated whether the patient had attended the activities offered by this service (which shall be described in chapter II) and often offered a further picture of the patient's behavior in respect to these activities. The Vocational Rehabilitation records told whether the patient had received the benefit of the vocational and educational services of this unit. And finally, a record of social work activity during the patient's hospitalization and after his release, and a description of his adjustment during his residence in the community, was yielded from the Social Service files.

The data for this study was obtained by means of a schedule which is included in the appendix. Case material was chosen which the writer felt to be illustrative of and containing sufficient descriptive data for brief qualitative analysis of the quantitative findings.

The questions listed in the schedule reflect the purpose of Parts III and IV in their relationship to the group study. The primary purpose of Parts III and IV has been to collect data which may contribute toward answering the questions raised in the group study: What are some of the medical and social factors which have contributed to the readmissions and how have they contributed to the readmissions? The group study lays special emphasis on the part social work has played and can play in helping the patient stay out of the hospital, how

social work may help to prevent or widen the intervals between readmissions.

The data collected in Parts III and IV cannot in itself answer the questions raised in the total study. These contributory studies can only hope to supply quantitative data which may have some bearing upon these questions. Parts III and IV can only show what the characteristics of some of the readmitted patients were and what was and what was not done for them in the way of hospital treatment. These studies may perhaps be able to show whether there were any differences in characteristics and treatment received between patients who returned within a few months and patients who were able to remain in the community for longer periods of time.

For purposes of statistical validity, Parts III and IV of the group study have used the same criteria for evaluation of data, the same classifications of material, and the same specific questions that were used in Parts I and II. However, Mr. Woodfork and this writer have included some specific questions which were not included in the previous studies and which, it was felt, might contribute towards answering the general questions of the study. The questions added in Parts III and IV include a limited attempt to measure attitudes and movement, and concern the patient's attitude toward leaving the hospital, an attempt to evaluate movement in the casework

with the patient during trial visit, and an attempt to evaluate the patient's hospital adjustment prior to his release.

#### Other Studies in the Group Study of Readmissions

To complete the group project and to contribute toward answering the questions raised by the group study, four more studies have been undertaken. Miss Martha Shaber<sup>8</sup> and Mr. Edward W. Sterling<sup>9</sup> have done control studies of 150 patients who remained in the community for two or more years after being released from Bedford. They have used essentially the same questions and classifications as were used in Parts I, II, III, and IV for the purposes of comparative study. In addition, Miss Olga J. Vessel<sup>10</sup> and Mr. Raymond A. Koleski<sup>11</sup> have done

<sup>8</sup>Shaber, Martha, A Study of Seventy-Five Patients Who Left the Veterans Administration Hospital, Bedford, Massachusetts, and Remained in the Community at Least Two Years, Part I, Unpublished Master's Thesis of Simmons College School of Social Work, 1951.

<sup>9</sup>Sterling, Edward W., A Study of Seventy-Five Patients Who Left the Veterans Administration Hospital, Bedford, Massachusetts, and Remained in the Community at Least Two Years, Part II, Unpublished Master's Thesis of Simmons College School of Social Work, 1951.

<sup>10</sup>Vessel, Olga J., A Study of the Factors Contributing to the Readmissions of World War II Veterans Who Have Been in the Community at Least Six Months as Seen in a Study of Five Cases at the Veterans Administration Hospital, Bedford, Massachusetts, Unpublished Master's Thesis for Boston College School of Social Work, 1951.

<sup>11</sup>Koleski, Raymond A., Problems Encountered in Trial Visit Supervision of Patients Between the Ages of Fifty and Sixty-Five Who Have Been Readmitted to the Veterans Administration Hospital, Bedford, Massachusetts, for 1949, Unpublished Master's Thesis for Boston College School of Social Work, 1951.

qualitative studies of five readmitted patients each, each five representing a different age group, in order to study more intensively the ways in which such factors as the patient's illness, attitudes and hospital treatment, family and community attitudes, and casework preparation and supervision in the community may affect readmissions.

#### Limitations of Part III of the Group Study

Limitations of this study involve limitations of scope, due to limitations in method, and material. In scope, this study cannot presume to determine the causative factors in readmissions. The primarily quantitative method employed here can show only whether or not there is a relationship between these factors and the readmissions, but just how these factors are significant, in what ways they are interrelated and contribute to the readmissions would require for analysis a more extensive qualitative study than can be attempted here. A brief qualitative analysis of some of the social work factors has been included because this study is focused primarily upon the part social work has played and can play with the readmitted patient.

This emphasis upon the part social work plays limits the extent to which other factors which may have an equal bearing upon the problem of readmissions may be investigated or stressed. For example, a more extensive and intensive

study of the problem of readmissions might further analyze the development and progress of the patient's illness in dynamic rather than descriptive terms; it might wish to explore further the patient's response to the medical and ancillary treatment he received; it might study more carefully the interrelationships between the patient and parents, spouses, siblings, between the patient and his employer and co-workers, between the patient and the community; it might investigate further the emotional conflicts as well as the environmental stresses which precipitated the readmissions.

Finally, the records from which this data was gathered have not been kept primarily for research on the readmission problem: in many instances they are brief and do not distinguish between what occurred and the recorder's evaluation of what occurred. Therefore, only such factors could be studied as could in most cases be found in the available records. And since the information used in this study was gathered from so many sources including so many people's impressions and subjective evaluations, only such material could be studied as was least likely to be colored by the subjectivity of its recorders. Thus it is seen why a more extensive investigation of attitudes and movement could not be made: these factors are least likely to be recorded and most difficult to evaluate objectively from the material available.

## CHAPTER II

SERVICES AND PROCEDURES AT BEDFORD<sup>1</sup>Patients Receiving Care

The Veterans Administration Hospital at Bedford was established in 1928 for the care and treatment of veterans with nervous and mental diseases. Since 1947, facilities have been available for the treatment of women as well as men. As of December 31, 1949, 4 per cent of the hospital population was female.

Beds at Bedford are available in the following order to a) emergency cases, b) veterans with service-connected disabilities, c) veterans with non-service connected disabilities. A service-connected disability is one which results from a disease or injury incurred in or aggravated by military or naval service in the line of duty. In addition to treatment or hospitalization, when indicated, for the physical or mental disability, the veteran receives a monthly pension, or compensation, which is given in accordance with the degree of disability rated in multiples of 10 per cent and ranging from \$15 to \$150 monthly. This pension may be increased or reduced as the disability is lessened or increased.

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<sup>1</sup>The information in this chapter has been taken from the following publications: Veterans Administration Hospital, Bedford, Massachusetts, The Oval Mirror, Twentieth Anniversary 1928-1948, May, 1948, and Handbook of Information, September, 1949, as well as from interviews with hospital personnel and the writer's own knowledge of the hospital.

In order to receive a pension for a non-service connected disability--for a disability not incurred in or aggravated by active service--the veteran must be permanently and totally disabled and credited with ninety days or more service. For a non-service connected disability, the veteran receives a fixed monthly pension of \$60.<sup>2</sup>

#### Commitment to and Release From Bedford

Patients are committed to Bedford under the laws of the state from which they are committed. Commitments are of three types: voluntary commitment, temporary commitment, and regular commitment. In the voluntary commitment, the patient alone requests hospitalization for himself and may request his own discharge. If the members of the medical staff do not feel that the patient is ready for discharge, they must arrange for a temporary or regular commitment.

Temporary commitments are for ten or thirty days for the purpose of observation and study of the patient. The ten day commitment requires the signature of someone in the legal or medical profession; the thirty day commitment requires a court order signed by the judge of the probate court. Under temporary commitments, the patient must be released at the end of the designated period of time. Again, if the medical staff

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<sup>2</sup>Veterans Administration Information Service, Federal Benefits Available to Veterans and Their Dependents as of October 15, 1950.

does not feel that the patient is ready for discharge at this time, they must arrange for another commitment.

Regular commitment is for an indefinite period of time. It requires a court order and the signature of two doctors outside of the hospital.

In all forms of involuntary commitment, the patient's relatives must either request or consent to commitment.

The patient may leave the hospital by trial visit, elopement (escape), medical discharge, discharge against medical advice, and transfer to another hospital. In trial visit, the patient is given an opportunity to see how well he can adjust in the community under the supervision and help of the social worker. The patient is usually discharged at the end of a year's trial visit if he has made an adequate adjustment in the estimate of the social worker and the patient's doctor.

In modes of release other than trial visit, the hospital does not usually take further responsibility for the patient--except of course in the instance of elopement when every effort is made to have the patient returned to the hospital. Occasionally, a patient who adjusts well during the time he is on elopement status may be put on trial visit status or he may be discharged when he does not return. Discharges not preceded by trial visit usually take place when the patient is on a voluntary or temporary commitment. Although the hospital is

not officially responsible for discharged patients, social work supervision which has been started before discharge is sometimes continued when it is felt that further casework help by the worker will benefit the patient.

Discharge may be against medical advice when the relative requests the discharge of a patient who the hospital feels may benefit from further hospitalization. The hospital may refuse the request of a relative for a patient's discharge when it is felt that the patient would be dangerous to himself or to others in the community, as when the patient is considered to be homicidal or suicidal.

Finally, patients are discharged when they are transferred to other hospitals.

#### Treatment Facilities at Bedford

The hospital provides various facilities which aid in the care and treatment of the patient. Definitive treatment and psychiatric treatment for the patient's illness includes electro-shock therapy, insulin shock therapy, lobotomy, and psychotherapy. These treatments are prescribed by the medical staff on the basis of such factors as the patient's response to previous treatment for mental illness, the nature of the illness, the length of the illness, and age.

The Physical Medicine Rehabilitation Service provides the following services for the rehabilitation of the patient

while he is in the hospital:

a) Physical Therapy concerns itself with the management of the disease by physical agents such as heat, light, electricity, water, and mechanical apparatus.

b) Corrective Therapy includes systematic progressive exercises and activities, individually administered, designed to aid the patient in both social and physical correction and adjustment.

c) Occupation Therapy is available in six shops and provides activity, mental and physical, for the specific purpose of contributing to or hastening the patient's recovery.

d) Educational Therapy offers numerous courses either as refresher study or in preparation for a trade or occupation.

e) Manual Arts Therapy utilizes at the pre-vocational level projects of an industrial, agricultural, or trade nature, into which a patient enters to explore the possibilities and determine the feasibility of continuing such activities as a post-hospital vocation with economic possibilities, or as a field for further training through the opportunities afforded by Vocational Rehabilitation.

The Vocational Rehabilitation and Education Service helps, in conjunction with the other hospital services, to prepare the patient for functioning in the community by helping him with his choice of a vocational or educational objective.

This service offers the patient tests to determine his interests and abilities, information concerning his educational entitlements under government laws, and advice and counselling in locating a suitable job.

Patients who have been more recently hospitalized at Bedford are more likely to have been helped by Social Service, since the department has grown from one worker before the second World War to today's staff of eleven trained social workers and six second-year student social workers. The social worker now attempts to have at least one interview with each patient at the time of his admission to make known to him the services of the hospital which are available to him and to relieve his fears and problems connected with his hospitalization. The social worker may continue to be active with the patient while he is hospitalized as problems arise concerning his hospital adjustment, his family, or his finances.

The social worker, from the beginning, works not only with the patient, but with his relatives who are concerned about him and to whom he may eventually return. Relatives are seen at the earliest opportunity for as many contacts as may be needed by the social worker to interpret hospital services and procedures to them and to reduce their anxiety about the patient's hospitalization. When the patient is himself unable to supply the information about his past history which is

needed by the medical staff to facilitate treatment, the social worker will seek this information from the relatives.

Since social work treatment always has as its long term goal the patient's return to the community, the social worker, from his beginning contacts with the patient and his family is evaluating the home situation and preparing the family for the eventual return of the patient. However, the worker's contacts in the months prior to trial visit or discharge may be more specifically focused on pre-release preparation--handling the patient's fears about leaving the hospital, facing with him the problems he will meet in returning to his family, friends, and job, enlisting the relatives' cooperation in helping the patient while he is home, helping the relatives to modify attitudes which are unfavorable to the patient. Finally, the social worker sees the patient and his family regularly while he is on trial visit to assist the patient in his problems of readjustment to the community.

#### Other Services and Personnel

In addition to these services directed specifically at the treatment of the patient's psychiatric illness, the hospital provides recreational services which serve to stimulate and provide an outlet for the patients' energies and interests. This recreational program includes such activities as supervised group and individual sports, moving pictures,

parties, dances, picnics, sightseeing trips, hobby clubs, patients' orchestra and glee club, the hospital magazine, radio, television, and professional and amateur entertainment. Recreational opportunities are provided both for the more disturbed patients who are confined to the wards and to the improved patients who are permitted the freedom of the hospital grounds.

Finally, the hospital has many more personnel as nurses, dieticians, attendants, volunteers, who give additional service to provide for the patients' well being, and who may create the emotional tone--the warmth and friendliness--of the hospital which is in itself considered to be beneficial in the patients' recovery.

## CHAPTER III

IDENTIFICATION AND DESCRIPTION OF THE PATIENT  
AND HIS ILLNESS

In order to identify the situations and illnesses of the patients under study, in this chapter a statistical examination has been made of the group with regard to sex, age, marital status, religion, war of service, pension status, diagnosis, length of illness, and hospital treatment. Wherever the figures were available, these patients have been compared in these respects with the Bedford Hospital population as a whole or with a random sample of first admitted patients to Veterans Administration hospitals, in order that a better perspective might be gained of the readmitted patients in their relationship to the total group of veterans with psychiatric illnesses requiring hospitalization. Since in this chapter the patients themselves are of more interest than the readmissions, the data has been presented on the basis of the number of patients--sixty-eight--rather than the number of readmissions--seventy.

