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Factors affecting disposition of mental patients: Part I - A disposition survey of fifty patients at the Veterans Administration Hospital, Bedford, Massachusetts

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1952

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SCHOOL OF SOCIAL WORK

FACTORS AFFECTING DISPOSITION OF  
MENTAL PATIENTS

PART I

A DISPOSITION SURVEY OF FIFTY PATIENTS  
AT THE VETERANS ADMINISTRATION HOSPITAL  
BEDFORD MASSACHUSETTS

A Thesis

Submitted by

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(B.S., Boston University 1950)

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

1952

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CHAPTER I  
INTRODUCTION

The need for increased facilities for psychiatric patients is one of the major health problems facing this country. This is emphasized by the fact that in 1949 there were only 680,913. neuropsychiatric beds for an estimated 8,500,000. psychiatric cases in the United States.<sup>1</sup> The Veterans Administration is constantly expanding its hospital facilities for treating psychiatric disorders, but there still remain many more veterans in need of psychiatric care than there are facilities to meet these needs.

One approach to the alleviation of this problem is to increase the number of dispositions from neuropsychiatric hospitals.

This survey is an analysis of selected medical and social factors which may deter or facilitate the disposition of patients. The survey is made with a view to the ways in which the Social Service Department may aid in increasing the number of dispositions. It is designed also to throw light on the general problem of disposition and to serve as a basis for further study.

This survey represents Part I of a group project on

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

the problem of disposition at Bedford Veterans Administration Hospital. Parts II, III and IV have been undertaken by Bernard Pendleton<sup>2</sup> Kathleen Geathers<sup>3</sup> and Dorothy Shorey<sup>4</sup> in that order.

The group project is a continuation and extension of the staff Disposition Survey started concomitantly and which eventually will cover all patients in the hospital.

The patients selected for the group project consist of two hundred patients admitted as of August 16, 1944 and still hospitalized as of October 1, 1951.

The patients selected for this survey were the first fifty patients admitted as of August 16, 1944 and who were still hospitalized as of October 1, 1951. Each of the other three participants, studied the next consecutive fifty to total two hundred patients in all, the last patient in Part IV being admitted on February 25, 1946. For the purposes of

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Pendleton, Bernard., Factors Affecting Disposition of Mental Patients, Part II. Unpublished Master's Thesis of Boston University School of Social Work, 1952

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Geathers, Kathleen., Factors Affecting Disposition of Mental Patients, Part III. Unpublished Master's Thesis of Boston University School of Social Work, 1952

4

Shorey, Dorothy., Factors Affecting Disposition of Mental Patients, Part IV. Unpublished Master's Thesis of Simmons College School of Social Work, 1952

this survey whatever happened to the patients after October 1, 1951 was disregarded.

The term "disposition potential" when used in this survey, means the patients mental readiness to leave the hospital as determined by the medical staff. Other factors that may deter the disposition of patients are referred to in appropriate terms.

The data upon which this study is based were obtained from the hospital clinical records, correspondence folders, registrar's records, social service records and interviews with the doctor about each case. The clinical records contain medical and psychiatric treatment data. The correspondence folder contains letters received and written regarding the patient. Social service records contain social service activity with the patients and their families. The registrar's record contains essential face sheet information.

The scope of this survey was limited by the number of patients considered. The length of time these patients were hospitalized is another limiting factor. Most of the patients were hospitalized for an average of seven years. The records from which most of the data were gathered have not been intended primarily for research purposes, and were sometimes inadequate. Finally, this survey was not intended to deal with every factor which may affect the problem of disposition.

CHAPTER II  
INFORMATION ABOUT THE HOSPITAL<sup>1</sup>

The Veterans Administration Hospital at Bedford was established in 1928 and licensed under the laws of Massachusetts to specialize in the care and treatment of veterans with neuro-psychiatric disorders. In 1947 facilities for treatment were made available for women as well as men. Patients are accepted from eastern Massachusetts, Rhode Island, New Hampshire, Maine and northern Connecticut.

Some form of commitment is usually required at the time of admission of patients to the hospital. Veterans residing in Massachusetts and New Hampshire may be committed under Massachusetts laws. Those residing in Maine, Rhode Island, Connecticut and Vermont are committed under the laws of those states. This formality, when necessary, will be arranged by the Veterans Administration.

Commitments are of three types: voluntary, temporary and regular. In the voluntary commitment, the patient requests hospitalization for himself and may, if he wishes, request his own discharge, upon three days notice. If the medical staff decides that he is not fit for discharge they must seek a

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The information in this section has been gathered from the following publications: Veterans Administration Hospital, Bedford, Massachusetts. The Oval Mirror, Fby 1951-1952 and Handbook of Information, September, 1949

temporary or regular commitment.

Temporary commitments are for ten or thirty days during which time the patient is observed and studied. If at the end of this time the medical staff still feels that the patient is not well enough to leave, they must seek another commitment. In most cases this is usually a regular commitment which is for an indefinite period of time and requires a court order and the signature of two physicians who have no immediate connection with the hospital. In contrast, the ten day temporary commitment requires only the signature of someone in the legal profession if a doctor is not available. The thirty day commitment requires a court order signed by a judge of the probate court.

Involuntarily and regularly committed patients can be detained only if their relatives give consent. This is not the case however if the patient is suicidal or homicidal.

The principal ways in which a patient may leave the hospital consist of medical discharge, discharge against medical advice, elopement and trial visit. In the first two cases discharge is immediate and permanent. The patient can be readmitted only through regular channels which usually entails a waiting period which varies from weeks to many months depending upon the number of veterans waiting to be admitted. In the case of trial visits the patient is allowed to leave to reside

in the community for ninety days. At the end of this time his trial visit may be extended for another ninety days if his adjustment has been adequate. Usually the trial visit is renewed for ninety day periods until the patient has been in the community a year, at which time he is discharged from the hospital. If a patient elopes every effort is made to return him to the hospital. If he has eloped to his home and is adjusting well there, he may be granted a leave of absence or a trial visit without returning to the hospital.

