Michigan State University
School of Social Work

A Descriptive Study of Twenty Aged Patients Using Social Work Services At the Veterans Administration Hospital Battle Creek, Michigan

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A DESCRIPTIVE STUDY OF TWENTY AGED PATIENTS USING SOCIAL WORK SERVICE AT THE VETERANS ADMINISTRATION HOSPITAL BATTLE CREEK, MICHIGAN

By

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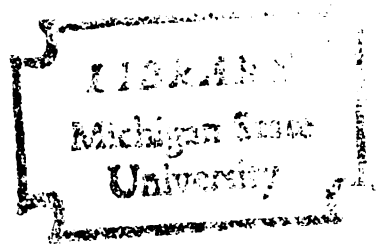

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TABLE OF CONTENTS

CHAPTER I

THE CHALLENGE

Some aged patients at the Veterans Administration Hospital, Battle Creek, Michigan, have been helped through social work service to become sufficiently well, to become sufficiently stabilized, to leave the hospital and to return to the community, where they have been able to make a sufficiently satisfactory adjustment to remain. Other aged patients at this hospital with whom social work service has worked, have remained in the hospital. Exactly what factors contribute to some patients being able to return to the community from the hospital, and to make an adjustment in the former; and how these factors contribute to this return, is not clearly known. Neither is it known exactly which factors have contributed, and how they have contributed, to the fact that some elderly patients have not been able to leave the hospital to return to the community.

Therefore, it was decided to do this descriptive study of elderly patients with whom social work service at the Veterans Administration Hospital, Battle Creek, Michigan has worked, with the hope that this study may help in indicating at least some of the factors which contribute, and how

they contribute, to an aged patients' becoming sufficiently well to leave this hospital and to maintain an adequate adjustment in the community, through the efforts of social work service, that additional oldsters may be helped by social work service to leave the hospital and to make an adequate adjustment in the community. It is hoped these modest findings thus can possibly be used practically and directly, but perhaps they will serve as a necessary preliminary for opening up for solution, a wider problem area and will be useful in the solving of other similar problems, perhaps leading to even further studies in this particular area.

What have been some of the possibilities for aged patients becoming sufficiently well to leave a mental hospital and make an adjustment in the community? Several authors relate experiences and viewpoints on this question, as follows.

"One cannot assume that . . . mental illness [is an] unalterable concomitant(s) of aging.[1] In fact, "in the majority of cases, appropriate protective services and suitable resources enable the client to remain in, or to return to, the community instead of being cared for indefinitely in

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[1]H. Lokshin, "Critical Issues in Serving an Aging Population," Social Casework, XLII (January, 1961), p. 22.

mental hospital."[2] C. M. Lyle and O. Trail studied psychiatric patients in foster homes and conclude: "These findings indicate that patients who have attained stability in their behavior and who have potential capacity for constructive relationships with even a very few people, may be helped to move from institutional living and make further progress toward resocialization in carefully selected homes other than their own."[3] ". . . this type of care has a stimulating effect upon the institutionalized patient."[4] Indeed much can be done to improve the emotional, mental, social, spiritual and mental condition of the emotionally, mentally ill aged person.

At the Veterans Administration Hospital at Tomah, Wisconsin, group centered activities with elderly psychotic patients "met with much success." Self government, corrective therapy, recreational therapy and group psychotherapy, one or more of these activities each day, improved health, morale, cleanliness, ward adjustment, social behavior. Even long

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[2] M. L. Hemmy, N. S. Farrar, "Protective Services for Older People," Social Casework, XLII (January, 1961), p. 19.

[3] C. M. Lyle and O. Trail, "A Study of Psychiatric Patients in Foster Homes," Social Work, VI (January, 1961), p. 88.

[4] Ibid.

term sitters were motivated.[5]

W. Pappas, W. P. Curtis, and J. Baker describe a controlled study of 266 aged hospitalized patients. The control patients were given only custodial care. The experimental group was given intensive treatment including: somatic therapy, occupational therapy, recreational therapy, volunteers services, personalized attention from aides, in accordance with a specific plan. They conclude that intensive treatment, even if limited, "is of distinct benefit to geriatric patients."[6]

At the Osawatomie State Hospital from September, 1954, to January, 1957, group work was carried out with 28 patients. The therapist introduced the group members to each other, and told them they had come together to become friends, to help each other, to learn about each other's troubles. The therapist was passive, encouraging the patients to talk about their problems. All of the patients were urged to take part in occupational therapy and recreational therapy also.

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[5]Charles N. Bourestom, Peter R. Brasic, "Group Centered Therapy As a Motivational Catalyst in a Geriatric Program," Journal of the American Geriatric Society, VI (December, 1958), pp. 391-94.

[6]W. Pappas, W. P. Curtis, and J. Baker, "A Controlled Program for Hospitalized Geriatrics Patients," Journal of the American Geriatric Society, VI (January, 1958), pp. 17-26.

Of the 28 patients in the group, two died, four were unimproved, eight showed slight improvement, 14 showed definite improvement. There was better socialization, increased self-esteem, decreased hostility, lessening of delusions.[7]

The author of the above article, in an article published 15 months later, about the same hospital, states that in the hospital custodial care was replaced by an active psychiatric treatment program conducted by trained personnel. That, "the results of this treatment . . . are very encouraging. More patients than ever before are leaving the hospital to be restored to their communities, to their families, to foster homes, or to nursing homes. Many of them are able not only to adjust well outside the hospital after 20 or more years of hospitalization, but to begin a more active, useful, and meaningful life."[8]

L. E. Moody describes a release program at Norfolk State Hospital in 1955, including individual casework as well as participation in orientation groups. He states that this program has helped patients approved for release from the

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[7]Kurt Wolff, M.D., "Group Psychotherapy With Geriatric Patients in a Mental Hospital," Journal of the American Geriatric Society, V (January, 1957), pp. 13-19.