Sixty-three, or 93 per cent of the readmitted patients, were male; five, or 7 per cent, were female. As of December 31, 1949, 4 per cent of the total population of the hospital was female--a very slightly smaller proportion than existed among the readmitted patients.

The age range of the patients under study, as of the dates of their readmissions, was from eighteen to sixty-two, with 40 per cent, twenty-eight patients, between the ages of thirty and forty. Fifty-four patients, 65 per cent of those studied, were below the age of forty.

TABLE I

AGE DISTRIBUTION OF SIXTY-EIGHT PATIENTS ADMITTED TO THE VETERANS ADMINISTRATION HOSPITAL, BEDFORD, MASSACHUSETTS, JULY TO SEPTEMBER, 1949

Age Groups	Number
Total	68
Under 20 years.....	1
20 to 24 years.....	8
25 to 29 years.....	7
30 to 34 years.....	17
35 to 39 years.....	11
40 to 44 years.....	5
45 to 49 years.....	7
50 to 54 years.....	10
55 to 59 years.....	1
60 to 64 years.....	1

TABLE II

MARITAL STATUS OF THE PATIENTS

Status	Number
Total	68
Single.....	44
Married.....	18
Divorced.....	3
Separated.....	3

Forty-four, or 65 per cent of the readmitted patients, were single, eighteen patients were married, three were divorced, and three were separated. As to their religion, forty-nine patients, or 72 per cent of those studied, were Catholic; seventeen, or 25 per cent, were Protestant; and two, or 3 per cent, were Jewish.

TABLE III

WAR SERVED BY  
THE PATIENTS

War Served	Number
Total	68
World War I.....	19
World War II.....	44
Peacetime Veteran.....	5

TABLE IV

PENSION STATUS OF  
THE PATIENTS

Type of Pension	Number
Total	68
Service-connected.....	54
Non-service connected.....	6
None.....	8

Forty-four, or approximately two-thirds of the patients, had served in World War II, nineteen had served in World War I, and five had served in the peacetime army. These figures show a reversal of the figures of the hospital as a whole. Approximately one-third of the hospital patients on December 31, 1949 were World War II veterans and almost two-thirds were World War I veterans.

Examining the pension status of the readmitted group, fifty-four, or four-fifths, were found to be receiving service-connected pensions, six were receiving non-service connected pensions, and eight were receiving no pensions. In contrast

with these figures, in a 30 per cent sample of patients admitted to Veterans Administration hospitals during April, 1948, three-fourths were found to be non-service connected.<sup>1</sup>

TABLE V

DISABILITY FOR WHICH THE SERVICE-CONNECTED  
DISABILITY WAS AWARDED TO PATIENTS

Disability	Number
Total	54
Physical Disorder.....	3
Psychoneurosis.....	11
Psychosis.....	40

Of the fifty-four patients receiving service-connected pensions, forty, or 74 per cent, were receiving them for psychoses. The remaining 26 per cent were service-connected for psychoneuroses (eleven patients), or for physical disorders (three patients).

Table VI shows the breakdown of the patients according to diagnosis. For the purposes of consistency, diagnosis here refers to the diagnosis of the patient at the time of his last release from Bedford prior to the readmission under study. This diagnosis is taken rather than the preliminary diagnosis which may in some instances be different, since the writer is most interested in what the patient was diagnosed at the time he left for the community.

<sup>1</sup>Veterans Administration, Department of Medicine and Surgery, "A Study of the Duration of Hospitalization and Re-admission Rates of a Group of Psychiatric and Neurologic Patients," Information Bulletin, Psychiatry and Neurology Division Issue, No. 10-5-23, January, 1951.

TABLE VI  
DIAGNOSTIC DISTRIBUTION OF THE PATIENTS<sup>2</sup>

Diagnosis	Number	
Total		68
I Psychoneurotic disorders		
A. Anxiety reaction.....	2	
B. Conversion reaction.....	0	
C. Depressive reaction.....	0	
D. Dissociative reaction.....	<u>1</u>	3
II Character and behavior disorders		
A. Pathological personality types.....	0	
B. Immaturity reactions.....	<u>2</u>	2
III Alcoholic intoxication and drug addiction....		
A. Alcoholism		
1. Acute.....	2	
2. Chronic.....	3	
B. Drug Addiction		
1. Barbiturates.....	<u>1</u>	6
IV Psychoses without known organic etiology		
A. Schizophrenic disorders		
1. Simple type.....	5	
2. Hebephrenic type.....	4	
3. Catatonic type.....	11	
4. Paranoid type.....	18	
5. Unclassified type.....	6	
6. Mixed type.....	1	
7. Latent type.....	2	
B. Affective disorders		
1. Manic-depressive, depressive type.....	0	
2. Manic-depressive, manic type.....	2	
3. Manic-depressive, circular type.....	1	
4. Involutional melancholia.....	<u>2</u>	52
V Psychiatric conditions with demonstrable etiology or associated structural changes		
A. Infections		
1. General Paresis.....	2	
B. Intoxications		
1. Chronic alcoholism with psychotic reaction	3	
C. Trauma		
1. Encephalopathy.....	0	
D. Convulsive disorders		
1. Epilepsy.....	<u>0</u>	5

<sup>2</sup>Veterans Administration, Nomenclature of Psychiatric Disorders and Reactions, Technical Bulletin 10A-78, October 1, 1947.

Forty-seven patients, or 69 per cent of the group, carried a diagnosis of schizophrenia. The next largest group of readmitted patients were the eight alcoholics. Three of these suffered from a psychotic reaction with deterioration. Of the thirteen remaining patients, three suffered from psychoneurotic disorders, two from character and behavior disorders, one from barbiturate addiction, five from affective disorders, and two from tertiary syphilis.

An attempt was made to discover whether there was a relationship between the patient's diagnosis and the length of time he was able to remain in the community after his last hospitalization before his readmission. The results are shown in Table VII. Sixty-five per cent of all the readmitted patients, forty-three patients, were unable to remain in the community more than five months. The largest proportion of patients able to remain out of the hospital for a year or more occurred in the schizophrenic group. Thirty-two per cent of the schizophrenics, fifteen out of forty-seven patients, remained in the community twelve months or longer. Only 14 per cent of the patients with other diagnoses, three out of twenty-one patients, were able to stay out of the hospital for a year or longer. The schizophrenic classification also included four out of the five patients who remained in the community for two or more years.

TABLE VII

DIAGNOSTIC DISTRIBUTION OF THE PATIENTS AND THE LENGTH OF TIME  
THEY REMAINED IN THE COMMUNITY

Diagnosis	Total	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	68	28	15	4	3	6	4	3	0	5
Psychoneurotic disorders	3	1	2	0	0	0	0	0	0	0
Character and behavior disorders	2	1	0	1	0	0	0	0	0	0
Alcoholic intoxication and drug addiction	6	4	0	1	0	1	0	0	0	0
Schizophrenic disorders	47	19	10	1	2	5	4	2	0	4
Affective disorders	5	2	2	0	0	0	0	1	0	0
Psychiatric conditions with demonstrable etiology and/ or associated structural changes	5	1	1	1	1	0	0	0	0	1

TABLE VIII  
 NUMBER OF PREVIOUS HOSPITALIZATIONS FOR MENTAL  
 ILLNESS UNDERGONE BY THE PATIENTS

Number of Hospitalizations	Number of Patients
Total	68
1.....	5
2.....	26
3.....	16
4.....	9
5.....	7
6.....	0
7.....	2
8.....	0
9.....	2
10.....	0
Over 10.....	1

Two indicators were used to show the length of time the patients had been ill: the number of hospitalizations he had had prior to his readmission, and the number of years he had been hospitalized. Both of these were used since some patients were hospitalized for many years in one or two hospitals, whereas other patients, especially among the alcoholics, were hospitalized numerous times for very brief periods of time. For example, one patient, an alcoholic, had nine different hospitalizations, but the total time spent in hospitals amounted to only one year; a second patient, a schizophrenic unclassified, spent twenty-five years in four hospitals; a third patient, a paranoid schizophrenic, was hospitalized nine times and had nine years of hospitalization.

In counting hospitalizations, all hospitalizations which occurred while the patient was in the armed forces are counted as one, since during this time the patient was often frequently moved from one hospital to another and the number of moves does not always appear in the patient's record.

The number of previous hospitalizations as seen in Table VIII on page 26 ranged from one (one patient) to sixteen (one patient). Forty-two patients, or 62 per cent of the group, had had two or three previous hospitalizations prior to their readmissions; only five patients had had over five previous hospitalizations.

The number of years spent in hospitals for mental illness ranged from less than six months (nine patients) to over fifteen years (two patients). The largest concentration of patients, fifty-three patients, comprising 78 per cent of the group, came between six or less months and four years. Nine patients had had six or less months of hospitalization; fifteen had approximately one year; eleven, approximately two years; eight, approximately three years; and ten, approximately four years. The remaining fifteen patients, or 22 per cent of the total number of patients, were about equally spaced over a period of from five to fifteen or more years of hospitalization.

Table IX shows the time the patients spent in the community before their readmissions in relation to the number of years they had been hospitalized. There seems to be very little relationship in this group of patients between length of

TABLE IX

NUMBER OF YEARS OF HOSPITALIZATION AND LENGTH  
OF TIME THE PATIENTS REMAINED IN THE COMMUNITY

Number of Years	Total	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	68	28	15	4	3	6	4	3	0	5
6 or less months	9	3	3	0	0	1	0	1	0	1
1 year	15	4	5	1	1	1	1	0	0	2
2 years	11	8	1	0	0	0	0	1	0	1
3 years	8	2	3	1	1	0	1	0	0	0
4 years	10	4	1	0	1	2	1	1	0	0
5 years	2	1	0	1	0	0	0	0	0	0
6 years	0	0	0	0	0	0	0	0	0	0
7 years	3	1	0	1	0	1	0	0	0	0
8 years	3	2	0	0	0	0	1	0	0	0
9 years	2	1	0	0	0	0	0	0	0	1
10 years	0	0	0	0	0	0	0	0	0	0
11 years	2	2	0	0	0	0	0	0	0	0
12 years	0	0	0	0	0	0	0	0	0	0
13 years	1	0	0	0	0	1	0	0	0	0
14 years	0	0	0	0	0	0	0	0	0	0
15 years and over	2	0	2	0	0	0	0	0	0	0

hospitalization and time spent in the community.

TABLE X

DEFINITIVE TREATMENT GIVEN THE PATIENTS DURING THEIR  
LAST HOSPITALIZATION FOR THEIR PSYCHIATRIC CONDITIONS

Kinds of Treatment	Number
Total	68
Electric Shock Therapy.....	10
Insulin Shock Therapy.....	1
Lobotomy and electric shock therapy.....	2
Psychotherapy.....	4
Psychotherapy and insulin shock therapy.....	2
Without definitive treatment.....	49

In investigating the extent of medical treatment received by the readmitted patients during their last hospitalization (Table X) it is seen that 72 per cent of the patients, forty-nine patients, received no definitive treatment, psychiatric or somatic, for their mental illnesses. Of the nineteen patients whom the medical staff chose to give definitive treatment, ten received electric shock therapy; one insulin shock therapy; two, lobotomy and electric shock therapy; four, psychotherapy; and two, psychotherapy and insulin shock therapy. The number who received psychotherapy may actually be somewhat higher, as psychotherapeutic interviews are not always recorded by the medical staff.

Table XI gives an overall picture of the combined treatments from medical and ancillary services of the hospital

TABLE XI

TREATMENT FROM MEDICAL AND ANCILLARY SERVICES GIVEN THE PATIENTS DURING THEIR LAST HOSPITALIZATION AND LENGTH OF TIME THE PATIENTS REMAINED IN THE COMMUNITY

Services	Total	0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	68	28	15	4	3	6	4	3	0	5
Med. <sup>a</sup>	1	0	1	0	0	0	0	0	0	0
Med. and V.G. <sup>b</sup> and S.S. <sup>c</sup>	1	1	0	0	0	0	0	0	0	0
None	1	0	0	0	0	1	0	0	0	0
P.M.R.S. <sup>d</sup>	6	3	1	2	0	0	0	0	0	0
P.M.R.S. and Med.	1	1	0	0	0	0	0	0	0	0
P.M.R.S. and Med. and V.G.	0	0	0	0	0	0	0	0	0	0
P.M.R.S. and Med. and S.S.	7	3	0	0	1	1	0	1	0	1
P.M.R.S. and V.G.	4	3	1	0	0	0	0	0	0	0
S.S.	7	0	1	0	1	1	1	0	0	3
S.S. and Med.	1	0	1	0	0	0	0	0	0	0
S.S. and P.M.R.S.	18	5	4	1	1	2	3	1	0	1
S.S. and P.M.R.S. and V.G.	10	4	4	1	0	0	0	1	0	0
S.S. and P.M.R.S. and V.G. and Med.	9	6	2	0	0	1	0	0	0	0
S.S. and V.G.	2	2	0	0	0	0	0	0	0	0
V.G.	0	0	0	0	0	0	0	0	0	0
V.G. and Med.	0	0	0	0	0	0	0	0	0	0

a. Med.-Medical treatment including electric shock therapy, insulin shock therapy, lobotomy, and psychotherapy.

b. V.G.-Vocational Rehabilitation and Education Service

c. S.S.-Social Service

d. P.M.R.S.-Physical Medicine Rehabilitation Service

that each patient received during his last hospitalization. Social Service here refers to any work the social worker did with the patient or his relatives while the patient was hospitalized. This does not include trial visit supervision, but does include pre-release preparation. A more detailed analysis of social work services to the patient in the hospital will be presented in the next chapter.

