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A study of the accepted, referred and rejected applications from October 14, 1946 to February 28, 1947 at the Veterans Administration Mental Hygiene Clinic, Providence, Rhode Island

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE ACCEPTED, REFERRED AND REJECTED APPLICATIONS FROM OCTOBER 14, 1946, TO FEBRUARY 28, 1947, AT THE VETERANS ADMINISTRATION MENTAL HYGIENE CLINIC, PROVIDENCE, RHODE ISLAND

A Thesis

Submitted by
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In Partial Fulfillment of Requirements for
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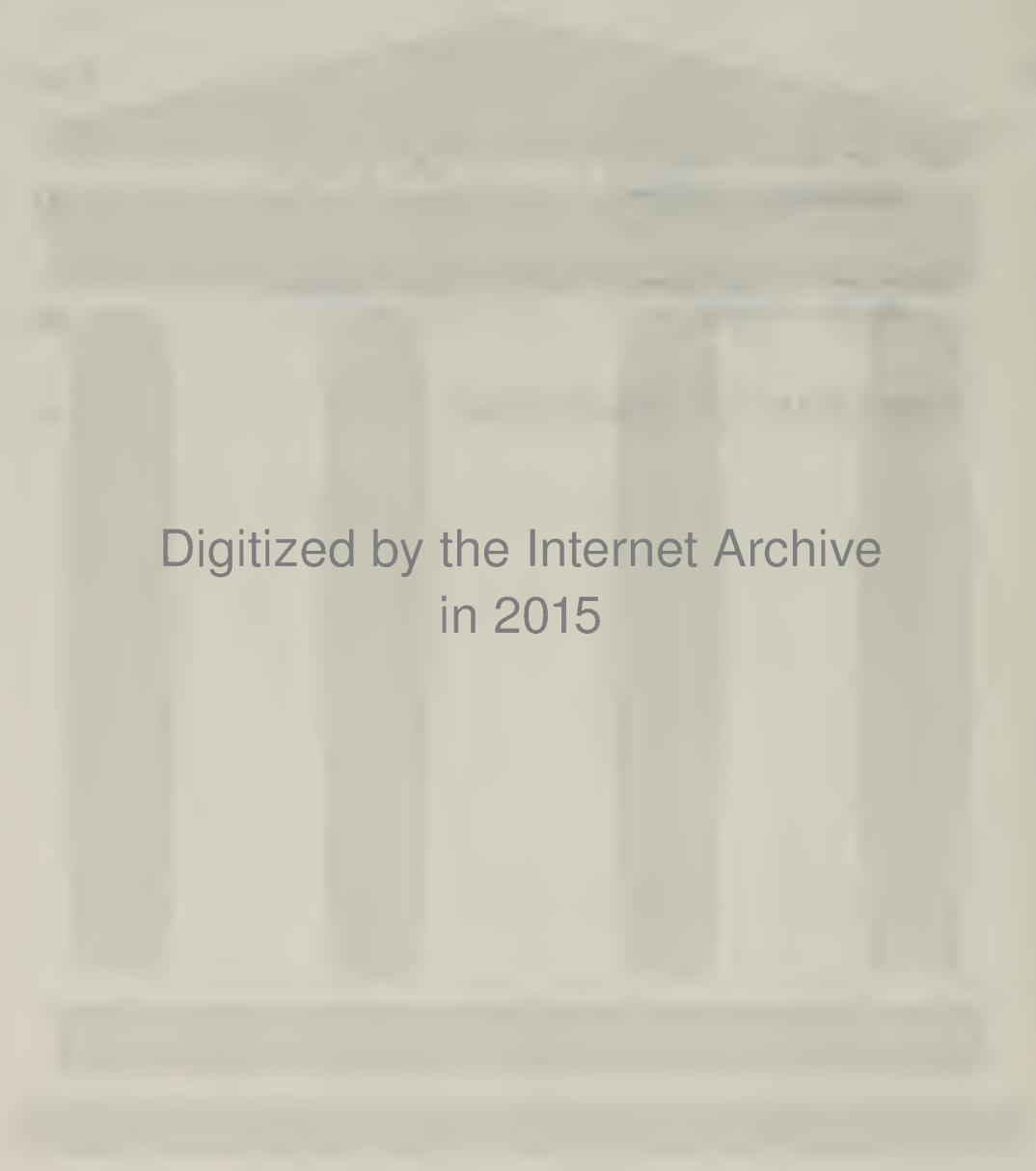

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CHAPTER I

INTRODUCTION

A. Purpose of Thesis

This thesis is a study of the applications accepted, referred to other agencies and rejected at the Veterans Administration Mental Hygiene Clinic in Providence, Rhode Island, from October 14, 1946, to February 28, 1947. Determination of the ability of the Clinic to care for veterans eligible for and desiring treatment, as seen through the disposition of applications, is the primary purpose of the thesis. Inquiry beyond the application or intake interview has not been made unless it affected the referral of the applicant. In selecting the application as the focus of study, the writer believed that justice could not be done to the Clinic's work function in the period under consideration were a wider range of work investigated. The thesis is also intended as a basis for further studies regarding treatment procedures, treatment results and changes in function which are illustrated here. The initial work

of the Clinic in fulfilling its purpose can be the basis for hypothesizing the character of future work. The material indicates present practices and areas in which changes may be necessary. The recent origin of the Clinic and the refinements both in procedure and technique, which are yet in development, precluded any attempts to draw conclusions from this material at such an early date.

Selection of the months indicated in the title was based on real factors: the date of origin of the Clinic and a period representing, as closely as possible, a third of a year's applications during the student placement period.

The difficulties inherent in such a highly personalized service which attempts to work in what might be called a large and decentralized public welfare program can be seen readily; the limitations imposed on the Clinic by the magnitude of a program which is in its initial stages must be considered throughout.

There were 287 applications for treatment during the period studied and all were considered in this thesis.

B. Plan of Thesis

The plan of the thesis entails first, an account of the Clinic's origin and the nature of the agency of which the Clinic is a part. Background material, including letters and Veterans Administration Circulars, were gathered for this presentation. The writer also secured

data from Miss Hope L. Joslin, Chief Social Worker, of the Providence Regional Office, and from Doctor Joseph M. Zucker, Chief Neuropsychiatrist of the Mental Hygiene Clinic. Following the background data, the nature of similar community resources and use by the Clinic of contract physicians will be presented.

The total applications received in the period indicated will be analyzed in regard to the source of referral, number of applicants receiving disability compensation, number receiving compensation for other disabilities in addition to psychoneurosis and the number of case work contacts previous to acceptance. Religion, marital status and residence will all be included in the section devoted to total applications to present a general idea of the clients applying. Tables are given in the section on religion, marital status and residence but no conclusions can be drawn from this material.

The disposition of the cases as regards acceptance, referral to other agencies or rejection by the Clinic is, by reason of the purpose of the thesis, of primary importance. In collecting this material the writer compared such items as accepted cases, both those which continued under treatment and those which did not; referred cases including those referred to outside clinics, to fee-basis physicians and to other resources; and rejected cases including those rejected for non-eligibility, for non-interest

of the applicant, or for other reasons.

Tables and, in some cases, graphs will be used. Statistical material from the Clinic's monthly reports, from application card index, from medical records and from Clinic case records has been developed and then analyzed for the conclusions drawn. Disguised and summarized case records have been used to illustrate the three items covered and to indicate the nature of and basis for acceptance, referral to other agencies and rejection.

Throughout the study, the word clinic when capitalized refers to the Veterans Administration Mental Hygiene Clinic.

CHAPTER II

HISTORY AND BACKGROUND OF THE MENTAL HYGIENE CLINIC - COMMUNITY RESOURCES

A. History and Background

In July, 1930, the Veterans Administration was created by an executive order under authorization of an act of Congress. The Congressional act authorized the President to consolidate and coordinate under a single control all federal agencies then dealing with veterans' affairs. When this was accomplished, the Veterans Administration became an independent establishment under the President. Its purpose is to administer laws relating to relief of, and other benefits provided by law for, former members of the military and naval forces. Included in these laws are regulations for physical examinations, hospital and outpatient treatment, and domiciliary care.[1]

Previous to this, the lack of treatment facilities of a preventive nature during and after World War I had resulted in the situation described below:

> ...three out of every five beds in the 75 Veterans Administration hospitals were occupied by patients with mental or nervous disorders, at an average cost to American

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1 Bureau of the Budget, United States Government Manual, 1947, pp. 517-544.