The patient may leave the hospital for shorter periods by obtaining, with the doctors' permission, a leave of absence or a pass. A leave of absence is for a period of more than twenty-four hours but not more than two weeks and may be renewed only twice in succession. If at the end of four weeks the patient is considered well enough to remain at home for a longer period of time, a leave of absence may be converted to a trial visit. A pass is good for twenty-four hours only.

All proved types of treatment are available at Bedford. Insulin shock therapy, electro-shock therapy, pre-frontal lobotomy and psychotherapy. These treatments are prescribed by the medical staff on the basis of the patient's fitness, the nature of his illness, length of illness, age and response to any previous treatments. Before such treatment is given, written permission must be obtained from a relative or guardian.

Other existing services are the Physical Medicine and Rehabilitation Service, the Vocational Rehabilitation and Educational Service and the Social Service Department.

The Physical Medicine and Rehabilitation Service consists of:

1. Physiotherapy which provides such treatment as diathermy, ultra-violet ray, infra-red heat, massage and exercise.
2. Hydrotherapy which utilizes the soothing and sedating effect, as well as the stimulating action of water, in the form of continuous tub baths, wet sheet packs, sitz baths and Scotch Douche.
3. Occupational therapy which is available in some six individual shops. Patients do weaving, rug making, wood carving, work with plastics, painting or drawing, make pottery and carry out other activities of a similar nature under the guidance of trained occupational therapists.
4. Corrective physical rehabilitation which is carried out in a gymnasium. Patients who have suffered physical or brain injuries, injuries resulting in muscle weakness or paralysis are given, on an individual basis, special exercises which serve to strengthen weakened muscles. In addition patients who are restless, over-active and disturbed are encouraged to expend their excess energy in such activities as calisthenics, swimming and various ball games.

5. An educational section which offers numerous courses, either as refresher study, or in preparation for a trade or occupation. Patients who have not quite completed high school prior to admission to the hospital may take courses here and receive credits which are accepted as part of the requirements for a high school diploma.

6. Manual arts therapy which provides, through various shops, opportunities for patients either to continue to exercise skills which they have known prior to admission or to learn new skills. The objective of this program is varied. Some patients pursue a hobby, others either refresh a skill or learn new ones which may be used to earn his livelihood when he leaves the hospital. For other patients, work in these as well as occupational therapy shops, provides an opportunity to release tension and restlessness, helps build confidence as he completes tasks of increasing complexity. For many patients whose illness is characterized by a tendency to excessive day dreaming, this type of work helps bring them back to contact with reality through the medium of tangible wood, clay, plastic materials etc.

The Vocational Rehabilitation and Education Service aids in preparing the patient for living in the community by helping him with his choice of a vocational or educational objective. The patient is offered tests which help determine his interests

and abilities, and this, in conjunction with able counseling, often helps the patient find the type of pursuit best fitted to him.

The Social Service Department is an integrated part of the professional services rendered at the hospital. It consists of eleven trained social workers and for nine months each year has six second year graduate student social workers, two from each of the three schools of social work in the area. The department serves as a link between the patient, the hospital, the patient's family and the community. On entering the hospital the patient is seen by an admitting staff, including a social worker, which begins a plan for care and treatment. While the patient is hospitalized, a social worker is available whenever a patient feels he has something to discuss. Usually the patient expresses some feeling about being hospitalized or his financial situation or his family problems. The immediate aim is to make the patient feel as comfortable as possible in his new environment.

The ultimate goal of all services is to help the patient become well enough so that he can again function as a part of society. When the medical staff feels that the patient is well enough to leave the hospital, he may be granted a trial visit in the community. This is arranged through the co-operative efforts of the social worker, the doctor and the vocat-

ional rehabilitation worker. A large share of the responsibility for this plan is undertaken by the social worker. The patient is usually referred to a social worker as soon as the doctor feels that he may leave the hospital. This facilitates a relationship with the patient in order to make it easier for him to relate to the worker who will be seeing him throughout his trial visit at home.

During the patients' stay in the community the social worker is able to relate the dynamic factors of the patient's past experiences to his present mental diagnosis and both of these to the trial visit environment, in order to develop with the patient some tentative goal in the type of adjustment he may be able to make in the family, in the community or at work.

Family care, which is the placement of patients with families other than their own for care and treatment and which is recognized as a major development in the care of psychiatric patients, was begun at Bedford in 1949. Family care of mental patients is not a new venture. In Massachusetts patients have been placed in homes since 1886, but it is only in the past few decades that increasing interest has been shown in the program. Since 1949 a total of forty-six patients have been placed in family care homes from Bedford. It is wished that this number were larger but in view of the fact

that only one worker, who was already on the staff, has been allotted to work in this area and because family care homes must be selected with the greatest of care regarding the suitability of the family, the home and the community, and the number of persons interested is limited. Considering these circumstances it is felt that no greater number of patients could be placed in the period of time which the program has been active at Bedford. The placement of a patient in a family care home is designed primarily to be a therapeutic measure and not merely custodial care.

The patients selected for family care placement are those who are quiet, well-behaved mentally ill patients who are no longer in need of the highly specialized services offered by the institution. These are patients who, because of their mental condition, are not able to maintain themselves by their own work or to carry on their own affairs sufficiently well to be placed in the community without some supervision.

The objectives of family care are to give patients the advantages of home life and as much freedom in their living as is compatible with their mental condition and to free hospital beds for patients who, because of their acute mental symptoms are more in need of the services of the institution. It is hoped that the response of the patients to the individual attention they receive as members of a family group will

be favorable. This does not mean that the patients are expected to recover, for their illness is so deeply rooted that they may never be well again. It is hoped rather that the patient responds to the individual attention by becoming a happier, more useful person and may, through interest, come to take advantage of activities which exist only outside of the institution. The patients placed in family care homes are on trial visit status and as with those patients on trial visit in their homes, must make a fair adjustment for a period of one year in order to be discharged from the hospital. During their stay in a family care home visits are made or reports obtained by a social worker regarding their adjustment whenever it is felt they are required. In many instances a more frequent contact is maintained, particularly during the earlier months of trial visit.