[8]Kurt Wolff, M.D., "Active Therapy Replaces Custodial Care for Geriatric Patients in Mental Hospitals," Geriatrics, XIII (March, 1958), pp. 174-75.

hospital to accept a change in their environment. "Since its inception . . . the program has been instrumental in the release of more than 450 patients who would probably have remained in the hospital for life."[9] The program has allowed the hospital to accept transfer of patients from more crowded hospitals, within the state, and to maintain vacancies so no patient in the area served by the hospital is denied admission to the hospital for lack of room. Through this program patients can live out their lives in their home community, some returning to their own home as well. This gives a fuller, more expressive life during the patient's remaining years.

In an article entitled "An Intensive Treatment Program for State Hospital Geriatrics Patients," S. Atkinson, S. P. Field, and J. G. Freeman describe an intensive treatment program for geriatric patients at the Fergus Falls State Hospital. They state that the first six months of this intensive treatment program resulted in a 338% increase in discharges, adding that after the first six months' period discharges decreased from this amazing rate, but stabilized at a rate considerably above that prior to the instituting

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[9]L. E. Moody, "Release Program for Geriatric Patients at a State Mental Hospital," Geriatrics, XIV (March, 1959), pp. 182-84.

of the program. These three authors state that, "Even with definite limitations, state mental hospitals can inaugurate treatment programs that will increase the discharge rate."[10] They add, "The importance of the social worker on the team must not be underestimated."[11]

C. M. Light and O. Trail agree with the importance placed on the role of the social worker in the rehabilitation of the aged, affirming, ". . . and the social worker in the mental hospital is vitally important in the rehabilitation of aged, emotionally ill persons. Indeed, the older person ventures toward new contacts, experiences, activities, over the bridge of his dependence on a worker. His security as a human being is revived by the worker's acceptance of him and from this he can move on to further growth and new adaptations."[12]

S. Bowers defines social casework as, ". . . an art in which knowledge of the science of human relations and skill in relationships are used to mobilize capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any

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[10] S. Atkinson, S. P. Field and J. G. Freeman, "An Intensive Treatment Program for State Hospital Geriatrics Patients," Geriatrics, X (March, 1955), pp. 111-17.

[11] Ibid.

[12] C. M. Light and O. Trail, "A Study of Psychiatric Patients in Foster Homes," Social Work, VI (January, 1961), pp. 82-88.

part of his total environment."[13]

In the article, "Rehabilitation of the Mentally Ill Aging," David Freeman agrees with the importance of social work in the rehabilitation and returning of mentally ill patients to the community. He affirms, "For the job of returning patients to the community and sustaining them there, social work is the key discipline. Social work supplies the skills and the methods to bring the patient and his family together, or to bring the patient and a substitute family together if his true family has disintegrated; to stir patients out of the torpor of institutional life and stimulate their interest in social satisfactions; and to assemble the resources of a community for their use and welfare."[14]

Why should there be concern over whether or not aged patients in mental hospitals remain in these hospitals, or return to the community and make an adequate adjustment there? In a booklet, "Senior Citizen at the Crossroads," reprinted from "What's New," Number 214, Early Winter, 1959, Abbott Laboratories, North Chicago, Illinois, we find this statement:

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[13]Walter A. Friedlander (ed.), Concepts and Methods of Social Work (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1958).

[14]David Freeman, "Rehabilitation of the Mentally Ill Aging," Social Work, IV (October, 1959), pp. 65-71.

"According to expressed desires of average aging individuals, they want more than anything else to live their retirement years independently at home -- be it in a house, hotel, or an apartment." This is based on an reference to: R. J. VanZonneveld, "Geriatrics," 13:668-672, October, 1958.

To live independently at home, in the community, may be the desire of aged persons, as expressed above, but what are the needs of the elderly person, and are these better met and more completely met at home, in the community, than in the mental hospital? "The basic psychological needs of man have been identified as the need for affection, security, status, expression, achievement, independence, and, possibly, novelty. Man's psychosocial needs are for participation or the sharing of experiences, for conformity to the pattern of the group, for social approval and recognition. If these needs are denied expression, frustration results. This is not to say that all frustration is harmful, for one of the marks of maturity is a certain capacity for frustration tolerance; but frustration may give rise to unhealthy mechanisms and undesirable behavior reactions.

"While it is true that the degree of these needs varies from individual to individual, they are the needs of every man. Needs may be reinforced or inhibited, manifestations

of the same need may be different, and men want much beyond their basic needs; the dynamics entering into the formation of each personality are unique."[15]

Authors O. Spurgeon English, M.D., and Stuart M. Finch, M.D., state: "The mentally healthy individual is an active, interested, enthusiastic, and constructive member of society. The individual suffering from mental or emotional disturbance is an unhappy, struggling, inefficient person who is a drain on himself, his family, and often society."[16]

In their book, Emotional Problems of Living, O. Spurgeon English and Gerald H. J. Pearson speak of emotional health, which it is hoped that the mentally ill can be helped to obtain. "Gloom, pessimism, apathy, inactivity, feelings of inferiority, self-pity, self-criticism and hopelessness about life not only limit an individual's effectiveness but also make him an unattractive and even burdensome member of society whether he be at work, at home, or at play . . . . A person needs to think well of himself and be in fairly continuous rewarding relationship with life and people in

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[15]Felix P. Biestek, The Casework Relationship (Chicago: Loyola University Press, 1957), p. 34.