> taxpayers over the years of more than $30,000 per patient. From 1923 to 1940 nearly a billion dollars was paid by the Government for the care and treatment of World War I veterans with service-connected psychiatric disabilities.[2]

World War II focused attention on the lack of facilities, either public or private, to care for discharged veterans and civilians. At the ninety-ninth annual meeting of the American Psychiatric Association in Detroit in May, 1943, Doctor Arthur E. Ruggles of Providence said, " I have estimated...that under the present procedure of induction at least 200,000 young men will be discharged from the Army and Navy with neuropsychiatric disabilities.[3]

Although the need was seen, little community action resulted. The military situation was different, however; the need was apparently seen and met. Psychiatrists were on duty in combat zones and in many army camps and hospitals. The army established mental hygiene clinics at various replacement training centers in an effort to screen neuropsychiatric individuals who had been accepted by the Selective Service Boards. The purpose of these clinics in the replacement training centers was:

> ...to aid the adjustment of normal individuals and those with minor difficulties and to detect and eliminate the men-

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2 Thomas A.C. Rennie, "Mental Hygiene," Social Work Year Book, 1947, p. 317.

3 Edward Folliard, "We're Losing an Army," Washington Post Reprint, May 16, 1943, p. 1.

> tally unstable who are or may become a distinct liability to military training.[4]

The exigencies of total war demanded quantity rather than quality of personnel, and the individual who appeared qualified was more often than not selected to serve. As a consequence, many men were discharged after a short period of service for a psychoneurotic disability. It is estimated by Charles M. Griffith (see below) that these psychoneurotic cases which are service aggravated and veterans whose cases are definitely service-connected account for between 35 and 45 per cent of the medical discharges from the army alone.

The lessons learned in the war by the medical department in the treatment of the psychoneurotic serviceman have been found applicable to the needs of communities in planning treatment in mental hygiene clinics. In addition, literature published during the war and based on war experience, as well as training and teaching methods, can be used in the development of such resources in the community. Realization of the facilities necessary to care for these men in the post-war period prompted the following letter, which is quoted in part, from the Medical Director, Veterans Administration.

> The need for the establishment of outpatient clinics for the treatment of indivi-

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4 Folliard, op. cit., p. 1.

> duals suffering from neuropsychiatric conditions is being amply demonstrated at this time in connection with the returning veterans. However, such needs are not confined to veterans. Interest in this problem has been directed to the scattered and meager facilities that are available to the general public. The majority of the facilities that do exist are over-burdened and under-manned due to lack of qualified personnel.
>
> Available statistics indicate that between thirty-five and forty-five per cent of the discharges from the Army for disability are because of neuropsychiatric conditions. Many of these veterans are still in need of treatment and in order to fulfill this need the Veterans Administration has embarked on a program to establish special Mental Hygiene Clinics for out-patients at a number of readily accessible facilities and regional offices...
>
> These clinics are being developed and will be operated in accordance with the latest information available from authoritative sources. ...In many instances, the use of group psychotherapy will be indicated and will at the same time permit treatment of a greater number of patients. If necessary, such treatment may be supplemented by individual treatment...[5]

The letter further outlined in part the requirements for the clinic, both location and personnel, and indicated that work was being done to establish a definite plan for clinics within the Administration. At the time this letter was issued, a major reorganization of the Veterans Administration was taking place. Changes in policy and procedure, particularly in the Department of Medicine and Surgery, may have been instrumental in the initiation of the clinics. The functions of the Administration were decentralized by

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5 Charles M. Griffith, Veterans Administration, Medical Director's Letter, Sept. 17, 1945 (unpublished)

the establishment of branch offices and regional offices throughout the country.

In a Projection of Veteran Population for Branch Area Number One (this area covers New England and is the immediate headquarters for the Providence Regional Office) an estimate of the veteran population within New England is found. For the various regional and sub-regional offices, the percentage of veterans is estimated as well as the estimated number of men in hundreds. Territory covered by the Providence Regional Office would serve 11.9 per cent of the total veterans in the area. This number was estimated as 142,100 on September 30, 1946, and as 146,600 on March 31, 1947.[6] There is no indication of the number of these men who would have medical discharges and, therefore, no estimate of the neuropsychiatric discharges can be made. The number of men mentioned above would be residents of Rhode Island and Massachusetts. The area covered by the Providence Regional Office includes the entire State of Rhode Island and Providence Plantations; Bristol County, Massachusetts, in the towns of Attleboro, Berkley, Dighton, Fall River, Freetown, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton and Westport; and Plymouth County, Massachusetts, in the towns of Lakeville and Middleboro. (See Figure I.)

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6 Veterans Administration, Projection of Veterans Population for Branch Area Number One, Oct., 2, 1946, p. 1.

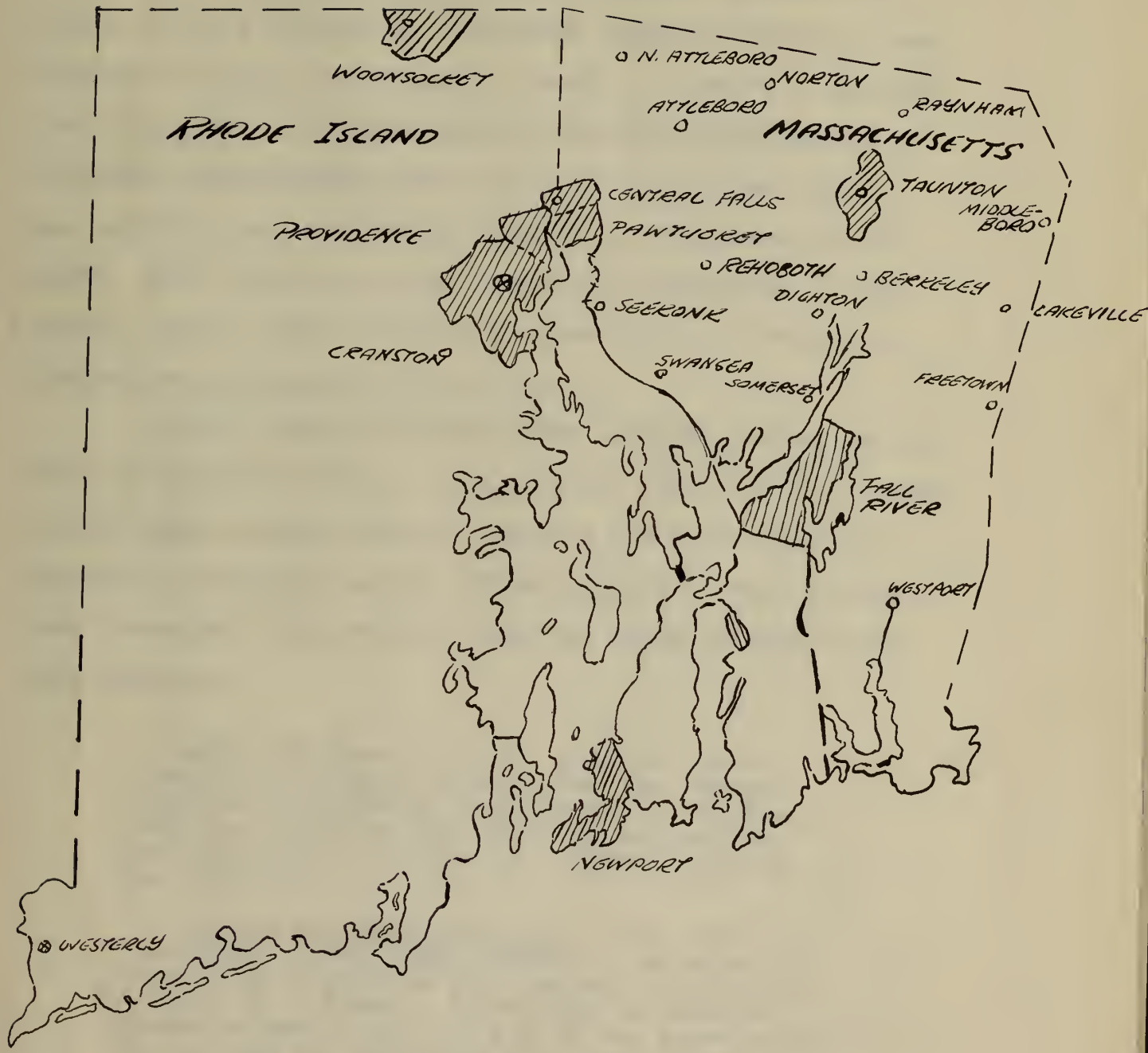

Figure I. Map of Area Covered by the Providence Regional Office

The number of applications at the Providence Regional Office for treatment prior to the Medical Director's Letter and the opening of the Mental Hygiene Clinic in the Providence Office is unknown. However, in order to provide facilities for such applicants, a contract by which the Veterans Administration would pay for out-patient care was entered into with Chapin Hospital, Providence, in October, 1945, and with Butler Hospital, Providence, in December, 1945. These contract clinics will be further explained under community facilities.