Only one patient received no medical treatment or treatment from the three ancillary services listed here. Nine received medical treatment and treatment from the three ancillary services as well. The largest number of patients receiving any one combination of treatments received treatment from both Social Service and the Physical Medicine Rehabilitation Service. Twenty-six per cent, eighteen patients, were active with these two services. The next largest group, ten patients, were treated by the three ancillary services but did not receive any definitive medical treatment. Only seven cases were known to Social Service which were not at some time during the patient's hospitalization active with some other service or services.

## CHAPTER IV

## PREPARATION OF THE PATIENTS FOR LEAVING THE HOSPITAL

Planning and preparations for the patient's release from the hospital is not the function of the Social Service department alone, but rather is usually a cooperative undertaking among the various hospital personnel--the social worker, the doctor, the Vocational Rehabilitation worker, the occupational therapist. However, a large share of the responsibility for the planning is often given to the social worker. Therefore, this chapter is concerned with the part the social worker has played in pre-release planning and preparation. In order to estimate how far the need for pre-release preparation has been met, an examination has been made of the readiness of the patient to leave the hospital at the time of his release as seen in his hospital adjustment, competency, and attitude toward leaving the hospital. The data used here and in the following chapters has been analyzed on the basis of seventy readmissions rather than sixty-eight patients so that the factors involved in each readmission of the two readmitted patients may be included, so that the total amount of social service rendered may be seen. "Patients" from this point on, therefore, means readmissions.

Social Service Pre-release Planning and Preparation

Preparation of the patient for his return to the community is in some ways not a separate activity of the social

worker but part of her goal in all of her contacts with the patient and relatives while the patient is hospitalized. However, an attempt has been made here to analyze the activity of the social worker prior to the release of the patient in which pre-release planning was the primary focus of the worker.

TABLE XII

TYPE OF RELEASE FROM THE HOSPITAL AND PRE-RELEASE PLANNING  
WITH THE PATIENTS BY SOCIAL SERVICE

Type of Release	Total	Pre-Release Planning	
		Yes	No
Total	70	39	31
Trial visit	51	36	15
Discharge	11	3	8
Elopement	5	0	5
Transfer to other hospital	2	0	2
A.M.A. <sup>a</sup>	1	0	1

a. A.M.A.-Against medical advice (discharge)

The ways in which the patients were released from the hospital are shown in Table XII in relation to whether they had some kind of planning or preparation from Social Service for this release. Fifty-one of the patients left the hospital by trial visit; eleven were discharged; five eloped; one was discharged against medical advice; and two were transferred to

other hospitals. (The patients who eloped or were transferred to other hospitals later had their status changed from elopement to either trial visit or discharge by the medical staff and are, therefore, included in this study). Of the fifty-one patients who left by trial visit, thirty-six received some kind of pre-release planning or preparation; of the eleven who were discharged, three received preparation or planning.

Forty-four per cent, thirty-one of all the readmissions received no planning or preparation from Social Service. In fifteen instances patients left on trial visit without any Social Service planning. In four of these cases, the patient had returned from a previous trial visit within three months before the present trial visit. In five cases, the doctor had been in contact with the patient and his relatives prior to the patient's release and had taken the responsibility for the planning. Little is known from the recording about the circumstances under which the other five patients left on trial visit.

Of the eight patients who were discharged without Social Service planning, seven were on temporary or voluntary commitments and had not been in the hospital over two months. All but one of these seven had a primary or secondary diagnosis of alcoholism. The circumstances under which the eighth patient was discharged are not known.

The following case summaries show different kinds of pre-release planning and preparation by Social Service:

Case I. Patient was a twenty-nine year old World War II veteran who had been hospitalized for two years at Bedford. This was his second hospitalization for catatonic schizophrenia. During his two years at Bedford he was at first hyperactive, later became untidy, depressed, and mute. Patient gradually improved, became interested in the Occupational Therapy landscaping detail, sought out other patients for discussions of current events, was allowed home for a week's leave of absence, and was considered by the doctors "cheerful and well behaved" when the case was referred to Social Service for pre-trial visit investigation of the home.

Worker interviewed patient's mother and brother, who told that they live in a three tenement dwelling in a downtown area close to movies, bowling, and other recreational opportunities. They discussed the patient's adjustment on his recent leave of absence and reported that he had been quiet and shy as he had been prior to his illness, but had enjoyed such activities as movies, and bowling with the family and had done some reading. Brother stated that he would encourage patient to join the "Y" after he had been home a month or so, that he wished to do everything possible to help him adjust. Brother expressed the opinion that mother was somewhat overprotective of him and patient.

Mother questioned worker about patient's readiness to work, feeling that the noise and pressure of patient's old mill job would be upsetting to him. Worker explained to mother that patient was not well enough to work yet, and that any job he might eventually take should be one with little pressure and requiring limited responsibility.

It was worker's impression that there was a strongly positive feeling between all

members of the family, that despite mother's concern for patient she would be able to allow him some independence of activity, that the family accepted patient's illness on the basis of his always having had to assume more responsibility than he was capable of.

Patient was released on trial visit a month later and was able to remain in the community for seventeen months with social work supervision during the twelve months before he was discharged from trial visit. He was reported to have gotten along well with his family and continued limited recreational activities as movies and bowling. After his discharge he became rather restless and expressed dissatisfaction with not being able to find a job. He was returned to Bedford when he again became mute, untidy, and depressed.

Case II. Patient was a thirty-one year old veteran of World War II carrying a diagnosis of simple schizophrenia. He had been hospitalized for six years, the last ten months at Bedford. During his Bedford hospitalization he was extremely talkative, complained of asthenia and vague feelings of pain and tingling in his body which were felt to have no organic basis. He was in good contact and worked as a clerk in the hospital and participated in recreational activities. He was referred to Social Service for pre-trial visit preparation about a year before he actually went out.

Worker saw patient on a weekly basis. Patient continually expressed feelings that the hospital was trying to get rid of him in wanting him to go out on trial visit: "He likes it in the hospital, has a good place to sleep and eat, likes his work, and has many privileges, has friends, goes to dances, and can't imagine how he could live so pleasantly on the outside." Patient felt incapable of a work or social adjustment on the outside, felt that he had little intelligence or ability. In her contacts with

him, worker recognized with him his difficulties and fears around leaving the hospital, explained that trial visit would offer him some protection in its supervision and the possibility of returning to the hospital if he did not get along well, and praised his achievements in the hospital as indicative of his ability. Patient brought up objections of having no one to whom to go because he did not get along with his stepmother, brother, or sister-in-law, of having nothing to live for as he felt incapable of meeting girls and eventually marrying. Worker suggested that she could help him to make the best possible arrangements for himself which would enable him to meet girls, to have a satisfactory job, that he need not live with his family, Patient finally agreed to try trial visit if a job could be found for him, saying that perhaps he was capable of doing well on a job and that perhaps a job might offer him sufficient satisfaction so that he would not mind so much the strain of his family relationships. At the same time, however, he continued to express many doubts about his abilities.

Patient went voluntarily to the Vocational Rehabilitation adviser in the hospital for suggestions about job possibilities. He went for job interviews which were arranged for him by the Vocational Rehabilitation adviser, but expressed the hope that he would be rejected. Patient was finally accepted as a clerk in a public utilities office. He was elated that he had been hired, but still talked of his insecurity about his ability to get along. Worker found for him a list of rooms where he might live and patient went out and found a room for himself from among these. In the two interviews with the worker which followed before he went out, patient expressed anger toward the hospital for wanting him to leave and care for himself and described feeling tense and anxious about the struggle he felt was ahead of him. But he was pleased by the prospect of supervision by his social worker while he was on trial

visit and expressed willingness to leave with the hope that she might be able to help him to get along on the outside.

Patient remained in the community for four weeks after he left the hospital. He talked of his satisfaction with his job at first, but later complained of dizzy spells and dissatisfaction with his job and insisted upon returning to the hospital.

TABLE XIII

KINDS OF ACTIVITIES BY SOCIAL SERVICE IN PRE-RELEASE PLANNING

Kind of Activity	Number
Total	57
Evaluation of home.....	28
Casework preparation of patient.....	17
Casework preparation of relative.....	12

The above table shows the kinds of activities or services the social worker performed in the cases of the thirty-nine patients who were active with Social Service for pre-release planning and preparation. No attempt has been made to show combinations of services received by each of the thirty-nine patients; the table shows rather, the number of patients receiving each separate service.

In twenty-eight of the cases in which there was pre-release planning, an investigation and evaluation of the home situation was made by the social worker. Case I shows some of the kinds of factors which the social worker looked for in

making the evaluation of the home: community resources available to the patient, patient's home adjustment on leaves of absence from the hospital as an indication of how the patient may get along with the family on trial visit, attitude of the relatives toward the patient, relatives' understanding of patient's illness. This case also indicates that in the pre-trial visit home evaluation, the worker may also give the relatives some help in understanding and preparing for the patient; in this case an interpretation was given of what the patient might be able to do vocationally. In some cases, the worker had to interview a number of relatives before one was found who was willing to take the patient and whose whom the worker gave a positive evaluation.

There were seventeen cases in which the social worker worked directly with the patient to prepare him for trial visit. In case II the worker attempted to handle the patient's dependency upon the hospital and fear of the responsibility of living in the community by a primarily supportive relationship. By supporting his ego strengths--as in focusing on his work achievements in the hospital--by reassuring him that some of his dependency needs would be met in the community through social work supervision, the worker was able to bring the patient to the point where he was able to take some initiative in seeking vocational help, in choosing a room, and in accepting a job--although with many misgivings. Although it is not clear what

actually happened when the patient was in the community, it is evident that he did not find sufficient satisfaction to meet or compensate for his dependency needs: he soon insisted upon returning to the hospital.

It is not possible to tabulate the kinds of casework help given to each patient who was prepared for trial visit. However, the casework in these seventeen cases involved help with such problems as dependency on the hospital, resistance toward trial visit supervision, and difficulties and needs in the areas of finances, employment, family relationships, relationships with people outside the family, recreational activities, and living arrangements. In some cases, the worker's primary help was through her relationship with the patient, clarifying his feelings about going out, supporting the strengths he showed, facing him with the problems he might meet in the community. In the case of one paranoid patient who wished he could become an actor although he showed no talent for this, the worker allowed him to make his own decision but attempted to clarify reality factors in his situation by pointing out his lack of preparation and skill in the field and the difficulties he might meet in trying to break into it. The patient finally decided to become a shoe salesman.

With other patients, patients who because of their strong dependency needs and poor ego strength were not able to take much responsibility for their own planning, the worker was

more active with the patient's environment, finding rooms for patients who did not live with their families, arranging for recreational activities for patients, talking with prospective employers and arranging for employment which would be suitable for the patients.

In twelve instances the worker worked with a relative to prepare for the patient's homecoming. This work involved such activities as interpretation of the patient's illness, suggestions for his supervision, attempts to relieve fears about his behavior, attempts to modify attitudes which might prove harmful to him.

It is not possible in a study of this nature to evaluate the success of pre-release casework or to analyze the ways in which it affected the patient's eventual readmission. In Case II it is seen that supportive casework over the period of a year was able only to encourage the patient to make the attempt to leave the hospital, but could not outweigh the satisfactions he got from his illness and hospitalization sufficiently to enable him to remain in the community for longer than a month. On the other hand, in Case I, the patient's home environment was sufficiently favorable, and the patient was sufficiently ready to leave the hospital at the time of his release that with no social service preparation of the patient, and only a few suggestions to the mother about employment for him, he was able, with social work supervision in the community to stay out of the

hospital for seventeen months.

#### Patient's Readiness to Leave the Hospital

Three factors have been studied which may indicate, from different points of view, the condition of the patient at the time he left the hospital. These factors are the patient's hospital adjustment at the time of his release, his competency rating, and his attitude toward leaving the hospital. Each of the seventy readmissions has been investigated here, regardless of whether pre-trial visit planning or preparation was given by Social Service.

The criteria for evaluating the patient's adjustment in the hospital just prior to his release<sup>1</sup> were formulated by Mr. Woodfork and this writer. In regard to his participation in activities, the patient was rated on a scale of "none", "limited", or "full". Since the only activities offered to the patient are the hospital recreational or Physical Medicine Rehabilitation Service activities, the patient was considered to have had "full" activity if he participated regularly in some form of Occupational Therapy or Manual Arts Therapy and at least three of the recreational activities. If he participated in less than this, but still participated in some activity or activities, he was rated "limited". "None" indicates that the

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<sup>1</sup>Clinical records, nurses' notes, Social Service files and Physical Medicine Rehabilitation Service files were studied for their reports of the patient's behavior in the month prior to his release.

patient participated in no form of recreational or rehabilitative activities. (If patient was required to attend a rehabilitation activity, but did nothing when he got there, he was also rated as "none".)

