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A STUDY TO IDENTIFY FACTORS
ASSOCIATED WITH THE RECIDIVISM RATE OF SCHIZOPHRENIC PATIENTS
AT THE MENLO PARK VETERANS ADMINISTRATION
HOSPITAL IN CALIFORNIA

A Thesis

Presented to

The Faculty of the Department of Social Work
San Jose State University

In partial Fulfillment
of the Requirements for the Degree
Master of Social Work

By

Cynthia Lorene Sharp McClellan

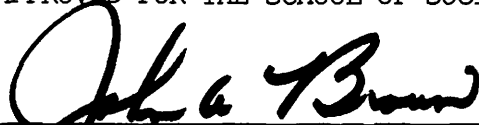
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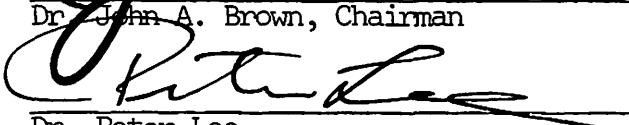
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APPROVED FOR THE SCHOOL OF SOCIAL WORK



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APPROVED FOR THE UNIVERSITY



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ABSTRACT

A STUDY TO IDENTIFY FACTORS ASSOCIATED WITH THE RECIDIVISM
RATE OF SCHIZOPHRENIC PATIENTS AT THE MENLO PARK
VETERANS ADMINISTRATION HOSPITAL
IN CALIFORNIA

Cynthia Lorene Sharp McClellan

Given the severity, the prevalence, and the cost of recidivism of mentally ill patients, there is a growing concern regarding the high rate of readmissions to psychiatric hospitals. Due to these concerns, this research involves discovering factors which cause the schizophrenic to continue to return to the hospital. Research has shown that schizophrenic patients have a high rate of recidivism within the first two to four weeks after discharge. Do factors such as stable income, stable shelter, lack of stable relationships, alcohol or drugs contribute to the rate of recidivism?

The research design was exploratory utilizing a survey technique. This research study consists of administering a questionnaire to a sample of ten male schizophrenic patients at the Menlo Park Veterans Administration Hospital (VA) just prior to discharge. A seven week follow-up study was completed while the subjects were residing in the community using the same questionnaire, by telephone contact or personal interview. If the subject returned to the hospital before the seven week follow-up, the questionnaire was administered, at that time, in the hospital.

The most significant finding was that veterans who were discharged without supportive networks in the community were more likely to encounter problems which led to rehospitalization. In addition, stable income, stable shelter, stable relationships reduced recidivism. Substance abuse was not found to be a factor in this study.

Continuing a supportive network and aftercare services after discharge reduced the rate of recidivism among schizophrenics at the Menlo Park Veterans Administration Hospital.

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CHAPTER 1
INTRODUCTION

Historical Perspective

In 1952, it was discovered that chlorpromazine (Thorazine) helped to reduce the symptoms of mentally ill patients. By 1955, the use of medications for the mentally ill was widespread (Torrey, 1983; Bernheim and Lewine, 1979; Arreti, 1979). Due to this introduction of antipsychotic drugs in the United States, over 200,000 psychiatric patients were released from county and state psychiatric hospitals over a 12 year period (Torrey, 1983). The majority of these discharged patients were schizophrenics. By the late 1960's approximately 200,000 additional mentally ill patients were discharged. The first group was relatively prepared for release and in most cases returned to relatives. The second group was ill prepared to leave the hospital. They were patients who had not responded well to the anti-psychotic drugs and had nowhere to reside when they were discharged. They were returned to a community which was not prepared to receive them. The result was that most of the mentally ill presently reside in boarding houses, board and care facilities, nursing homes, hotels, halfway houses or on the streets. Approximately 50 percent of the homeless in our communities today are mentally ill patients (king, 1984).

One of the reasons which brought about this unplanned exodus from hospitals was the legal suit, Wyatt v. Stickney which mandated hospitals to provide better care for psychiatric patients. State

and county hospitals fearing the results of legal suits began mass emptying of the psychiatric hospitals. California was in the forefront of this movement. In addition, State Legislatures, eager to reduce state budgets, passed the financial burden to the federal government and local welfare departments through medicare, medicaid, general assistance, Supplemental Security Income (SSI), and food stamps.

Although it would be inhumane to return to the prior state hospital system of "warehousing" psychiatric patients, the movement to deinstitutionalize has been a failure. Not only were few states prepared for the change in policy, but the cost of maintaining the patient within the community has been just as expensive as keeping the patient in the hospitals. Transferring or shifting the cost represents no savings (Bernheim and Lewine, 1979).

Community mental health centers have been negligent in providing services for the mentally ill (Gomez, 1979). They prefer to provide services to those who can benefit from insight therapy, than for schizophrenics who are thought of as "untreatable". One study revealed that only 25 percent of the schizophrenic population was receiving aftercare services (Torrey, 1983).

As a result of this trend, the vast majority of the schizophrenic population have become part of the revolving door syndrome (Arreti, 1979). Rapid discharge of patients has led to the increase in the number of readmissions. Readmission rates in state and county hospitals from 1955 to 1975 has increased from 178,003 to 374,554. The readmission rate in state hospitals in New York

increased during this same period from 27.2 percent to 60.6 percent (Gomez, 1979). Other studies show a smaller recidivism rate of psychiatric patients of approximately 50 percent (Rosenblatt and Mayer, 1974a; Dincin and Witheridge, 1982). Due to the change in admission practices, the reduced stay in the hospital and the increased number of patients living in the community, there are more patients available for readmission. In addition, discharged patients who live on welfare or in poverty conditions in hostile communities return to the hospital as a refuge from these conditions. Hospitals today are no longer "snake pits". The hospital milieu is supportive with recreational activities, friendships, and a solicitive staff. It is not surprising that the patient finds the hospital environment more comforting than the community. It may be that pleasant memories of the hospital, knowledge and familiarity with the staff and the routine is related to recidivism (Rosenblatt and Mayer, 1974a).

Schizophrenic individuals represent 1 percent of the population or approximately forty million people in the entire world. It is estimated that only 25 percent of the mentally ill population is self-supporting. The majority of this group receive Supplemental Security Income (SSI) for mentally ill disabled individuals, the majority of which are schizophrenics. Approximately \$2.25 billion is paid out each year for SSI benefits in the United States (Torrey, 1983). Not only is schizophrenia costly in terms of SSI benefits, welfare payments, hospitalizations, and lost wages, it is devastating to the family both financially and emotionally (Arreti, 1979).

The cost of hospitalization, alone, in 1982 was from \$310.00 to \$470.00 per day (Torrey, 1983). Although there are some who recover from the illness after one episode, for the majority, it is a lifelong illness.

Rationale for the Study

Given the severity, the prevalence, and the cost of the problem, there is a growing concern regarding the high rate of readmissions to psychiatric hospitals for mentally ill patients. Schizophrenics make up the majority of the mentally ill population in psychiatric hospitals, approximately 80 percent. The Veterans Administration Medical Center, Menlo Park Division, reports a 50 to 60 percent readmission rate (Moltzen, 1984a). These factors have led to a growing need to uncover the causes, conditions and factors related to the high rate of recidivism among the schizophrenic population. In addition to this, the community is concerned regarding the large number of patients who have been discharged to their communities without proper planning and without sufficient resources. If variables could be discovered which contribute to rehospitalization of schizophrenics, resources could then be mobilized to reverse this trend.

Problem Statement

Due to the above concerns, this research involves uncovering factors which cause the schizophrenic to continue to return to the hospital. Research has shown that schizophrenic patients have a high rate of recidivism within the first two to four weeks after

discharge (Moltzen, 1984b). Do factors such as stable income, stable shelter, unstable relationships, consumption of alcohol or drugs contribute to the rate of recidivism?

Methodology

This research study consists of administering a questionnaire to a sample of male schizophrenic patients at the Menlo Park Division of the Veterans Administration Medical Center, Palo Alto, just prior to discharge. A seven week follow-up study using the same questionnaire was completed while the subjects were residing in the community, either by telephone contact or by personal interview. If the subject had returned to the hospital before the seven week follow-up, the questionnaire was administered in the hospital at that time.