In July, 1946, Circular Number 169 was issued by the Veterans Administration. This circular indicated the nature of the newly created clinics, purpose and responsibility, function, qualifications of personnel, and routing and intake procedure. The extract below is taken directly from this circular.

> Mental Hygiene Clinics...will be established in regional offices when the Deputy Administrator having jurisdiction determines that such clinics are necessary and can be properly staffed within the approved personnel ceiling.
>
> Purpose and Responsibility. The need for treatment of the large number of veterans discharged from service with mental and nervous illness is evident. Experience in civilian practice before the war and in the armed service during the war indicates that the majority of these cases can be treated effectively in a clinic without hospitalization. The Mental Hygiene Clinics will render this treatment on an out-patient status and will be responsible for conducting the entire out-patient treat-

ment program in the selected regional offices. This program will serve to alleviate a minor neuropsychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization.

Functions of the Mental Hygiene Clinic. ...treat the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization. The veteran may present himself or be referred by another component of the Veterans Administration, a public or private agency, or an organization in the community... Emphasis will be placed on the utilization of group therapy. Individual treatment will be provided as necessary, and as facilities and time are available...

Routing and Intake Procedure. a. When a decision has been made to refer a patient with a nervous or mental illness to the Mental Hygiene Clinic, or when a patient presents himself and states he has such illness, whether or not he asks for treatment, he will be referred to the Mental Hygiene Clinic immediately. There he will first be interviewed by a social worker of the Mental Hygiene Clinic where, under the direction of the case supervisor, a statement will be prepared to assist the neuropsychiatrist in determining the patient's suitability for treatment. There also the social worker will, if necessary, orient and prepare him for treatment. On the same day, the patient will be interviewed by a neuropsychiatrist of the Mental Hygiene Clinic to insure that patients with certain mental and nervous conditions such as severe anxiety and depression will be put under care at the earliest time possible. Suitability for treatment will also be determined at this time or at a succeeding visit, if necessary...[7]

The circular setting up the Mental Hygiene Clinics is quoted at length to illustrate the procedures governing work in such clinics. In addition, the qualifications

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7 Veterans Administration, Circular Number 169, July 15, 1946, p. 1.

of all personnel attached to the clinics were outlined. During the first four months studied and until February 14, 1947, treatment pending adjudication of claim was authorized under Circular Number 215, dated August 31, 1946 (Out-Patient Treatment or Emergency Hospitalization). On February 14, 1947, Circular 215 was rescinded and Circular Number 17 (Out-Patient Treatment or Hospitalization, Section I) became effective in its place. The changes effected the basis for referring veterans to outside medical or clinic treatment but did not change the clinic's procedures.

The Providence Clinic was opened, in compliance with Circular 169, on October 14, 1946, with a Chief Neuropsychiatrist, two psychiatric social workers and two social work students in attendance. Inability to secure a psychologist has necessitated working without one since the Clinic's opening but psychological testing and study when necessary are done at both Butler Hospital, Providence, and in the Vocational Guidance and Training Division of the Veterans Administration.

For the first month, the Clinic operated with only one psychiatrist. In November, 1946, three psychiatrists devoting partial time to Clinic work were added to the staff. During the latter part of the interval considered in the study, there were six psychiatrists in the clinic on a part-time basis and one full-time psychiatrist. The

six part-time physicians devote in all a total of twenty-seven hours a week to clinic duties.

The basic purpose of the Clinic, as seen in Circular 169 is to "reduce the number of veterans requiring hospitalization." [8] In the Medical Director's Letter, previously mentioned, a broader purpose is given which appears to be more the long range purpose of the clinics rather than present scope. This section reads:

> The purpose of the Clinic will be to assist the patient through personal interviews, supplemented by the selective use of resources within the family and community, to adapt himself to his environment and its stresses; to relieve his anxieties and integrate conflicting feelings and tendencies in his personality; to improve the quality of his relationship with others and afford him an opportunity to know and understand himself better. [9]

B. Community Resources

Similar community resources used by the Clinic have been the two civilian hospitals mentioned above. The first of these hospitals to enter a contract with the Veterans Administration was the Charles V. Chapin Hospital, Providence. Formerly the Providence City Hospital, this institution was opened in 1910 for the care of communicable diseases. It was the first of its kind in this country

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8 Circular 169, op. cit., p. 1.
9 Griffith, op. cit., p. 2.

providing for the care of several infectious diseases in a single building. Facilities for patients with tuberculosis, mental and nervous diseases, and certain surgical conditions have since been added. In addition, the hospital has clinics and treats veterans who have service-connected disabilities and who are authorized and referred by the Veterans Administration. Non-service connected veterans, with minor neuropsychiatric diseases, are accepted in free clinics in the hospital, if they are unable to afford treatment and live in Providence. The Veterans Administration reimburses Chapin Hospital for any treatment received by a veteran authorized and referred to this hospital. Since contracting with the Veterans Administration for services, the hospital has accepted twenty-seven patients referred for service-connected disabilities. Of this number, twenty-five were treated, one never came for treatment when sent from the Veterans Administration, and one was referred but authorization was later cancelled.

In December, 1945, a contract between the Veterans Administration and Butler Hospital, Providence, was signed. This institution was organized through the instigation of Dorothea Dix for the care of the indigent insane in Rhode Island and established through the generosity of a few charitable citizens. In addition to caring for mental patients, it has trained many of the country's leading psychiatrists. The same principles applying to veterans

referred to Chapin Hospital regarding authorization and service-connection are necessary for referral to Butler Hospital. However, the clinic at Butler Hospital was also open to non-service connected veterans and their families as well as to non-veterans in the community. Referrals are accepted from private physicians and a fee, according to means, is charged if the applicant has a non-service connected disability and is not authorized by the Veterans Administration. Evening appointments are made when the veteran so desires.

Since the opening of this resource in January, 1946, 229 veterans have been treated here. There is no breakdown in the number referred by the Veterans Administration Mental Hygiene Clinic and those applying through private physicians or self-referral. Figures were not available regarding the number of veterans referred by the Clinic to this resource after the opening of the Clinic.

Agreements with private physicians in the community are also used as a resource by the Clinic. Such agreements are subject to the same requirements regarding authorization as are hospital contracts. There are five of these fee-basis physicians presently available.

The Clinic may refer men to any of these resources when authorization is given by the Chief of the Mental Hygiene Clinic.

There have been few referrals to agencies other than

to clinics and physicians. The Clinic accepts referrals from public and private social agencies in the community and is free to make referrals to these agencies.

CHAPTER III

ANALYSIS OF TOTAL APPLICATIONS

Having considered the function of the Clinic and its connection with community clinics and resources, a study of the total applications by months, within the given dates, will be presented. The plan is to show the source of referral to the Clinic, the number of applicants receiving disability compensation, the number receiving compensation for other disabilities in addition to psychoneurosis, the number of case work contacts previous to acceptance, referral to community resources and rejection, and the religion, marital status and residence of the veterans applying.

A study of the total applications is made in this Chapter as it best illustrates the Clinic's work within its function. Tables and graphic representations (when the latter are considered necessary) will be used.

A. Sources of Referral

The process by which men come to the Clinic is of importance in showing both Clinic growth in community relations and in indicating what the sources of future referrals to the Clinic may be. Because of this, the number of applications by source is first considered. In

TABLE I

SOURCES OF REFERRAL OF
APPLICATIONS FOR THE MONTHS UNDER STUDY

Sources of Referral	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Out-Patient Dept.	39	29	25	55	55	203
Self or Family	7	2	6	2	3	20
Other	10	11	10	8	18	57
Unknown	5	2	0	0	0	7
Total	61	44	41	65	76	287

TABLE II

SOURCES OF REFERRAL OF APPLICATIONS
PERCENTAGES FOR THE MONTHS UNDER STUDY

Sources of Referral	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Out-Patient Dept.	64.0	66.0	61.0	84.6	72.4	70.8
Self or Family	11.4	04.5	14.6	03.1	03.9	06.9
Other	16.4	25.0	24.4	12.3	23.7	19.9
Unknown	08.2	04.5	00.0	00.0	00.0	02.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Tables I and II, the results of this analysis are shown. It is evident that the large majority, 70.8 per cent, of the total applications have been referred by the Medical Out-Patient Department of the Veterans Administration. This can be explained by consideration of Circular 169 which established Mental Hygiene Clinics within the Veterans Administration. In this circular, relation between the Neuropsychiatric Examinations and Hospitalization Section and the Mental Hygiene Clinic is outlined. While having separate and distinct functions, the circular states that:

> ...there will be close liason between the two to insure active professional relations and mutual availability of records. The Neuro-psychiatric Examinations and Hospitalization Section is expected to be a major source of referrals to the Mental Hygiene Clinic.[1]

As the Clinic accepts veterans who have service-connected disabilities, these men are often first examined for pension purposes, adjudication of claim, and for Rating Board purposes by the Examination and Hospitalization Section. The men are then sent to the Clinic when such disposition is approved by the examining physicians. Often veterans who are actually self-referrals are first examined by the section mentioned and then further referred to the Clinic. This indicates that the small percentage of Self or Family referrals, 6.9 per cent, are men who come directly

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1 Circular 169, op. cit., pp. 1-2.

to the Clinic without first being examined as indicated above. Because of this system, an exact evaluation of the number of Self or Family referrals is impossible yet there is more awareness on the part of the veteran and his family than figures indicate. This has been discovered during interviews with the men but because of their contact with the Examination Section they are considered as having been referred by this source.