The general duties of the Social Service Department are more fully outlined as follows:

The department will be responsible for (1) collaboration with the physicians in the social study and treatment of the personal circumstances related to veterans' health, recovery, community adjustment and reduction of disablement; (2) cooperation with adjudication, insurance and vocational rehabilitation authorities, and the chief attorney in securing data pertinent to the veterans' and other beneficiaries' maximum utilization of the benefits administered by those authorities; (3) completion of field examinations when the nature of the contacts, the information desired, or the interests of economy of travel make it advisable to utilize the services of a

social worker . . . . (4) the establishment of coordinated, useful working relationships with private and public social and health agencies in advancing the hospital and community adjustment of veterans; (5) . . . . (6) co-operation in research projects aimed at improving Veterans Administration services to veterans.

The social study and treatment undertaken whether in the out-patient department, this hospital or the field, will be in close collaboration with the physician responsible for the examination and treatment of the veteran, to insure that it constitutes an integral part of the physician's over-all plan for that veteran. The individual social worker is responsible for the complete harmony of the social measures taken with the physician's program. This requires frequent conferences between the physician and social worker as well as precise social work entries in the veterans' file. <sup>2</sup>

### CHAPTER III

#### INFORMATION ABOUT THE PATIENTS

This chapter is devoted to an examination of the patients studied with regard to age, marital status, wars served in, diagnosis of illness, physical disorders, record of visits received, financial status and previous dispositions.

The first three of the tables in which the above information was compiled, are presented in order to afford a background of the patients studied, and the information contained in them will not be discussed other than in this chapter.

The information compiled in the last five tables will be examined at greater length and discussed in relation to other data in Chapter IV. All of the patients studied were males. As of December 31, 1949, 4 per cent of the total population of the hospital were female. From the time of the admittance of the first patient in this study on August 16, 1944 to the time the last patient in this study was admitted on January 4, 1945 263 patients besides the fifty considered in this study, left the hospital before October 1, 1951. Most of them were discharged at the end of their trial visit period, a few died and some are presently on trial visit.

Of these 263 patients probably about 4 per cent were women but they were among the patients who left the hospital and as such are not taken into account in this study which is

concerned only with those patients who were still hospitalized as of October 1, 1951.

The age range of the patients under study varied from twenty-three to sixty-four. Twenty-eight patients or 56 per cent were between the ages of twenty and thirty-nine, while twenty-two or 44 per cent were between the ages of forty and sixty-four.

TABLE I  
AGE OF PATIENTS

Age Groups	Number
20 to 24 years . . . . .	1
25 to 29 years . . . . .	9
30 to 34 years . . . . .	12
35 to 39 years . . . . .	6
40 to 44 years . . . . .	1
45 to 49 years . . . . .	2
50 to 54 years . . . . .	7
55 to 59 years . . . . .	9
60 to 64 years . . . . .	3
Total	50

TABLE II  
MARITAL STATUS OF PATIENTS

Status	Number
Single . . . . .	40
Married . . . . .	5
Divorced. . . . .	3
Separated . . . . .	0
Widowed . . . . .	2
 Total	 50

The largest number, forty, or 80 per cent of the patients were single. Five, or 10 per cent were married. Three were divorced, none were separated and two were widowed. Most of the patients were single and this fact has an effect on their disposition potential simply because there is one less person who might be interested in them. This, however, is not a major detriment to disposition and is not treated in any other part of the study. The ages of these patients does not reflect the ages of the hospital population as a whole. This will be explained further in connection with the wars that the patients served in shown in Table III.

TABLE III  
WARS SERVED BY PATIENTS

War Served	Number
World War I . . . . .	16
World War II. . . . .	32
World War I and II. . . . .	1
Peace time Service. . . . .	1
 Total	 50

Thirty-two or 64 per cent of the patients served in World War II while sixteen or 32 per cent served in World War I. One served in both World War I and World War II and one served in the peace time army. These figures do not accurately represent the wars served in by the population of the hospital as a whole since World War I veterans actually outnumber the World War II veterans. The figures in the table can be explained on the basis that these fifty patients were admitted after August 16, 1944 and it would normally be expected that World War II patients would outnumber World War I patients after this time, since a peak of admittances for World War I service men had been reached some fifteen years earlier. This also explains why the ages of the patients given in Table II are not representative of the hospital as a whole.

TABLE IV  
DIAGNOSTIC DISTRIBUTION OF THE PATIENTS<sup>1</sup>

Diagnosis	Number
I Psychoneurotic Disorders	
A. Anxiety reaction . . . . .	0
B. Conversion reaction. . . . .	0
C. Depressive reaction. . . . .	0
D. Disassociative reaction. . . . .	<u>0</u> 0
II Character and Behavior Disorders	
A. Pathological personality types . . .	0
B. Immaturity reaction . . . . .	<u>0</u> 0
III Alcoholic Intoxication and Drug Addiction	
A. Acute. . . . .	0
B. Chronic. . . . .	0
C. Drug Addiction . . . . .	0
1. Barbiturates. . . . .	<u>0</u> 0
IV Psychosis Without Known Organic Etiology	
A. Schizophrenic disorders	
1. Simple type . . . . .	2
2. Hebephrenic type. . . . .	14
3. Catatonic type. . . . .	16
4. Paranoid type . . . . .	5
5. Unclassified type . . . . .	1
6. Mixed type. . . . .	2
7. Latent type . . . . .	<u>0</u> 40
B. Affective Disorders	
1. Manic-Depressive, depressive type.	1
2. Manic-Depressive, manic type . . .	0
3. Manic-Depressive, circular type. .	0
4. Involutional Melancholia. . . . .	<u>0</u> 1
V Psychiatric Condition with Demonstrable Etiology or Associated Structural Changes	
A. Infections	
1. General Paresis . . . . .	5
B. Intoxications	
1. Chronic alcoholism with psychotic reaction . . . . .	4

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

C. Trauma	
1. Encephalopathy . . . . .	0
D. Convulsive Disorders	
1. Epilepsy . . . . .	<u>0</u> 9

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Total	50
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The diagnosis used in classifying the patients studied was the most recent one made by the medical staff. The diagnosis of many patients was changed three or four times since their admittance. The largest group, forty or 80 per cent, were diagnosed as suffering from schizophrenic disorders, the next largest group, nine or 18 per cent, suffered from psychiatric conditions with demonstrable etiology, while one suffered from an affective disorder.