[16]O. Spurgeon English and Stuart M. Finch, Introduction to Psychiatry (New York: W. W. Norton and Co., Inc., 1954).

order to avoid the distress of lowered self-esteem. An individual cannot afford, if he is to keep his emotional health, to withdraw interest and permit his self-esteem to fall for long periods at a time.[17]

"Some people may derive their satisfactions in more glamorous and interesting ways but to have a healthy sense of well-being one must (1) start life with a sense of security, if possible; (2) accept new responsibilities all the time; (3) be able to endure some sense of inadequacy daily; (4) keep that sense of inadequacy neutralized by warm, enriching friendships and constructive activity (work); (5) keep in step with the changing demands and gratifications of each decade of life; (6) visualize future goals; and (7) build up a reservoir of pleasant memories and be resourceful and useful to others so as to neutralize the disallusionments of the aging process.

". . . threats to the disturbance of the desirable level of psychic equilibrium we call 'normal.' . . . . must be compensated for by new knowledge, new skills, new wisdom, new scenes, new usefulness, new outlooks, new undertakings,

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[17] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living (New York: W. W. Norton and Co., Inc., 1945), p. 574.

in other words, by self development."[18]

The authors quoted above, Felix P. Biestek, O. Spurgeon English and Stuart M. Finch, and O. Spurgeon English and Gerald H. J. Pearson, state that the needs of the aging and aged include the following: affection, security, status, expression, achievement, independence, novelty, participation or sharing of experiences, conformity to the pattern of a group, social approval, social recognition, to think well of themselves, to be in a fairly continuous rewarding relationship with life and people, to have responsibilities, and friendships. Additional needs of these becoming elderly, and of those elderly, include: building up a reservoir of pleasant memories, goals to be worked toward, to be resourceful, to be useful, to acquire new knowledge, to gain new skills, to accumulate new wisdom, to observe new scenes, to participate in new undertakings, to gain new outlooks.

While it is possible that some of these needs of the aging and aged can be met in a mental hospital, it is possible, and more possible, for them all to be met while the individual is living in the community. While for some persons becoming elderly and the elderly, these needs possibly may be better

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[18] Ibid.

met in a mental hospital, for the majority of oldsters, these needs can best be met in the community. Indeed, for some oldsters, some of these needs can be met only in the community, and not in the mental hospital. Therefore, so that most of these needs can best be met for a majority of the aging and aged, it is helpful to help them to become sufficiently well enough so that they can leave the mental hospital and return to the community.

L. E. Moody claims that returning to the community from the mental hospital, gives fuller, more expressive life to a patient's remaining years. He adds that releasing patients from the mental hospital who have been helped to improve to the point that they can make an adjustment in the community, has allowed the hospitals to accept transfer of patients from more crowded hospitals, to maintain vacancies so that no patient in the area the hospital serves need be denied admission for lack of room in the hospital.[19]

In their book, Introduction to Psychiatry, O. Spurgeon English, M. D., and Stuart M. Finch, M.D. state that, "Many millions of dollars are spent annually upon the protracted

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[19]L. E. Moody, "Released Program for Geriatric Patients at a State Mental Hospital," Geriatrics, XIV (March, 1959), pp. 182-84.

care of those who are mentally ill."[20]

They add that it is much more expensive to maintain the aged in mental hospitals than it is to help them to improve to the point that they can be returned to the community.

Therefore, the answer to our question, Why should there be concern over whether or not aged patients in mental hospitals remain in these hospitals or return to the community and make an adequate adjustment there? may be answered by saying that, in general, it is fully possible for aged patients in mental hospitals to become sufficiently stabilized, to become sufficiently well, to leave the hospital, to return to the community and to make a satisfactory, or even more positive adjustment there. It is believed that aged patients prefer to live in the community; that they would be happier and better adjusted living in the community; that they could thus lead more productive lives. Some elderly patients have families to whom they can return, thus re-establishing their families.

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[20] O. Spurgeon English, M.D., and Stuart M. Finch, M.D., Introduction to Psychiatry (New York: W. W. Norton and Co., Inc., 1954).

In addition, hospital care is expensive, and more expensive than out-patient care, even should the oldster need continued care while living in the community. And, hospital space is needed for those completely unable to live in the community; when aged patients who can adjust outside the hospital are living in the community this frees space for those needing in-patient care. There is a shortage of facilities for the mentally ill who need hospitalization.

CHAPTER II

THE SETTING FOR THE STUDY

The study was done at the Veterans Administration Hospital, Battle Creek, Michigan. It is felt knowledge about the hospital will help in understanding this study.

The material for the first part of this chapter is taken from the "Social Service Orientation and Resource Handbook,"[1] published by the Hospital.

The Veterans Administration Hospital, Battle Creek, was first opened October 15, 1924. The original hospital housed 500 beds, and now can accommodate 2,055 patients. Originally the hospital was built for veterans with mental illness, and continues to serve the veteran with mental illness. The hospital is under the direction of the Manager, a psychiatrist, who is responsible to the Administrator of Veterans Affairs and to the Medical Service of Central service. The Assistant Manager and Chief of Professional Services, a psychiatrist, are directly responsible to the Manager.