Perhaps of greatest interest is the third title or Other referrals as shown in Table I. This section indicates the degree of community and other agency interest, and while comprising but 19.9 per cent of the total referrals, illustrates a substantial interest on the part of the community in the work of the Clinic. Such diverse sources as friends of the veteran, contact representatives, American Red Cross, Family Welfare Society and private physicians have been instrumental in sending these men for treatment. In Figure II, the graph illustrates a rise of such referrals within the last month studied. This may be the result of the Clinic's facilities becoming better known in the community. Because of lack of staff, little work has been done to publicize the Clinic. Meetings with Red Cross members and later with contact representatives of the Veterans Administration were the only attempts made during the months under study but future publicity is planned when the Clinic can handle referrals resulting from such publicity.

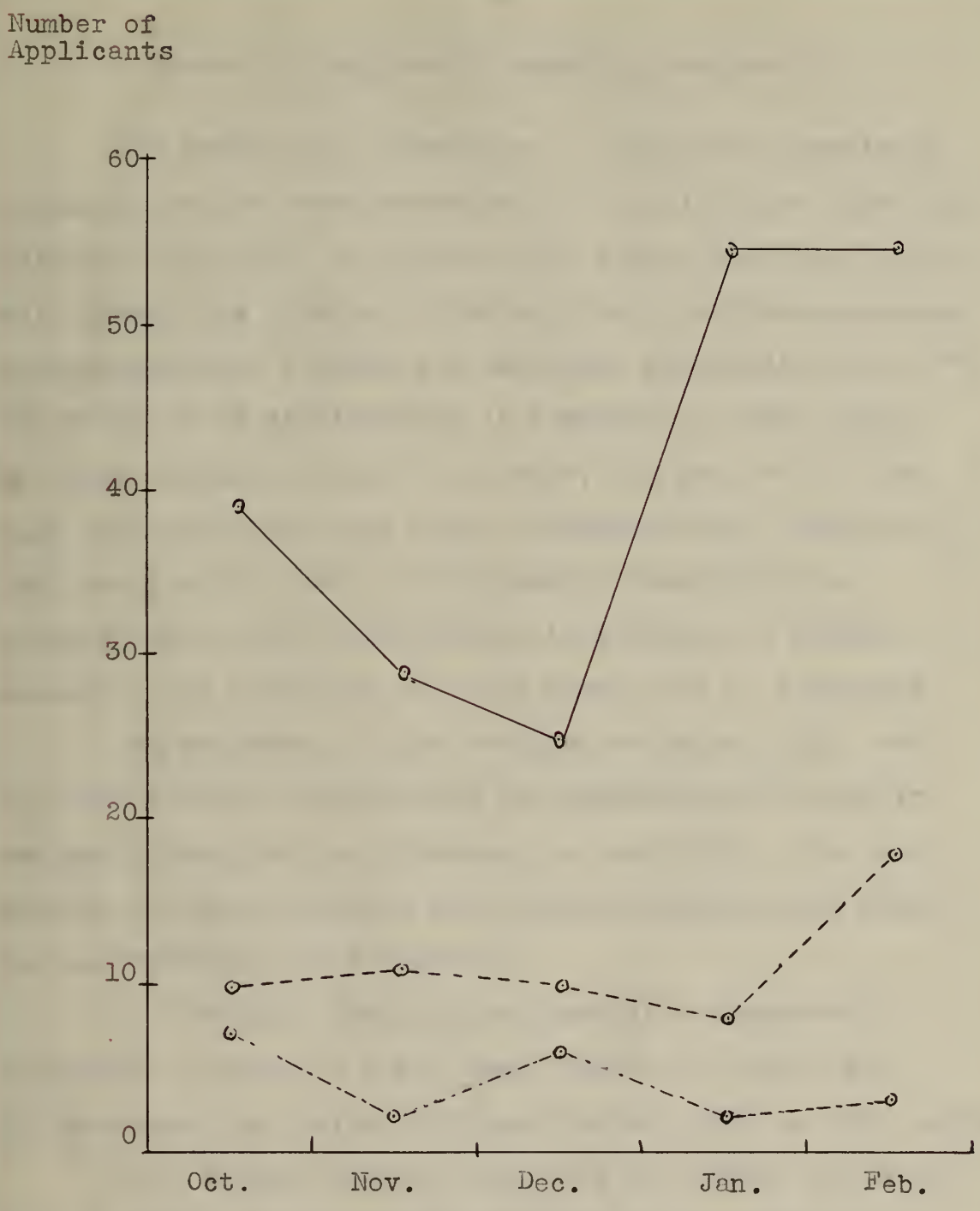

Figure II Sources of Referral During the Months Under Study

Legend

Out-patient dept. ————————

Self or family —·—·—·—·—

Other - - - - - - - - -

B. Number of Applicants Receiving Compensation

The number and percentages of applicants receiving compensation for service-connected disability are shown in Tables III and IV. As Circular 169 states that the Clinic will treat "the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization..."[2] the majority of applications is comprised of such cases. Of those applying during the period, 216 men or 75.3 per cent were receiving some type of compensation. Under the next section (C. Number of Applicants Receiving Compensation for Other Disabilities in Addition to Psychoneurosis) the breakdown of these cases will be discussed.

The veterans, in the section now under study, who had even partial compensation for psychoneurosis were immediately eligible for treatment in the Clinic. The catagories of those eligible and possibly eligible are given in the following brief summary.

1. Veterans receiving a disability compensation allowance or having a 0 per cent disability status for psychoneurosis or related illness are eligible on their claim.

2. Veterans who are under the provisions of Public Law 16, either in On-the-job training or in school, are eligible for treatment regardless of compensation status.

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2 Circular 169, op. cit., p. 1.

TABLE III

NUMBER OF APPLICANTS RECEIVING
DISABILITY COMPENSATION FOR THE MONTHS UNDER STUDY

Status of Applicant	Oct.	Nov.	Dec.	Jan.	Feb.	Totals
Receiving Compensation	46	35	32	45	58	216
0 per cent	2	2	4	18	2	28
Pending	8	1	3	1	10	23
Not Receiving	5	6	2	1	6	20
Total	61	44	41	65	76	287

TABLE IV

NUMBER OF APPLICANTS RECEIVING DISABILITY
COMPENSATION PERCENTAGES FOR THE MONTHS UNDER STUDY

Status of Applicant	Oct.	Nov.	Dec.	Jan.	Feb.	Totals
Receiving Compensation	75.5	79.6	78.0	69.0	76.4	75.3
0 per cent	03.2	04.5	09,8	27.7	02.6	09.7
Pending	13.1	02.2	07.3	01.7	13.2	08.0
Not Receiving	08.2	13.6	04.9	01.7	07.9	06.9
Total	100.0	99.9	100.0	100.1	100.1	99.9

3. Veterans filing claims for a nervous condition were eligible for treatment under Circular 215. (Later under Circular 17) Should it appear during the interview with the social worker that there is a possibility of the veteran's condition being declared not service-connected, then interpretation of this to the veteran and explanation of outside clinics which he may attend is made.

In the group indicated as 0 per cent, the veterans having such status were but 9.7 per cent of the number applying. These twenty-eight applicants were considered as having a psychoneurotic disability established as service-connected but one which was not incapacitating and, therefore, non-compensable. This is usually the designation given to men who are entitled to less than 10 per cent compensation but who are eligible for treatment upon application.

Cases pending are those which have been referred to the Clinic for treatment while the veterans' claims are being adjudicated. During the months studied and until February 14, 1947, Circular 215 gave authority for this as mentioned above.

The men not receiving compensation amounted to but 6.9 per cent and consisted of only twenty applicants. In such cases, the existence and use of community facilities were explained to and offered the veteran, although where evidence from the applicants' statements indicated their

illness had its origin or aggravation in service, the men were told of their rights to file a claim, and upon doing so could be accepted at the Clinic.