Description of the Veterans Administration Medical Center

The Veterans Administration Medical Center, Menlo Park Division, provides services to veterans, primarily males who have been in the military. A number of outpatient and inpatient services are provided. A few of the programs available are the Community Service Section (CSS) which provides follow-up to veterans in the community, who live in Residential Care Homes; Community Training Center (CTC), and Veterans Environmental Training School (VETS), which provides day treatment for veterans who reside in the community and need to improve social and life management skills. There are also a number of inpatient treatment units which specialize in the treatment of psychiatric patients, alcoholics and drug addicts.

Location of the Study

This research study involves male schizophrenic veterans who were hospitalized in one of the four wings in Building 324 at the Menlo Park Division, which is the Inpatient Treatment Unit for psychiatric patients. Each wing has the capacity to house 60 inpatients, which means the total capacity for the unit is 240. Although each wing has developed its own specialized treatment program for veterans, they share many things in common. The primary services provided are group therapy, group meetings, recreational activities, psychotropic medications and a supportive hospital milieu. The emphasis is toward a multidisciplinary approach to the treatment of veterans. The goal is the reintegration of the veteran into the community. Prior to discharge, appropriate veterans are referred for outpatient treatment, which may include individual and group therapy, or drug therapy at the Mental Hygiene Clinic, CSS, CTC, VETS, or other appropriate programs which may assist the veteran's to reintegrate into the community.

Definition of Terms

Significant terms as used in this research study are as follows:

- 1) Schizophrenic. Any patient diagnosed by a psychiatrist as a schizophrenic during the period of service, during the admission evaluation, or during the current hospitalization.
- 2) Readmission. Any patient readmitted to a hospital for psychiatric problems for 24 hours or more.

- 3) Substance abuse. When alcohol or drugs have effected the patient in a negative manner as noted by the self report of the patient or as noted in the records at the VA.
- 4) Stable income. A consistent source of income which has been received by the patient on a regular basis, without problems, for the past six months, prior to admission to the hospital. The amount and source is not of primary importance.
- 5) Stable shelter. A consistent physical structure, where the patient has maintained residence for the past six months prior to admission to the VA.
- 6) Stable relationship. A frequent, regular companion, who has remained in the patients life for six months prior to admission to the VA, such as a spouse, sibling, relative, companion, friend or roommate.
- 7) Service connected (SC). Income received by the veteran for a disability which had its onset while the veterans was in the military. The Government determines a percentage, depending upon the degree of the disability. SC veterans are given priority in receiving the services at the VA.
- 8) Non-service connected (NSC). A veteran whose disability has not been determined to be related to the service.

9) Social Security Disability Insurance (SSDI).

Income for those who have worked before they became disabled. They are allowed to work part-time without losing benefits.

10) Supplemental Security Insurance (SSI). Income for those who are disabled and do not have an employment history.

11) Medicaid. Medical benefits for the indigent.

12) Medicare. Medical benefits for the aged and disabled.

Research Questions

The following questions will be guides to the investigation of the problem of recidivism:

- 1) What are the factors which contribute to the high rate of recidivism?
- 2) Is there a significant difference between those who follow their discharge plan and those who do not?
- 3) What are the factors which reduce the recidivism rate?
- 4) What are the common experiences from discharge to readmission?
- 5) Do factors such as stable income, stable shelter, stable relationships and substance abuse play a role in recidivism?

CHAPTER 2

LITERATURE REVIEW

Introduction

Causation. The most recent research indicates that schizophrenia is a "biological disease of the brain". Schizophrenia has not been proved to be caused by bad mothering, emeshed families, mixed communications, repression of the libido or double bind. The schizophrenic's brain has been found to be different from normal people (Torrey, 1983).

Myerson found that schizophrenia is mainly hereditary (Chase and Silverman, 1941). The discovery of Thorazine in 1955 and twin studies have led to the belief that schizophrenia is biological or has a genetic component (Bernheim and Lewine, 1979).

Schizophrenia occurs in both identical twins in 85 percent of the cases. With fraternal twins, the incidence is no more than with normal families, approximately 10 to 15 percent (Torrey, 1983; Pfeiffer, et al., 1970). A Scandinavian study reports that if one twin becomes schizophrenic, the other twin becomes schizophrenic in 35 to 50 percent of the cases, even if reared separately. Therefore, since the concordance is not 100 percent, it is believed that hereditary predisposition toward schizophrenia is only part of the answer. There are other unknown factors which play a role as well (Arretti, 1979).

Because schizophrenia runs in families (Torrey, 1983; Bernheim and Lewine, 1979), it was felt that interpersonal factors, environmental deprivation, or faulty families were the cause of the disease.

Recent adoption studies and twin studies have shed more light on the combination of genetic predisposition and environmental factors. What is inherited is a "predisposition to become ill" under a set of conditions which may vary with each schizophrenic (Bernheim and Lewine, 1979).

Theories related to causation of schizophrenia, such as genetic, biochemical, viral and nutritional have some support in the literature. Other theories such as psychoanalytical and family interaction are not supported by the literature (Torrey, 1983).

Twin studies have shown that siblings have a 10 percent chance of developing schizophrenia. Children born of normal parents have a 1 percent chance of developing schizophrenia. Children with two schizophrenic parents have a 30 percent chance of becoming schizophrenic. When one parent is schizophrenic and the other normal, the child has a 10 percent chance of developing schizophrenia (Torrey, 1983).

Stress factors. Stress leads to precipitating the symptoms of schizophrenia (Arreti, 1979), however, research has not proven that schizophrenia is caused by stress. Seeman, et al (1983) found that stress and over-stimulation, such as alcohol, drugs, loss of a support system, or life changes, could trigger symptoms in schizophrenic individuals. Yet, precipitants do not occur before onset of symptoms in all schizophrenics. Fifty percent of the schizophrenics did not have an obvious precipitant prior to onset of symptoms (Tsuang, 1982). Therefore, genetic, biochemical, and biological factors have a more conclusive research basis, than

environmental stress factors.

Recidivism

Symptoms. Angrist, et al, and Freeman and Simmons found that patients symptoms were related to recidivism rate (Rosenblatt and Mayer, 1974b; Arthur, Ellsworth and Kroeker, 1968).

Marks and Odegard found no significant relationship between symptoms and recidivism (Rosenblatt and Mayer, 1974b; Gurel and Lorei, 1972; Bernheim and Lewine, 1979).

The degree of recovery or the extent of amelioration of symptoms at the time of discharge did not prove to be good predictors of readmission of schizophrenic patients to the hospital (Williams and Walker, 1961; Gomez, 1979).

Marks, Stauffacher, and Lyle found that ratings on the Symptom Rating Scale (SRS) was related to adjustment in the community but not to readmission within one year (Gurel and Lorei, 1972).

Freeman and Simmons found by using the SRS that symptoms at the time of release and at the time of follow-up three weeks later, were related to success of finding and holding employment (Gurel and Lorei, 1972; Bernheim and Lewine, 1979).

Therapy. Dincin and Witheridge in a study of the effectiveness of two different treatment programs, using male and female schizophrenics patients found at a nine month follow-up that the recidivism rate of those who participated in the comprehensive program was reduced. Those who participated in the comprehensive rehabilitation program had a 14 percent relapse rate, whereas those who participated

in the part-time supportive-training program had a 44 percent relapse rate. A review of the literature reveals relapse rates from 14 percent to 50 percent. Therefore, a relapse rate of 14 percent is considered to be a positive reduction in recidivism (Dincin and Witheridge, 1982).

Mendel and Rapport (1963) in a study of chronic schizophrenics who had frequent hospitalizations, found that "here and now" existential therapy led to a reduction in recidivism. Seventy percent of the sample stayed out of the hospital over a fifty-one month follow-up period of observation and treatment. In addition, they found that nonprofessionals, who were taught existential therapy, were just as successful as psychiatrists.

Haven and Wood found no significant difference between psychiatric patients who received group psychotherapy and those who did not, at the time of a one year follow-up (Moltzen, 1984a).