TABLE V  
PHYSICAL DISORDERS OF PATIENTS

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Physical Disorder	Number
Tuberculosis . . . . .	2
Blindness . . . . .	1
Cardiovascular disease . . . . .	2
 Total	 5

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The two patients suffering from tuberculosis may recover, but the other three have incurable disorders which affect

their disposition potential adversely. This will be discussed further in Chapter IV.

TABLE VI  
VISITING RECORD OF PERSON WHO VISITED MOST REGULARLY

Type of Visits Received	Number of patients visited
Regular . . . . .	12
Irregular . . . . .	12
Rarely. . . . .	18
None. . . . .	8
 Total	 50

Regarding Table VI this study is concerned only with the effect that the regularity of visits had upon the disposition potential of the patient.

The regularity of visits will be correlated in Chapter IV with the disposition potential of the patient. The visits for each patient were tabulated over a period of two years from January 1950 to January 1952. The visits of the person who made the most visits were tabulated on the basis of more than once every two months being regular, one visit or less every two months being irregular, and two or less visits a year being considered rarely. If members of a family took turns visiting the patient the whole family was considered as

one unit or as the most frequent visitor.

It was said by the aides, who did not feel they could estimate the number or per cent, that some of the visitors saw the patients without receiving a pass and consequently their visits were not recorded and are not represented in this table. In three cases, visits reportedly upset the patient and the visitor was asked, for a time, to refrain from visiting in the interest of the patient.

TABLE VII  
FINANCIAL STATUS OF PATIENTS

Dollars per month	Number
\$0 to 50. . . . .	7
51 to 75. . . . .	11
76 to 100 . . . . .	0
101 to 125. . . . .	0
126 to 150. . . . .	29
Over 150. . . . .	3
Total	50

The breakdown in this table partially reveals the financial status of the patients. This table is based on known income received rather than upon veterans' pensions only. For example, if a patient receives a pension from private sources of 125 dollars or more a month, he will be included in the

group who receive pensions of this amount from the Veterans Administration. However, most of the patients derive their income from pensions given by the Veterans Administration and any exceptions are noted below.

Of the seven patients who receive from zero to fifty dollars a month, five receive nothing. Of the remaining two, one receives twenty-two dollars a month as the result of a service connected physical disability and one receives fifty dollars a month for a psychoneurotic condition although he is diagnosed as psychotic. The eleven patients in the second group receive non-service connected pensions of sixty dollars a month. Of the twenty-nine patients in the group which receives 100 to 150 dollars a month, five have had their pension discontinued because their estate is in excess of \$1500. Twenty-three patients are receiving their pensions regularly from the Veterans Administration and one receives a pension from the New York City Fire Department.

Of the eleven patients who receive fifty-one to seventy-five dollars, five have guardians or conservators, and of the twenty-nine patients who are classified in the 126 to 150 dollar group, fifteen have a guardian or conservator. It was not felt necessary to assess the amount of money held by the fiduciary of these twenty patients since they all have adequate funds.

The three patients who receive over 150 dollars are those with dependents who have been awarded a dependency apportionment. In these cases the dependents may receive more money than the patient. However, when the patient is discharged the full amount of the pension is returned to him. In the case of a family who is receiving an apportionment and refuses, without good reason, to have the patient home on trial visit, their apportionment may be rescinded by the Veterans Administration.

TABLE VIII  
PREVIOUS DISPOSITIONS

Type	Number
Trial Visit . . . . .	13
Leave of Absence. . . . .	6
Pass. . . . .	5
Discharge . . . . .	2
None. . . . .	24
Total	50

Thirteen or 26 per cent of the patients have left the hospital on trial visit some time after their admittance and were returned before being discharged. One of these patients has received three trial visits and another has received two. The remaining eleven received one apiece. Six patients had

leaves of absences ranging in number from one to five. Five patients received passes, the number of which varied greatly. Two patients were discharged from Bedford and were later re-admitted. Twenty-four or 48 per cent of the patients have not left the hospital, except perhaps for recreation outings under the auspices of the hospital, since they were admitted.

CHAPTER IV  
EVALUATION OF DISPOSITION POTENTIAL  
AND RELATED FINDINGS

This chapter deals with the disposition potential of the fifty patients chosen for this survey and findings which seem related to disposition. The disposition potential or mental condition of each patient was determined by his doctor as either poor or unlikely to leave in the foreseeable future,\* fair or likely to leave in the foreseeable future, and good or able to leave.

When the patients were classified according to the above categories they fell into three major groups. Group I consists of thirty-five patients who, it was felt, had a poor disposition potential or would not be likely to leave in the foreseeable future. Group II consists of eight patients who had a fair disposition potential or were considered likely to leave in the foreseeable future. Group III consists of seven patients who had a good disposition potential or were able to leave the hospital.

Groups II and III were divided into subgroups which the writer felt to be significant. Group II is divided into two subgroups, A and B. Group II A consists of four patients

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For the purposes of this survey the term "foreseeable future" means within six months

whose main characteristic is an incapacitating degree of institutionalization. Group II B consists of the remaining four patients whose condition is such that a little more improvement may possibly bring them to the point where they will be able to leave the hospital. Group III is divided into three subgroups, A, B and C. Group III A contains four patients who are mentally able to leave the hospital but had either no interested relatives who were able to have them home or insufficient funds to maintain them in the community or a combination of these factors. Group III B contains two patients who were active with the Social Service Department for disposition planning. Group III C contains one patient that the doctor wished to refer to the Social Service Department for disposition planning.