Professional services include these divisions:

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[1]Katharin denEleyker, Social Service Orientation and Resource Handbook (Fort Custer, Michigan: Veterans Administration Hospital, revised August, 1952).

Medicine, Denistry, Pharmacy, X-ray, Laboratory, Dietetics, Nursing, Psychology, Physical Medicine Rehabilitation, Vocational Rehabilitation, Contact and Social Work Service.

How did the social work service become established in the Veterans Administration Hospital? Following World War I, the American Red Cross assigned social workers to Veterans Hospitals with the understanding they would carry on social work until the Veterans Bureau was able to assume this program, which it did in 1926. On October 16, 1926, the first Veterans Administration social worker was assigned to the hospital. The first Casework Supervisor joined the staff in January, 1949. The Student Training Program was begun September, 1951. There is now a Chief Social Worker as administrator of Social Work Service and nine social workers.

Social Work Service is under the supervision of the Chief Social Worker who is directly responsible to the Chief of Professional Services. In general, the function of Social Work Service is the facilitating of medical treatment by helping the patient to deal with personal and social problems which might prevent his maximum recovery. This is done by working directly with the patient and often with his family, also by furnishing the physician with data concerning the patient's history which will be significant to him in

diagnosis and in planning treatment.

More specifically, on admission the patient is interviewed by the social worker who establishes a professional relationship to allay some of the patient's anxieties and worries about his hospitalization, the worker also working with other problems and fears related to the patient's illness. The worker employs the relationship to evaluate potential for, and methods of, further casework services with the patient, family, community; the relationship also involves the caseworker acting as a resource person. When the patient's family, relatives or others accompany the patient or visit the hospital, the social worker works with them to help them accept the patient's illness and hospitalization; interprets the hospital's functions and facilities; and helps them with their own feelings and problems relative to the patient's hospitalization.

The worker does a social study which may help in establishing a medical as well as social diagnosis, and in formulating treatment plans. In diagnostic conferences, the worker states his formulation of social factors in assisting in the establishment of the diagnosis and treatment plans. Such plans are made in team meetings conducted by psychiatrists as head of the team, and includes social workers, psychologists,

and representatives from auxiliary services.

At the time of the patient's admission, ground work is laid with the family which will permit the return of the patient to the community. Through casework service the family is enabled to modify and change harmful attitudes and improve environmental conditions. Contact may be made with employers, friends, and other agency persons in the community, through whom desired attitudes may be affected, which will help the patient return to a more accepting, understanding, community.

After the patient leaves the hospital on trial visits he is referred to out-patient which is responsible for giving supervision to the patient and his family, either directly or through a community agency. With patients who remain hospitalized for years, the social workers' role is helping regressed patients participate in Special Services and in the Physical Medicine Rehabilitation Program.

Veterans who are resident patients or who are receiving treatment in a clinic under jurisdiction of the hospital will be eligible for social service. Also, applicants for hospitalization who need assistance with plans to facilitate hospitalization; and those in need of referral to community medical or social resources instead of hospitalization, may

receive social service help. Referrals for social service may be received from physicians and other hospital personnel who work directly with the patients, from the patient himself, from private individuals, other veterans administration stations, community agencies, etc. Referrals made by veterans administration sources will state the nature and extent of the service requested and will be brought to the attention of the ward physician. They will be evaluated to determine if an actual problem or need exists before social service action will be initiated.

For the purposes of this study, it will be of value to know how patients may leave the hospital, and there are several ways. Patients may be given passes by their medical officer or a leave of absence may be granted and issued by the ward physician and may be extended. Trial visits also are granted. Social workers have special responsibility for patients on trial visit. Patients may be discharged with Maximum Hospital Benefit, meaning they will no longer benefit from hospitalization; Against Medical Advice, meaning the patient may demand a discharge and if he is not committed, the hospital cannot hold him; and Away Without Leave.

The "Information Handbook for Hospital Volunteers Veterans Administration Hospital, Battle Creek, Michigan,

states, page 10: "The family care [now called foster care] program is a specialized way for patients to leave the hospital. A foster home is the home of a private individual or private family, who board and room the patient, and who accept him as a member of their family. The patient pays for his board, room and laundry. The program is based on the fact that home life is the natural setting for human beings. A patient who has no home, or cannot return to his own home, can enjoy a sense of belonging to a family unit. People need to feel that someone cares, and this is true to a larger extent of persons who have become mentally ill. A wholesome family environment helps in the patients readjustment to normal living.

Family care is the combined responsibility of all hospital units, the social worker being the liason person between the hospital, the patient, the Family Care home and community."

This additional information is added to that obtained from the "Social Service Orientation and Resource Handbook."

There are insufficient social workers to work with every patient at this hospital, and so a choice needs to be made as to which patients with whom to work. The decision at present is to work with primarily the younger patients

whose prognosis would indicate ability to again work and adjust in his home and who has a wife and children who need his emotional and financial support; who is more likely to be able to be self supporting; and who may, in general, be more amenable to treatment.

In selecting the aged patients with whom to work to help him become sufficiently well to return to the community, the first consideration is given to those who are not dangerous to themselves or to others; next necessity is whether they have a home to return to; or sufficient funds to support themselves in a Foster Care.

It is of interest to note that senile patients are among those considered for assistance by social work service. (Many patients leave the hospital who have not been helped by social work service, many of them medical patients, but it is felt by social work service that these could have been helped further in their adjustment had they too had the services of the social worker.)