Walker and Selly found no difference in recidivism rates of those who received inpatient psychotherapy and those who did not, at the time of a one year follow-up after discharge (Moltzen, 1984a).

Anthony found that traditional psychotherapy, work therapy and drug therapy did not affect the psychiatric patients recidivism rate and his employability in the community (Rosenblatt and Mayer, 1974b).

Carl Rogers, in a study of chronic schizophrenics, found that those who recieved therapy did only slightly better than those who did not receive therapy. Freud found that psychoanalysis did not help the schizophrenic. Several studies have shown that psychotherapy

does not help schizophrenics or is the least effective method of treatment (O'Brian, 1978; Wasow, 1982).

Yalom (1970) and Torrey (1983) found that high intensive psychotherapy was detrimental to the schizophrenic. Torrey found that insight-oriented therapy was not only useless but detrimental to schizophrenic individuals. On the other hand, supportive therapy was found to be successful with schizophrenics. O'Brian (1978) agrees that supportive group therapy appears to be beneficial for the schizophrenic following an acute episode.

Medication plus therapy. Several studies have found that the combination of psychotherapy and drug therapy helped to reduce symptoms so that hospitalization is unnecessary (Arreti, 1979; Orlinsky and D'Elia, 1964). Wasow (1982) found that the best therapy was a combination of medication and supportive environment. Torrey (1983) found that the combination of a supportive case manager and drug therapy were the most helpful in reducing recidivism for the schizophrenic.

Hogarty, et al, who studied 374 schizophrenics found that those patients receiving a placebo relapsed in 80 percent of the cases. Those receiving medication alone had a 48 percent relapse rate; and those who had a combination of therapy and medication had a 37 percent relapse rate after a two year period (Wasow, 1982).

Medication therapy. The studies regarding the effectiveness of medication are contradictory. William and Waler (1961) found that tranquilizers were not enough to prevent rehospitalization of schizophrenic patients. They found no evidence to support the theory that patients receiving medication do better than patients who do not receive medication. Ellsworth and Clayton found that tranquilizers had no effect on the length of stay in the hospital or readmission rates within one year of discharge (Williams and Walker, 1961).

In addition, Ellsworth and Clayton were unable to find a significant difference between the rate of return to the hospital of patients who were taking medication and those patients who were discharged, prior to the advent of neuroleptic medications (Orlinsky and D'Elia, 1964).

On the other hand, Katz and Cole found a lower rehospitalization rate for patients who were on medication than for those who were taking a placebo after one year (Orlinsky and D'Elia, 1964). John Davis, in a study of schizophrenics had similar positive results for those who took medication versus those who did not (Torrey, 1983; Orlinsky and E'Elia, 1964).

Prior hospitalization. Research studies show that the number of prior hospitalizations was more predictive of readmission for the mentally ill than any other variable (Dincin and Witheridge, 1982; Rosenblatt and Mayer, 1974b).

Arthur, Ellsworth and Kroeker (1968) in a study of twenty-three schizophrenic patients readmitted to the VA, using the SRS, found that out of nineteen demographic variables only four were related to readmission rates. Their variables were a high number of prior hospitalizations; a high number of months of prior hospitalization; an active participation of the patient in effecting his own hospitalization and a significant relative who scored low on benevolence.

Lorei (1964) found that the readmission rate was greater for patients who had a higher number of previous hospitalizations in combination with poor hospital adjustment and failure to have been recently employed.

Marks, Lyle, and Strauffacher (1963) in a study of seventy-one male schizophrenic veterans, found at the one year follow-up that poorly adjusted patients were more likely to be 100 percent service connected veterans. They had a higher number of previous hospitalizations and had been disturbed for a longer period of time.

Rosenblatt and Mayer (1974a) found, on the other hand, that there was no relationship between severity of illness and recidivism. Factors which appeared to be related to recidivism were the number of previous hospitalizations, employability and receptivity of the patients' family.

Weisman, Feirstein and Thomas (1969) who studied chronic psychopathology of patients admitted to their Three-Day Hospital Emergency Treatment Unit, found a correlation between high recidivism and three or more prior hospitalizations.

Moltzen (1984a) followed for 365 days, 50 schizophrenic patients who had been discharged from the Intensive Psychiatric Unit, VA Medical Center, Menlo Park Division. She found that only three variables out of ten were significantly related to recidivism: 1) high number of previous hospitalizations, 2) longer stay in the hospital, and 3) patients discharged to board and care homes were more likely to be rehospitalized.

Dincin and Witheridge (1982) found that schizophrenics who had the highest number of prior hospitalizations coupled with the highest number of life stressors, had the highest rate of recidivism irregardless of treatment.

High level of expressed emotions. Leff found that a "high level of expressed emotions" was related to a high relapse rate. This variable contributed to a 58 percent rehospitalization rate of the schizophrenics in this study (Wasow, 1982). Brown found similar results, in that schizophrenics who were not taking medication and were in an environment of a "high level of expressed emotion" had a 92 percent relapse rate (Bernheim and Lewine, 1979). Therefore, the quality of the relationship between schizophrenics and their families were correlated with recidivism.

Prediction. Walker and Kelly (1961) were not able to isolate any factors which could lead to accurate prediction of recovery from symptoms for the schizophrenic patient. Bloom, Lang, and Goldberg (1970) found that a multidisciplinary staff in a psychiatric hospital were unable to successfully predict the adjustment of the patient in

the community after discharge. However, when there was a high level of agreement among the various disciplines prediction was more accurate. They felt that this speaks well for the utilization of a multidisciplinary approach to treatment and discharge. Group decisions are more accurate than a single decision by one discharge planner (Bloom, Lang, Goldberg, 1970). Perhaps if prediction was improved, recidivism would decrease.

Onset and Prognosis

A review of the literature shows that an obvious event, exogenic factors, a dramatic life change which occurs prior to onset of symptoms in the schizophrenic, is an indication of favorable prognosis (Chase and Silverman, 1941; Torrey, 1983; Bernheim and Lewine, 1979).

Schizophrenics, whose symptoms occur suddenly, have a better prognosis than those whose symptoms occur slowly over a long period of time without a clear precipitant (Chase and Silverman, 1942; Bernheim and Lewine, 1979; Torrey, 1983). Bernheim and Lewine indicate that the precipitating stress may be positive or negative, such as a birth, a death, or a loss of a job.

One's adjustment prior to the psychosis is a good predictor of one's adjustment after the onset of the illness. Those who have developed adequate social and employment skills, and were considered close to normal before the psychosis, have a better prognosis (Chase and Silverman, 1941; Bernheim and Lewine, 1979; Torrey, 1983).

Based on a literature review by Stephens, one-third of the schizophrenic patients recovered completely, one-third improved partially and one-third did not get well (Torrey, 1983). Finnish authors, Niskanen and Achte found similar results. Approximately one-third of the schizophrenic population recovered completely over a five year follow-up period (Arreti, 1979; Seeman et al., 1983).

Research shows that 10 to 50 percent of the people who are hospitalized for psychosis have a single episode in their life (Chase and Silverman; Bernheim and Lewine, 1979).

Prognosis is poor for schizoid personality, because they are withdrawn and isolated (Bernheim and Lewine, 1979; Torrey, 1983). Other subtypes of schizophrenia which show some type of emotion or affect have a good prognosis, such as schizoaffective, catatonic and paranoid (Schofield et al., 1954; Torrey, 1983; Chase and Silverman, 1941).

Demographic Factors

Stotsky (1952) compared schizophrenic patients who recovered with schizophrenics who remained in the hospital and found no significant difference in demographic variables and recidivism (Marks, Stauffacher, and Lyle, 1963; Walker and Kelley, 1970). Stotsky did find that those patients who were discharged were of higher intelligence than those who remained in the hospital. Chase and Silverman (1941), on the other hand, found no significant relationship between education, intelligence and prognosis.

Ellsworth and Clayton contended that social adjustment was more predictive of functioning in the community than psychopathological factors (Marks, Stauffacher, and Lyle, 1963). Pishkin and others found that demographic factors are more predictive of readmission than social skills or psychopathological factors (Arthur, Ellsworth and Kroeker, 1968).

