A DESCRIPTIVE STUDY OF THE FAMILY CARE PROGRAM AT THE VETERANS ADMINISTRATION HOSPITAL BATTLE CREEK, MICHIGAN

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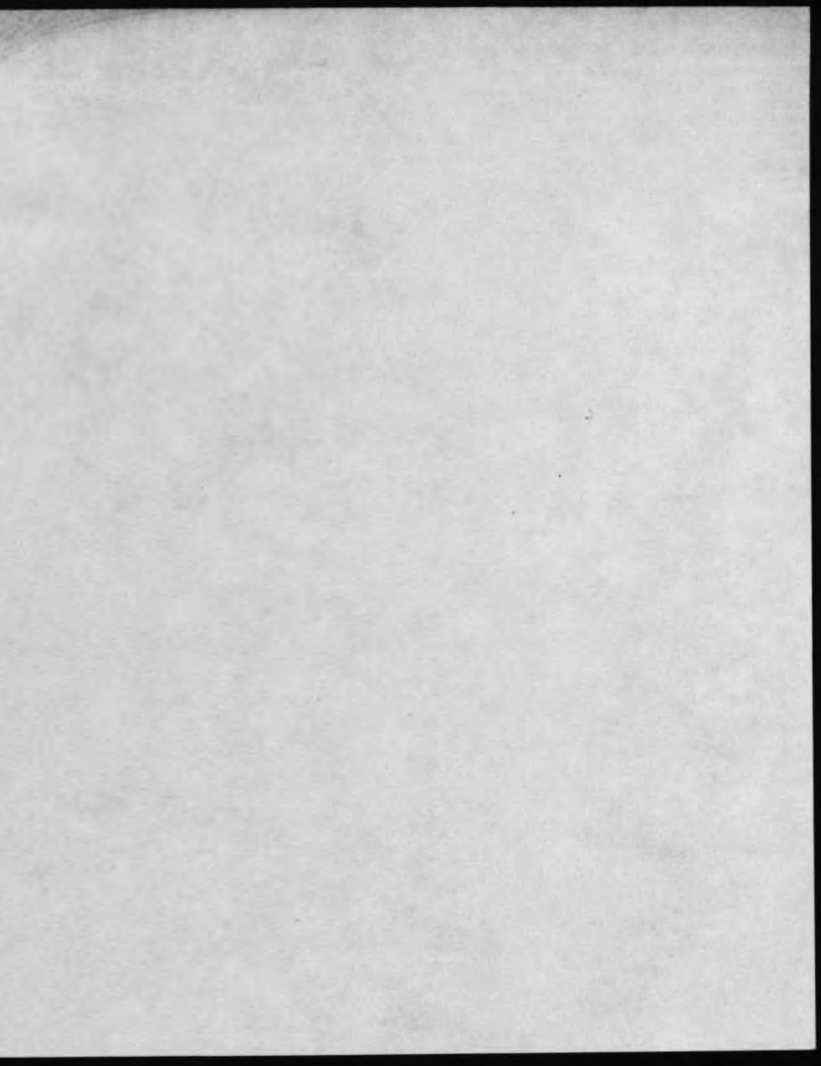

A DESCRIPTIVE STUDY OF THE FAMILY CARE PROGRAM AT THE VETERANS ADMINISTRATION HOSPITAL, BATTLE CREEK, MICHIGAN

by

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Submitted to the School of Social Work
Michigan State University
in Partial Fulfillment of the
Requirements for the Degree
of

MASTER OF SOCIAL WORK

May 1956

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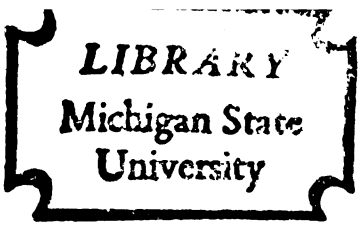

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12-28-07

ACKNOWLEDGEMENTS

Particular acknowledgement is expressed to the members of the Research Project Committe, Dr. Gordon Aldridge, Chairman, Dr. Lucille Barber and Mr. Manfred Lilliefors, under whose inspiration and guidance this study was compiled. The author is also grateful to the other members of the School of Social Work of Michigan State University for their helpful suggestions and assistance.

The author extends sincere thanks to the members of the Social Service Department at the Veterans Administration Hospital, Battle Creek, and to Mr. Clarence Cole, Mrs. Dorothea Hunter and Mr. Eugene Plewka in particular for their help in gathering the material for this study. Grateful acknowledgement is due to Mr. William Brewer for the suggestions and support that he gave to the author.