Socialization, which refers to the nature of the patient's contacts with other patients and with personnel was seen to be either positive or negative. Negative socialization indicates either no contacts with other people in the hospital--rated as, "withdrawn"--or contacts of a hostile nature, threatening, sarcastic, assaultive--rated as "overaggressive".

TABLE XIV

## PATIENT'S HOSPITAL ADJUSTMENT PRIOR TO HIS RELEASE

Participation in Activities	Number	Kind of Socialization	Number
Total	70	Total	70
Full.....	33	Negative	
Limited.....	33	Withdrawn.....	7
None.....	4	Overaggressive.....	5
			12
		Positive	
		Passive.....	26
		Active.....	25
		Unable to differentiate	3
			54
		Unknown.....	4
			4

Positive socialization is also further broken down into active and passive socialization. A patient is rated as active when he initiates contacts of a friendly nature with other persons. A patient is rated as passive when he does not initiate contacts with other persons, but responds in a friendly manner when he is approached by other persons.

It is recognized here that evaluation of a patient as "friendly", "sarcastic", "assaultive", is not entirely objective, as it is based for the most part, as is some of the other material in this study, upon the impressions of nurses, doctors, social workers, occupational therapists, rather than upon a descriptive account of the patient's behavior.

The patients were equally divided as to whether they were "full" or "limited" in their participation in activities. Thirty-three were rated as limited, thirty-three as full; only four participated in no activities. With none of the four patients who participated in no activities was there any Social Service pre-release planning or preparation. One of these patients was an alcoholic who was discharged after a month's voluntary commitment. His lack of participation in activities was due to a physical disability which kept him bedridden during most of his hospitalization. Pre-release planning was not undertaken with a second patient because he left by elopement which was later changed to trial visit. In the case of a third patient, the relatives were very concerned with his lack of im-

provement in the hospital and felt that the home environment might aid in his recovery. The relatives were seen several times by the doctor who took the responsibility for the planning. The circumstances under which the fourth patient was released are unknown.

As to their socialization, in fifty-four cases, or 71 per cent of the readmissions, the patients made a positive adjustment prior to their leaving the hospital. Again, these were about equally divided as to whether they were passive or active in their adjustment, twenty-six being passive and twenty-five active. Three patients made a positive, friendly adjustment to other persons in the hospital, but the differentiation as to whether they were "active" or "passive" in their adjustment could not be made from the limited data available.

Of the twelve patients who made a "negative" social adjustment, seven were found to be withdrawn and five over-aggressive. Of the seven who were withdrawn, two had Social Service pre-release planning. In these two cases the patients' seclusiveness was consistent with their pre-morbid personalities and was not considered by Social Service or the medical staff as a contraindication of their returning to the community since they were no longer agitated or hallucinated as they had been during much of their hospitalization.

Only one of the five overaggressive patients, described as "sarcastic and biting" in his relationships with other

patients, had had pre-release planning by Social Service. The social worker in this case had thought through with the patient what effect his overaggressiveness might have on his home and community adjustment. The patient was described as less belligerent on leaves of absence to his home than he was in the hospital, and his wife was sufficiently interested in him to give up her job to stay home and supervise him.

TABLE XV

COMPETENCY OF PATIENTS AND LENGTH OF TIME THEY  
REMAINED IN THE COMMUNITY

Time in Community	Number of Competent Patients	Number of Incompetent Patients
Total	32	38
0 to 2 months.....	15	13
3 to 5 months.....	6	10
6 to 8 months.....	1	3
9 to 11 months.....	0	3
12 to 14 months.....	3	3
15 to 17 months.....	1	2
18 to 20 months.....	2	1
21 to 23 months.....	0	0
24 months and over.....	2	3

When a patient leaves the hospital, he is rated as either competent or incompetent by the medical staff. The competent patient is considered capable of managing his financial affairs; the incompetent patient is considered incapable of handling his financial affairs. Thirty-two, or 46 per cent of the patients studied, were considered competent; the other

thirty-eight patients, incompetent, at the time of their last release from the hospital. However, there seems to be no relationship between the competency rating of these patients and the length of time that they remained in the community. Table XV shows that the proportion of competent and incompetent patients returning within each three month period is in most instances similar.

The patient's feelings about leaving the hospital at the time he was released are considered here to give some indication of the patient's desire to succeed in the community apart from the hospital's evaluation of his readiness to leave. The patients' feelings were evaluated as "positive", "ambivalent" or "negative, according to the patient's own statements of his feelings about leaving as found in the records. It is recognized that this is not an entirely accurate gauge of the patient's real feelings about leaving, as what the patient expressed to the social worker, doctor, nurse, would depend on his relationship with, his feelings toward these personnel. Again the patient may also have had feelings about going out which he himself did not recognize. It is felt that a more accurate measure of the patients' feelings would probably indicate a higher number of "ambivalents" than are found here. However, this method seems the best that can be used under the conditions of this study, as the patient's own statement is the one which is most frequently recorded.

The expressed feelings of only forty-nine of the seventy readmissions could be found. Of these, thirty-seven, or 53 per cent of the readmitted group, expressed only positive feelings about leaving. Several of these thirty-seven patients resented being hospitalized; some were repeated elopers. Others did not express negative feelings toward the hospital, but rather talked only of their eagerness to return to their homes, jobs, and friends, when these existed.

Twelve, or 17 per cent of the readmitted patients, expressed ambivalent, or both positive and negative feelings about leaving. Four of these twelve had had Social Service pre-release planning. One of these was the patient of Case II whose worker had helped him to move from completely negative feelings about leaving to some interest and desire for leaving, although a good deal of fear and reluctance about leaving still remained.

All twelve of the ambivalent patients returned within six months. Eight returned within three months.

## CHAPTER V

SOCIAL SERVICE TO AND ADJUSTMENT OF THE PATIENTS  
IN THE COMMUNITYSupervision in the Community

Forty-six, or 65 per cent of the readmissions, received supervision from Social Service on trial visit. Patients who were discharged after a year's trial visit received no supervision after that point. Of the twenty-four patients who received no supervision, seven left on trial visit, eleven were directly discharged from the hospital, three were discharged after they had eloped, one was discharged against medical advice, and two were transferred to other hospitals. The seven patients who left on trial visit and received no supervision all returned to the hospital within a few weeks--before the social worker had had a chance to make his first visit.

The following case summaries show some of the kinds of trial visit supervision:

Case III. Patient was a thirty year old latent schizophrenic World War II veteran who had become ill in the army and had been continuously hospitalized for four years, the last two months at Bedford. Patient received no medical treatment at Bedford, but was an active participant in Occupational Therapy, Physical Therapy, Educational Therapy, and social functions such as dances. However, he was considered unreliable and egotistical with poor judgment. Patient eloped twice during these two months, the second time going to the home of his cousin. A social service investigation of his cousin's home revealed that the cousin and his wife "seemed sincerely interested in

patient's welfare and recognized his limitations... wanted to include him in their recreational activities...felt it was pleasant to have the patient in their home." Patient's status was then changed from elopement to trial visit and he was allowed to remain in his cousin's home. The doctors felt that he might be able to get along in the community, but did not recommend his working.

The patient remained in the community for two months, during which time he had three interviews with his social worker. When the worker first saw him, the patient complained that the Veterans Administration and his family were plotting his downfall and taking all of his money. He complained that his cousin was paying all his bills with the patient's money, and that his cousin's wife nagged him constantly about his companions and the hours he kept. The patient wished to move to the home of a friend. The worker discussed the situation with the patient and reported that he attempted to clarify with the patient what was fact and what was fantasy. Worker felt that the patient's angry manner and many complaints were symptomatic of his emotional disturbance, that his thinking was probably paranoid. He suggested to the patient that he delay the move until worker had had a chance to speak with his cousins to see what might be done about the situation. However, before the worker had had a chance to talk with the cousins, the patient moved to the home of his friends. Worker visited the friends, felt that they seemed very interested in and concerned about patient and attempted to include him in their social activities. The friends reported that the patient seemed well and happy; he would occasionally call his cousin and chastise them about having taken his money, but generally seemed less disturbed about this. In a later contact with the patient, patient talked of being satisfied with this arrangement, felt that his friend and his friend's wife "understood him". He then brought up a series of angry complaints against such things as the Veterans Administration who had cut his compensation, Federal Civil Service that wouldn't give him a job, and having been "shell-shocked". Patient talked in a rapid,

hostile manner and worker was unable to break through and discuss any item with him. Worker again felt his manner and complaints to be indicative of his paranoid psychotic symptoms.

Patient and his friends continued to be satisfied with his adjustment. Patient participated in fishing and other recreational activities with these friends. However, patient was returned to Bedford when he went to the Veterans Administration Regional Office to see a doctor about an application he wished to make for training under Public Law 16. When the doctor suggested that he was not ready for work, patient became very angry and again began making accusations against the Veterans Administration. The doctor felt the patient to be paranoid and in need of hospitalization and arranged for his return to Bedford. At the hospital the medical staff felt that he did not seem to be in the condition the Regional Office had intimated, that although overtalkative, he seemed less paranoid than he had been prior to his release, more relaxed and agreeable. He was allowed to remain on trial visit after to weeks in the hospital.

Case IV. Patient was a fifty-six year old, paranoid schizophrenic, World War I veteran who had been hospitalized for four years at Bedford. He had had four previous trial visits during which time he was reported to have made an excellent work adjustment. However, he showed at these times some paranoid ideas toward his wife, especially that she was trying to poison him with her food, and insisted upon buying and cooking his own food. Wife would become upset by these accusations and argue with patient, threatening to call the F.B.I. and report his behavior. This led to further hostility and further accusations on the part of the patient. Eventually wife would become so upset that she would insist upon patient's return to the hospital. When patient would return to the hospital, wife would say that she felt sorry for him and again request his release. During the four trial visit periods, social workers had worked with wife. Previous workers had felt that if the wife could accept patient more, he might be

able to remain out of the hospital. At the time of the present trial visit, the social worker evaluated wife as ambivalent in her attitude--punitive and hostile toward the patient, yet concerned about the pleasures, the hunting and fishing, he was missing by being at the hospital.

During the year this patient was on trial visit, worker visited him at regular intervals. Patient would tell worker of his work as a carpet weaver at which he was doing well and of his recreational activities of playing cards and hunting which he enjoyed. He was complacent in his attitude and brought up no problems with which the worker might help him. He never brought out any paranoid thinking with the worker.

On the other hand, the wife always appeared very agitated and would continually request additional interviews with worker because of her concern about patient's behavior. She reported that he continued to fear that she and other people might poison or harm him in other ways, that the F.B.I. was after him. She said that she tried to "talk him out of" his delusions and to threaten him with returning him to the hospital. Worker reports that he attempted to interpret to wife that patient's delusions were part of his illness and to give her encouragement and support, recognizing her difficulties with patient and the attempts she was making to cope with them. Worker also pointed out to wife that her threats only served to increase patient's suspicions.

Wife made some attempts to improve the situation by accepting without protest patient's deviant behavior as eating only his own food, and for a time the arguments and tension in the home decreased. Patient soon became somewhat less suspicious of his wife and began accepting her food. However, after a few months his paranoid suspicions about his neighbors increased and he began to act upon them, going to his neighbors and accusing them of making trouble for him and wanting to hurt him. Whereas earlier the neighbors had been

willing to accept the patient, now they began complaining to the wife. The wife soon reported that the tension that this situation caused in her was intolerable and again requested that patient be returned to the hospital, stating that she needed a "vacation".

Case V. Patient was a fifty year old widow, with a diagnosis of involuntional melancholia, who had had three years of continuous hospitalization, two years of which were at Bedford. She received no definitive treatment for her illness at Bedford, but had received electric shock therapy and insulin shock therapy at another hospital.

Patient was first hospitalized when she began hearing voices and having ideas of persecution. Prior to her illness, she had been sociable and outgoing, enjoying gatherings of people. She had done some painting, enjoyed singing and acting, and had done much travelling in Europe and the United States. After her husband's death she had taken some courses in engineering draftsmanship and had worked in a defense plant.

Although during her first year at Bedford patient was somewhat apathetic and withdrawn, prior to her release she was showing active interest in hospital activities and the other patients: she did much painting, she was on an art committee, she sewed, she was a member of a discussion group, she took classes in French. Although she still occasionally heard voices, they were not especially disturbing to her.

When patient was referred for pre-release planning, she said that she was very pleased to be able to leave the hospital. Worker discussed patient's plans with her and arranged for her lawyer, who was in charge of her financial affairs, to find her a hotel apartment as a temporary living arrangement.

On worker's early visits to patient while she was on trial visit, worker found that she had been spending some time shopping, but spent most of her time close to her apartment as she

feared wandering off and getting lost. Patient expressed the desire for further activities. Patient expressed interest when worker suggested some museums she might visit and a stock company where she might do volunteer work. Patient followed through some of these suggestions; she visited museums and enrolled in a French class.

Patient, however, made no friends at first and talked of her loneliness. Worker spent much time with her on each visit as, worker felt, patient had begun to look to her as a friend. Because patient was so alone, worker accepted such things as dinner invitations from her patient which seemed to give her satisfaction. Worker continued to encourage further activity and socialization for the patient and gradually her activities increased: she began to visit neighbors in her hotel and was invited to some parties by them; she went to concerts and attended a series of lectures.