C. Number of Applicants Receiving Compensation For Other Disabilities in Addition to Psychoneurosis

Table V indicates the number of men applying to the Clinic who were receiving compensation for other disabilities and psychoneurosis. Of these 216 men receiving compensation, 184 or 85.2 per cent were receiving some compensation for a psychoneurotic condition and thirty-two or 14.8 per cent had additional disabilities for which they were receiving compensation. The applicants with a psychoneurotic condition were eligible for treatment when considered suitable for and desiring psychotherapy. No breakdown as to specific

TABLE V

NUMBER OF APPLICANTS RECEIVING COMPENSATION FOR OTHER DISABILITIES IN ADDITION TO PSYCHONEUROSIS

Nature of Disability	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Psychoneurosis	41	31	29	37	46	184
Other	5	4	3	8	12	32
Total	46	35	32	45	58	216

type of disability other than psychoneurosis has been made.

D. Number of Case Work Contacts

The number of case work contacts before the applicant was accepted, referred to other resources, or rejected is of interest in that it indicates the degree of social work activity previous to disposition. Table VI shows that 107 or 37.2 per cent of the applicants were seen only once previous to disposition, and 167 or 58.2 per cent were seen more than once by the social worker. Of the latter number, the interviews included the history-taking previous to contact with the psychiatrist. Of the number seen only once, the history taking was done at times, if the man was being referred to an outside clinic, but the usual one interview case was a rejected case. Only in 4.5 per cent or thirteen of the cases were the number of contacts unknown, and these were all in the first month of the Clinic's operation. In cases rejected or referred, the initial case work interview was sufficient to indicate that the applicant was to be referred to another facility or was neither desirous of, nor suitable for, psychotherapy. The history-taking involved more than one interview, and was usually an indication of acceptance in the Clinic. However, in the latter two months under study the large number of referrals, which will be discussed later, necessitated more than one contact for accurate referral.

TABLE VI

NUMBER OF CASE WORK
CONTACTS PREVIOUS TO DISPOSITION

Number of Contacts	Oct.	Nov.	Dec.	Jan.	Feb.	Total
One	18	19	7	30	33	107
Two or More	30	25	34	35	43	167
Unknown	13					
Total	61	44	41	65	76	287

TABLE VII

RELIGION OF APPLICANTS

Religion of Applicants	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Catholic	40	31	24	47	52	194
Jewish	3	1	2	2	3	11
Protestant	6	7	3	10	19	45
Other	1	0	1	1	0	3
Unknown	11	5	11	5	2	34
Total	61	44	41	65	76	287

E. Religion, Marital Status and Residence

Statistics in Tables VII, VIII and IX concerning religion, marital status and residence were studied in evaluating total applications in order to present a picture of clients applying and to supply the reader with a general idea of the group served by the Clinic. No attempt at interpretation has been made and no conclusions can be drawn from this material. In addition, there was no method by which proportions could be shown as the Massachusetts territory covered by the regional office is based more upon convenience of location than upon population figures.

TABLE VIII

MARITAL STATUS OF APPLICANTS

Marital Status	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Married	38	21	19	33	35	146
Single	23	17	14	29	36	119
Other		5	1	2	4	12
Unknown		1	7	1	1	10
Total	61	44	41	65	76	287

TABLE IX

RESIDENCE OF APPLICANTS

Residence	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Rhode Island	47	39	36	60	64	246
Massachusetts	14	5	5	5	12	41
Total	61	44	41	65	76	287

CHAPTER IV

DISPOSITION OF APPLICATIONS

The disposition of the applications to indicate the number accepted, referred to other agencies, and rejected is now presented to disclose how the Clinic has fulfilled its function in the work undertaken. The writer will present in this Chapter the accepted cases, both those which continued and those which withdrew, the referred cases and resource to which referred, and the rejected cases and reasons for rejection. Case examples illustrating each category will be given. The method of selecting cases has of necessity followed no definite sampling procedure. Cases were selected which seemed best to illustrate the sections under which they are included. In cases referred to other agencies and rejected, filing procedures made sampling unfeasible. Many cases were incomplete, referred and rejected cases were filed together, processed records were not used and an unprocessed pre-treatment summary contained the case history. In order to keep the procedure uniform in all three categories, the method of illustration was chosen. Source of illustration in all situations presented is the case history. Cases are disguised and summarized.

A. Accepted Applications

Because the study attempts to draw conclusions re

TABLE X

DISPOSITION OF APPLICATIONS
FOR THE MONTHS UNDER STUDY

Disposition	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Accepted	32	21	25	29	14	121
Referred	22	9	11	30	51	123
Rejected	7	14	5	6	11	43
Total	61	44	41	65	76	287

TABLE XI

DISPOSITION OF APPLICATIONS
PERCENTAGES FOR THE MONTHS UNDER STUDY

Disposition	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Accepted	52.5	47.8	61.0	44.6	18.4	42.2
Referred	36.0	20.4	26.8	46.2	67.1	42.8
Rejected	11.5	31.8	12.2	09.2	14.5	14.9
Total	100.0	100.0	100.0	100.0	100.0	99.9

garding the Clinic's function from its work between the time of origin and the end of February, 1947, consideration of the accepted applications is of primary importance. The stated function of the Clinic is to "treat the veteran suffering from a service-connected neuropsychiatric illness not requiring hospitalization." [1] In addition, the Clinic can treat those veterans who are waiting for adjudication of claim for an allegedly service-connected disability. [2]

It has been the policy of the Clinic to accept applications pending adjudication of claim when the applicant is interested in treatment, when the applicant's condition is amenable to treatment and when it appears likely that adjudication will be in the veteran's favor so that treatment will not be interrupted and a referral made necessary after rapport has been established between the patient and physician.

Of the applications received, 121 or 42.2 per cent were accepted for treatment. Of this number, 81.8 per cent continued under treatment and 18.2 per cent withdrew. Approximately four-fifths of those continuing under treatment remained under treatment in the Clinic during the months studied.

a. Accepted Continued Cases

The accepted continued cases are those with which

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1 Circular 169, op. cit., p. 1.
2 Circular 215, op. cit., p. 1.

TABLE XII

ACCEPTED APPLICATIONS
FOR THE MONTHS UNDER STUDY

Accepted Cases	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Continued	30	20	21	20	8	99
Withdrew	2	1	4	9	6	22
Total	32	21	25	29	14	121

the Clinic is presently concerned. Acceptance was indicated both by the veteran's acceptance of psychotherapy and his eligibility for treatment in the Clinic. Such eligibility was denoted by his pension status, i.e., psychoneurosis, claim pending or 0 per cent, by his understanding and acceptance of the therapy involved, and by his suitability for treatment.

The first of two illustrations of accepted cases is that of an applicant referred by out-patient department for psychotherapy; the illustration indicates the nature of the accepted continued cases.

> Mr. M. was first seen by an examining physician in the medical section. He had a 0 per cent rating for a stomach condition and applied for compensation for his nervous condition. Upon examination it was found that while he was receiving treatment for various complaints there were no clinical findings. He was sent to the mental hygiene clinic by the ex-

amining section.

During the first interview the veteran expressed an interest in, and desire to receive, psychotherapy. He had done little about seeking help until this time, feeling that he could solve his problems himself. However, the pain in his leg, desire to smash objects, irritability with people, and his violent headaches and dizziness as reactions to routine things, made it necessary for him to apply for medical attention. The applicant dated the onset of his illness to a routine meeting of officers in Hawaii. He was present to make recommendations for improvements in the ordinary office routine and found that his recommendations were over-ridden by men with higher rank. He lost control of himself and directed his animosity toward the others present, but said that his immediate superior covered for him and he was not reprimanded. Later in a combat zone he was subjected to bombing and tropical storms, and was hospitalized for a recurrent pain in his back and neck. When placed in a ward for psychoneurotic cases, Mr. M. became indignant that the doctors had directed such a placement for him. Through the intervention of a friend high in government circles, the veteran was returned to the United States and immediately discharged. Since that time he sought to relieve his symptoms by working hard, but on finding this of little benefit he applied for treatment of his somatic complaints at the Veterans Administration.

The veteran related easily to people. He was able to accept the probability of an emotional basis for his illness and desired treatment at the Clinic.