The author wishes to express sincere appreciation to his wife, Helen, for her endless encouragement during this study and for its typing.

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CHAPTER I

THEORETICAL BASIS OF THE STUDY

This study is based on the premise that the placement of certain selected patients from a neuropsychiatric hospital in homes other than their own can be a valuable tool in rehabilitation of these patients. It is also assumed that in order to choose carefully not only those patients who can benefit from the program but those homes and families that can be of the greatest benefit, certain social work skills and techniques must be employed in order for the program to be of the greatest therapeutic value to the patient.

This study will be chiefly concerned with the role of the social worker in the total planning and execution of the family care program in the hospital. The social worker acts as a member of a team comprising the ward doctor, nurses, administrative and other hospital personnel in order to use this plan effectively.

This topic was chosen for study for these reasons: (1) there is a scarcity of information on this topic in the field of social work; therefore, it is the aim of this study to present a general picture of a program as it is used in one Veterans Administration Hospital at this time

in an effort to be of some benefit to others who are dealing with this problem. (2) The family care workers of the Social Service Department of this Veterans Administration Hospital are attempting to draw together the details of the family care program in order to publish a manual to be used by the hospital; it is hoped that this study will be of some assistance in this. (3) The author gained a personal interest in this program when faced with the question of what plans were in effect to care for those patients who have sufficiently recovered from their illness but for one reason or another could not return to their own homes.

The movement of the patient through the various stages of treatment from admission to discharge, is the focus of the services offered by the hospital. Family care is one phase or step of the total movement of the patient through the treatment process. Family care is treatment on a community level as compared to the other steps of the treatment which are on the institutional level. For some patients family care is the last step in their treatment, while for others it may serve as a period to determine whether or not they can satisfactorily function in the community. If it is found that they cannot adequately adjust to community life they will be returned to the hospital for further treatment. For the majority of the patients this step in the treatment process is

never reached. Either they do not recover sufficiently from their illness to be considered for placement, they leave the hospital against medical advice or they are discharged directly to the community after a trial visit period. Family care serves as a bridge between the protective atmosphere of the hospital and the competitive community in which the patient must live after leaving the hospital. This program enables the patient to make the transition from the hospital to the community slowly, and thus be more able to function effectively in the community after he is discharged from the hospital.

Although it is recognized that other benefits are derived from family care in addition to the rehabilitative benefits it holds for the patient, this study is primarily concerned with the use of this program as a step in the total treatment of the patient. Some of the other benefits deserve mention here. Among the reasons for using family care is that it makes beds available on the hospital wards for patients who can profit from the intensive treatment program. In family care the patient uses his own funds to meet the cost of his care while still receiving hospital benefits and supervision. This releases funds to be used for the treatment of other patients. Another benefit of the family care program is that it shows the patient unable to return to his own home that there are provisions existing that will enable

him to go from the hospital to the community after he receives the full measure of treatment in the hospital. This knowledge might help him engage himself more fully in the treatment program. The prospect of leaving the hospital in the future under supervision may help keep the patient's morale up while he is recovering from his illness. These reasons for the use of family care are cited to illustrate that the program can have an effect upon the entire hospital population that goes beyond the rehabilitation of those qualified to receive this care. Actually, these are secondary benefits but do have an indirect effect on the total treatment services in the hospital.

This study will be concerned first with definitions of family care taken from the literature in this field. This will be followed with a brief history of the family care movement in Europe, in the United States, in the Veterans Administration[1] and, finally, in the VA Hospital at Battle Creek. The setting in which this work is being carried on will be described briefly. A chapter will be devoted to the method used in making this study.

The main concern of the study will be an account of how patients are selected for family care, the moti-

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[1]The Veterans Administration will be referred to hereafter as VA.

vation of the patient to consider this treatment procedure and the preparation of the patient for placement in a family care home. The area of home finding and preparation of the family care therapist[2] and other members of the family to receive and work with the patient will be considered. The supervision of the patient in the family care home and of the family care therapist by the hospital social worker, will be included. The final part of the study will include a summary and a statement of conclusions.

The material for this project will be drawn from the literature on the subject, documents and other material made available at the hospital by the Social Service Department, and from interviews and personal observations made by the author in dealing with patients being prepared for family care and those already in the program. Statistical data will not be used as a primary source of information.

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[2]The term, family care therapist, refers to the person in the family care home who assumes the responsibility for the care of the patient. The possible reasoning behind the use of the word therapist is to help that person feel that he is part of the hospital's treatment team.

CHAPTER II

DEFINITIONS, HISTORY, AND DESCRIPTION OF THE SETTING

The literature on family care uses various terms to describe this program. Sometimes it is termed foster family care, foster home care, boarding home care, home care, or trial visit in a home other than his own. In this study, however, the term family care will be used.