After five months, however, patient began to become more disturbed by the voices which she had continued to hear during trial visit; she began to seclude herself, she became anxious, and preoccupied and returned voluntarily to the hospital. No factors are mentioned in the record which might have precipitated this exacerbation of symptoms.

Case VI. Patient was a twenty-five year old, single, catatonic schizophrenic. He had been continuously hospitalized for seven years in three hospitals. His last four years were spent at Bedford. Four months before patient was released on present trial visit he had returned from a previous trial visit. He was felt by the social worker to have made a fair adjustment on this earlier trial visit. He had worked most of the time in the cranberry bogs near his home, but had left saying that he did not like this work but would prefer to be a ball player, chemist, or nurse-fields for which he had had no training. After leaving his job patient became sullen and uncommunicative, admitted to auditory hallucinations, and "acted like a small child--having to be told to do everything and going about his tasks in a daze."

During this trial visit, it was reported that his mother was quite willing to care for him although discouraged by his slow progress and constantly worried that he might get into difficulty. His brother and sister were quite hostile toward him, feeling that he was "no good" and constantly urging mother to have him returned to the hospital.

At the hospital, patient continued to be "seclusive, unfriendly, and withdrawn", but denied hallucinations and gradually began to show some interest in an occupational therapy work detail. He was granted a leave of absence when his mother requested this from the doctor, and this was changed to trial visit when mother reported to the doctor that his leave of absence adjustment was satisfactory.

During this trial visit, worker visited patient and his mother regularly. In his early reports worker does not indicate his own activity but describes patient's adjustment. Mother first reported to the worker that patient was working in the cranberry bogs, was visiting friends, and was quite sociable with them. However, he had been causing the neighborhood some concern by following girls home from work and attempting to kiss them, by standing on side streets and staring at lighted bedroom windows. Mother seemed to worker very tolerant of patient's behavior although a little overprotective of him.

After two months patient left his job but returned after a few days. After four months of trial visit, patient again left his job without giving any reason. Patient then became uncommunicative, seemed preoccupied, and spent most of his time reading or taking walks without any destination. He occasionally visited one friend, but ignored most of his friends. Worker attempted to discuss this situation with patient, focusing on his leaving his job and attempting to point out to him his pattern of leaving a job which he essentially enjoys whenever he meets a slight irritation. Patient again brought up job objectives which worker considered unrealistic. However, whenever the worker would say anything which the patient construed as at all critical, he would become incoherent and irrational in his speech.

Worker felt that return to work would be beneficial to patient since patient's emotional ups and downs seemed to have corresponded with whether or not he was working. Worker interviewed employers in local farms in an attempt to find work for patient. When he found a job possibility for patient, patient reported that he had obtained a job for himself as a mess attendant at an army camp. Mother reported that patient left the house each day apparently going to work, but later discovered that patient did not really have a job. Patient continued to be rather withdrawn and preoccupied although not hallucinated. He also continued to approach young girls by staring at them or asking them if they would go with him. When worker suggested to mother the possibility of patient's return to the hospital, mother was ambivalent "speaking at one moment as though return to the hospital were indicated and shortly later as if his adjustment were satisfactory and it was only the stories by townsfolk that made it seem as if he were not doing well." Patient himself felt that he was doing well, and expressed the desire to secure employment, buy a car, and get married. He was returned to the hospital at the end of a year so that his trial visit might be extended and his adjustment in the community further evaluated before it would be decided whether he should be discharged or returned to the hospital.

The forty-six patients who had trial visit supervision were first studied to see who was the primary contact of the social worker. In almost all of the cases studied, the worker at some time saw the patient and any relatives that were concerned with him. However, in almost all of the cases one person was seen more often or worked with more intensively than the other members of the family. For example, in some instances, a parent or wife was seen only to obtain reports of the patient's adjustment whereas the patient was seen to clarify his reasons for not wishing to work, or to encourage him to participate in

more activities, or to help him to see his part in arguments with his family. In other instances a patient was given help in one or two interviews, whereas a relative was seen regularly over the period the patient was on trial visit for help in understanding and supervising the patient.

In twenty-nine, or 63 per cent of the forty-six cases receiving trial visit supervision, the patient was the primary person seen by the social worker. In the remaining seventeen cases, seven parents, four husbands or wives, and three siblings were the primary contacts of the social worker. In three cases, the primary person worked with could not be isolated from the recording, as the worker reported that he had seen both the patient and relatives but did not indicate which he had seen more frequently or intensively.

TABLE XVI

PRIMARY PERSON WORKED WITH BY SOCIAL WORKER  
DURING TRIAL VISIT

Primary Person	Number
Total	46
Patient.....	29
Parent.....	7
Spouse.....	4
Sibling.....	3
Unknown.....	3

The case summaries give some indication of the bases upon which a parent or sibling or spouse or patient was chosen as the primary contact. In Case III, the relatives and friends of the patients, when visited by the worker, always indicated that the patient was getting along well, that they were satisfied with his adjustment. Since the patient, on the other hand, brought up many complaints and sources of dissatisfaction, the worker concentrated on working with him, seeing the people he lived with only to obtain their impressions of the patient in order to make a more objective evaluation of the situation. On the other hand, in Case IV, the patient was the one who brought up no difficulties to the caseworker, whereas the patient's behavior was causing great concern to the wife. Work with the wife was further indicated by the evaluation of previous social workers who had felt that if the wife's hostility toward the patient could be reduced, he might be able to remain out of the hospital.

In Case V, the patient was considered well enough by the medical staff to be allowed to live alone and was, therefore, obviously the person to be worked with.

In some cases the worker was unable to help the patient directly because he was unable to form a close relationship with, for example, a very suspicious or withdrawn patient. In these instances, if the patient had a close relationship

with a relative, the worker attempted to help the patient indirectly by giving the relatives suggestions for his supervision. In one case the patient became angry and excited and threatened to leave home when the worker suggested he spend more time in activities outside the home. However, when the patient's mother, at the worker's suggestion, encouraged the same activities, the patient was more responsive and began attending movies and ball games and going to the "Y".

Casework activities have been classified according to their spheres--the area of the patient's upon which the caseworker focused. In keeping with Parts I and II of the group study, the spheres of activity are defined as follows:<sup>1</sup>

Socialization: By socialization is meant the attempts of the social worker to become active with the patient personally on a social level, or to help the patient move into community activities other than employment and family activities.

Employment: By employment is meant the attempts of the social worker to help the patient find employment, or become established in a training program or to work through the problems of present employment situations, or to help the patient work through his feelings of not wanting to be active on an employment or training level.

Intra-familial adjustment: By intra-familial adjustment is meant the attempts of the social worker to understand, or interpret the feelings of one or more members of the family to the patient, when it is necessary to change these emotional interactions

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<sup>1</sup>Redding, op. cit., p. 38.

before the patient can attempt to resume life in the community.

Intra-familial adjustment, it would seem, also includes the attempts of the social worker to help the patient understand his own feelings which are blocking satisfactory adjustment with his family, as well as the worker's help to members of the patient's family in understanding their own and the patient's feelings and behavior in order to obtain more harmonious family interaction.

Table XVII shows the sphere or combination of spheres in which the worker was active with each of the forty-six supervised patients. "Unknown" indicates that the worker has not included his own activity in his recording. The spheres considered here are the primary sphere or spheres worked in; problems may have been brought up in other spheres, but these are not considered unless the worker made some attempt to handle them with or for the patient.

In addition to classifying these spheres, an attempt has been made to show whether there was any movement toward the casework goals in these spheres by the ratings of "some", "none", and "unknown". "Some" indicates some progress by the patient which is related to the worker's efforts and goal, no matter how slight the progress or limited the goal, and no matter whether the patient later slipped back to his original condition. "Unknown" indicates that either the patient's

TABLE XVII

SPHERES OF SOCIAL SERVICE ACTIVITY WITH THE PATIENTS IN THE COMMUNITY, MOVEMENT IN THE SOCIAL SERVICE ACTIVITY, AND LENGTH OF TIME THE PATIENTS REMAINED IN THE COMMUNITY

Activity	Total	Move- ment	Time in the Community (Months)								
			0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	70		30	15	4	3	6	4	3	0	5
None	24		19	2	1	1	1	0	0	0	0
Unknown	11		8	2	0	1	0	0	0	0	0
Emp. <sup>a</sup>	10	S. <sup>d</sup>	0	0	0	0	1	3	0	0	2
		N. <sup>e</sup>	0	1	0	1	1	0	0	0	0
		U. <sup>f</sup>	0	1	0	0	0	0	0	0	0
Soc. <sup>b</sup>	8	S.	0	3	1	0	0	0	0	0	0
		N.	0	0	1	0	0	0	1	0	0
		U.	1	1	0	0	0	0	0	0	0
Fam. <sup>c</sup>	7	S.	0	2	0	0	1	1	0	0	0
		N.	1	0	1	0	0	0	0	0	0
		U.	1	0	0	0	0	0	0	0	0
Emp. and Fam.	4	S.	0	0	0	0	0	0	0	0	1
		N.	0	0	0	0	0	0	1	0	0
		U.	0	2	0	0	0	0	0	0	0
Emp. and Soc.	4	S.	0	0	0	0	1	0	0	0	1
		N.	0	1	0	0	0	0	0	0	0
		U.	0	0	0	0	0	0	0	0	1
Emp. and Fam. and Soc.	2	S.	0	0	0	0	1	0	1	0	0
		N.	0	0	0	0	0	0	0	0	0
		U.	0	0	0	0	0	0	0	0	0
Soc. and Fam.	0	S.	0	0	0	0	0	0	0	0	0
		N.	0	0	0	0	0	0	0	0	0
		U.	0	0	0	0	0	0	0	0	0

a. Emp.-Employment

d. S.-Some

b. Soc.-Socialization

e. N.-None

c. Fam.-Intra-familial adjustment

f. U.-Unknown

progress or the worker's goal is not clearly defined in the records. When the worker worked in more than one sphere, "some" indicates that there was movement in at least one of the spheres, "unknown" indicates that in least one of the spheres, movement cannot be evaluated.

The criteria used for judging movement and sphere may be seen in the case summaries in this chapter. In Case III, the worker's main activity was seen to be in the intra-familial sphere. This judgment is somewhat arbitrary: the patient brought up other complaints, but the record indicates that his complaints about his cousin were the only ones that the worker was able to discuss with the patient, attempting to clarify the reality of the situation and suggesting that the patient make no move until the worker had explored the situation more fully by talking to the patient's cousin. The movement in this case is classified as "unknown": although the patient was able to alleviate the intra-familial problem by moving out of the home, it is not clear whether the casework had any influence on this move. The move itself was contrary to the worker's suggestion, but it is possible, although doubtful, that the worker's clarification of the situation gave the patient some help in coming to his decision. Again it is not clear whether the caseworker's goal was to help the patient remain in his cousin's home or to help him make a choice as to whether or not to move on a more realistic basis.

In Case IV, the sphere of activity has been classified as "intra-familial": the worker attempted to help the wife modify her attitudes toward and her treatment of the patient in order to lessen the tension between them. It has been judged here that there was "some" movement. For a time the wife became more accepting of the patient, which led to less suspiciousness on the part of the patient and less tension between them. Similarly in Case V, the worker's attempts to become active with the patient on a social level and to have the patient engage in more social and recreational activities,--the sphere of socialization --were for a time realized, although the patient later reverted to her earlier seclusion and withdrawal. Therefore, the movement here is evaluated as "some".

In Case VI, the sphere of activity is considered to be employment. Although problems in the sphere of socialization are evident, it is not indicated that the worker attempted to handle them. Movement here is classified as "none". The worker attempted to help the patient to understand his reactions toward working by clarifying these reactions for him, and to help the patient to return to work by seeking employment for him. The patient, however, was resentful and resistant toward clarification of his attitudes, and made no real effort to return to work--although he seemed to make some attempt to please the worker by pretending to be working.

In Table XVII on page 61, it is seen that with the

number of patients, ten, or 22 per cent of the forty-six patients receiving supervision, the worker was active in the sphere of employment. In eight cases the worker worked in the sphere of socialization; in seven, the sphere of intra-familial adjustment. In four cases the worker was active in both the employment and intra-familial spheres; in four, both the employment and socialization spheres; and in two, all three spheres.

The proportion of cases in which there was movement to those in which there was no movement is about the same for all the spheres: two to one, except in the combined employment and intra-familial spheres and in the combined three spheres. In nineteen cases movement was evaluated as "some"; in nine, "none"; and in seven, "unable to evaluate". Thirteen of the nineteen patients for whom some progress toward the worker's goal was evident were able to remain in the community a year or longer. Included in this group were four of the five patients who stayed out of the hospital two years or longer. Only three of the nine patients for whom no movement was noticed were able to stay out a year or longer; the longest one of these patients remained out was twenty months.

In comparison with these figures, it may be noted that of those patients for whom no sphere of activity of the worker could be determined and who were classified as "unknown", seven out of eleven returned within two months. Of those patients who received no supervision while in the community, an even

higher proportion--nineteen out of twenty-four--returned within two months. It must be remembered that seven out of these twenty-four patients left on trial visit and it is likely that supervision was planned for them but that they returned before the worker had a chance to visit them. This, however, still leaves twelve out of twenty-four, one-half of the patients for whom no supervision was planned, returning within two months. Only two of the unsupervised patients were able to stay out a year or longer.