This is typical of the accepted cases and the eligibility, plus desire of the applicant for the Clinic's services. In addition, the veteran was considered as being suitable for effective treatment, as stated in Circular 169 showing the purpose of the mental hygiene clinics.

b. Accepted Cases Which Withdrew

The cases which were accepted but in which the applicant withdrew either during the history taking or after

a few contacts with the psychiatrist were accepted on the same basis as were the cases which continued. No attempt has been made to learn from the veterans the reason for withdrawal. In the case below, it may be that the veteran was not ready for treatment or was dissatisfied with the Clinic because of his experiences while in service. However, until a more accurate survey of these cases has been made, no definite conclusions can be drawn. The overtones throughout the following illustration suggest that, although the veteran was a self-referral, he was unwilling to accept the Clinic and the therapy involved. His indication of previous unsatisfactory experiences with psychiatrists may have been an additional influence in his decision to withdraw.

> Mr. L. is receiving compensation for psychoneurosis and for a wound suffered in combat. He had been with the Marine Corps and received an honorable discharge for the disabilities indicated. Because his condition did not improve, he applied for treatment. The onset of his illness was dated by him as January, 1945, during combat in the South Pacific. A shell explosion killed three of his friends and made him apprehensive and uneasy to such a degree that he was hospitalized and then returned to the United States. While on limited duty, he became eligible for discharge and returned home. His complaints on application were nightmares, headaches, insomnia, depression and fatigue. These interfered with his job as a salesman. Medication by his family physician proved useless and he applied for treatment.
>
> The veteran, although apparently desirous of treatment and accepting of the explanation offered him regarding the method of clinic treatment, said that he had received no benefits from experiences with military psychiatrists. During the intake interview he seemed willing to cooperate fully and

> was considered suitable for treatment. However, during the history taking he was reticent, and seemed to relate only on a superficial level. He stated at this time that his desire, were he able to afford it , would be to attend a large, well-known diagnostic clinic and he expressed concern about qualifications of physicians in the Veterans Administration. Mr. L. kept one appointment with the psychiatrist and then withdrew from treatment. Letters were sent offering another appointment but these were unanswered and the case was closed.

This veteran, while having some insight concerning his condition, was unable to accept treatment of his problem on other than a superficial level. He was eligible and apparently good material for treatment, both from his self-referral and attitude toward treatment. However, during history taking he indicated unwillingness to discuss his problems and later withdrew because of this. The policy of the Clinic has been to contact these men by letter offering new appointments, but no further contacts are made when the veteran does not respond.

B. Applications Referred to Other Resources

In Table XIII, the referred applications by month are shown. These cases (see Figure III) have necessarily risen as the ability of the Clinic to absorb them diminished. This was primarily due to the large number of veterans remaining under treatment. Of the total applications, 123 or 42.8 per cent were referred to outside resources. Of the 123 applications 92.6 per cent or 114 applicants were sent to clinics or to contract physicians. In presenting

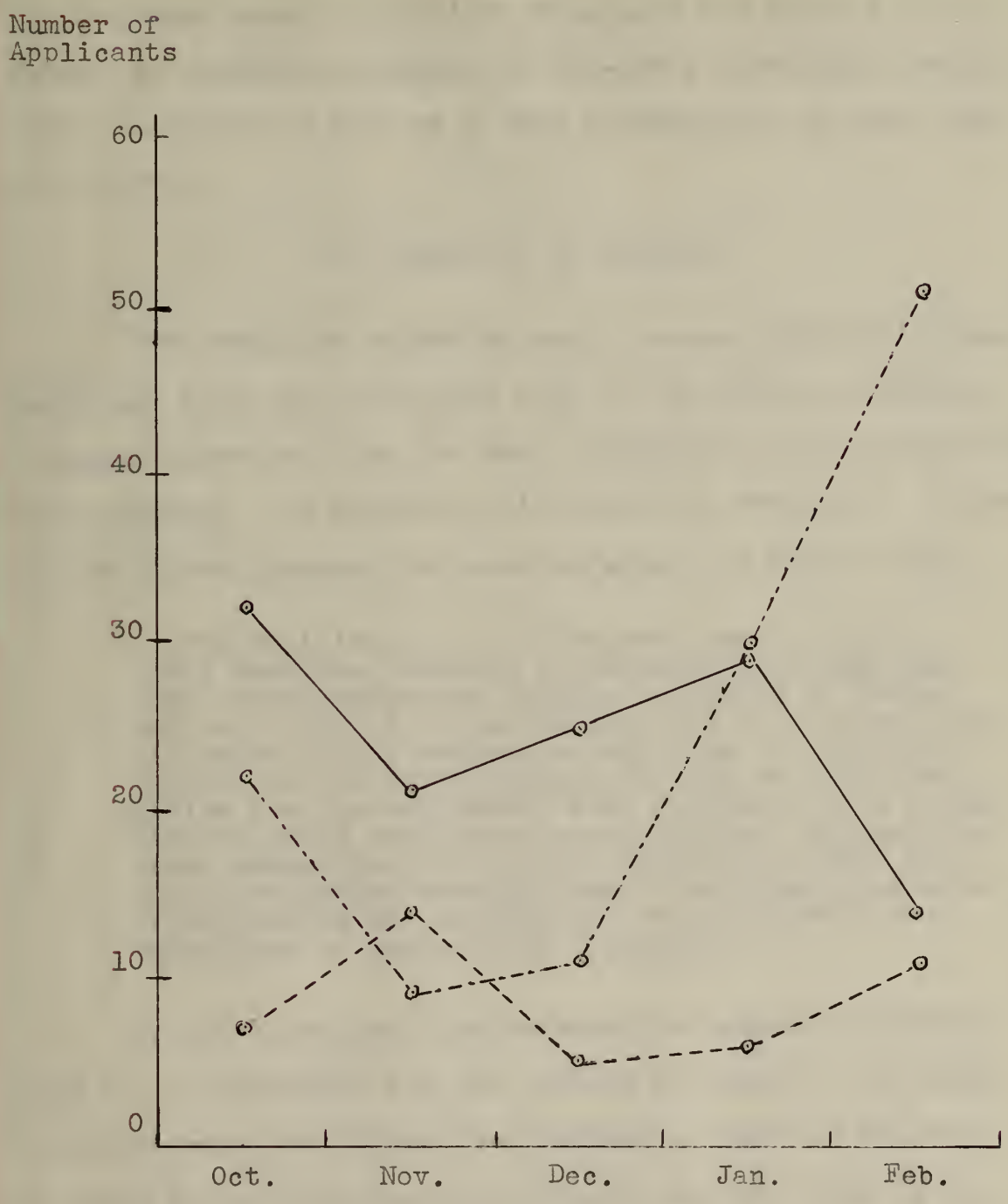

Figure III Disposition of Applications

Legend Accepted ————
Referred —·—·—·—
Rejected - - - - - -

the referred cases, the writer will give the basis for referral to community clinics, to fee-basis physicians and to other resources as well as a case illustration of each type of referral.

a. Referrals to Clinics

The basis for referring men to other clinics has been dependent both upon available time at the Veterans Administration Clinic and upon the man's eligibility and suitability for treatment. In addition, Circular 252, Section I, indicates the additional factors for such referral and states that:

> The facilities of the Veterans Administration Field Stations, staffed by Department of Medicine and Surgery personnel, will be utilized to their fullest extent for examinations and for out-patient treatment...if a veteran establishes to the satisfaction of the Chief Medical Officer of a Regional Office (or his designate) that reporting to a field station would work unnecessary physical hardship or cause excessive loss of time from employment, fee-basis designates working under state-wide contracts or agreements may be utilized for performing examinations or out-patient treatment. [3]

Cases, therefore, are referred to community clinics when it is a hardship for the veteran to come to the Veterans Administration Clinic for treatment, when the man has no claim for service-connected disability, and when it appears that the nature of his condition can be better treated in a community clinic. If the man is eligible and referred,

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3 Veterans Administration, Circular 252, Oct., 21,1946, p. 1.

authorization must be given. Such authorization is made in writing by the Chief Neuropsychiatrist in the Clinic. If the

TABLE XIII

APPLICATIONS REFERRED TO OTHER RESOURCES FOR THE MONTHS UNDER STUDY

Disposition	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Clinics	16	5	7	17	35	80
Fee-basis Physicians	6	2	4	8	14	34
Other	0	2	0	5	2	9
Total	22	9	11	30	51	123

man is ineligible for treatment, and material both from his statements and essential folder indicate that he will not be eligible should he file a claim, fee-treatment at the community clinics is explained to him. If he so desires, an appointment is made for him. Of the 123 cases referred, eighty or 65.0 per cent were referred to community clinics.

The following case is that of a man eligible for treatment at the Veterans Administration Clinic but the nature of his condition made a referral necessary.

Mr. P. was referred by the out-patient department. He is receiving 30 per cent compensation for psycho-

neurosis, mixed type, severs, shown by insomnia and aggressive behavior. During the first interview the veteran was resentful, highly suspicious and aggressive. His understanding of therapy consisted of talking to a psychiatrist and getting medication when he desired it. Mr. P. had paranoid ideas and spoke at length of his desire to kill people and of his efforts to get some weapon to protect himself against people who bothered him.