The number of patients 65 years and older at the Veterans Administration Hospital, Battle Creek, Michigan, has varied somewhat during the past several years. In 1958, there were 228 patients 65 years plus, in 1957 there were 237 patients 65 years and over, the number of patients 65 years

and over in the hospital in 1959 was not available, and in 1960 there were approximately 300 patients 65 years of age and older.

CHAPTER III

METHODOLOGY

As several authors have been quoted in a previous chapter, the social worker in the profession of social work can be the prime factor to help the aged patient to help himself to become sufficiently well and stabilized to leave the mental hospital and to return to the community and make an adjustment there. A patient is considered to be making a satisfactory adjustment if he is able to care for his bodily needs, if he can function without harm to himself and others, if he can handle his finances or have them handled by a guardian or his family. A patient may be able to make a more positive adjustment, which may include his being able to make and maintain satisfactory relationships with others, being helpful to others, increasing in knowledge and skills, or even being productive.

In this descriptive study, only those patients who left the hospital MIB, i.e., with having received maximum hospital benefits, are considered; not those who left AMA, i.e., against medical advice, or AWOL, i.e., absent without leave.

The aged person is considered to be one who is 65 years of age and older; and in this study, 65 years and

older by January 10, 1961.

As closely as could be determined by interviewing social workers in the Veterans Administration Hospital, Battle Creek, Michigan, social work service, and by searching the social service files back to January, 1958, and from there through January, 1961, there are currently (up to January 10, 1961) 29 patients 65 years of age and older being worked with in social service.

The records of these 29 patients were obtained and read. These records are compiled by the social workers working with the patient. They include identifying information about the patient, the precipitating cause of the patient's entering the hospital, the history of his illness, the patient's social history--including the military history of the patient, psycho-social diagnosis, treatment plans, information about the carrying out of treatment plans, about the social worker's contacts with the patient. In addition, the records may also include results of testing, reports on interviews with relatives, reports on the patient from collaborating agencies, reports on the social worker's contacts regarding the patient with other hospital personnel, and process recordings. These records were added to periodically by the social worker as he worked with the patient. The

length of the records varies, depending on the nature of the case. The records are used to facilitate treatment of the patients by the social worker, and also by other hospital personnel.

After reading these 29 records several times, it was determined that four of the records provided insufficient information to warrant their being used in this study. This left 25 records which would seemingly prove of value to this descriptive study, 12 of these records being of patients in the hospital, and 13 of the records being those of aged persons who had left the hospital, having received maximum hospital benefits. Ten cases of elderly patients remaining in the hospital were selected randomly as were ten cases of elderly patients who had left the hospital. After this selection of a total of 20 cases, the various social workers in the hospitals social work service were asked if they felt these particular records should prove of value to the study, or if they knew of some reason why they should not be utilized. They felt these 20 records should prove of value to this study.

Pertinent and helpful background for this descriptive study of 20 aged patients worked with by social work service at the Veterans Administration Hospital, Battle Creek, Michigan,

was gained by a conducted tour of one of the two buildings housing most of the aged patients there, by a conducted tour of the hospital's family care ward. Background was also gained by assisting a social worker with two aged patients who left the hospital for a family care home, and by a visit to them in their family care home some weeks later. Further background was secured through interviewing the wife of one aged patient who remained in the hospital, and working with an elderly patient for the purpose of motivating him toward an interest in leaving the hospital, and helping him move into family care.

A school of social work second year field placement at the Veterans Administration Hospital, Battle Creek, Michigan, provided understanding of the situation there which was of inestimable value in this descriptive study, and also was invaluable in the understanding of the aged mentally ill patient, including what is involved in his diagnosis, treatment planning and treatment--including helping him to become sufficiently well to leave the hospital, to return to the community, and to make and, hopefully, to continue, an adequate adjustment there.

The categories on which information were gathered, from the social work service case records of the patients,

are as follows: age of the patient at admission to the Veterans Administration Hospital, Battle Creek, Michigan; age of the patient when social service began working with him; how long the patient had been in the hospital before social work service began working with him; date of admission to the hospital; employment; competency; race; religion; marital status. Other categories including schooling; interest of his family in him; interest of his friends in him; activities in which the patient engaged while at the hospital; diagnosis; motivation for leaving the hospital; financial status of the patient; birthplace; physical condition; war served in; service connection; commitance; guardianship; direct activities of social work service with the patient. A copy of the schedule can be found in the appendix.

Social service activities with and for the patients were considered to include interviews with the patient, contacts with the patient's relatives, assisting the patient to move to and utilize the family care ward, assisting the patient move to a family care home, following up a patient's move to a family care home to help him adjust there, assistance with financial matters, assistance with clothing needs, encouraging the patient's participation in activities, helping the patient with his medical needs, assisting the patient's

arrangement for a trial visit, helping with arrangements with a patient's passes and leaves of absence, help with plans to leave the hospital other than to a family care home, contacting other resources which may be of help to the patient, exploring job possibilities, giving help in the patient's learning to improve his appearance and personal habits, checking with other hospital personnel regarding the patient.

The following information on competency has been extracted from the M-2 Part X dated October 11, 1958, and is used as a definition of competency in this thesis. The following general criteria will be observed in determining the competency of a veteran:

1. To render a medical opinion of incompetency it must be established that the veteran has:

    a. Psychosis or psychotic reaction.

    b. Chronic brain syndrome.

    c. Prolonged amnesia, confused, dissociated, clouded, or fugue state.

    d. Mental deficiency.