Brown (1959), who studied 156 schizophrenic patients who were discharged after two years of hospitalization, found that those patients who were married were at a higher level of social functioning than those who lived with their parents. However, as a rule, schizophrenics do better living away from families and tend to function at a higher level when living independently (Torrey, 1983; Brown, 1959). Weisman, Feirstein, and Claudewell, who studied psychiatric patients in an Emergency Three-Day Treatment Hospital, found that 90 percent of the patients were rehospitalized within one year.

Scheflen (1981) and Brown (1959) found that schizophrenic patients who resided with siblings or in other housing, rather than with parents or spouses, had a lower recidivism rate.

Freeman and Simmons found that husbands returned to the hospital more often than sons, perhaps because wives expect more of husbands than parents expect of children (Marks, Stauffacher, and Lyle, 1963). Walker and Kelley (1960) found that unmarried patients stayed in the hospital longer than married patients who tended to be discharged earlier. Weisman, Feirstein, and Thomas (1969) found that single psychiatric patients had a higher recidivism rate than did others.

Class and race. Research shows that nonwhites have a higher rate of rehospitalization than do other racial groups. These nonwhites tend to be from the lower social stratification (Torrey, 1983); and reside in large, urban areas (Bernheim and Lewine, 1979; Orlinsky and D'Elia, 1964). Some suggest that this is related to the higher level of stress in the lower classes, especially in the inner city. Nonwhites are predominant in the poor sections of the inner city, where stress is higher. Others suggest that schizophrenics drift to the lower class due to their inability to maintain employment, adequate concentration, and adequate social skills.

Sex. Research shows that schizophrenia occurs approximately the same for males and females (Torrey, 1983; Chase and Silverman, 1941).

Age of onset. The onset of schizophrenia usually occurs during adolescence or early adulthood and before age 45. Usually the first onset occurs in 75 percent of the cases between the age of sixteen to thirty years of age (Torrey, 1983), which may be related to the stress of attempting to accomplish the developmental task of separation, puberty, and independence from parents. Research shows that the onset of schizophrenic symptoms is five to ten years earlier for males than for women. This may be related to the pressures of society for males to be independent at an earlier age than for women. Women often do not leave home until they marry, whereas males are expected to be independent earlier. Females tend to develop schizophrenic symptoms at the time a child enters the school system. The first hospitalization for females is approximately age thirty-two

and for men twenty-five years (Bernheim and Lewine, 1979; Torrey, 1983).

Torrey (1983) and Bernheim and Lewine (1979) agree that the later the age of onset of symptoms the better the prognosis, and the earlier the onset of symptoms the poorer the prognosis. Perhaps, a person who has developed social skills and maintained gainful employment before the onset of the symptoms has a better outcome than those who never developed these skills before the onset of the illness.

Employment. Torrey (1983) indicates that one study estimates that only 6 percent of the chronic schizophrenic population is capable of full time employment. A person who was employed before the onset of the illness has a better chance of maintaining employment after recovery and discharge from a hospital than a person who has never been employed. Miller and Weller found that patients ability to handle money, and their ability to maintain employment were more significantly related to recidivism, than the number of prior hospitalizations. (Moltzen, 1984a).

Education. Walker and Kelley (1960) found that patients who had more education were discharged sooner than those who were less educated. They also found that demographic factors could not be used to reliably predict duration of symptoms.

Summary. There are no clear answers to the significance of demographic variables. The results differ in many cases. However, all of the factors mentioned in this chapter give us some clues to the causes of recidivism.

CHAPTER 3

METHODOLOGY

Population and Selection Procedures

Discharge planners at the Menlo Park Veterans Administration Hospital were asked to select male schizophrenic patients who were about to be discharged from the hospital, who would be interested in being interviewed for the research. The patients had to be capable of answering questions about themselves in a thirty minute interview.

A population of twenty male schizophrenic veterans were selected and approached for the interview. A questionnaire (see appendix) was administered in a face-to-face interview while the patients were still in the hospital. All patients were interviewed by the author. All patients were asked to sign a permission form, as they would be contacted by telephone seven weeks after they were released from the hospital for the follow-up. The subjects were asked to give permission for the author to contact their therapist, nurse, or case manager, who would be involved in their reintegration into the community. Subjects were advised that they could withdraw permission at any time during the research process.

Out of the twenty male schizophrenic patients selected, two refused to begin the interview; one refused to complete the interview midway through the process; one refused to sign the permission form for the follow-up in the community; one refused to be interviewed at the time of the seven week follow-up; and one left the hospital against medical advise before the interview could be arranged.

The resulting sample consisted of fifteen schizophrenic patients who were interviewed in the hospital prior to the time of their discharge. For a variety of reasons, five of this sample were not discharged as planned and were in the hospital at the time of the follow-up. This left ten patients for the seven week follow-up. As mentioned earlier, one patient refused to complete the interview at the time of the follow-up. Therefore, the follow-up sample consisted of nine patients.

A seven week follow-up study was completed while the subjects were residing in the community using the same questionnaire, by telephone contact or by personal interview. If the subject returned to the hospital before the seven week follow-up, the questionnaire was administered, at that time, in the hospital.

Research study design. The research design was exploratory, utilizing a survey technique. The data will be presented in three sections. The first section represents an analysis of the demographic data as obtained by written records. The second section represents the results of the questionnaire administered in the face-to-face interview, shortly before the subjects were scheduled for discharge. The third section represents the follow-up data, either at the time of readmission to the hospital or at the seven week period. Veterans receiving outpatient care at the Menlo Park Division of the Medical Center were interviewed in person. All others were contacted by telephone.

The population consisted of all male veterans, who had been diagnosed as schizophrenic by a psychiatrist. All the subjects had been diagnosed as schizophrenic or a subtype of schizophrenia either at the time of the current admission, or at the time of discharge, or during previous period of military service.

Patients' medical records were used to collect demographic information. Medical Administration Service's patient locator cards were used to collect data on prior admissions to the Veterans Administration Hospital at the Menlo Park Division and at the Palo Alto Division. Admission records were checked daily regarding readmissions to the hospital.

Results were evaluated by the use of the I.B.M. Personal Computer utilizing PFS Report and PFS File.

Study Limitations

There were some limitations to the study which need to be mentioned. The population consists of only veteran males. This population may not be representative of the total schizophrenic population. The size of the resulting sample, which is not large, may weaken the significance of the findings. One cannot generalize widely, because the results are based on a small sample rather than a large one.

The self reports of the subjects in the face-to-face interview presupposed verbal facility, sufficient cognitive functioning and willingness to provide accurate information. Those who were not able to complete the questionnaire may represent a different group

of people. Refusals to participate in the study may be significant.

The information gathered during the interview was retrospective, which is subject to error. Recalling facts is sometimes inaccurate, because reliance on verbal or self reports frequently requires self diagnosis.

Problem Statement

Research has shown that schizophrenic patients have a high rate of recidivism within the first few weeks after their release from the hospital (Moltzen, 1984a). Are factors such as alcohol and drug abuse, steady income, stable shelter, stable relationships related to the high recidivism rate? Taking the above factors into consideration, this study will identify factors which contribute to the high rate of recidivism among schizophrenic patients at the Menlo Park Division of the Veterans Administration Medical Center.

Research Objectives

This study is interested in discovering factors which contribute to the high recidivism rate of schizophrenic patients. And conversely, identifying factors which contribute to the reduction of the recidivism rate.

CHAPTER 4
DATE ANALYSIS

Introduction

This chapter consists of the analysis of the data as collected by self report of the subjects, demographic information gathered from the inpatient charts, a follow-up telephone conversation with the subject's case manager, and admission information from the daily admission records.

As mentioned earlier, the beginning sample consisted of twenty schizophrenics. Five refused to participate, and five remained in the hospital at the seven week follow-up period. The reduced sample consisted of ten subjects.

Subjects who refused to participate. The demographic variables of the five subjects who refused to participate were found not to be significantly different from the resulting sample (see TABLE 1). There were, however, two primary differences: 1) they were all diagnosed as paranoid schizophrenics, and 2) their average age was younger.