The veteran dated the onset of his illness to his service experience as a gunner, but said that he had been aggressive and irritable all his life. He received a promotion while in the United States and to celebrate this he became intoxicated, fought with the men in his barracks and was demoted. He was sent overseas and finished forty missions, but his increasing aggressiveness and hostility made it necessary for authorities to return him to America for hospitalization. While in Jefferson Barracks, Mo., he expressed his hatred for the state of Missouri and fought with St. Louis police who clubbed him into submission. Although himself of German descent, he shot at a German prisoner-of-war who was on duty near the barracks and spoke of his hatred of this national group. The veteran received a certificate of disability discharge (honorable) in January, 1945.

The civilian record of this man shows inability to conform, constant aggressiveness, both in school and work situations, and lack of insight. He desired his own way and reacted aggressively when thwarted. He enlisted so that he could choose his branch of service and not be told where he was to go.

In this case the client was referred to a community clinic as it was felt that this was a long time case and the man's paranoid ideas made successful treatment doubtful. Possible need for hospitalization at an early date was also considered.

b. Referral to Fee-basis Physicians

Fee-basis referral is dependent upon the same con-

sideration as is clinic referral. From Table XIII it can be seen that only 27.6 or thirty-four referred cases were sent to fee-basis physicians. There is a gradually rising total as the period of this study ends and this is indicated in Figure III. It appears related to the same factors as the community clinic referrals, but is not so sharply defined. Community clinic referral is considered preferable as the facilities offered closely approximate those offered by the Veterans Administration Clinic. Men needing special physical examinations and testing, who attend community clinics, receive this treatment at the clinics, while men sent to fee-basis physicians must assume the extra cost of tests given if the physician does not indicate that such tests are necessary for treatment. However, "unnecessary physical hardship" and "excessive loss of time from employment" [4] which the veteran might encounter make him eligible, upon authorization, to be attended by fee-basis physicians. In addition, some applicants request certain physicians, having been treated previously by the doctor requested. The establishment of a positive transference in such a case is considered of sufficient importance to warrant referring the case back to the physician whom the applicant desires.

The application of Mr. J.,which follows, is indicative of factors considered in referring a veteran to a fee-basis physician.

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4 Circular 252, op. cit., p. 1.

Mr. J. applied for treatment upon being referred by the medical section where he had been examined for adjudication purposes. He was receiving 10 per cent compensation for a shoulder condition and had filed for compensation for a nervous condition. At the time of application, he was eligible under Circular 215 for treatment, pending adjudication of his claim. Mr. J. expressed hostility at the treatment he received during his contacts with the Veterans Administration. He was being "pushed around" and could not understand why his condition was not receiving attention as he was severely incapacitated. After several visits to a contact representative, he went to a psychiatrist as a private patient and said that this physician helped him greatly, but the cost was prohibitive if continued treatment was needed. His complaints were bilious vomiting, insomnia, headaches, excessive sweating, irritability and stuttering. He dated the onset of his illness to an experience in the army, when he saw several tanks blown up and he volunteered to try to remove injured men and cases of ammunition near the resulting fire. Shortly after this incident, the veteran, while again handling ammunition in a truck convoy, experienced the first of his stomach symptoms and was hospitalized. He started to stutter at this time. Mr. J. indicated difficulties with accepting army discipline and told of the injustices he believed he suffered during his time in service. He was unable to advance in rank because the men in his company were all from the west and promotions were given to them. He received a court-martial for returning late from leave and was tried by a drunken officer and sentenced to six months confinement. The veteran expected to encounter the same unjust treatment in civilian life and stated he now would accept no affront either real or imagined. His contacts with the Veterans Administration were made in an effort to be treated and he desired no further compensation if this treatment could be given. However, his private contacts with the psychiatrist were helpful to him, and he wished to continue with this man. In addition, the hours available to him at the Clinic interfered with his work and he was referred to the doctor of his choice.

In this case, the positive transference had been made; the man was eligible under Circular 215 for treatment and the Mental Hygiene Clinic could not offer him an appointment without causing excessive loss of time from employment.

c. Other Referrals

Referrals indicated as Other in Table XIII, while representing but nine applications or 7.3 per cent of the referred cases, are applications in which the client was seen but was obviously not a Clinic case. These applications were referred to a suitable agency or Veterans Administration department and might be called brief service to the applicant. The following is an illustration of this service.

> Mr. B. was referred to the Clinic when the examining physician in the medical section found no organic basis for a leg condition which the veteran claimed. The veteran was receiving 10 per cent compensation for malaria but was eligible for treatment as he was in school under Public Law 16. The veteran was resentful when he learned the reason for referral and when the social worker discussed the situation further with the referring physician, the latter agreed to consult with other physicians concerning Mr. B's. disability. It was found upon further physical examination that the veteran may have sustained an injury from his pre-service participation in sports and he was referred for physio-therapy.

Although this application was referred properly, and the veteran was eligible for treatment, it was not considered a Clinic case. The appropriate referral was then undertaken by the Clinic worker. There was no psychiatric problem and the man neither desired nor needed treatment. Other cases concern referrals to Regional Office Social Service, to private agencies and to medical facilities within the Veterans Administration.

C. Rejected Applications

Rejected applications comprised forty-three of the total applications or 14.9 per cent. In Table XIV, the distribution of these applications is shown. The group has been divided into non-eligible applicants, non-interested applicants and other applicants. The cases in which non-interest of the veteran is discussed are, perhaps, the most important in this section.

TABLE XIV

REJECTED APPLICATIONS
FOR THE MONTHS UNDER STUDY

Distribution	Oct.	Nov.	Dec.	Jan.	Feb.	Total
Non-eligibility	2	0	1	0	1	4
Non-interest	3	7	4	6	10	30
Other	2	7	0	0	0	9
Total	7	14	5	6	11	43

a. Non-eligibility of Veteran

Veterans applying for treatment were eligible, in most cases, either on their disability or pending adjudication of claim. However, some men did not wish to

claim such disability and were usually referred to community facilities. The applicants in this section were men so classified. When it had been decided that the nervous condition claimed did not originate, or become aggravated, in service, there was little which could be done except refer them to appropriate agencies or clinics in the community.

The following illustration is an example of such a case.

> Mr. O. was a self-referral and came to the Clinic seeking treatment for a non service-connected nervous condition, for which he refused to file a claim. He had over three years army experience, some in combat in Europe. While in service, he married a girl of different religious persuasion and he dated his difficulties to his arguments with her regarding religious issues. He had become asocial and nervous and had left his religion. Mr. O. feared that if his employer learned of his marriage and his present nervousness, he would be discharged. When questioned concerning his army experience, the veteran stated he had no history of nervousness while on duty and his only concern was to seek some arbitrator between himself and his wife. As he needed treatment, the facilities of a community clinic were offered. The man said he intended to accept treatment on a fee-basis at such a clinic.

Because of the broad basis for accepting veterans for treatment, only four of these cases existed during the months studied. Every opportunity was given the veteran to file for compensation and treatment under Circular 215 (later Circular 17) was assured, pending adjudication. It is expected that in the future there will be few such applications referred to the Clinic.

b. Non-interest of Veteran

Cases referred to the Clinic of veterans who were not interested in psychotherapy comprised thirty or 69.8 per cent of the rejected applications and 10.4 per cent of the total applications received. Throughout the period studied, these veterans pose a problem in that they consist wholly of men eligible for and needing treatment yet often unwilling to accept the emotional basis for their illness or unwilling to make any constructive change. Without exception, these applicants attempt to rationalize their illness or deride psychotherapy to justify their resistance to treatment. The majority receive compensation for a psychoneurotic disability and have had experience with psychotherapy in a military situation. The problem of the intake worker has been to discuss with these men the treatment they will receive and, in the face of their objections, to make it possible for them to return to the Clinic when they can accept the treatment to be undertaken. The intake worker must also handle and accept their feeling of resistance and resentment and try to stimulate the veteran to make a constructive change.

> Mr. T. was referred to the Clinic by the medical section after an examination for pension purposes. He is receiving 60 per cent compensation for hysteria and was resentful at being referred, as he had not been told the reason for such a referral. The veteran's only complaint was a facial tic which became severe when he was nervous or excited and while

accepting the possibility of an emotional basis for the condition, he was not interested in treatment for it.

Mr. T. came to the Clinic only because he had been told to do so by the medical section and said he had no use for psychiatrists, having been treated, but not helped, by them when in service. The veteran expressed a superficial interest in the Clinic and attempted to justify his not coming for treatment by his odd working hours. He said he would discuss the matter with his family and contact the Clinic but again repeated his lack of interest in psychotherapy and his feeling that he could help himself.