2. It must be shown that one of the above has led to one of these incapacities:

a. Squandering or dissipation of funds or other assets due to lack of appreciation of value. Incompetency cannot be adjudicated simply because of bad judgment due to lack of sophistication, inadequate education, or inexperience.

b. That the veteran has been, or almost certainly would be, victimized by designing persons and that such gullibility is due to one of the disorders listed.

c. That there has been, or almost certainly would be, unnecessary refusal to spend money or to expend other assets because of delusional thinking or because of lack of appreciation of the needs of himself or his dependents, that such refusal is due to one of the disorders listed above, that such refusal would deprive the veteran or his family of otherwise obtainable comforts of life.

CHAPTER IV

SUMMARY OF THESE FINDINGS

The case records of each of the 20 aged patients using social work service at the Veterans Administration Hospital, Battle Creek, Michigan, were studied in an endeavor to obtain information about each category for each of the patients. It was found that information about each category for each patient was not always available. As much information as was available was gathered and listed for each patient. This information was then divided into two groupings, for those patients who had been helped to leave the hospital, and those who remained in the hospital. A comparison of these two groups was then made. A summary of the findings follows, and a table of the findings is to be found in the appendix.

Admittance

On the average, from the date December, 1960, patients remaining in the hospital were admitted 18 years ago, and patients having left the hospital were admitted 13 years ago, a difference of five years.

Length of Time Patient Was In the Hospital Before Social Work Service Reached Him

Patients who had left the hospital were reached by

social work service at an earlier stage of their hospitalization than those who are still in the hospital. For those who left, the average amount of time which elapsed between this entry into the hospital and their first contact with social work service was nine years. This compares with an average of 14 years for those who are still in the hospital. Five of the patients who have left the hospital had been seen by social work service immediately upon their original hospitalization, whereas, two of the patients remaining in the hospital had been seen by social work service immediately upon their original hospitalization.

Age at Admittance

The age at admission was younger for those patients remaining in the hospital, than for those who had left. Of those patients still in the hospital, four had been in the 30 to 39 age range at time of their admission, but five were over 50. Of the ten patients who had left the hospital, six had been between 60 and 69 upon admittance but eight were over 50.

Religion

The faiths represented were the Catholic and the Protestant. Of those patients remaining in the hospital, eight were reported on, and of these six were Protestant, and

two were Catholic. Of those patients in the study who had been helped to leave the hospital, six were reported on and of these, four were Catholic and two were Protestant.

Marital Status

Of the ten patients remaining in the hospital, four were married and of those out of the hospital, three were married. In addition, of the patients in the hospital, three were single, while of those out of the hospital, five were single. The remainder were divorced or widowed: two of those in the hospital were divorced and one widowed; one of those out of the hospital was divorced and one widowed.

Activities, Socializing and Community Contacts

Concerning activities, socializing and community contact by the patient, of those in the hospital, nine were reported on. Of the nine, five engaged in activities (such as occupational therapy, educational therapy, corrective therapy, manual arts therapy, recreational activities, etc.). Of the nine, six were said to socialize, and two had community contacts (such as going into town on passes). Of those patients who had left the hospital, seven were reported on.

Of these seven, six engaged in actities, six were said to socialize, and three had community contacts.

Education

Such information is given for only three of the patients remaining in the hospital, and these had reached the seventh and eighth grades, while information is available for five of the patients out of the hospital, and these were evenly distributed between grades four and eight. It is of interest to also note that of the total of eight patients for whom educational information is available, none went beyond the eighth grade. It should probably be borne in mind that in the days of the youth of these elderly patients, such a limited education may have been quite general and not unusual.

Competency

Of those out of the hospital, seven were reported on, and of those in the hospital, five were reported on. Of these, of those out of the hospital, six were not competent, whereas four of those remaining in the hospital were non-competent.

Race

Information is available for five patients out of the hospital, and available for seven patients remaining in the

hospital. Of these, of those out of the hospital, one was a Negro and four were white. Of these, of those remaining in the hospital, none were Negro and all were white.

War Served In

All of those patients considered in this study, both in the hospital and those who had left it, served in World War I.

Service Connection

Of those in the hospital, nine were reported on; seven were service connected, two were not. Of those out of the hospital, eight were reported on; three were service connected and five were not.

Guardianship

Of those in the hospital, eight were reported on; seven had a guardian. Of those who had left the hospital, six were reported on; five had a guardian.

Occupation

Of those who had left the hospital, ten were reported on. Of these, eight were laborers, and two were skilled laborers. Of those remaining in the hospital, six were reported on; three were laborers, one was a skilled laborer, one was in management and one was in sales. Also, the

occupations for 16 of the total of 20 patients were given, and 11 were laborers.

Motivation

Of those patients who had left the hospital, information is given for eight. Of these, two had no motivation, four had average motivation, two had high motivation. Of those remaining in the hospital, information is given for ten: three had no motivation, two had little motivation, two had average motivation and three had high motivation. Five of those in the hospital had no or little motivation and two of those who had left; whereas five of those in the hospital had average or high motivation and six of those who had left had average or high motivation.