This sample consisted of five, single, unemployed, service connected, paranoid schizophrenics. There were three caucasians, one Black and one Asian. Only one had been diagnosed as having a substance abuse problem (ETOH). Two received social security benefits as well as the service connected income. The average income for this group was approximately \$1000.00.

TABLE 1

Demographic Information for Five Schizophrenics
Who Refused to Participate in the Research

Diagnosis	Subtype	Substance Abuse	Age	Race	SC	Other Income	Total Income (Monthly)	Employment	Marital Status	Education
Schizophrenic	Paranoid	None	36	W	100%	SS	Unk	None	Single	12
Schizophrenic	Paranoid	None	30	W	100%	SSDI	1800	None	Single	Unk
Schizophrenic	Paranoid	None	35	W	10%	None	64	None	Single	-12
Schizophrenic	Paranoid	None	26	B	50%	None	354	None	Single	+12
Schizophrenic	Paranoid	ETOH	38	A	100%	None	1000	None	Single	+12

There service connection percentage varied from 10 percent to 100 percent. All of the subjects had received a high school education or better, except one subject.

Subjects who were not discharged. The sample of subjects who were not discharged as planned consisted of five, unemployed, schizophrenics (see TABLE 2), with an average age of fifty-four years. This sample consisted of three caucasians, one Hispanic, and one Asian. Two received a service connected income as well as a supplementary income. The three who were non-service connected received Social Security benefits, a retirement income, and a monthly income from a savings account. The service connected pension was 50 percent and 60 percent. The average income for the five was \$660.00. Only one subject had been diagnosed as having a substance abuse problem (LTOH). All of the subjects, but one, had graduated from high school. There were two subjects who had a diagnosis of chronic paranoid schizophrenia. The sample consisted of one divorced subject, one single subject and three separated subjects. This sample differs from the first sample mentioned on page thirty, in that, here the majority of the subjects had experienced a marital relationship. This may be indicative of a group who has higher social skills.

The results show that all five subjects had lived at the same residence for the past six months prior to hospitalization (see TABLE 3). In addition, four of the five subjects had a stable income and a stable relationship within the past six months

TABLE 2

Demographic Information for Five Schizophrenics Who
Were Not Discharged as Planned

Subtype	Substance Abuse	Age	Race	SC	Other Income	Employment	Total Income (Monthly)	Marital Status	Education
None	None	62	W	NSC	SS	None	300 ^b	Divorced	12
None	None	40	A	60%	SSD	None	900 ^b	Seperated	+12
None	ETOH	60	W	NSC	Retirement/SSD	None	800 ^b	Single	-12
Paranoid ^a	None	48	H	50%	Retirement	None	900 ^b	Seperated	12
Paranoid ^a	None	59	W	NSC	Savings Account	None	400 ^b	Seperated	12

^aChronic

^bRounded Amounts

prior to hospitalization. Four of the five subjects admitted to consuming alcohol. One subject lived alone in a hotel, had no stable income, and no stable relationship. One subject lived in a board and care home, two lived with relatives, and one lived in his own house.

TABLE 3

A Comparison of the Stability of Five Schizophrenics Who
Were Not Discharged as Planned

Alcohol/ Drug Consumption	Stable Relationship	Stable Shelter	Stable Income
Alcohol	Brother	House	Yes
Alcohol	Brother	Board & Care	Yes
Alcohol	Children	Daughter	Yes
Alcohol	None	Hotel	No
None	Brother	Brother	Yes

There appears to be no correlation between the number of times the subject was hospitalized and whether he had a stable income, stable relationship, stable shelter or had a substance abuse problem (see TABLE 4).

TABLE 4

A Comparison of Stability With the Number of Total
Hospitalizations of Five Schizophrenics Who
Were Not Discharged as Planned

Total Number of Hospitalizations	Alcohol/ Drug Consumption	Stable Relationship	Stable Shelter	Stable Income
1	Alcohol	Brother	House	Yes
2	Alcohol	None	Hotel	No
2	Alcohol	Brother	Board & Care	Yes
3	None	Brother	Brother	Yes
6	Alcohol	Children	Daughter	Yes

The subjects' attitude toward the hospital or community, or remaining out of the hospital, was not correlated to the number of total hospitalizations (see TABLE 5).

The self report of the subjects as to why their prior discharge from the hospital had failed were varied (see TABLE 6). Basically the reasons were an inability to adjust or maintain themselves within the community or family setting. The expressed reasons were poor supervision at the board and care home, conflict with a brother, loneliness, lack of funds, and failing to eat properly.

The subjects self report regarding why the previous discharge plan failed, was directly related to their self report of potential problems which might arise upon their discharge in the future. (see TABLE 6).

TABLE 5

A Comparison of the Attitudes of Five Schizophrenics
Who Were Not Discharged as Planned With The
Total Number of Hospitalizations

Total Number of Hospitalizations	Attitude Toward the Community	Attitude Toward the Hospital	Attitude Toward Staying Out of the Hospital
1	Fair	Fair	Poor
2	Fair	Fair	Poor
2	Good	Good	Poor
3	Poor	Poor	Good
6	Good	Poor	Good

TABLE 6

A Comparison of Self Reported Reasons for Prior Discharge
Failure With Possible Future Problems in the
Community

Why Prior Discharge Failed	Future Problems in Community
Failure to eat properly	Eating and Medication Compliance
Family Conflict	Medication Compliance
Loneliness	Loneliness
Poor Supervision	Alcohol Consumption
Unemployment	Financial Problems

INITIAL INTERVIEW FINDINGS

The remaining sample, which consisted of ten subjects, was interviewed just prior to discharge and again, in the community, seven weeks after discharge from the psychiatric unit at the Menlo Park Division of the Veterans Administration Medical Center. Nine of the subjects were schizophrenics and one was diagnosed as schizotypal. Four of the schizophrenics were also diagnosed as chronic undifferentiated, two as paranoid, two as chronic, and one as undifferentiated. Fifty percent of the sample had been diagnosed as having a substance abuse problem (ETOH).

The ten subjects were all unemployed, white, male, veterans, with an average age of 44 years (see TABLE 7). One subject was married, two were divorced, one was separated, and six were single. The majority of the sample had never married.

Five subjects had more than a high school education. Three had high school degrees, and two had not completed high school.

The average income for the subjects was \$1150.00. Seven of the sample were service connected veterans, and three were non-service connected veterans. All of those who received a service connected pension, also received another type of income such as SSI, and SSD. Those who were non-service connected had no other income except, SSI, SSD, or a retirement pension.

The findings show that those schizophrenics who had a twelfth grade education had the highest average number of hospitalizations, (8.33). Those who had more than a twelfth grade education had an

TABLE 7

Demographic Information For Ten Subjects
Who Participated in the Survey

Diagnosis	Subtype	Substance Abuse	Age	Race	SC	Other Income	Employment	Total Income (Monthly)	Matrilal Status	Education
Schizophrenic	Chronic	None	30	W	100%	SSI	None	1700	Divorced	+12
Schizophrenic	Chronic	None	36	W	36%	SS	None	800	Divorced	12
Schizophrenic	Chronic ^a	ETOH	39	W	100%	SS	None	1500	Single	12
Schizophrenic	Chronic ^a	None	58	W	100%	SS	None	1600	Single	+12
Schizophrenic	Chronic ^a	None	35	W	100%	SS	None	1700	Separated	+12
Schizophrenic	Chronic ^a	ETOH	55	W	100%	SS	None	1300	Single	-12
Schizophrenic	Paranoid	None	41	W	40%	SSD	None	1000	Married	-12
Schizophrenic	Paranoid	ETOH	48	W	NSC	SSD	None	500	Single	+12
Schizophrenic	Undif ^a	ETOH	60	W	NSC	Retirement	None	900	Single	+12
Schizotypal	None	ETOH	35	W	NSC	SSI	None	500	Single	12

^a Undifferentiated

average of 5.4 hospitalizations. Those subjects who had less than a twelfth grade education had an average of 7.0 total hospitalizations (see TABLE 8).