The patients who were worked with in either the intra-familial sphere or the socialization sphere alone were generally not able to remain out as long as those who were worked with in the employment sphere alone or in the combination of spheres. Only one of the eight "socialization" patients and two of the seven "intra-familial" patients were able to remain out a year or more, whereas seven of the ten "employment" patients, two of the four "employment and intra-familial" patients, three of the four "employment and socialization" patients, and both of the "employment, intra-familial, and socialization" patients were able to stay out a year or longer. That is, 80 per cent of the patients in the first two categories returned within a year, whereas only 30 per cent of the patients in the last five categories returned within this time.

#### Patients' Adjustment in the Community:

##### Employment

Another way in which this study has attempted to describe the patients' experience in the community in relation to their readmissions is by an analysis of their adjustment while in the community. The adjustment of the seventy readmissions has been broken down into the same classifications which were used to describe Social Service supervision: employment, family, and socialization.

TABLE XVIII

EMPLOYMENT SITUATIONS OF THE PATIENTS AND LENGTH  
OF TIME THEY REMAINED IN THE COMMUNITY

Employment Situation	Total	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	70	30	15	4	3	6	4	3	0	5
Regularly Employed	20	9	4	1	1	3	1	0	0	1
Irregularly Employed	6	1	1	0	0	1	1	1	0	1
Not employed	43	20	10	3	2	2	1	2	0	3
Went to school	1	0	0	0	0	0	1	0	0	0

Forty-three, or 61 per cent of the patients, were unemployed while they were on trial visit. Twenty patients, or 22 per cent of the group, worked regularly, and six patients were employed for short periods of time during their residence in the community. Patients who were employed seemed generally to remain in the community only a somewhat longer time than

patients who were unemployed. Seventy per cent, thirty, of the unemployed patients returned to the hospital within five months, whereas 54 per cent, fifteen, of the regularly and irregularly employed patients returned within this time. However, three of the five patients who remained in the community two or more years were unemployed.

Of the forty-three patients who were unemployed, twenty-nine had been supervised on trial visit by Social Service. In three of these twenty-nine cases the worker was considered to have made "some" progress in the employment sphere; although they did not find employment, the worker helped them to the point where they went out and looked for work.

Case VII. Patient was a single, twenty-one year old, patient carrying a diagnosis of hebephrenic schizophrenia. He had had only one hospitalization in the service and two years of hospitalization at Bedford. Previous to his hospitalization, patient had begun training as a Catholic Brother, but could not continue with this as he developed fainting spells, lapses of memory, confusion, and irrelevance. After this he worked for a short period of time as a busboy in a restaurant.

No definitive or ancillary treatment is noted for patient during his hospitalization at Bedford, but patient is reported to have improved gradually and was granted trial visit after a pre-trial visit home investigation was made finding the sister with whom he was to live "cooperative, intelligent, and has some understanding of patient's condition." Patient had had several weekend passes and was reported to be "most anxious to go on trial visit". It was felt by patient's doctor that he should be encouraged to find employment which was not too physically strenuous or involving too much responsibility.

Trial visit supervision was primarily with the patient although sister was seen for reports of his adjustment. When worker visited the first few times patient reported that he was getting along well with his sister and her husband and was spending his time helping with minor tasks, swimming, and visiting an aunt. He was not working and attributed his last breakdown to his strenuous work as a busboy. Worker suggested job possibilities of a less strenuous nature. Patient showed interest in each possibility, but would conclude by offering his objection to accepting it. In speaking of jobs, worker reported that patient asked questions which showed little or no understanding of the reality situation--as wanting to know if he had to take a civil service test to work in his brother-in-law's gas station. Worker felt that it was apparent that patient preferred the sheltered environment of his home to the struggle he might have to make on a job, and that his feeling of dependency was being fostered by his brother-in-law who would not permit him to work about the house unless he was present to supervise the work. Patient frequently brought up the possibility of working in a hospital as a kitchen helper. Worker felt that he would like this type of work, but that he had such strong feelings of inadequacy he would not present himself to an employer and request a job. However, worker felt that patient might make a good adjustment in the protected environment of a hospital. Worker continued to encourage patient to seek work, but at the same time worker explored the vacancies in kitchen work in hospitals near patient's home and was able to find him a job as a cook's helper at a State Farm. Patient had an interview with the employer at the Farm, but decided to turn down the job, saying that the hours were too late and that living at the Farm was not as desirable as living at home. During a discussion of his working in his next interview with the worker, patient stated that he wanted to work, but that his father felt that since he was getting 100 per cent compensation, there was no need for him to work.

Worker continued to seek for employment for patient and found him another job at a county sanitarium. Patient kept the appointment for an

interview with the manager and was placed on a waiting list for a job in kitchen work. Patient was reported to show a mild interest in the prospect of working, but not enough to inquire about the salary. When patient did not hear from the sanitarium, he at first made no attempt to contact them although continuing to express a desire to work. After three months he called the sanitarium and was told that they would not be hiring help for some time. Patient seemed disappointed. After this he began to go to local firms and apply for jobs but met with no success. He rejected several offers of work that the worker brought to his attention on the grounds that they were over six miles from his home and the transportation problem was too difficult to overcome. Finally, patient found a job as a waiter. He remained at this job for one day, but left because "he was unable to stand the noise". Patient was discharged from trial visit at this time.

During the year of trial visit, worker reported that patient was very attached to his sister and brother-in-law. Sister at times seemed very willing to help patient and showed insight into his condition, at other times "did not seem to have any feeling about his presence in the house one way or another. She makes no demands on his time, does not suggest that he help around the house when he does not wish to". Patient's activities during most of this time consisted of caring for his sister's children, going to the movies, and dancing. His friends would visit occasionally and he would be friendly when they came although somewhat shy and withdrawn.

Four months after his discharge, patient was returned to the hospital in a similar condition to that in which he was originally admitted--subtotally mute, untidy in his personal needs, laughing inappropriately. His sister could give no precipitating factors in this recurrence of symptoms except for the "extremely hot weather".

In this case is seen an overdependent patient desiring to work but fearing it because of his feelings of inadequacy and dependency. Because of his extreme dependency, the worker

took the initiative in seeking employment for him, but at the same time encouraged the patient's own attempts to look for work. There is judged to be some movement here in that the patient was eventually able to keep interviews for employment and to seek employment on his own, although he still had much resistance to working. This case shows that in addition to the emotional reasons behind a patient's not working, there is, for these veterans, sometimes another influence on the side of their not working--their pension which allows them to maintain themselves financially without working.

#### Relationship with Family

"Family" here is defined as those persons with whom the patient lived. In some instances the patient lived with friends and was treated as part of the family. However, if the patient lived in a rooming house, his landlady is not considered as "family"; he is classified under "no family". The patient's relationship to his family has been measured by the presence or absence of conflict. As indicated in Part I of the group study,

...because the evidence of conflict has been ascertained by examining the Social Service and clinical records, in many cases hidden feelings and relationships are not uncovered. Only an indication of the surface relationship between the patient and those he lived with is revealed.<sup>2</sup>

Since an analysis of underlying feelings cannot be attempted,

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<sup>2</sup>Macalaster, op. cit.

TABLE XIX

FAMILY ADJUSTMENT OF THE PATIENTS AND LENGTH  
OF TIME THEY REMAINED IN THE COMMUNITY

Family Adjustment	Total	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	70	30	15	4	3	6	4	3	0	5
Conflict	28	12	6	2	2	3	0	1	0	2
No conflict	18	7	2	0	1	2	3	1	0	2
No family	9	6	1	1	0	0	1	0	0	0
No conflict to conflict	2	0	0	1	0	1	0	0	0	0
Conflict to no conflict	1	0	1	0	0	0	0	0	0	0
Unknown	12	5	5	0	0	0	0	1	0	1

conflict here is defined as conflict expressed verbally or in behavior as in arguments and fights. Since the more subtle manifestations of conflict are not included, the proportion of actual conflict is perhaps higher than is indicated here.

Forty per cent, twenty-eight of the readmitted patients, were seen to have experienced some conflict in relationship to those with whom they live; 26 per cent, eighteen, did not show any overt conflict. Thirteen per cent, nine, of the patients lived alone. In twelve cases it could not be determined whether conflict existed. Two of the patients are listed as no conflict to conflict to show that no conflict was evident in the first

part of their trial visit, but manifested itself in the latter part. One, the patient in Case III, experienced conflict with his family at first, but later moved out of the home and got along well with the people with whom he later lived.

The patients for whom no conflict is recorded were able to stay out in the community in general somewhat longer than the patients for whom conflict is evident or the patients who lived alone. Eighteen, or 64 per cent of the patients with conflict, returned within five months; 50 per cent, nine, of the patients for whom no conflict is evident and seven of the nine who lived alone returned within this time.

Of the twenty-eight cases where there was conflict, twenty had Social Service supervision in the community. In four of these cases the worker made "some" progress in the intra-familial sphere, in helping to reduce some of the tension in the home although conflict with all members of the family was not entirely alleviated. One of these cases was Case IV where the social worker helped the mother for a time to become more accepting of the patient.

#### Social Adjustment

As in Parts I and II of the group study, the patients were classified as to their participation in community activities while they were in the community. This classification includes the amount, rather than the quality, of both the patient's participation in activities and his contacts with people.

TABLE XX

SOCIAL ADJUSTMENT OF THE PATIENTS AND LENGTH  
OF TIME THEY REMAINED IN THE COMMUNITY

Extent of Activities	Total	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	70	30	15	4	3	6	4	3	0	5
Confined to home	16	10	4	0	1	0	0	1	0	0
Limited outside activity	30	12	4	3	2	3	2	2	0	2
Full outside activity	2	0	0	0	0	1	0	0	0	1
Confined to home to limited	2	0	2	0	0	0	0	0	0	0
Limited to confined to home	2	0	1	0	0	0	1	0	0	0
Limited to full	2	0	1	0	0	1	0	0	0	0
Unknown	16	8	3	1	0	1	1	0	0	2

"Confined to home" indicates that the patient spent his time at home with the people with whom he lived and confined himself to activities at home--from doing nothing to reading, watching television, playing games with the family, doing household tasks.

"Limited outside activity" indicates one or two activities outside the home--as meeting a few friends and fishing. Four or more different activities would be considered full outside activity.

The patients who were confined to their homes varied from those who kept themselves occupied around the home to those

who did nothing. For example, one patient did some painting, helped with the housework, did some gardening, read, and listened to the radio, while another either slept or followed his wife around while she did her housework.

Patients varied in the kinds of "limited" activities they pursued. One patient took a correspondence course and went to ballgames. Another wrote songs, gambled on horses, and visited a couple of friends. Another practiced typing, read, and bowled with a friend. Another spent most of his time drinking and watching television with his drinking acquaintances.

Cases IV, VI, and VII are all classified as limited outside activity, although in Case VI, much of the outside activity, annoying girls, is not of a particularly constructive nature, but rather symptomatic of the patient's illness. Case V is classified as "limited to full" activity.

Of the readmitted patients, the largest number, thirty, or 43 per cent, participated in limited outside activity. Sixteen, or 23 per cent, were confined to the home and only two patients had full outside activity. As in family adjustment, an attempt was made to indicate marked changes during trial visit in the extent of activity. Two patients changed from confinement to the home to limited outside activity; two went from limited outside activity to confinement in the home; and two went from limited to full outside activity. The extent of activity of sixteen patients was unknown.

These figures stand in contrast to those which were gathered for the patients' hospital adjustment in which almost one-half of the patients participated fully in hospital activities and more than one-third were rated as "active" in seeking out friendly contacts with other people.

Patients who were confined to their homes while in the community generally returned to the hospital much sooner than patients who participated in limited outside activities. Fourteen of the sixteen patients confined to their homes returned to the hospital within five months, whereas only sixteen of the thirty patients with limited outside activity returned within this time. Three of the five patients staying out two years or longer had limited or full outside activity; the extent of activity of the other two staying out two years or longer is unknown.

Ten of the sixteen patients who were confined to their homes had trial visit supervision. In none of these cases was the worker able to help the patient in the sphere of socialization.

## CHAPTER VI

IMMEDIATE REASONS FOR THE PATIENTS' RETURN  
TO THE HOSPITAL

Thirty-eight of the patients returned to the hospital for reasons having to do with their psychotic symptoms. These patients returned because, in the estimate of the hospital, they suffered from an exacerbation of symptoms; they became too ill to remain in the community. These patients may have been returned by a relative, at the initiation of a social worker, or may have returned by themselves. However, in all these instances the hospital--the medical staff-- did not feel that the patient was well enough to have remained out any longer. Cases V and VII in chapter V give examples of this situation.

TABLE XXI

## IMMEDIATE REASONS FOR THE PATIENTS' RETURN TO THE HOSPITAL

Reasons for Return	Number	Time in the Community (Months)								
		0 to 2	3 to 5	6 to 8	9 to 11	12 to 14	15 to 17	18 to 20	21 to 23	24 and over
Total	70	30	15	4	3	6	4	3	0	5
Psychotic Symptoms	38	18	8	1	1	3	2	2	0	3
Acute Alcoholism	15	7	3	1	0	1	1	0	0	2
Physical disorder	5	2	2	0	1	0	0	0	0	0
Convenience of family	4	1	2	0	0	0	0	1	0	0
Extension of trial visit or discharge	4	0	0	1	0	2	1	0	0	0
Lack of finances	2	2	0	0	0	0	0	0	0	0
Physical checkup	2	0	0	1	1	0	0	0	0	0

In only four of these cases were specific events or situations seen to be directly associated with the exacerbation of psychotic symptoms. One patient who was evaluated as getting along very well with his family was returned when his wife became ill. Another patient, who was making a very tenuous adjustment, drinking and fighting with her husband, spending much of her time doing nothing, began to have hallucinations again when she had a miscarriage. One patient broke down when faced with making about whether or not she should marry the man she was going with; another became extremely depressed when he was refused a job he had been hoping for. In the cases of the other thirty-four patients, no one event or situation could be found that seemed directly associated with the patient's breakdown, although many factors such as family conflicts which were shown in chapter V seemed to have a contributory influence.