Financial

Of those out of the hospital, information is given for nine patients, but not complete information for all of these. Of these, one had between $700 and $2,999, one between $3,000 and $8,999 and two had $9,000 or more. Of those remaining in the hospital incomplete information is given for nine patients. Two had between $700 and $2,999, three had between $3,000 and $8,999. Of those in the hospital, five had funds, and of those out of the hospital, seven had funds saved. Of those out of the hospital, six had a monthly income,

and of those staying in the hospital, all reported on did.

Birthplace

Only seven of the 20 cases provided this information, so that this evidence is, therefore, too inconclusive to consider.

Areas Help Given With

Social work service helped those patients remaining in the hospital with fewer areas in which aid was needed, six; than those patients leaving the hospital, ten areas.

Diagnosis

Of those in the hospital, six had a diagnosis of schizophrenia, two had a diagnosis of chronic brain syndrome, one had a diagnosis of dementia praecox, and another one was diagnosed as a medical problem. Of those patients who had left the hospital, six were diagnosed as schizophrenic, three were diagnosed as chronic brain syndrome, and one as psychosis. In the total number of cases studied, 12 were schizophrenic, five were chronic brain syndrome; with medical problem, dementia praecox and psychosis accounting for one patient each.

Committed

Of those patients remaining in the hospital, seven were reported on. Four were committed and three were not. Of those patients who had left the hospital, six were reported on and all six were committed.

Family and Friends

Of those patients in the hospital, four had family or friends to return to, whereas of those who had left the hospital, three had family or friends to return to. Of those in the hospital, one had no family or friends at all, and of those out, two had none. Of those out of the hospital, one had family or friends but they expressed no interest, while two of those in the hospital had the same situation. Of those who had left the hospital, four had interested friends and of those patients in the hospital, three had interested friends.

Beginning Age at Which Social Work Service Worked With a Patient

The majority of all patients of the total of 20 cases were in the 60 to 69 age range, seven of those in the hospital, and eight of those out of the hospital. Two of those in the hospital were in the 70 to 79 age range and one was in this

age range of those who had left the hospital. One of both those in and out of the hospital were in the 50 to 59 age range.

Physical Condition

Of those in the hospital, eight were reported on, and seven of those out of the hospital. Of these, of those in the hospital, approximately four had physical difficulty, and four had none. Of those patients having left the hospital, it was indicated that approximately six had physical difficulty and one had none.

SUMMARY

It seems that the patients who are older at admittance are most likely to leave the hospital.

There is some indication that the younger the age of patients when they are begun working with, the greater is the possibility they will be able to be helped to leave the hospital.

It seems that possibly patients admitted the most recently have a better possibility of leaving the hospital, with the aid of social work service. However, the two patients who entered the hospital in 1925 and were in the hospital 32 and 35 years were helped to leave, so there is hope for such.

The sooner social work service begins working with a patient after his admittance, the stronger may be the possibility of helping him to leave the hospital.

More of those who were Catholic left than those who were Protestant.

It would seem that having physical symptoms is not necessarily a deterrent to helping a patient leave the hospital.

It seems committed patients are more likely to leave the hospital.

There is some indication that a patient is more likely to be helped to leave the hospital if he were judged incompetent.

Service connected patients seem more likely not to leave the hospital than non-service connected.

There is some indication that patients with a guardian are more likely to be in the hospital than those without a guardian.

There is some indication that patients in the laboring class are more likely to leave the hospital than other working classes, and that the majority of the 20 patients were in the laboring class.

It appears that the single patient is more likely to be able to be helped to leave the hospital.

Apparently those with family or friends to return to are more likely to stay in the hospital. Those who do not have a family home to return to, but do nevertheless have interested relatives and friends, are most likely to leave the hospital. But the difference is not very great, which indicated these factors can be overcome through the help of social work service.

It seems it is important that social work service help the aged mental patient with such matters as medical and

financial problems, activities, contacts with relatives, and so on.

The patient's degree of motivation for leaving the hospital is significant, the higher the more likely he is to be helped to leave the hospital.

Findings on financial status, birthplace, education and race were too incomplete to warrant any conclusions.

There does not seem to be too great a difference between those in and those out of the hospital as far as diagnosis is concerned.

CONCLUSIONS

The following are not definite conclusions. The material gathered in this study is too limited to permit generalizations. The purpose of the study was to try to identify some of the factors that might contribute to the adjustment of an aged person, so that he may be helped to leave the hospital. The following are not conclusions, but suggestions as to what factors may have such significance. Only more systematic research with large numbers of cases could determine their actual effect.

It seems to be indicated that the older a patient is at admittance, the more likely he is to leave the hospital. Therefore, the question may be raised, should patients be encouraged to remain out of the hospital as long as possible, perhaps with the help of a mental health out-patient clinic, or mental health private services?

On the other hand, the younger in age patients are when worked with in the hospital, once there, the more likely they are to leave the hospital.

The sooner they are worked with after admission, the more likely are patients to leave the hospital. Perhaps a big factor here is helping to prevent the patient from becoming institutionalized.

This seems indicated also by the fact that those patients admitted more recently have more tendency to leave; and it is of late years that it has become apparent that patients can become institutionalized, and efforts to prevent this have been worked toward.

It seems important that the patient be motivated to leave the hospital. That a major help in this may be encouraging his participation in activities, socialization and community contacts.

It seems evident also that unless a patient is severely incapacitated physically, his physical condition need not be a deterrent to his leaving the hospital.

Nor need the patient's diagnosis prevent his leaving the hospital, unless he is severely emotionally ill.

It does not seem to deter a patient's leaving the hospital if he is incompetent nor does it seem to deter his leaving if he is committed.