TABLE 8

A Comparison of Education and Total Number of Hospitalizations of Ten Subjects Interviewed at the Point of Discharge

Education	Total Hospitalizations	Average Number of Hospitalizations
+12	16	
+12	3	
+12	3	
+12	3	
+12	2	5.40
-12	7	
-12	2	7.00
12	17	
12	5	
12	3	8.33

The subjects which had the highest average number of hospitalizations were thirty to Thirty-nine years old (see TABLE 9). The group, sixty to sixty-nine years of age, had the lowest average number of hospitalizations.

TABLE 9
A Comparison of Number of Hospitalizations
and Age Groupings

Age	Number of Hospitalizations	Average
30-39	44	8.8
40-49	5	2.5
50-59	9	4.5
60-69	3	3.0

Those subjects who were divorced had the highest average number of total hospitalizations, (10.5). Those who were separated had 3.0 average number of total hospitalizations. Those who were single had 5.8 hospitalizations, and those who were married had 2.0 hospitalizations (see TABLE 10).

The majority of the subjects stayed in the hospital a longer period of time during their current hospitalization than during previous hospitalizations (see TABLE 11). Those schizophrenics who had the highest total number of hospitalizations were currently in

CHART 10

A Comparison of Marital Status With
Total Number of Hospitalizations

Marital Status	Total Hospitalizations	Average Number of Hospitalizations
Divorced	16	
Divorced	5	10.5
Married	2	2.0
Single	17	
Single	3	
Single	2	
Single	3	
Single	7	
Single	3	5.8
Separated	3	3.0

the hospital longer than those who had only two or three total hospitalizations. Chronic schizophrenics tended to stay in the hospital longer than others and tended to have the highest number of total hospitalizations.

TABLE 11

A Comparison of the Length of Prior Hospitalizations, Current Hospitalizations, Subtype, and Total Number of Hospitalizations

Subtype	Length Current Hospitalization	Length of Last Hospitalization	Total Hospitalizations
Chronic	121 days	8 days	16
Chronic	52 days	Unknown	5
Chronic ^a	111 days	27 days	2
Chronic ^a	126 days	73 days	17
Chronic ^a	129 days	2 days	7
Chronic ^a	8 days	6 days	3
None	57 days	7 days	3
Paranoid	114 days	21 days	2
Paranoid	55 days	74 days	3
Undiff ^a	96 days	34 days	3

^a Undifferentiated

The findings show that NSC veterans had fewer hospitalizations than did SC veterans. In addition, those who were 100 percent SC had the highest number of total hospitalizations. This may be indicative of the VA policy which gives preferential services to SC veterans (see TABLE 12). It also may be indicative of the SC veterans dependency on the VA system and his growing familiarity with the VA staff and the hospital routine.

TABLE 12

A Comparison of SC Veterans and NSC Veterans
Total Number of Hospitalizations

Service Connection	Total Number of Hospitalizations
100%	16
100%	17
100%	2
100%	3
100%	7
36%	5
40%	2
NSC	3
NSC	3
NSC	3

Those patients who had recently moved from a protective environment with a friend or relative, and patients who had recently moved to a hotel returned to the hospital soon afterward (see TABLE 13). Those who were able to stay with family for long periods of time were able to stay out of the hospital longer. The discharge plans failed for a number of reasons, such as alcohol consumption, family conflict, non-medication compliance, depression and irregular discharges.

The majority of the subjects were going to be discharged to board and care homes upon release. One was going to be discharged to a sister, one to a wife, one to an apartment, and one to a hotel. All were referred to the Medication Clinic. In addition to these support systems in the community, three were to be followed through CSS, two through CTC, one at VETS, and one at the Alanon Club (see TABLE 13).

Nine subjects in the sample had a stable income, and a stable relationship for the past six months prior to hospitalizations. Five subjects in the sample had a stable shelter, where they had resided for the past six months prior to hospitalization. Fifty percent admitted to consuming alcohol in the community. They all denied using any illegal drugs. Those who did not have a stable shelter for the past six months lived in hotels or on the streets. Those who had stable shelters lived with relatives. One lived with a spouse, another with a sister, and two lived with parents. One subject lived in a board and care home prior to his current hospitalization. Those who had stable relationships were involved mainly with relatives, such as a sister, a father, parents, a

TABLE 13
Factors Related to Discharge Failure

Discharge Plan	Period Between Hospitalization	Stable Shelter	Reason for Discharge Failure
Apt, Med, CTC ^a	40 days	Board & Care	Medication Compliance
BC, Med, CSS ^b	+14 years	None (Room)	Depressed
BC, Med, CSS	+15 years	None (Hotel)	Unknown
BC, Med, CSS	+24 months	None (Street)	Irregular Discharge
BC, Med, CSS	12 months	Parents	Alcohol
BC, Med, VETS ^c	171 days	None (Hotel)	Alcohol
BC, Med, CTC	59 days	Mother	Unknown
Family, Med, OPT	24 months	Family	Medication Compliance
Hotel, Med, AA	196 days	None (Hotel)	No Discharge Plan
Sister	18 months	Sister	Family Conflict

^a Apartment, Medication Clinic, Community Training Center

^b Board and Care, Medication Clinic, Community Service Section

^c Board and Care, Medication Clinic, Veterans Environmental Training School

TABLE 14
Factors Related to Stability^a

Alcohol/ Drugs Consumption	Length Stable Relationship	Stable Relationship	Length Prior Shelter	Stable Shelter	Length Stable Income	Stable Income
Alcohol	+6 months	Father	30 days	None (Hotel)	+6 months	Yes
Alcohol	+6 months	Father	18 months	Board & Care	+6 months	Yes
Alcohol	+6 months	Sister	24 months	Sister	+6 months	Yes
Alcohol	+6 months	Parents	12 months	Parents	+6 months	Yes
Alcohol	None	None	21 days	None Hotel	-6 months	No
None	+6 months	Friends	None	None Street	+6 months	Yes
None	+6 months	Family	36 months	Family	+6 months	Yes
None	+6 months	Friend	4 months	None Room	+6 months	Yes
None	+6 months	Mother	30 months	Mother	+6 months	Yes
None	None	None	30 days	None Hotel	+6 months	Yes

^a Ten Subjects

spouse and children. There were two subjects who had friendships. One subject had no relationships with friends or relatives (see TABLE 14).

Seven subjects in the sample were not planning to return to the same housing as they had resided in before hospitalization. The majority were going to be discharged (60 percent) to board and care homes (see TABLE 15).

TABLE 15

A Comparison of the Living Arrangements
Before and After Hospitalization

Living Arrangement Before	Living Arrangement After
Board and Care	Apartment
Family	Family
Mother	Board and Care
Street	Board and Care
Hotel	Board and Care
Hotel	Board and Care
Hotel	Hotel
Room	Board and Care
Parents	Board and Care
Sister	Sister

Attitude toward staying out of the hospital, attitude toward the hospital and attitude toward the community were not related to the number of hospitalizations (see TABLE 16). Seventy percent of the sample felt that they would not return to the hospital again. Forty percent had good attitudes towards the hospital services, 50 percent had fair attitudes towards the hospital services, and 10 percent had poor attitudes towards the hospital. Sixty percent had a fair attitude about the community, 10 percent had a good attitude, and 10 percent had a poor attitude toward the community.

TABLE 16

A Comparison of Attitudes With Total
Number of Hospitalizations

Attitude Toward Staying out of the Hospital	Attitude Toward the Hospital	Attitude Toward the Community	Total Hospitalizations
Fair	Fair	Fair	17
Fair	Fair	Fair	3
Fair	Good	Fair	3
Good	Fair	Fair	16
Good	Fair	Poor	3
Good	Fair	Poor	3
Good	Good	Fair	2
Good	Good	Fair	5
Good	Good	Good	2
Good	Poor	Good	7

Follow-Up Findings

Contrary to the research, only one schizophrenic returned to the hospital during the seven week follow-up period. On the surface, he appeared to be higher functioning than the other schizophrenics interviewed. He was more articulate and verbal than the other schizophrenics. He was well groomed, neat, and clean in appearance. His affect was appropriate.