The thirty-five patients in Group I all have a poor disposition potential and this is the main characteristic that distinguishes them from the remaining fifteen patients in this survey. Eight of these patients were visited regularly, eight received irregular visits, thirteen were visited rarely and six received no visits. Four of the patients received from zero to fifty dollars a month, seven received from fifty-one to seventy-five dollars a month, twenty-nine received from 126 to 150 dollars a month and three received an amount in excess of 150 dollars a month. Ten patients had been granted trial

visits, four had received leaves of absence, none received passes, two had been previously discharged and nineteen had received no previous dispositions. If and when these patients are able mentally to leave the hospital it will probably be found that other factors will prevent a number of them from doing so. Which factors will prove most deterring at that time is impossible to say now. However, the principal concern of this survey is the fact that these thirty-five patients are deterred from disposition because of their poor disposition potential. These patients in Group I represent 70 per cent of the total number of patients in this survey. This percentage has limited usefulness. It can only be used to determine the disposition potential of a similar number of patients who have been hospitalized for the same length of time and have had the same diagnosis as the patients in this survey.

Group II A consists of four patients who, the doctor felt, would be able to leave the hospital except for their unwillingness to do so. The case of one of these patients is presented below.

This fifty year old, single, World War I veteran carries a diagnosis of manic depressive psychosis, depressed type. He was reported to have been introverted and fearful since earliest childhood. He was always attached to his mother and would confide in no one else. No history of his service adjustment is available. After being discharged from the service he made a good occupational adjustment. He was an inspector in a machine shop and worked regularly for

seven years, supporting his mother who was bedridden with arthritis. When she died he became overly attached to his sister. In 1931 he complained of nervousness and deafness and was awarded fifty per cent disability for psychoneurosis. He worked until 1945 at which time he became increasingly incapable of socialization. A month before his admission he became very depressed and sat with his head in his hands all day and refused to go to work. He was fearful of everything, felt guilty about everything he could possibly find a reason for and threatened suicide.

It was learned later that his sister bore an illegitimate child for whom the patient took the responsibility of raising. This child is also a patient at Bedford. His brother, to whom he was very attached, died in 1913. Patient liked sports and never went out with girls.

Late in 1945 the patient began to improve and was transferred to the semi-acute ward. After showing further improvement in 1947 he was transferred to the continued treatment service where he began to take an interest in working on the ward. He was given work in the hospital laundry where he was employed steadily. In 1951 he received a series of shock treatments which were discontinued after marked improvement was shown. He became cooperative, polite, friendly, coherent and relative.

At present there is no real indication of psychosis. However, he is addicted to his routine and life at the hospital and does not want to leave. The doctor feels that he may be able to overcome this attachment to the hospital with some individual attention.

The second patient in this group is fifty-four, diagnosed as schizophrenic reaction, simple type. The fact that he receives no compensation or pension may affect his attitude toward leaving the hospital. He rarely has a visitor and has

not left the hospital once. His judgement and insight are impaired, but the doctor feels that it is not enough to prevent some kind of adjustment in the community. When approached about leaving the hospital, he ignores the question or complains of feeling ill.

The third patient in this group has a diagnosis of schizophrenic reaction, catatonic type, is thirty-four years old and receives 150 dollars a month compensation. He has two brothers, one of which lives in Arkansas and the other lives near the hospital. He also has an aunt. None of them have visited him for two years. When asked if he would like to leave the hospital he states quite frankly that he likes it at Bedford and does not want to leave. Though he has slight delusions, the doctor feels that he could make a fair adjustment if his attitude toward leaving the hospital could be changed.

This part of the survey shows that , of the fifty cases studied, 8 per cent were deterred from disposition primarily because of institutionalization.

Two of the patients receive 150 dollars a month compensation and one receives sixty dollars a month pension, while one receives nothing. None of the four patients had been out of the hospital on passes, leaves of absence or trial visits. Visits received by all patients occurred only rarely.

Group II B consists of four patients whose conditions are such that with a little more improvement they may be considered for disposition. The case of one of these patients is presented below.

This twenty-seven year old, male, World War II veteran carries a diagnosis of schizophrenic reaction, paranoid type. In his childhood he was reported as being a quiet, well-behaved boy. He appeared to get along with others and was reported as being a follower rather than a leader. He made a fair school adjustment until the tenth grade, when his grades fell below average. He was allowed to leave school and go to work. His occupational adjustment was not too good. He went from job to job until he joined the Marines in 1942. After four months in the service he began to display odd behavior. He became careless in personal hygiene and often sat staring into space. He was discharged and, since his symptoms were not too bizarre, was allowed to go home. During the six months period he was at home, he became increasingly worse. He refused to work or leave the house. He became depressed, seclusive in his relations with the members of his family, apathetic, blocked, partially mute and at times incontinent. He was admitted to Bedford directly from his home and was assigned to the acute service where he was given eighteen electric shock treatments during 1944 and 1945. After these treatments he improved slightly. As a result he was transferred to the semi-acute service where no improvement was noted until after he received a second series of electric shock treatments in 1947. He began to control his bowels a little better, but he remained inaccessible, mute, withdrawn, seldom moving from one position. Recently he became more active and talkative and will converse in a negative way.

This case is illustrative of the extreme type which doctors feel will benefit from individual attention.

The second patient in this group is thirty years old, and

is receiving 150 dollars a month compensation. He had a previous trial visit in 1945 but was returned when his symptoms re-occurred. Since then his mother has visited him irregularly even though she rejects him. She told the doctor that she will not have him home until he is cured. When told that he may always display some psychotic symptoms, she said she could not be expected to care for him. The social service history reveals that her other son, who has no interest in the patient, has always been her favorite. The doctor feels that with a little more improvement the patient may be able to adjust in a family care placement.

The third patient is fifty-one years old, diagnosed as schizophrenic reaction, paranoid type. He received no compensation from the Veterans Administration but has an adequate pension from the New York City Fire Department. He has no family and has received no visits in two years. He has improved considerably in the past two years and with a little further improvement may be able to leave.

The last patient in this group is forty-nine years old, and is diagnosed as schizophrenic reaction, catatonic type. He receives 150 dollars a month compensation from the Veterans Administration. He is visited regularly by his brother who is his only living relative. He was on trial visit status in 1944 but failed to adjust and was returned to the hospital. He

works steadily on the farm detail. He is partly deluded and hallucinated, but his doctor feels he may be able to leave with a little more improvement.

Two of these patients were visited regularly, one irregularly and one received no visits in the past two years. Three of the four received 150 dollars a month compensation and one received sixty dollars a month pension. One patient had previously been on trial visit, two had one pass and one has not left the hospital at all.