Two patients returned to the hospital because their behavior was such that people in the community insisted upon their return. One patient was returned to the hospital when the police caught him trying to break into an empty camp and arranged for his return. Worker knew of no other such incidents during his three month trial visit and patient was later released from the hospital on another trial visit. In the second case, the patient was returned when a neighbor whom he had been annoying by writing her letters proposing marriage and attempting to break into her house had him picked up by the police. The patient had been writing such letters prior to his trial visit

and before he left the hospital, worker had interviewed the neighbor, who had seemed accepting of the patient and agreeable to having him in the community.

Fifteen of the patients returned because of acute alcoholism. Fourteen of these had been directly discharged from the hospital; one had been released on trial visit. The worker had attempted to encourage this patient to change to soft drinks, but with no success. Four patients returned for the "convenience of their families". These were patients whose families could no longer have them in their homes, but not because their behavior was disturbing to them. One sister was an elderly woman who was unable to care for the patient longer than three months at a time; after this he would become a physical and emotional strain upon her. Another patient was returned because the mother claimed that the home was too crowded to accommodate the patient any longer. Another was returned when his father had to go out of state on a business trip and his mother was too ill to care for him.

Five patients returned because they were in need of care for physical disorders--including an acute respiratory infection, epileptic seizures, and a bronchial attack. The two patients with tertiary syphilis returned for a check on their luetic status. Three patients returned at the end of twelve months to have their trial visits extended for another year; one returned for an examination by the doctors because he wished to be

considered for discharge. (It is the policy of the hospital when extension of trial visit is indicated, to have the patient return to the hospital for a few days to be examined by the doctors. Trial visit is extended when it was felt that continued supervision by the social worker would help the patient to improve his adjustment to the community, or that the patient might slip back to his earlier condition without supervision.) Cases VI and VII show patients who were returned for the renewal of trial visit.

Finally, two patients returned because their funds ran out. One had been working and had lost his job (the reason is unknown); the other had been unable to find work. The first had been directly discharged from the hospital; the second was on trial visit but the worker had not yet had a chance to visit him. Both received a pension, but the first was having difficulty in securing his funds from his guardian and the second had already spent his compensation check.

## CHAPTER VII

## SUMMARY AND CONCLUSIONS

Summary

This study is Part III of a group study of the problem of readmissions which hopes to answer the following questions: What are some of the medical and social factors which have contributed to the readmissions? How have these factors contributed to the readmissions? The study especially hopes to discover what part social work has played and can play in helping the patient to stay out of the hospital, how social work may help to prevent or widen the intervals between readmissions.

The purpose of Part III has been to contribute quantitative data which might help to answer the questions raised in the larger study; it does not purport, however, to answer any of these questions itself. It was hoped, however, that this study might show what were the characteristics of some of the readmitted patients and what was and was not done for them in the way of hospital treatment. It was also hoped that Part III might show whether there were any differences in characteristics and treatment between patients who returned within a few months and patients who were able to remain in the community for larger periods of time.

To elicit the data which might bear upon these questions, sixty-eight patients were studied who had had seventy readmissions to Bedford from July to September, 1949.

The following were the findings about the readmitted patients studied.

Ninety-three per cent of the sixty-eight readmitted patients were male. The age range of the readmitted patients was from eighteen to sixty-two with 46 per cent of the patients between the ages of thirty and forty, and 65 per cent below the age of forty. Sixty-five per cent of the group were single. Seventy-two per cent were Catholic. Approximately two-thirds of the patients were World War II veterans. These figures stood in contrast to the figures for the hospital as a whole, in which only one-third of the total patient population were World War II veterans. Four-fifths of the readmitted patients were receiving service-connected pensions. In contrast with these figures, in a 30 per cent sample of patients admitted to Veterans Administration hospitals during April, 1948, only one-fourth of the patients were found to be service-connected. Of the readmitted patients receiving service-connected pensions, 74 per cent were receiving them for psychoses.

As to their diagnoses, 69 per cent of the patients carried a diagnosis of schizophrenia. Thirty-two per cent of the schizophrenic patients remained in the community for a year or longer after their last hospitalization whereas only 14 per cent of patients with other diagnoses were able to stay out of the hospital for a year or longer.

Sixty-two per cent of the group had had two or three previous hospitalizations. Seventy-eight per cent of the pa-

tients had been hospitalized for four or less years; 35 per cent of the patients had been hospitalized for a year or less. There seemed to be very little relationship between the number of years the patients were hospitalized and the length of time they remained in the community.

Seventy-two per cent of the patients received no definitive treatment for their psychiatric illnesses during their last hospitalization. Ten out of the nineteen patients who did receive definitive treatment received electric shock therapy. Only one patient received no treatment from either the medical or ancillary services in the hospital during hospitalization; thirteen per cent of the patients received treatment from all four of the hospital services included.

In 44 per cent of the seventy cases of readmissions studied, the patients received no pre-release planning or preparation from Social Service. Fifteen of these thirty-one patients left the hospital by trial visit; eight were discharged.

The primary pre-release activity of the social worker was an investigation and evaluation of the home situation, seen in twenty-eight cases. In seventeen cases, the social worker worked directly with the patient to prepare him for trial visit either through her relationship with the patient or through environmental manipulation. In twelve instances, the worker worked with a relative to prepare for the patient's homecoming.

Three factors were studied as possibly indicative of the patients' readiness for leaving the hospital: adjustment toward

the hospital, competency, and attitude toward leaving. In regard to the patients' participation in hospital activities, 48 per cent of the patients were rated as "full"; 48 per cent were rated as "limited". With none of the four patients who participated in no activities was there any Social Service planning or preparation.

Seventy-one per cent of the patients were rated as "positive" in their "socialization". These were about equally divided as to whether they were "passive" or "active". Three of the patients who were rated as "negative" had had Social Service pre-release planning.

A rating of "incompetent" was given by the medical staff to 54 per cent of the patients at the time of their last release from the hospital. No relationship was seen between the competency rating of the patients and the length of time they remained in the community.

Seventeen per cent of the readmitted group expressed ambivalent feelings about leaving the hospital. Four of these twelve ambivalent patients had had Social Service pre-release planning: all twelve of the ambivalent patients returned within six months; eight returned within three months.

Sixty-five per cent of the readmitted patients received supervision while on trial visit. In 63 per cent of the cases receiving trial visit supervision, the patient was the primary person seen by the caseworker. The worker was seen to have

worked primarily with the person the family who voiced complaints and dissatisfaction or the person with whom he was able to establish a relationship.

The spheres of activity in which the caseworker was active with the patient were classified as employment, socialization, and intra-familial. With 22 per cent of the patients, the largest proportion worked with in any one sphere or combination of spheres, the worker was active in the sphere of employment. Eighty per cent of the patients who were worked with in either the intra-familial or socialization spheres returned within a year, whereas only 30 per cent of the patients who were worked with in the employment sphere alone or in a combination of spheres returned within this time. Sixty-four per cent of the patients for whom no sphere of activity of the worker could be found and who were classified "unknown" returned within two months; 78 per cent of the patients who received no supervision while they were in the community returned within this time.

Movement toward the casework goal was rated as "none", "some", and "unknown". The proportion of cases in which there was movement to those in which there was no movement was approximately two to one. Of the patients for whom some progress toward the worker's goal was evident, 69 per cent were able to remain in the community for a year or longer, whereas only 33 per cent of the nine patients for whom no movement was noticed were able to remain out as long as this. Included in the group with "some" movement were four out of the five patients who were able to

remain out for two or more years.

With regard to the patients' adjustment while in the community, 61 per cent of the patients were found to be unemployed while in the community. Seventy per cent of the unemployed patients returned to the hospital within five months, whereas 54 per cent of the regularly and irregularly employed patients returned within this time. Sixty-seven per cent of the unemployed patients received Social Service supervision in the community.

The patient's relationship to his family was measured by the presence or absence of conflict. Forty per cent of the patients were seen to have experienced some conflict in relationship to those with whom they lived; 26 per cent showed no overt conflict; 13 per cent of the seventy patients lived alone. Sixty-four per cent of the patients with conflict returned within five months; 50 per cent of those for whom no conflict was evident and 78 per cent of those who lived alone returned within this time. Of the cases in which there was conflict, 71 per cent had social service supervision while they were in the community.

The patients were further classified according to the amount of participation in community activities while they were in the community. Forty-three per cent of the readmitted patients participated in limited outside activity; only 3 per cent had full outside activity. Of the patients who were confined to their homes, 87 per cent returned to the hospital within five months, whereas only 50 per cent of the thirty patients with limited outside activity returned within this time. Three of the

patients who participated in full outside activities during some part of their time in the community were able to remain out for a year or more. Ten of the sixteen patients who were confined to their homes had trial visit supervision.

The immediate reasons for the patients' return to the hospital were investigated. Fifty-four per cent of the patients returned to the hospital for reasons having to do with their psychotic symptoms. In only four of these cases were specific events or situations found which seemed to be directly associated with the exacerbation of psychotic symptoms. Two patients returned to the hospital because their behavior was such that people in the community insisted upon their return.

Twenty-one per cent of the patients returned because of acute alcoholism. All but one of these had been directly discharged from the hospital and had no trial visit supervision. Six per cent of the patients returned for the "convenience of their families"--because their families could no longer have them in their homes for reasons other than disturbing behavior. Seven per cent of the patients returned because they were in need of care for physical disorders; 6 per cent returned for the extension of their trial visits; 3 per cent returned because their funds ran out; and 3 per cent returned for a physical checkup.

### Conclusions

It is not possible to see clearly and objectively the meaning of these findings in relation to the readmissions without a comparison of these findings to those of the control

studies of patients who remained in the community for two or more years. It is only possible to note certain trends among the readmitted patients which further study may prove to be of significance.

More of the readmitted group were found to be service-connected than a group of first admitted patients to Veterans Administration hospitals. One of the implications of this finding may be that the pension received for service-connected illnesses may foster the dependency needs of the patients as seen in one of the case illustrations. This factor may be related to the finding that such a large proportion of patients were unemployed; and it was seen that unemployed patients generally returned to the hospital sooner than patients who worked during some part of their trial visit.

It was noted that 71 per cent of the patients received no definitive treatment for their psychiatric illnesses during their last hospitalization. Further study may indicate why these patients did not receive medical treatment, whether these were patients who were considered by the doctors to have a poor prognosis in their illnesses--a factor which would also bear upon their prognoses for remaining in the community.

Neither the patients' adjustment in the hospital nor their competency ratings at the time of their last release were seen to be related to their adjustment in the community and their eventual readmissions. It would seem that although the patient may be able to make a good adjustment to the hospital with its

protected environment, its easily available activities, and its permissive atmosphere, this is not necessarily an indication that he will be able to withstand the greater pressures of the community, that he will have the initiative and strength to seek out less easily accessible friendships and activities in the community.

Although the numbers are too small to be significant, it is interesting to note that all of the ambivalent patients returned to the hospital within six months, eight within three months. One might surmise that the patient's own desire to leave the hospital and to attempt to succeed in the community may be a determining factor as to whether he will be able to remain out of the hospital.

It was generally seen that the patients who were able to make a better adjustment in the community in terms of employment, family relationships, and socialization were the ones who remained in the community for longer periods of time. This study also shows that social work has been of benefit to some of the readmitted patients in terms of helping them to make a somewhat better adjustment and enabling them to remain in the community for a somewhat longer period of time. However, for the patients who were discharged without trial visit, casework help while they were in the community was not available from the hospital. Since only two of these unsupervised patients were able to remain in the community for a year or longer, it might be recommended that

the possibility of casework help to these patients in the community be considered, either from Social Service in the hospital, or through referral to community agencies.

Approved:

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## APPENDIX

VETERANS ADMINISTRATION HOSPITAL  
BEDFORD, MASSACHUSETTS

A STUDY OF READMISSIONS TO A VETERANS PSYCHIATRIC  
HOSPITAL

A PRELIMINARY REPORT

With the need for psychiatric beds greater than ever before, high admission rates in psychiatric hospitals have raised increasing concern. At this hospital, about one-half of all patients admitted have previously been hospitalized here. A study was, therefore, undertaken to determine the characteristics of the readmission problem, such as personal data of readmitted patients, facts surrounding the illness, treatment, preparation for community life, and the post-hospital period. This study is regarded as a first step in the systematic investigation and possible alleviation of this problem.

The series under study are the 149 readmissions which occurred during the first six months of 1949.<sup>1</sup> For the purpose of this study, readmissions were defined to include patients who returned to the hospital while still on trial visit status. There were 134 patients involved, with one patient admitted three times, and 13 admitted twice during the period. The thrice-admitted patient was an alcoholic, and the 13 twice-admitted patients represented a miscellany of diagnoses.