Hester B. Crutcher defined family care as:

> Foster family care as used here is the placing of the mentally ill or defective with families other than their own for care....They have responded to institutional treatment and training to such an extent that it is felt that they can adjust to living under close supervision in a home and profit from the individual attention which comes with family life. However, family care is also used for some patients who have responded so well to the intensive hospital treatment that they are placed in homes as a therapeutic measure with the purpose of hastening their recovery and rehabilitation.[1]

Horatio M. Pollock defined family care as follows:

> ...if a patient no longer needs active institutional treatment but needs psychiatric help and guidance indefinitely and is placed in the custody of a family not his own, he may be regarded as being in 'family care.' With this broad interpretation of the term the family care group would include convalescent patients as well as the chronic type in which little

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[1]Hester B. Crutcher, Foster Home Care For Mental Patients, New York, The Commonwealth Fund, 1944, P. 2.

or no improvement can be expected.[2]

The Michigan State Department of Mental Health defines family care as follows:

> Family care in Michigan connotes the placement of special types of mental patients including the defective individual with families other than their own. Generally speaking, the broad classification of patients selected covers two groups, the type of patient who is classified by the hospital as being a continuous treatment case...(and) patients selected primarily for therapeutic reasons.[3]

The VA defines family care in still another way:

> An important goal of the hospital treatment is to enable the patient to re-establish himself in the community under the most satisfactory conditions. The placement of patients on trial visit provides an intermediary step for those patients who are believed able to live outside the hospital but are not ready for complete discharge. Those patients who do not have a supportive family situation to which they can return may be helped to find suitable homes other than their own in the community.[4]

In an article on family care in the Veterans Administration's Program Guide family care is defined like this:

> VA foster home care is defined as placement of psychotic patients on trial visits in homes other than their own, where responsible persons are receiving payment from the patient for giving him care and

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[2]Horatio M. Pollock, Ph. D., (ed.), Family Care of Mental Patients, Utica, N. Y., State Hospital Press, 1936, p. 74.

[3]Family Care Manual, State Department of Mental Health, Lansing, Michigan, 1951, pp. 1-2.

[4]Veterans Administration Technical Bulletin, TB 10A-279, Washington, D. C., Veterans Administration, 1951, p. 1.

> guidance in direct collaboration with the Veterans Administration.[5]

At the VA Hospital in Battle Creek the purpose of family care is defined as follows:

> Family care is designed to provide homes for improved patients who for one reason or another may not be sent out on trial visit to their own homes or to their relatives. Family care is extended hospital treatment used by many hospitals for the rehabilitation of their patients. Frequently, following family care, patients are able to return to their own homes and communities.[6]

The above definitions agree that family care may be used for the placement of patients in the community who are not able to return to their own homes for any number of reasons. It allows the patient to live in the community and still have contact with hospital personnel for supervision and assistance in making the transition from the hospital to the community. The definitions point out that two types of patients are placed in family care, that is, the continuous treatment cases placed in family care for custodial purposes and those who can use family care as a therapeutic device to assist them in recovering from their illness. Although some definitions include

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[5]Roger Cumming and Irene Grant, "Foster Home Care for Psychiatric Patients in the Veterans Administration: Developments in 1953," Program Guide, Psychiatry and Neurology Service, G-1, M-2, Part X, Washington, D. C., Veterans Administration, March 1955, p. 15.

[6]Some Facts About Family Care, Battle Creek, Michigan, Veterans Administration Hospital, (no date), p. 1.

the mentally defective with the mentally ill, in this study only family care of the mentally ill will be considered.

Although family care has not been used to any great extent in this country, it has been more popular in Europe as a means of caring for the mentally ill. This type of treatment had its origin in Europe during the Middle Ages. Gheel, Belgium seems to be the place where the family care plan originated. Pilgrims from all over Europe came to Gheel to worship at the shrine of Dymphne, the daughter of an Irish king who fled to Gheel to escape the incestuous advances of her father. Soldiers of the king sought out and killed Dymphne and her companion, a priest, at Gheel. Her tomb became a shrine to those afflicted with mental illness because it was believed that by worshiping there they could be cured of their illness. Because this shrine became so well known in Europe, great numbers of mentally ill came there and the town became so crowded that its meager facilities could not accommodate them. As a result, the townspeople began to take the pilgrims into their homes. It was observed that the attention given to the mentally ill in the homes helped them recover from their illness. Later, a small hospital was built at Gheel which was to become the center of a state colony for the mentally ill. Since that time, it has been the tradition of the people of Gheel to

provide care for the mentally ill in their homes. In 1852 the plan was taken over by the state. Patients would be admitted to the hospital and, within a short time, to a home that it was felt could help them recover. Doctors and other hospital personnel would then go out from the hospital to visit the patients in the homes on a regular basis. This program is still being carried out.