The veteran dated his facial tic to an accident in childhood when he had been hit by a stick. He had difficulty adjusting to the disciplinary system in the army and felt superior to many of the officers in charge. Because of his complete lack of interest in treatment, he was rejected as unsuitable for help in the Clinic.

This is typical of the men rejected because of lack of interest in treatment. The tendency to project their difficulties, and the resistance to treatment after having experienced it previously, are found in the majority of cases in this group. Expressions of resentment and surprise at having been referred to the Clinic, and disinclination to consider involving themselves in the psychotherapeutic relationship are frequently found. It is possible that further interest and discussion by the examining or referring source might make the applicants more amenable to treatment.

c. Other Rejections

Other rejections in this section consist of cases involving psychotic patients and veterans who were referred but found not in need of treatment. These cases, as seen

in Table XIV, have been peculiar to the early months of Clinic operation. Since the work of the Clinic has become better known, such referrals are handled by the medical section or by Regional Office Social Service Department, rather than being referred to the Clinic. For this reason, no case illustration is given.

CHAPTER V

SUMMARY AND CONCLUSIONS

The Veterans Administration may be considered as a public welfare organization operating as an independent executive department under the President. Its concern is with former members of the military and naval forces. The controlling agency under which the mental hygiene clinics function is, by its nature, non-sectarian and non-racial. Eligibility for treatment is determined by service in the armed forces and resulting service-connected or service aggravated disabilities. Compensation is determined by laws covering the disability claimed.

Circulars pertaining to work and function of all departments within the Veterans Administration are issued in Washington and insure national uniformity. Decentralization of function was accomplished by the creation of branch and regional offices throughout the country. Mental hygiene clinics are authorized to be set up in regional offices and are responsible to the chief medical officer of the regional office in which such clinics exist.

A letter from the medical director of the Veterans Administration, dated September 17, 1945, told of the need of such clinics because of the number of men medically discharged for neuropsychiatric condition. The manner in

which the clinics would be established was also pointed out. Pending establishment of clinics within the Veterans Administration, contracts with community clinics and physicians were authorized to care for men eligible for treatment, or awaiting adjudication of claims for compensation and treatment. During the period between the issuing of the medical director's letter and the issuing of Circular 169 authorizing the establishment of clinics, mental hygiene clinics were developed and tested in certain Veterans Administration regional offices and hospitals. The results of this development were used to formulate the plan, purpose and function of the clinics in Circular 169, issued on July 15, 1946.

The Providence Regional Office Clinic was opened on October 14, 1946, in compliance with Circular 169. At that time, the deputy administrator determined that the clinic was necessary and could be properly staffed; this is an essential requirement as outlined in the Introduction of the above Circular. The Providence Mental Hygiene Clinic renders service on an out-patient status to the veteran with service-connected neuropsychiatric illness. The Clinic is responsible for conducting the entire treatment program for out-patient neuropsychiatric applications and is responsible to the chief medical officer. The program is to be preventive and is intended to serve to alleviate minor illness of this type, to check the development of serious illness, and, as a consequence, reduce the number of veterans requiring

hospitalization.

The establishment of the Clinic did not obviate the need of contracts already established with community clinics and physicians. On the contrary, the need for these additional facilities to care for cases became obvious as the applications increased. Applicants were referred to these clinics and physicians on a fee-basis as authorized under Circular 215 and later under Circular 17.

The Providence Mental Hygiene Clinic offers its services to veterans in an area covering the State of Rhode Island and towns and cities in Bristol and Plymouth Counties, Massachusetts. The majority of applications were from Rhode Island during the period studied.

Based upon the analysis of total applications in Chapter III, it is seen that the major source of referral has been the neuropsychiatric examining section of the Veterans Administration. This was anticipated in Circular 169. However, the procedures which the veterans necessarily follow in applying for treatment make it impossible to determine how many of such cases would have applied directly to the Mental Hygiene Clinic were the Clinic a completely separate unit. The men applying needed orientation in this program of the Clinic and in the type of treatment they were to receive. Although the clinic has a secondary educational purpose, it is neither equipped nor expected to handle this situation at the expense of its treatment

function which is outlined in Circular 169. Lack of staff requires that present personnel spend all available time in treatment.

Referrals from other resources have risen as the Clinic became better known. Indications of increasing referrals from agencies and individuals other than Veterans Administration personnel, shown during the last two months studied, give a picture of the expanding community awareness of the Clinic and its purpose. There has been little publicity work done and this has been due, also, to lack of personnel in the Clinic. However, social agencies and individuals are cooperating with the Clinic and it is expected that this will continue.

Veterans receiving compensation comprise the largest number of applications received. Of those receiving compensation, 85.2 per cent were receiving at least partial compensation for psychoneurosis. It is evident that the Clinic is here fulfilling its function as outlined in the initiating circular.

While Circular 169 indicated that only one case work contact would be necessary before disposition of application, it has been found that, in 58.2 per cent of the applications received, more information was necessary previous to any decision being made as to suitability and orientation of the veteran for treatment.

It is in the study of the accepted, referred and rejected cases that the function of the Clinic can readily be seen. A slightly larger percentage of applicants was referred than was accepted, and during the period studied, the rejected applications did not vary significantly. The latter classification was approximately one-fifth of the total applications received. In the accepted cases, the level of the Clinic's ability to absorb cases was apparently reached during and after the third month of operation as shown in Figure III (see page 38). At the end of December, 1946, the cumulative total of the accepted continued cases was seventy-one and referrals to clinics and contract physicians only forty. As a contrast, in January and February there were only twenty-eight accepted cases which continued and seventy-four applications were referred to similar community resources.

Under its present medical staff, the Clinic appears to be subject to a fluctuating or periodic change as regards the accepting of new cases. The accepted cases will increase only as men are discharged or withdraw from treatment. Present maximum ability of the Clinic psychiatrists to treat on an hourly basis is sixty-seven hours per week or sixty-seven men under treatment. The thirty-two applicants accepted since the capacity point was reached in December have been substitutes, as it were, for discharged patients or for men who discontinued treatment.

It appears that the most serious limitation, at present, to the Clinic's work is the lack of medical and professional personnel. While striving to work in spite of such a handicap, the Clinic must depend upon the community to help care for veterans who are eligible for treatment under Circular 169. Although established to care for these veterans, the Clinic is unable to do so with its present personnel; unless the shortage is relieved, the Clinic will continue to refer more cases than it accepts.

It is possible that a solution could be found through the adoption of a more restrictive policy at intake until sufficient medical personnel is obtained. Extensive use of group therapy by the psychiatrists presently available would allow for more veterans to be treated.

Suggested areas of further study would include a further analysis of situations where veterans rejected services after the intake interview, study of cases which withdrew after contact with psychiatrists, and the use of group therapy as a technique to meet the pressure of insufficient personnel. The work of the Clinic is a necessary one; it is hoped that the thesis will serve to indicate the directions in which changes are necessary if the Clinic's work is to be successful in the future.

Approved,

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BIBLIOGRAPHY

Beck, Bertram M., Short-Term Therapy in an Authoritative Setting. New York: Family Service Association of America, 1946.

Bureau of the Budget, United States Government Manual 1947 First Edition. Government Information Service, Division of Public Inquiries. Washington, D.C., 1947.

Dumas, Alexander G., and Grace Keen, A Psychiatric Primer for the Veteran's Family and Friends. Minneapolis: The University of Minnesota Press, 1945.

Folliard, Edward, "We're Losing An Army," Washington Post Reprint. Washington, D.C., May 16, 1943.

Griffith, CharlesM., Medical Director's Letter, Sept. 17, 1945. Veterans Administration. Washington, D.C. (Unpublished)

Grinker, Roy R., and John P. Spiegel, Men Under Stress. Philadelphia: The Blakiston Company, 1945.

Rennie, Thomas A.C., and others, Social Work Year Book 1947 New York: Russell Sage Foundation, 1947.

Veterans Administration, Mental Hygiene Clinics, Circular 169. Washington, D.C.: Government Printing Office, July 15, 1946.

_____, Out-Patient Treatment or Emergency Hospitalization, Circular 215. Washington, D.C.: Government Printing Office, August 31, 1946.

_____, Function of Civilian Physicians in VA Medical Program, Circular 252. Washington, D.C.: Government Printing Office, October 21, 1946.

_____, Projection of Veterans Population for Branch Area Number One. Washington, D.C.: Government Printing Office, October 2, 1946.

Wecter, Dixon, When Johnny Comes Marching Home. Cambridge: Houghton Mifflin Company, 1944.