He returned to the hospital, after spending \$1600.00 in seven days in an irrational manner. He spent \$700.00 to buy dinner for a number of strangers in a restaurant. He was totally noncompliant with the discharge plan. Instead of checking into the hotel as planned, he lived in his vehicle. He stopped taking his medication as soon as he was discharged. Although it is apparent that he needs a conservator, it would be difficult to obtain one for him. After two or three days of stabilization on medication, he appears capable of functioning independently in the community (see TABLE 17).

A significant difference between him and the other patients in the sample who remained out of the hospital, is that he lacked a backup support system in the community. When his funds were exhausted, he returned to the hospital. This is a pattern among some schizophrenics. In this particular case, a community companion may have been beneficial. A community companion could have provided a support system for the individual and helped with income management and encouraged medication compliance.

Eight of the other subjects, who remained out of the hospital, were discharged to more supportive networks in the community, such

TABLE 17

A Comparison of Discharge Plans and Discharge
Compliance With Rehospitalization

Reamitted	Discharge Compliance	Discharge Plan
No	None Compliance	BC, Med, CSS
No	Partial Compliance	Apt, Med, CTC
No	Total Compliance	BC, Med, CSS
No	Total Compliance	BC, Med, CTC
No	Total Compliance	BC, Med, CSS
No	Total Compliance	BC, Med, CSS
No	Total Compliance	BC, Med, VETS
No	Total Compliance	Family, Med, OPT
Yes	None Compliance	Hotel, Med, AA

as family, or board and care facilities. The one subject who was discharged to an apartment, which is a less support environment, was only partially compliant with the discharge plan.

Nine schizophrenics in the sample remained out of the hospital during the seven week follow-up (see TABLE 17). Six subjects were in total compliance with the discharge plan. One subject was partially compliant, and two were in total non-compliance. Although compliance varied, all but one remained out of the hospital during the seven week follow-up period.

Eight out of the nine subjects complied with pre-arranged housing, whether or not they agreed with the arrangement. A number of the men complained about having to attend CTC, but they continued to attend this program. The veteran who was completely non-compliant, with his discharge plan, was decompensating at the time of the follow-up. It is predicted that in the near future, he will be readmitted to the hospital.

At the time of the follow-up, seven out of the nine subjects had a stable income (see TABLE 18). The other two subjects had a problem receiving their income, because they had to reimburse the VA for overpayment, before they could receive another check.

During the seven week period, the eight subjects who remained out of the hospital, continued to live in the housing arranged at the time of their discharge. One of these subjects returned to his home, where he had lived for the three years preceding hospitalization, with his wife and children.

TABLE 18

Factors Related to Stability and Rehospitalization

Length Stable Relationship	Stable Relationship	Length Prior Shelter	Stable Shelter	Length Stable Income	Stable Income
+6 months	Attorney	7 weeks	Board & Care	+6 months	Yes
+6 months	Family	3 years	Family	-6 months	No
+6 months	Father	7 weeks	Apartment	+6 months	Yes
+6 months	Friend	7 weeks	Board & Care	-6 months	No
+6 months	Parents	7 weeks	Board & Care	+6 months	Yes
+6 months	Parents	7 weeks	Board & Care	+6 months	Yes
2 months	Friend	7 weeks	Board & Care	+6 months	Yes
None	None	None	None (Vehicle)	-6 months	Yes
None	None	7 weeks	Board & Care	+6 months	Yes

Six out of the eight subjects were discharged to board and care homes, one to an apartment and one to his wife and children. The one subject who was discharged to a hotel decided to spend his income on other things and resided in his vehicle. As mentioned earlier, he returned to the hospital within seven days.

Six of the subjects had maintained a stable relationship, primarily with a relative, in the six months prior to hospitalization and upon discharge. Two did not have a stable relationship with anyone, and one had a relationship with a friend for two months.

Alcohol consumption after discharge did not appear to be related to readmission. Three out of the eight indicated they were consuming alcohol in moderation. One was completely compliant, one was partially compliant and one was totally compliant with the discharge plan (see TABLE 19).

All eight subjects had a good attitude about staying out of the hospital. The one subject who was readmitted felt that he had been discharged before he was ready to leave. In addition, he had a poor attitude about the community. Four people had a good attitude about the hospital, two had a poor attitude, and three had a fair attitude about the hospital (see TABLE 20).

Six subjects had a good attitude about the community, one had a fair attitude, and two had a poor attitude about the community. Perhaps a good attitude about staying out of the hospital along with a good attitude towards the community, helps the subjects remain out of the hospital longer.

TABLE 19

A Comparison of Discharge Compliance
and Alcohol Consumption
With Rehospitalization

Discharge Compliance	Alcohol/Drug Consumption	Rehospitalization
None Compliance	None	YES
None Compliance	Alcohol	NO
Partial Compliance	Alcohol	NO
Total Compliance	Alcohol	NO
Total Compliance	None	NO
Total Compliance	None	NO
Total Compliance	None	NO
Total Compliance	None	NO
Total Compliance	None	NO

TABLE 20

A Comparison of Attitudes With Rehospitalization^a

Readmitted to Hospital	Attitude Toward Staying Out of the Hospital	Attitude Toward The Hospital	Attitude Toward The Community	Problem in the Community after Discharge
No	Good	Fair	Good	Alcohol
No	Good	Good	Fair	Board & Care Adjustment
No	Good	Good	Good	None
No	Good	Poor	Good	Finances
No	Good	Gair	Good	None
No	Good	Good	Good	Alcohol
NO	Good	Good	Good	Finances
NO	Good	Poor	Poor	Community Adjustment
Yes	Fair	Fair	Poor	Financial Maintenance

^a Nine Subjects

Summary

All of the subjects who were able to remain out of the hospital during the seven week follow-up period had support systems in the community, which had been part of their discharge plan. They all had case managers who assisted them with reintegration into the community. They had all continued to live in housing arranged at discharge. All but two subjects had a stable income after discharge. These two subjects had problems obtaining their income. One subject indicated that the stress of financial problems would probably precipitate returning to the hospital. The majority of the subjects had a stable relationship with a relative. In addition, the case manager served as a stable supportive relationship. Although 50 percent of the sample had substance abuse problems in the past, alcohol consumption was not a problem at the time of follow-up.

Having aftercare services available for the patient after discharge has a positive effect, and helps to reduce the rate of recidivism for schizophrenics. A stable income, a stable shelter, a stable relationship, especially with a case manager, has a positive effect in sustaining the schizophrenic in the community. A good attitude on the part of the subject also has a positive effect.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

As stated in Chapter one, page nine, the following questions were guides to the investigation of the problem of recidivism:

- 1) What are the factors which contribute to the high rate of recidivism?
- 2) Is there a significant difference between those who follow their discharge plan and those who do not?
- 3) What are the factors which reduce the recidivism rate?
- 4) What are the common experiences from discharge to readmission?
- 5) Do factors such as stable income, stable shelter, stable relationships and substance abuse play a role in recidivism?

Research Question One: The results show that eight of the nine veterans in the follow-up sample did not return to the hospital. The subjects who shared similar discharge plans, which included support systems in the community, remained out of the hospital. The two subjects who had the most different living arrangements were discharged to a hotel and to an apartment, rather than a more supportive environment, such as board and care home or to a family. This lack of support in the community is viewed as a factor in recidivism.

Research Question Two is also related to the discharge plan. One type of discharge provides more community support than the other. Those who were discharged to family or to board and care homes had more of a support network, which seemed to serve as a stabilizing function in the community.

In regards to Research Question Three, support systems in the community appear to be a positive factor in the reduction of recidivism.

In regards to Research Question Four, the common experience appears to be the presence of a support network in the community, which included family, board and care homes and involvement in a therapeutic program, such as CSS, VETS, or CTC. Two patients were discharged to the community without support systems in the community.

Finally, stable income, stable shelter, and stable relationships appear to play a positive role in reducing recidivism. Substance abuse was not a factor in this study.