Those patients not having guardians are more likely to leave; therefore, it seems that more work need be done with guardians to help them to be able to become a positive help in a patient's leaving the hospital.

If patients are to be helped to work upon leaving the hospital, it seems jobs for the unskilled will have to be

searched for, as most patients who had left were laborers, indeed, the great majority of the patients in this study were laborers.

As religion seems to be a factor in a patient's leaving, perhaps continued cooperation with the patient's pastor, priest or rabbi, and the hospital chaplains can be continued.

As more single patients leave the hospital, it seems necessary to do more work with married patient's families, that they may be better able to accept the patient's return home, and so better able to encourage him to leave the hospital.

As, at the present at least, the single patient is more likely to leave the hospital, family care homes seem needed for him as he is not likely to return to his family, according to the findings.

Service connected patients are less likely to leave the hospital: they are more likely to have funds connected with their remaining in the hospital and/or being declared ill. Here financial assistance and motivation may perhaps play an important part.

APPENDIX

APPENDIX TABLE

CHARACTERISTICS OF AGED PATIENTS LEAVING OR REMAINING IN THE VETERANS ADMINISTRATION HOSPITAL, BATTLE CREEK, MICHIGAN

Characteristics	Number of Aged Patients	
	Who Remained in the Hospital	Who Left the Hospital
TOTAL	10	10
Age At Admission		
20-29	0	1
30-39	4	1
40-49	1	0
50-59	2	2
60-69	1	6
70-79	2	0
Age When Social Service Initiated		
20-29		
30-39		
40-49		
50-59	1	1
60-69	7	8
70-79	2	1
Length of Stay in Hospital Before Social Service Initiated		
At once	2	5
Within 1 year	1	1
2 to 6 years	2	1
7 to 11 years	0	0
12 to 16 years	0	1
17 to 21 years	0	0
22 to 30 years	4	0
31 to 35 years	Ø	Ø

APPENDIX TABLE Continued

Characteristics	Number of Aged Patients Who Remained in the Hospital	Who Left the Hospital
Date of Admission		
1924-1934	4	2
1935-1944	21	1
1945-1954	0	4
1955-1960	5	3
Diagnosis		
Schizophrenia	6	6
Medical Problem	1	0
CBS	2	3
Dementia Praecox	1	0
Psychosis	0	1
Motivation for Leaving Hospital		
None	3	2
Little	2	0
Average	2	4
High	3	2
Unknown	0	2
Financial Amount Saved		
$ 700 - 2,999	2	4
3,000 - 8,999	3	0
9,000 plus	0	2
Unknown	5	4
Had Funds Saved	5	8
Unknown	5	2
Had Monthly Income	9	7
Unknown	1	3

APPENDIX TABLE Continued

Characteristics	Number of Aged Patients Who Remained in the Hospital	Who Left the Hospital
Physical Condition		
Difficulty	4	6
No Difficulty	3	1
Unknown	3	3
Service Connection		
Yes	7	3
No	2	5
Unknown	1	2
Committed		
Yes	4	6
No	3	0
Unknown	3	4
Guardianship		
Yes	7	5
No	1	1
Unknown	2	4
Employment		
Laborers	3	8
Skilled Laborer	1	2
Manufacturer	1	
Sales	1	
Unknown	4	0
Competency		
Yes	1	1
No	4	6
Unknown	5	3
Race		
White	7	4
Negro	0	1
Unknown	3	5

APPENDIX TABLE Continued

Characteristics	Number of Aged Patients Who Remained in the Hospital	Who Left the Hospital
Religion		
Catholic	2	4
Protestant	6	2
Unknown	2	4
Marital Status		
Married	4	3
Single	3	5
Divorced	2	1
Widowed	1	1
Unknown	0	0
Schooling -- Highest Grade Attended		
4th		1
5th		1
6th		1
7th	1	1
8th	2	1
Unknown	7	5
Family Situation		
Home Available with family	4	3
Relatives -- No home	3	4
No Family	1	2
Family -- Not interested	2	1
Unknown	0	0
Areas Help Given With - Average	6	10
Unknown	0	0
Birthplace		
Small town	3	0
Large City	2	2
Unknown	5	8

APPENDIX TABLE Continued

Characteristics	Number of Aged Patients Who Remained in the Hospital	Number of Aged Patients Who Left the Hospital
Activities In Which Patient Engaged at Hospital - Number of Patients Doing Same		
Activities	5	6
Socialization	6	6
Community Contacts	2	3
Unknown	1	3

SCHEDULE

Age of patient at admission -- as of December 31, 1960.

Age of patient when social work service began working with him.

Length of time the patient had been in the hospital before social work service initiated.

Date of admission to the hospital.

Employment the patient was engaged in the majority of his lifetime.

Competency of the patient -- at time of admission to the hospital.

Race of the patient.

Religion -- at the time the patient entered the hospital.

Marital status -- at the time the patient entered the hospital.

Schooling -- highest grade attended.

Family -- its interest in the patient, and friends whether or not they were interested in him, determined by whether they visited, called, wrote the patient, or contacted the hospital about him.

Activities in which the patient engaged at the hospital -- his socialization.

Diagnosis.

Motivation of the patient for leaving the hospital -- determined by the patient's expressed interest, and his reactions as observed and recorded by the social worker.

Financial condition of the patient, including source of his financial resources.

Physical condition.

War served in.

Service connection.

Committance.

Guardianship.

Activities of social work service directly with the patient.

Birthplace.

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