The main deterring factor with these four patients is their mental condition, that is they displayed more psychotic symptoms than the patients in Group II A. However, it was believed by the physician that, with some improvement, they would be able to leave within six months and might benefit by hospital case work.

These eight patients in Group II A and B, who it was felt may benefit from hospital case work, comprise 16 per cent of the patients in this survey. When this factor is compiled with the same factor in the other three surveys in the group project, a more accurate figure will be obtained. It appears that these eight patients had not been referred to social service because it was felt by their doctors that although they had a fair disposition potential - better than the thirty five patients rated as poor in Group I - and though they may

receive some benefit if worked with by social service, more dispositions could be achieved by having social service work with patients whose disposition potential was rated as good. So it would seem that doctors have a tendency to refer the more hopeful patients or those with a good disposition potential to social service.

The tendency for doctors to refer the most hopeful cases, is one with which most people agree in principle and is illustrated by the findings of a group study of readmissions made by six Bedford Social Work students, as the group student research project of the previous year.

The readmission study made by Loring Macalaster,<sup>2</sup> Robert Redding,<sup>3</sup> Harriet Belson,<sup>4</sup> Nelson C. Woodfork,<sup>5</sup>

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

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

4

Belson, Harriet., A Survey of Readmissions to the Veterans Administration Hospital, Bedford, Massachusetts, Part III Unpublished Master's Thesis of Boston University School of Social Work, 1951.

5

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

Martha Shaber,<sup>6</sup> and Edward Sterling,<sup>7</sup> considered a series of patients readmitted in 1949 consisting of about 300 cases. The control series consisted of 150 who left the hospital on trial visit and stayed out two years or more. When the results of the study were correlated it was found that only 50 per cent of the readmissions had been referred to social service for disposition planning, while 90 per cent of the control group had been referred for disposition planning. Because the two groups differed in their diagnoses and other basic factors, it was felt that a casual relationship between social service disposition planning and the ability of the controls to remain out of the hospital was not a valid conclusion. The fact that the control group was able to remain in the community for two years shows that they had a better disposition potential than the group which was returned to the hospital before finishing their trial visit. This indicates that doctors generally refer the more hopeful patients, or those with the best disposition potential to social service.

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

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

This policy has grown out of the recognition of the fact, by the medical staff, that all cases which show some indication that they would benefit from individual attention, cannot be dealt with because of the limited number of trained social workers available. When patients are placed in a continuum arranged from the most hopeful at the top to the least hopeful at the bottom, it means for reasons stated above that the poorer patients at the lower part of the continuum will receive less individual attention. In 1941 when there was only one social worker at Bedford, it was only possible to work with the patients in the upper part of the continuum. However, as the number of social workers increased, more and more of the patients in the lower part of the continuum were worked with.

This survey indicates that further study of this problem is needed. A control study of two similar groups of less well patients in which one group receives hospital case work while the other receives none may prove rewarding. Such a study may indicate at what point, in a continuum of such patients, the necessarily diminishing returns in terms of time expended and results achieved, would make further social work unprofitable or so costly as to be prohibitive.

The seven patients in Group III, who in their physician's opinion, are able to leave the hospital, are divided into three subgroups. Group III A consists of four patients who could

leave but for certain environmental deterrents. Group III B consists of two patients that are being worked with by social service for disposition planning. The patient in Group III C will be referred for disposition planning.

The four patients in Group III A have, in common, a mental readiness to leave the hospital, but due to circumstances beyond their control are unable to do so. The case of one, cited below, will demonstrate some of the deterring factors.

The patient is a forty-seven year old, World War II veteran with a diagnoses of schizophrenic reaction, paranoid type. His brother committed suicide and he has a paternal cousin in Taunton State Hospital. His birth and early development were normal. He was of average intelligence, had no court record and never kept company with girls. He was always slightly shy and retiring and as he approached puberty he became moody and brooded a great deal, became solitary, spending most of his time in the lonely pursuit of fishing. While in a row boat under a bridge, his boat somehow floated away and left him hanging from the bottom of the bridge, suspended over the water for two hours before he was rescued. This seemed to unnerve him, and while he had been working on a farm with his father previously, he did not work for the next three years. He joined the Army in 1942 and was discharged six months later as unfit for duty. On returning home he became paranoid toward his family and exhibited delusions of a marked sexual coloring, and threatened to kill them. He was taken to Taunton State Hospital from where he was admitted to Bedford in 1944. In a years' time he progressed so well that he was given a trial visit to his home where he lived with his mother, sister and two nephews. Although he had worked regularly in the hospital he did not work at home. Nevertheless, he made a good adjustment during the first three months and his mother requested an extension of his trial visit which was granted. Shortly thereafter his

symptoms became more pronounced. He became unmanageable, seclusive, made a feeble attempt to act out behavior of a sexual nature and was returned to the hospital. He became better in 1947, was again referred for disposition planning, and the family was interviewed by a social worker to determine their feeling toward having the patient home again.

The patient's mother said she was under the doctor's care for a heart condition and was unable to have the patient home because the ailment would prevent her from supervising him. Although the physician's recommendations were fully interpreted to the mother, she felt that if he were home he would become uncooperative, unwilling to work, difficult to manage as he was before being returned to the hospital from his last trial visit.

The veteran's sister very emphatically did not want the patient home. She said that there were no men at home to manage him if he became too disagreeable to live with. She feels that he is receiving good care and treatment at the hospital and it would be best for him to remain where he can receive adequate supervision. She said she is concerned with the effect it will have on her mother's health and that if her mother decided to have the patient home she would take her two children, aged sixteen and eighteen, and leave the home, leaving her mother to do cooking and necessary household chores. The mother and sister were unable to suggest any arrangements that might be made for him if he were to leave the hospital. The mother said she would contact the hospital if she ever desired to have the patient home. The family was interviewed again in 1950 for the same purpose. They maintained their former opinion and said that other relatives felt the same way.

The physician feels that this patient would do well in a family care placement but he does not have enough money to make this possible at this time.

The second patient in this group has a diagnoses of chronic alcoholism with psychotic reaction. He receives

sixty dollars a month as a non-service connected veteran, and has accumulated only ten dollars in his account at the hospital. He has a guardian who may have more funds for him, but his wife refuses to have him home, though she visits irregularly with the patient's son. The son seems interested but he lives at home with the mother. The only other living relative is a sister, the guardian, but she is elderly and would be unable to supervise the patient. His psychosis appears to be in complete remission, but he still drinks to excess when the opportunity presents itself. This would contraindicate a family care placement in the event that he does have money. In addition, he is unable to work because of a heart disease.

The third patient in this group has a diagnosis of chronic alcoholism with psychotic reaction and receives fifty dollars a month for psychoneuroses. He has accumulated eight hundred dollars in his account at the hospital. This would be considered sufficient funds to enable him to take a family care placement, if it were known that he would work. However, it was felt by the doctor, that this patient, although physically capable of work, would not do so. Consequently, he is not being referred to social service for family care. The patient's brother visits irregularly, and has taken the patient on a recreation outing twice in 1950. However, this brother

is single and could not supervise him, since he has to work. Two other brothers have shown no interest in the patient and his remaining sister works and would be unable to care for him.

The fourth and last patient in this group is a World War I patient, sixty-three years old, also carries a diagnosis of chronic alcoholism with psychotic reaction but has no income. The patient's wife is interested but she is ill and is unable to supervise the patient. The daughter works to support her mother and so would be unable to supervise the patient. The patient has one brother and three sisters, all of an advanced age, and unable to care for him. The patient has diabetes and though he works about the hospital he is not productive and would be unable to earn a livelihood in the community.

Three of these patients received irregular visits while one received none. None of the four have adequate funds to support them in the community if they did not work, and it was felt that none of these patients could be counted on to be self-supporting through work. One patient left the hospital on trial visit in 1945 and returned the same year, two were granted leaves of absence, while one received two passes. Three of the patients are diagnosed as suffering chronic alcoholism with psychotic reaction, while one was diagnosed as schizophrenic reaction, paranoid type.

The chief deterrents to disposition were a lack of funds and relatives who were either not in a position to have the patient home, or did not care to. The four patients with these handicaps comprise 8 per cent of the fifty patients in the survey, or 57 per cent of those who were considered well enough, mentally, to leave. These patients all express a desire to leave. However, it is not known how many, faced with the reality of leaving, would actually do so.

Group III B consists of two patients who are currently being worked with by social service for disposition planning.

The first patient is twenty-nine years old, and diagnosed as schizophrenic reaction, paranoid type. He left the hospital on trial visit status in 1946 and was returned after five months and his symptoms returned in full force. It was felt that the patient would benefit from a lobotomy and this was performed in 1948. He improved considerably and in 1951 was referred to social service for disposition planning. His family appear very interested and all indications are that he will again be placed in his home on trial visit status after the social worker had prepared the patient and the parents.

The second patient in Group III B is thirty-four years old, diagnosed as schizophrenic reaction, catatonic type, and has a brother in the Boston State Hospital. He improved under psychotherapy, engaged in hospital activities, and was able

to take advantage of passes without abusing the liberty given him. He works on the farm detail regularly. He asked to be put on trial visit status and his request was approved. The patient's brother showed interest by visiting regularly, but felt he could not impose on his wife by having the patient home. The doctor feels that the patient's sister-in-law is more genuinely interested than her husband. The patient will leave the hospital as soon as a family care home is available.

Both patients were visited regularly and both had adequate funds. One had been on trial visit status in 1946 but was returned, while the other patient received passes occasionally.

These two patients show that 4 per cent of the total number studied, or 36 per cent out of the fifteen more hopeful patients studied, were active with social service for disposition planning.

Group III C consists of one patient who is in the process of being referred to social service for disposition planning.

He is thirty-six years old, and is diagnosed as schizophrenic reaction, simple type. He received 150 dollars a month compensation. He is visited rarely, but the physician feels that the patient's relatives are genuinely interested and will have him home.

He has had four holiday passes in two years. He works productively and is well-behaved. Occasionally he becomes

very passive, but presents no problem otherwise. The physician feels that he has a good chance to adjust either at home or in a family care situation.

This case represents 2 per cent of the total number of patients surveyed, or a little under 7 per cent of the fifteen more hopeful patients.

## CHAPTER V

## SUMMARY AND CONCLUSIONS

The major purpose of this survey is to determine the chief factors which may deter or facilitate the disposition of patients and to point out the way in which the Social Service Department may aid in increasing the number of dispositions.

Of the fifty patients in this survey, thirty-five or those who were considered to have a poor disposition potential fell into Group I. Eight, or those who were considered as having fair disposition potential fell into Group II. Four of these eight patients were considered to be suffering from the effects of institutionalization. The remaining four were considered likely to leave the hospital with a little more improvement in their condition. The last seven patients, which comprises Group III, were considered mentally fit to leave the hospital at the time of the survey. Of this group four were hampered in leaving due to either uninterested relatives, relatives who could not have the patient home due to circumstances, lack of funds or a combination of these factors. Of the remaining three patients in Group III, two were in the process of disposition planning with the Social Service Department and one was in the process of being referred to Social Service for disposition planning.

The principle deterrent in the case of the first four patients in Group II, was their unwillingness to leave the hospital. These four cases comprise 8 per cent of the total cases studied and indicate the importance of institutionalization as a factor to be dealt with when disposition is considered. The physicians concerned felt that hospital case work might help these patients overcome their problem.

The problem of institutionalization arises regularly where the question of disposition is involved. The question of extramural care for psychotic patients was explored by a research group at the Chicago State Hospital in the years 1930 to 1932 and the results of this study were published by Florence P. Worthington in the Smith College Studies in Social Work, June, 1933, under the title "Suggested Community Resources for an Extensive Parole System for Mental Patients in Illinois." An attempt was made to place 290 carefully selected psychotic patients in the community. All of these patients were considered chronic. In 269 cases of the 290 cases studied, practical difficulties hampering disposition were discovered. Of the 269 patients it was found that ten were unwilling to leave the hospital. This is a little under 4 per cent.

In a study made by Donald Taylor<sup>1</sup> in which an attempt

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Taylor, Donald L., A Study of An Attempt to Place in The Community Selected Mental Patients From Two Wards of the Veterans Administration Hospital, Bedford, Massachusetts. Unpublished Master's Thesis of Boston University School of Social Work, 1948

was made to place twenty selected patients in the community, three or 15 per cent, were found unwilling to leave. It would be unfruitful to try to compare the percentages found in these two studies with that obtained through this survey because the patients were selected for different purposes and other variables exist as well. The partial results of these studies are noted here merely to point out that institutionalization as a deterring factor in disposition has been found to exist in other studies. There can be little doubt in the mind of anyone familiar with the life in an institution that the regimentation and lack of individualization so difficult to avoid in institutional life is a real and important factor that must be considered when one deals with the disposition of inmates.

The remaining four patients in Group II are those who, it was felt, may be able to leave with a little more improvement and who could possibly be helped by hospital case work. As indicated in Chapter IV, problems involved in social work with these eight patients in Group II are in need of further examination.

The first four patients in Group III were unable to leave because of environmental factors beyond their control. The first patient was rejected by his mother and sister and had the additional handicap of insufficient funds. The second

patient, whose wife rejected him, may or may not have sufficient funds since the amount of money held in trust for him by his sister, the guardian, was not available from hospital records.

The immediate family of the third patient in this group were unable to have him home, more distant relatives rejected him and he did not have enough money to support himself in a family care home. The average cost of a family care home is about twenty dollars a week. This includes all meals as well as room and laundry. The cost of the cheapest room obtainable would be about five dollars a week and if the patient ate in a restaurant, his food costs would be about twenty dollars a week. Thus, if a patient does not have sufficient funds to live in a family care home, he would probably not have enough money to live in the community unless he lived with relatives or worked.

The close relatives of the fourth patient were unable to have him home and other relatives were uninterested in him. This patient had no income whatsoever, and so would be unable to live in the community. The physicians believed that these patients would benefit from a family care placement.

From these four cases we see that the disposition of 57 per cent of the seven patients considered mentally able to leave, were hampered by families that were either unable to

have them home or rejected them. Since one of these patients cannot work and the other three probably would not work for some time, the financial condition of these patients is quite significant.

This survey shows that three of these patients who were considered able to leave are definitely known to be without funds to support them in the community. This is 42 per cent of the seven patients in Group III. The extent of one patient's funds is unknown while the other three receive 150 dollars a month.

In the second subgroup of Group III, we find two patients who were being worked with relative to disposition planning. These patients represent 4 per cent of the total number included in the survey, or 28 per cent of the patients felt able and ready to leave the hospital.

The remainign patient in Group III was in the process of being referred to social service for disposition planning.

A meaningful relationship between visits received and the disposition potential of the patients in Group II, the patients in Group III or the patients in Group II and III combined, could not be shown to exist. The writer feels, however, that other inferences regarding visits can be drawn from an examination of the visitors. Six of the seven patients in Group III received visits by relatives. Two patients were rejected

by their families and it was felt by the doctors concerned that the visitors of three other patients were not genuinely interested, while another relative who visited rarely was genuinely interested. This indicates that regularity or irregularity of visits cannot be used as a true indicator of the visitor's interest in the patient.

As already indicated in Chapter III some persons visit the patients without bothering to get a pass and consequently leave no record of their visits. This is also illustrated in a visiting study made by William J. Coyne.<sup>1</sup> It was found that of 295 patients shown by the visiting record to have received no visits during the period of a year, fourteen or a little under 4 per cent had in fact received visits.

As was the case in regard to the visits received by patients, no meaningful relationship between the amount or type of previous dispositions received by patients and their disposition potential, could be demonstrated.

The following conclusions are indicated by this survey:

1. In a significant number of cases it was found that the visiting record is not a true indicator of interest.
2. A number of patients could live in the community if sufficient funds were available.

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Coyne, William J., Study of Visiting to Mentally Ill Patients By Relatives, Veterans Administration Department of Medicine and Surgery, Information Bulletin, October, 1950

3. The rejecting attitude of some relatives and the inability of some relatives to have the patient in their home prohibit a number of patients from leaving the hospital.

4. Institutionalization appears as a barrier to disposition in a number of cases.

5. A study of the extent to which hospital case work would be worthwhile with the less hopeful patients is indicated.

Approved:

*Richard K. Conant*  
Richard K. Conant  
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APPENDIX

SCHEDULE

Identifying Data

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

Ward \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_ SC \_\_\_\_\_

NSC \_\_\_\_\_ Date of Birth \_\_\_\_\_ Admission Date \_\_\_\_\_

Marital Status \_\_\_\_\_ Competency \_\_\_\_\_ Commitment \_\_\_\_\_

No. of Dependents \_\_\_\_\_ Dates of Military Service \_\_\_\_\_

Mental Illness in family \_\_\_\_\_

Disability

Diagnosis: Mental \_\_\_\_\_ Physical \_\_\_\_\_

Adverse Social Factors:

Conflict with family \_\_\_\_\_

Illness in family \_\_\_\_\_

Adverse financial status of family \_\_\_\_\_

Previous Dispositions

Type	Dates	Reason for Return
_____	_____ to _____	_____

Residence During Previous Disposition:

Immediate family \_\_\_\_\_

Other relatives \_\_\_\_\_

Friends \_\_\_\_\_

Room \_\_\_\_\_

Financial Data

Source of Income \_\_\_\_\_

Remunerative Skill

Education

Persons Who May Affect Disposition

Relationship	Name	Address
_____	_____	_____

Visiting Record

Relationship			
a. Regular	_____	_____	_____
b. Irregular	_____	_____	_____
c. Rarely	_____	_____	_____

Attitudes of Persons Who May Affect Disposition

Relationship			
a. eager for release to home	_____	_____	_____
b. eager for release elsewhere	_____	_____	_____
c. disinterested	_____	_____	_____
d. complete rejection	_____	_____	_____

Doctor's Evaluation

Comments Pertinent to Disposition

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