The most significant finding is that veterans who are discharged without support networks in the community, are more likely to encounter problems which result in rehospitalization. The V.A. and psychiatric hospitals in general, practice of continually readmitting psychiatric patients during an acute psychotic episode may reinforce dependency and consequently, add to the problems of recidivism. The mismanagement of income and failure to take medication while in the community may be precursors of an acute psychotic episode. Therefore, this practice may well play an influential role in recidivism inasmuch as the patient is aware he may return to the hospital.

It has been shown, in the literature, that lengthy hospitalization is detrimental to the patient and may result in institutionalization. Lack of community resources and support systems encourages recidivism of psychiatric patients. Ample resources are not currently available in the community. The typical psychiatric patient needs long-term aftercare and a continuation of support systems in the community after discharge from the hospital.

Early discharge is recommended; however, community resources need to be readily available, such as day care, vocational training programs, sheltered workshops, halfway houses, recreational groups, small supportive residential units and improved board and care homes, with trained supportive staff. In addition, the schizophrenic needs community support networks, who assist with reality testing and who serve as "functioning egos".

Mental health centers need to play a stronger role in the prevention of recidivism. Programs need to be designed especially for the psychiatric patient. Mental health centers should work closely with the psychiatric hospitals to ensure continuity of care. The patient needs a supportive case manager in the community after his discharge. The mental health center could provide support groups for the mentally ill upon discharge. Mutual aid can help the patient remain in the community longer. Supportive group therapy can be utilized to help patients adjust to the community after discharge. The group can be used to teach social and life management skills. The family also needs a mutual support/education group, as sharing of common experiences with other families is helpful.

The case manager can teach the patient about schizophrenia, its ramifications, and the probable genetic predisposition. The case manager can help the schizophrenic establish goals consistent with his illness to help reduce stress. This may involve recommending the patient not enter a highly stressful work or school environment, that the patient not return home, or that the patient continue his medications (Bernheim and Lewine, 1979).

The case manager can make suggestions to the family regarding the problems of living with a schizophrenic. The case manager can educate the family about the behavior of schizophrenics, so that they can better understand and cope with the life-long problems. Families and friends can be taught to reduce the "high level of expressed emotion" in the home. They can be taught behaviors which will enhance the patient's chances of remaining in the community. They can be taught the importance of aftercare. They can be encouraged to decrease the level of stress in the family, and improve the level of communication. Workshops on medication can be given which will enhance understanding of psychopharmacology and the necessity for medication maintenance and stabilization.

Day care can be utilized to replace hospitalization in many cases. This approach is less expensive and operates only during the day hours, with a reduced staff. The patient is not locked up or stigmatized by a long hospitalization. The patient is able to maintain ties with his family and the community.

Dr. Israel Zwerling established small patient groups in the hospital, who were then discharged together as a group to a local residence in the community. This procedure was effective in reducing recidivism (Artietti, 1979). This group served as a support system in the community.

Psychiatric respite programs are necessary as periodic planned relief for the family. Respite helps the family continue to maintain care of the patient. The burden is reduced when relief from the stress is available through planned short term hospitalizations. The patient does not need to decompensate before hospitalization is made available. This program helps the family cope with the patient on a long term basis (Walker et al., 1984).

The Emergency Three-Day Treatment Hospital, as mentioned on page twenty-one, could help prevent long term hospitalization, in the majority of cases. The family and the patient receive intensive treatment during the three day hospitalization. Patients are stabilized on medications and the patient is able to return home within three days. Aftercare services then continue to provide support upon the patient's return to the community. This is an alternative to long-term hospitalization.

APPENDIX A
VETERANS ADMINISTRATION MEDICAL CENTER

Patients Name _____
SSN _____
DOB _____
170A _____

For the purpose of a research survey, we would like permission to contact you for follow-up information. The information you furnish will be kept strictly confidential by the staff. Your participation will not affect the benefits or compensation due to you. Hopefully, this survey will be effective in improving the services to you.

We are requesting your permission in contacting the following individual or agency:

I authorize the V.A.:

1. To contact my next of kin or person designated by me to request information regarding my current address and telephone number.
2. To contact my therapist for follow-up information regarding my discharge plan.

I authorize you to release the information requested above to the Veterans Administration.

I understand that I may revoke this authorization at any time to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire after the requested information has been supplied to the Veterans Administration.

Signature of Patient or Authorized Representative _____ Date _____

Note: The information requested on this form letter is solicited under Title 38, U.S.C. and will authorize the addressee to disclose the information you specify to the Veterans Administration. The information will be used to assist our medical staff in your examination and treatment. Your disclosure of the information requested is voluntary.

<u>NAME</u>	<u>DATE</u>
<u>SSN</u>	<u>DATE OF FOLLOW-UP</u>
<u>DIAGNOSIS:</u>	
<u>AXIS I</u>	<u>MARITAL STATUS:</u>
<u>AGE</u>	<u>DOB:</u>
20-29 years _____	MARRIED _____
30-39 years _____	SEP. VIV. WID. _____
40-49 years _____	SINGLE, NEVER MARRIED _____
50-59 years _____	<u>EDUCATION</u>
60-69 years _____	LESS THAN 12 YEARS _____
Over 69 _____	12 YEARS _____
	GREATER THAN 12 YEARS _____
<u>SERVICE CONNECTION</u>	<u>DATE OF LAST HOSPITALIZATION</u>
NSC _____	_____
SC _____	<u>DAYS IN LAST HOSPITALIZATION</u>

<u>SOURCE OF INCOME</u>	<u>PERIOD BETWEEN HOSPITALIZATION</u>
<u>EMPLOYMENT</u>	_____
SPOUSE, RELATIVE, FRIEND _____	<u>DATE OF CURRENT HOSPITALIZATION</u>
PUBLIC FUND, WELFARE _____	_____
RETIREMENT OR SS _____	<u>LENGTH OF CURRENT HOSPITALIZATION</u>
NSC _____	_____
OTHER _____	<u>TIMES HOSPITALIZED</u>
TOTAL INCOME _____	_____
<u>EMPLOYMENT</u>	<u>DISCHARGE PLAN</u>
UNEMPLOYED _____	Med Clinic _____
EMPLOYED _____	OPT _____
SHELTER WORKSHOP _____	CTC, CSS, VETS _____
<u>NEXT OF KIN</u>	Other _____
Name _____	<u>LIVING ARRANGEMENT</u>
Relationship _____	Hotel/Apartment _____
Address _____	Board & Care/Brdg.Hse. _____
City _____ State _____	Parents/Relative _____
Zip Code _____	Friend _____
Telephone Number _____	Spouse _____
	Transient _____

INCOME

Do you receive your income monthly? Yes _____ No _____
 Have you had problems receiving your
 income in the past six months? _____
 Does your income go to the same address? _____

SHELTER

When you were last discharged, where did you live? _____
 How long have you resided at this address? _____
 Where do you plan to live when you are discharged? _____
 How long have you resided at this address? _____

RELATIONSHIPS

Do you plan to live with someone? Yes _____ No _____ Relationship _____
 Do you have anyone you are close to? Yes _____ No _____
 Relationship _____
 How long have you had this relationship? _____
 Describe a typical day for you. _____

ALCOHOL/DRUGS

Do you consume alcohol/drugs? Yes _____ No _____ What type? _____
 How much? _____
 Do you mix medication with alcohol or drugs? _____

MISCELLANEOUS

How do you think the current discharge plan will work for you?

 What do you think will be the major problem which will result in
 your return to the hospital? _____
 Do you think you will have problems staying out of the hospital
 this time? _____
 How do you think your leaving the hospital will be different this
 time? _____
 Why do you think the discharge plan failed? _____
 What do you think of the services in the hospital? _____
 What is the hardest thing about leaving? _____
 What do you like least about living in the hospital? _____
 What is the hardest thing about living in the community? _____

 What do you like least about living in the community? _____

AFTERCARE FOLLOW-UP:

(Medication Clinic, OPT, CTC, CSS, VETS)

Did the patient go to OPT? Yes ___ No ___ What Type _____

Does the Patient keep his appointments? Yes ___ No _____

Does the Patient take his medication? _____

COMMENTS OR PROBLEMS:

CASE MANAGER

AGENCY

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