DATA

SEX

The 134 patients were overwhelmingly male, with 4% of them female. By coincidence, 4% of the hospital population as of January 1, 1949 was female, also.

AGE

69% of the readmitted patients were under 40 years of age. These were somewhat older than first-admitted patients, 82% of whom were under age 40.

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<sup>1</sup>Use was made of data from two unpublished Master's Dissertations, "A Survey of Readmissions to the V.A.H., Bedford, Mass." Parts I and II, by A. Loring Macalaster and Robert A. Redding, Simmons College School of Social Work. Mr. Macalaster studied 75 readmissions of the series, and Mr. Redding studied the remaining 74.

PENSION STATUS

109 or 82% of the patients had service-connected disabilities for the following primary conditions:

Psychosis.....	82	$\frac{76}{100}$
Psychoneurosis.....	21	19
Physical disorders only.....	<u>6</u>	<u>5</u>
Totals	109	100

COMPETENCY

The patients were rated as follows at last release from the hospital:

Competent.....	87	$\frac{60}{100}$
Incompetent.....	<u>47</u>	<u>40</u>
Totals	134	100

DIAGNOSIS

Following are the primary diagnoses of the readmitted patients at last release from the hospital, as compared to patients discharged during 1949:<sup>1</sup>

		Percentage of Those Discharged in 1949
Schizophrenic disorders.....	83 62	48
Organic psychoses.....	13 10	5
Alcoholic and drug addiction...	12 9	12
Psychoneuroses.....	9 7	16
Affective disorders.....	9 7	8
Others.....	<u>8</u> <u>5</u>	<u>11</u>
Totals	134 100%	100%

TIME IN COMMUNITY SINCE LAST HOSPITALIZATION

On the basis of the 149 readmissions, the length of time from last hospitalization to present readmissions was as follows:

Returned within 3 months.....	58	$\frac{39}{100}$
Returned within 6 months.....	80	54
Returned within 12 months.....	113	89
Returned within 24 months.....	<u>133</u>	<u>89</u>
During period over 2 years.....	149	100

<sup>1</sup>From the records of the Medical Records Librarian, VAH, Bedford, Massachusetts. The number of discharges in 1949 was 391.

### PREVIOUS HOSPITALIZATIONS

The readmitted patients were studied for number of previous hospitalizations for mental illness. 75% of them were found to have had three or more previous hospitalizations. Only 2 of the 134 patients had been readmitted for the first time.

### SHOCK TREATMENT AND LOBOTOMY

During the last hospitalization, only 46 of the 134 patients, or 34%, received definitive treatment, comprising electric shock therapy, insulin shock therapy, and lobotomy. The 46 patients received this treatment as follows:

Electric shock therapy.....	28	$\frac{61}{100}$
Insulin shock therapy.....	6	13
Combination of EST and IST.....	5	11
Lobotomy.....	7	15
Total	46	100

17 or 37% of the 46 shock and lobotomy treated patients returned within 6 months. The numbers returning within 6 months are broken down according to the specific treatment:

Electric shock therapy.....	8
Insulin shock therapy.....	1
Combination of EST and IST.....	3
Lobotomy.....	5
	17

### REHABILITATION SERVICES

Most of these readmitted patients received one or more of the following rehabilitation services during the last hospitalization: physical therapy, occupational therapy, corrective therapy (corrective or remedial exercise), educational therapy, manual arts therapy, and vocational guidance. 83% of the readmissions had one or more of these services. 38% had vocational guidance. 82% of those active with vocational guidance were concurrently active with one or more of the other rehabilitation services.

### INTRAMURAL SOCIAL SERVICE

50% of the cases were active with Social Service during the last hospitalization period. Very seldom was a case active with Social Service and not concurrently active with one or more of the rehabilitation services. Thus, in only

9% of the readmissions was Social Service active alone. In the history of Social Service activity on each case during the last hospitalization, preparation for leaving the hospital was involved directly or indirectly.

#### RELEASE PLANS

Modes of release were as follows:

Trial Visit.....	104	<u>70</u>
Outright Discharge.....	26	17
Elopement and discharge against medical advice	15	10
Transfers to other hospitals.....	<u>4</u>	<u>3</u>
Total	149	100

Of the 104 who left the hospital on trial visit to the care of a relative, 71 or 68% had the advantage of Social Service pre-trial visit home investigation and planning. Of the 26 who left on outright discharge, 14 or 54% had Social Service pre-discharge planning services, the others leaving on their own plans with some help from the vocational advisor.

#### TRIAL VISIT SOCIAL SERVICE ACTIVITY

A social worker was active in all instances during the period of trial visit supervision. It might be noted that a substantial number returned before completing the trial visit, which usually lasts for a 12 month period.

An effort was made to determine the social worker's spheres of activity. The predominant activities are noted:

Socialization.....	2	<u>2</u>
Employment.....	7	7
Family problems.....	17	16
Social and Employment.....	9	9
Social and Family Problems.....	8	8
Employment and Family Problems.....	10	10
Social, Employment & Family Problems.....	24	23
Unknown*.....	<u>27</u>	<u>25</u>
Total on trial visit	104	100

\*Determination could not be made because trial visit period was too brief and records were insufficient.

The social worker invariably worked primarily with one person out of the family constellation. This is shown as

follows:

Worked primarily with Patient.....	53	<u>50</u>
Worked primarily with a Parent.....	13	13
Worked primarily with a Spouse.....	8	8
Worked primarily with a Sibling.....	3	3
Worked primarily with a Relative, other.....	5	5
Unknown* .....	<u>22</u>	<u>21</u>
Total on trial visit	104	100

\*Contained in the 27 where social worker's spheres of activity could not be determined.

The kinds of services performed by social workers during the trial visit were enumerated in 93 cases. In the remaining 11 of the 104 on trial visit such determination could not be made from available records:

Interpreting patient's illness to family.....	58
Helping family in supervising the patient.....	52
Employment problems.....	28
Helping patient into community activities.....	25
Financial help thru veteran's pension.....	13
Referral to social agencies.....	12
Support thru listening to patient's problems.....	12
Housing problems.....	6

#### PCST-HOSPITAL ADJUSTMENT

With respect to adjustment to the family, the readmitted patients showed the following pattern:

Conflict with family.....	65	<u>44</u>
No conflict with family.....	45	30
No family (patients lived alone).....	29	20
Unknown.....	<u>10</u>	<u>6</u>
Total	149	100

With respect to adjustment to employment:

Regularly employed.....	31	<u>21</u>
Irregularly employed.....	28	19
Not employed.....	81	54
Attended school.....	4	3
Unknown.....	<u>5</u>	<u>3</u>
	149	100

With respect to general social adjustment:

Confined to their room.....	10	<u>7</u>
Confined to the home.....	42	28
Limited outside activity.....	66	44
Full outside activity.....	9	6
Could not be determined.....	22	15
Total	<u>149</u>	<u>100</u>

### REASONS FOR READMISSIONS

Finally an effort was made to determine why the patients returned. This was a complex problem, as in each instance there were indirect or background factors as well as the immediate reasons for the readmissions.

Both sets of factors are set forth. First, the background reasons:

Alcoholism.....	26
Family problems.....	19
Disappointments.....	12
Physical disorders.....	4
Reduction of pensions funds.....	4
Death of member of family.....	4
Drug addiction.....	3
Accidents.....	4
Overwork.....	3
Attitude of community.....	1
Unrest.....	1
Unknown*.....	68
Total	<u>149</u>

\*Because patients had been out a very short time on trial visit, or had left the hospital on outright discharge and so had not been followed by a social worker, or a substantial portion of the post-hospital period was after discharge from trial visit when there was no follow-up by Social Service.

Secondly, the immediate reasons, shown with length of time in community since last hospitalization:

	Out 0-3 <u>Months</u>	Out 3-6 <u>Months</u>
Exacerbation of symptoms.....	31	12
Acute Alcoholism.....	12	3
Physical Disorder.....	7	5
Convenience of Family.....	4	0

	Out 0-3 Months	Out 3-6 Months
To extend trial visit.....5	0	0
Lack of finances.....2	1	0
Physical check-up.....6	3	1
Total	149	

Note: Convenience of family--when family moves, patient is hospitalized till family is reestablished.

#### COMMENT

Many facts have been presented about readmitted patients. But what do they mean? For example, we learn that 3/4 of them have had 3 or more previous hospitalizations for mental illness. Does this show that the psychiatric "repeater" is a chronic recidivist? The same question can be raised about the significance of the other findings, regarding diagnosis; extent of, and kind of hospital treatment; extent and content of Social Service both in preparing for release and during the post-hospital period; and patient's adjustment in the community before readmission. In order to properly evaluate all these data as differential material for the group studied, a baseline is needed. This can be provided by a control study, i.e. of patients who were in the hospital, who left, and who did not return. The same data would be gathered concerning these patients who succeeded in staying out, and these data would serve as a baseline for judgment of the data on the returned patients. Such a study is, in fact, now in process at the Bedford Hospital.

Further steps in research being contemplated are study of further series of readmitted patients, and case studies of readmitted patients for a more microscopic view of the problem.

PREPARED BY: CHARLES L. ROSE  
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October 20, 1950.

SCHEDULE

Name \_\_\_\_\_ Case No. \_\_\_\_\_ Reg. No. \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ War \_\_\_\_\_ Religion \_\_\_\_\_

Pension status: S.C. \_\_\_\_\_ N.S.C. \_\_\_\_\_ Percentage of Disability \_\_\_\_\_

Disability for which pension awarded \_\_\_\_\_

Date of readmission \_\_\_\_\_

Diagnosis at end of last hospital period \_\_\_\_\_

Previous hospitalizations: Number \_\_\_\_\_ Total Years \_\_\_\_\_

List Hospitals and dates:

No. of previous trial visits from this hospital \_\_\_\_\_

During Last Hospitalization:

Medical treatment (check)

EST \_\_\_\_\_ IST \_\_\_\_\_ LOBOTOMY \_\_\_\_\_ OTHER (specify) \_\_\_\_\_

Rehabilitation (check)

corrective therapy \_\_\_\_\_ educational therapy \_\_\_\_\_

manual arts therapy \_\_\_\_\_ physical therapy \_\_\_\_\_

occupational therapy \_\_\_\_\_ vocational guidance \_\_\_\_\_

Intramural Social Service: Describe briefly reason for referral and type of service given:

Release Plans:

Modes of release: (check) Trial Visit \_\_\_\_\_ Discharge \_\_\_\_\_ A.M.A. \_\_\_\_\_

elopement \_\_\_\_\_ transfer to other hospital \_\_\_\_\_ Other (specify) \_\_\_\_\_

Hospital adjustment at time of release:

Participation in activities (check): none \_\_\_ limited \_\_\_ full \_\_\_

Socialization(check): Negative: withdrawn \_\_\_ overaggressive \_\_\_

Positive: passive \_\_\_ active \_\_\_

Was there Social Service Pre-release preparation? Yes \_\_\_ No \_\_\_

Patient's feelings about release at time of referral(check)

Primarily positive \_\_\_ Ambivalent \_\_\_

Primarily negative \_\_\_ unknown \_\_\_

Describe briefly type of activity and what was accomplished:

To whom was patient released (check): immediate relative \_\_\_

nonrelative \_\_\_

self \_\_\_

Competency of patient(check): Competent \_\_\_ Incompetent \_\_\_

Patient's feelings about release at time of release:(check)

Primarily positive \_\_\_ Ambivalent \_\_\_

Primarily negative \_\_\_ Unknown \_\_\_

Conditions to which patient released:

Describe briefly attitude of home toward patient:

Did patient have job to return to? \_\_\_ Describe employer's attitude.

Describe briefly attitude of community to patient, if available.

Social Work activity after release: (check)

None

Trial Visit Supervision

Who was the primary person worked with?

In work with patient:

Sphere of activity(check): Socialization\_\_\_Employment\_\_\_

Intrafamilial adjustment\_\_\_Other(specify)\_\_\_\_\_

Kind of service (specify):

Improvement: Use the following symbols after each sphere of activity:

I-improvement N-no improvement U-unable to evaluate

Describe briefly how patient saw worker and evaluate worker-patient relationship:-

In work with others than patient:

Who was worked with?

Spheres of activity (specify and use symbols for improvement)

Kinds of service (specify):

Post-discharge supervision:

Why recommended, tell briefly:

What social worker did, describe briefly:

Other post-hospital activity: describe briefly:

Adjustment during period outside hospital:

Relationship to family (check): conflict\_\_\_no conflict\_\_\_  
no family\_\_\_ unknown\_\_\_\_\_

Employment (check):

Not employed\_\_\_worked regularly\_\_\_worked irregularly\_\_\_

Adjustment to job(check): Satisfactory\_\_\_ Unsatisfactory\_\_\_

If left job, give reason for leaving:

Social Adjustment (check and tell whether this adjustment was maintained during the Beginning, Middle, and/or End of the period outside hospital):

Confined to room\_\_\_ Full outside activity\_\_\_

Confined to home\_\_\_ Limited outside activity\_\_\_

Cannot be determined\_\_\_

Participation in activities:      Socialization:

None\_\_\_

Negative: withdrawn\_\_\_

Limited\_\_\_

overaggressive\_\_\_

Full\_\_\_

Positive: passive\_\_\_

active\_\_\_

Reasons for readmission:

Background reasons: (describe briefly)

Immediate Reason: (describe briefly)

Remarks-Additional descriptive material: