Clinical Problems

Comprehensive Department of Psychological Medicine: Three-year Review of Inpatients Referred for Aftercare Visits

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Summary

All inpatients discharged in 1967 from a comprehensive department of psychological medicine who were referred for aftercare visiting by a mental welfare officer or psychiatric social worker were reviewed after a period of three years. Over this period half the patients had not been readmitted and only 6.3% of those below retirement age had been unemployed for 75% or more of the total time involved. Altogether 76% were assessed as socially integrated, though there had been a drift away from living at home.

It is probable that case conferences made the process of referral for aftercare more discriminating and that the follow up conferences contributed substantially towards the care, supervision, and maintenance of these patients in the community. Measures of this kind are essential if a general hospital psychiatric service is intended to cope with the total problem involved.

Introduction

The type of department studied has been described in previous publications, which dealt mainly with the extent to which such a department could cope with the total case load involved.¹⁻³ It is, however, of the utmost importance to ensure that the organization of a psychiatric service centred on a general hospital does not throw an excessive burden on the community, and partly with this in mind, three case conferences a week are held. Two of these take the place of traditional ward rounds, and the third, a means of reviewing and possibly salvaging cases already being visited in the community, includes (in addition to a consultant and a registrar) mental welfare officers, a psychiatric social worker, disablement resettlement officer, industrial workshop instructor, head occupational therapist, clinical psychologist, and the senior nurse in charge of day patients. All inpatients proposed for discharge are assessed at the former "medical" conferences, where the decision is made to refer a patient for aftercare visits by a mental welfare officer or psychiatric social worker. The cases reviewed in this report were all referred for aftercare as a result of this procedure.

Though other studies have analysed various aspects of aftercare supervision, either they were not undertaken on a comprehensive service centred on a general hospital⁴⁻⁵ or the

important technique of holding regular case conferences, orientated towards careful selection of appropriate cases for aftercare and maintaining them adequately in the community, was not employed.⁶

Material and Analysis of Findings

The total number of inpatients discharged in 1967 was 728 but of these only cases referred for aftercare visiting by a mental welfare officer or psychiatric social worker were investigated. Data at the time of or immediately after discharge from hospital are given in Tables I to III.

TABLE I—*Marital Status at Time of Discharge (Subdivided according to Sex)*

	No. of Men	No. of Women	Total	% of Total Referrals for Aftercare
Single	12	9	21	21.9
Married	17	38	55	57.3
Widow, separated or divorced	5	15	20	20.8

TABLE II—*Diagnostic Groups at Time of Discharge (Subdivided according to Sex)*

Diagnosis	No. of Men	No. of Women	Total	% of Total Referrals for Aftercare
Functional psychoses	24	44	68	70.8
Neuroses	2	10	12	12.5
Personality disorders	7	4	11	11.5
Senile and/or arterio-sclerotic psychoses	0	1	1	1.0
Other organic syndromes		2	2	2.1
Miscellaneous: chronic alcoholism	1	1	2	2.1

Altogether 36 (4.9%) men and 66 (9.1%) women of all inpatients discharged during the 12 months ending 31 December 1967 were referred for aftercare visits. Hoenig and Hamilton⁶ found that 31% of cases (inpatients, outpatients, and day patients) from a general hospital psychiatric unit were referred for aftercare follow-up but, of course, their case material was not strictly comparable with that reported here. They took a stratified research sample of 120 patients from a group incepted for the first time between 1 November 1958 and 31 October 1959 irrespective of whether the patients were first seen as inpatients or outpatients or on domiciliary visits. Their sample was therefore more diffuse than the present patients, who were limited to inpatients selected for discharge and aftercare at case conferences. Also the latter may have played a part in refining the process of referral for aftercare and introducing an added element of discrimination into the procedure.

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When the follow-up assessments were made three years later by a mental welfare officer or psychiatric social workers four women and two men had died. The case material finally used was therefore limited to the remaining 96 cases (13.2%). The patients' ages at the time of discharge ranged from 18 to 78 (mean 44) years for men and from 16 to 77 (mean 47) years for women. Surprisingly, perhaps, most of the 96 patients referred for aftercare were married (57.3%) (Table I).

By far the largest percentage of patients referred for aftercare were suffering from functional psychoses (70.8%). This is much higher than Hoenig and Hamilton's finding (43%) and is probably because our study was limited to discharged inpatients.

Most patients studied (74%; 24 men and 47 women) had been in hospital less than one month before being discharged to aftercare. Of the remainder (10 men and 15 women) none had been in hospital more than three months, even though, unlike the unit at St. Francis Hospital,⁷ there was no time limit on the duration of stay in the department and no excessive urge to discharge patients prematurely. This policy is exemplified by the fact that at the time of writing there were six patients who had been in the department longer than six months and 17 who had been there longer than one year.

One of the units studied by Hoenig and Hamilton had "no facilities for restraint or strict custodial care" and had not utilized long-term compulsory detention for many years. My experience leads me to conclude that if a unit is intended to be truly comprehensive one single room should be provided equipped with a low bed and designed to limit to a minimum the likelihood of self-injury. This department has one room for this purpose, used by male or female patients—usually for a matter of hours only—until difficult behaviour is brought under control. Also I find that a comparatively small number of patients suffering from intractable, basically chronic psychoses—especially relapsing schizophrenia⁸—can be controlled satisfactorily in the community only if they are kept on a treatment order for a lengthy period, even though for most of the time they may not even be residing in hospital but living at home on prolonged "leave". At the time of writing, for example, eight patients were in this category, seven of whom were day patients, who responded to being on a legal order by attending as day patients or taking part in the therapeutic club or other facility but who tended to withdraw into their homes, deteriorate, and relapse, necessitating readmission to hospital, if they were discharged from the legal order prematurely. The residential categories to which the patients were discharged when they left hospital are shown in Table III.

TABLE III—Residential Category Immediately after Discharge

	No. of Men	No. of Women	Total	% of Total Referrals for Aftercare
Family home (spouse/parents) ..	21	43	64	66.7
Private house (children/relatives/friends) ..	4	9	13	13.6
Home (alone) ..	6	9	15	15.6
Lodgings ..	0	1	1	1.0
Hostel ..	3	0	3	3.1

The data that emerged as a result of the three-year review are given in Tables IV to VI. Half of all patients referred for aftercare were not readmitted during the three-year period reviewed (Table IV). This is almost double the percentage not admitted during Hoenig and Hamilton's four-year follow-up, which is presumably due to the fact that their sample was not limited to patients referred for aftercare. This would lend support to Sheldon's^{4, 5} view that psychiatric aftercare leads to significantly lower admission rates, even though in Sheldon's studies "aftercare" means attendance at a psychiatric hospital as a day patient or outpatient. Probably the weekly conference with mental welfare officers and other personnel made a further

contribution to reducing the readmission rate. In this connexion it should be mentioned that I take to this conference a file containing copies of the discharge reports on patients referred for aftercare visits, and these reports provide ready summaries of the cases which are used for "on-the-spot" questioning of personnel following them up. By employing this kind of technique there is continuous communication between all the various personnel involved in the care, supervision, and maintenance of the ex-psychiatric patient in the community.

TABLE IV—Aggregate Duration of Inpatient Stay in the 3 Years after Discharge

	No. of Men	No. of Women	Total	% of Total Referral for Aftercare
Not admitted ..	18	30	48	50.0
1-4 weeks ..	6	18	24	25.0
5-12 weeks ..	7	4	11	11.5
13 weeks-6 months ..	3	7	10	10.4
6-12 months ..		2	2	2.1
1-2 years ..		1	1	1.0

Places where the patients resided when the follow-up assessments were made three years later are shown in Table V.

TABLE V—Residential Category 3 Years after Discharge

	No. of Men	No. of Women	Total	% of Total Referrals for Aftercare
Family home (spouse/parents) ..	16	35	51	53.1
Private house (children/relatives/friends) ..	7	15	22	23.0
Home (alone) ..	4	7	11	11.5
Lodgings ..	2	2	4	4.2
Hostel ..	3	3	6	6.2
Other (epileptic colony, subnormality Hospital) ..	2		2	2.1

Comparing Table V with Table III shows that after an interval of three years there was a drift away from living at home (with the spouse or parents or alone) in the direction of living with children, relatives, or friends, living in lodgings, or living in a hostel. This, of course, is what one might have expected, and it is noteworthy that the increase in the percentage of children, relatives, and friends in particular who gave support to these patients (9.4%) was greater than the combined increase in the percentage accommodated in lodgings and hostels (6.3%).

At the follow-up review 76% (25 men and 48 women) of the cases studied were regarded as positively socially integrated.

Hoenig and Hamilton⁶ referred to the purely psychological connotation of social isolation (for example, "feeling lonely") and, in contradistinction to this, the sociological interpretation of the concept. The latter (employed in their study) was used to describe "absence of social contacts", as a result of which they categorized their patients in terms of the degree of confinement to the home. An individual, however, may be by no means totally confined to his home and yet be socially isolated in so far as he is not in real contact with any other individual or groups of individuals in the community. In the present study, therefore, the assessment of positive social integration was made only if the individual was in regular contact—that is, not less than once a week—with relatives, friends, a club, or other social organization. This is a more meaningful assessment of social integration and more clearly related to the realities of daily living. In spite of these differences and the fact that the samples are not strictly comparable it is interesting to note that the percentage of patients socially integrated in the study reported here (76%) is closely similar to the aggregate percentage for those not totally confined to the home at the end of Hoenig and Hamilton's four-year review (74.5%).

The aggregate duration of employment in the three years reviewed is shown in Table VI. Altogether 17.7% of referred patients were employed for only 25% or less of the total time—that is, they were unemployed for 75% (or more) of the follow-up period. Hoenig and Hamilton found that 25% of their patients were unemployed for more than 75% of their follow-up period, but their case material was limited to those of below retirement age. If those over retirement age are excluded from the present study (two men and nine women) only 6.3% were unemployed for 75% or more of the period of follow-up. It should be added, however, that Hoenig and Hamilton did not assess housewives as “employed”, whereas in the present investigation if a housewife was actively and regularly engaged in routine housework it was considered more appropriate to include her within the category of the working population, and she was therefore regarded as employed.

TABLE VI—Aggregate Duration of Employment in the 3 Years after Discharge

% Time Fully Employed	No. of Men	No. of Women	Total	% of Total Referrals for Aftercare
76-100	15	24	39	40.6
26-75	14	26	40	41.7
0-25	5	12	17	17.7

Conclusion

It is considered that the weekly case conference with mental welfare officers and allied personnel was especially helpful in ensuring correct job placement, thereby minimizing subsequent

unemployment. As has been stated,⁹ “. . . the clinical psychologist can be extremely helpful in making an assessment of a patient's abilities, measuring progress, and forecasting the type of work suitable for the individual concerned. The occupational therapist and the workshop instructor report on a patient's progress at one of the case conferences, and if the situation warrants it the patient can then be referred to the disablement resettlement officer for help in securing a job in the community. By organizing occupational and rehabilitation procedures in this manner it has been found that the need to refer patients to an industrial rehabilitation unit is minimal.” With the implementation of the Local Authority Social Services Act 1970 measures of the kind described are likely to prove of increasing importance, especially in relation to supporting and maintaining the more disabled psychiatric patient in the community.

I thank the psychiatric social worker and the mental welfare officers who took part in helping to obtain some of the data for this investigation.

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Therapeutic Conferences

Upper Respiratory Tract Infections

FROM THE DEPARTMENTS OF THERAPEUTICS AND PHARMACOLOGY, MEDICINE, AND GENERAL PRACTICE, ABERDEEN UNIVERSITY

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PROFESSOR A. G. MACGREGOR: The management of infections of the upper respiratory tract arouses much controversy, and today we have asked a general practitioner as well as a specialist in chest diseases to join us. Can we get down to the basic contentions right away and discuss the use of antibiotics?

DR. J. G. R. HOWIE: It is very difficult for hospital physicians to discuss this problem authoritatively. There are theoretical reasons for not prescribing antibiotics, but there are strong pressures on the practitioner to do so.

DR. K. N. V. PALMER: It is important to remember that most upper respiratory tract infections are viral and that most antibiotics have no effects on viruses.

DR. J. C. PETRIE: Upper respiratory infections may be caused by over 100 different viruses. In coryza rhinoviruses are isolated in over half the cases. There are at least 89 serotypes. Para-influenza viruses are also frequently found. In patients with a sore throat and inflamed pharynx with lymph node enlargement and cough, adenoviruses (and there are at least 34 serotypes), influenza, Coxsackie, and ECHO viruses can usually be isolated.

DR. R. A. WOOD: The behaviour of viruses may be influenced by the age of the patient. For instance, the respiratory syncytial virus may cause a serious bronchiolitis or laryngotracheo-bronchitis in infants and young children, whereas in adults it usually causes a common cold.

DR. PALMER: Yes, the age of the patient is certainly important. Upper respiratory tract infections are much commoner in the younger age groups and are at a peak when the child

Appointments of Speakers

A. G. MACGREGOR, M.D., F.R.C.P., Professor of Therapeutics and Pharmacology
K. N. V. PALMER, M.D., F.R.C.P., Reader in Medicine
J. G. R. HOWIE, M.D., Lecturer in General Practice
J. C. PETRIE, M.B., M.R.C.P., Lecturer in Therapeutics
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