In 1857, Scotland initiated a plan whereby one or two patients were placed in various homes. The homes under the Scottish plan were widely separated so the patients were not able to get supervision and attention from the hospital physicians and staff as did those patients placed under the Gheel plan. In the Scottish plan the guardians who cared for the patients were selected by the Inspectors of the Poor instead of the hospital.

Other European countries began to use the family care plan including France in 1892, Switzerland in 1909, and Germany in 1911.

The family care program has been more widely used in European countries than in the United States to care for the mentally ill. As a whole, the Gheel or colony plan for family care has been more popular in both Europe and the United States than has the Scottish plan.[7]

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[7]For further history of family care in Europe see: Pollock, op. cit., pp. 115-135 and 161-175; also Maysie T. Osborn, "The Use of Family Care as a Treatment Procedure with the Mentally Ill," Mental Hygiene, XXVII, (July 1943), 412-423.

The first family care of mental patients in the United States was started in Massachusetts in 1885, with two men chiefly responsible; Frank B. Sanborn and Dr. Samuel G. Howe, both of whom served on the State Board of Charities. They seemed to be outstanding in their understanding of and interest in the mentally ill and retarded. The State Board of Charities stressed the importance of the family care program and in 1885 the State Board of Health, Lunacy and Charities was authorized to place patients in family homes and to visit or supervise them after placement. In 1915 the Board discontinued the placement of patients and this responsibility was taken over by the state hospitals.[8]

Since Massachusetts started this program in 1885 it has had a slow development in the United States. It was introduced in Pennsylvania in 1932; New York in 1933; Nebraska in 1934; California in 1939; Rhode Island in 1940; Illinois in 1941; Maryland in 1941; and Michigan in 1949.[9]

In the VA, the family care program grew out of a need to plan for those patients for whom maximum hospital benefit had been achieved. In 1936 a family care program

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[8]For further history of family care in the United States see: Pollock, op. cit., pp. 21-37; also Leo Maletz, M.D., "Family Care--A Method of Rehabilitation," Mental Hygiene, XXVI (October 1942), 594-605.

[9]Crutcher, op. cit., pp. 181-194.

was started on a small scale. By 1949 the program had expanded so as to affect more patients and a larger number of people within the community. In 1951, the VA fully adopted the family care program as a means of planning for the placement of patients in homes outside the hospital.

The family care program had its beginning in the VA Hospital at Battle Creek, in 1949. One patient was placed in a family care home as an experiment. By July, 1950 only one home was in use but three others were being studied as possible foster homes. By October, 1950 an additional placement had been made. In 1951 the Chief of Professional Services requested that serious consideration be given to the enlargement of the program, and at the same time it was recognized that adequate social planning was needed in considering a patient for family care placement.

In July 1952 one social service staff member was assigned to be the Supervisor of Home Care. This laid the ground work for expanding the program. There was communication between the Supervisor of Home Care and other VA hospitals, state hospitals, the State Department of Mental Health, and the State Department of Social Welfare, in an attempt to gather information on which to set standards for this program.

The program continued to grow, and in 1953 twenty patients were in family care. It became obvious that the

plan involved more work than one person could handle effectively. Therefore, in 1953, the former Supervisor of Family Care became the Family Care Home Finder. Two additional staff members of the Social Service Department were assigned to family care work with one becoming the new Supervisor of Family Care.[10]

In July 1954, the first family care meeting was held with 18 family care therapists attending. The therapists were given an opportunity to discuss with the social workers and doctors the problems facing them in their work with patients, discuss the dynamics of mental illness with two psychiatrists and to join in the planning of the program. The members of this group agreed that regular quarterly meetings would be helpful in their efforts in dealing with the patients and their care.

On December 31, 1955, there were 44 patients in family care. Thirty of these patients were placed during this year. The total number of patients in foster homes since the inception of this program is 72.[11] At this time there were 45 homes approved for use in the family care program.

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[10] Semi-Annual Narrative Report On Social Services, Battle Creek, VA Hospital. Unpublished reports prepared by the Social Service Department for use by the VA Central Office, June 1950 to March 1956.

[11] Report of Placement of Patients on Trial Visit in Homes Other Than Their Own During Calendar Year 1955, VA Form 10-2494 (NR).

A brief description of the setting in which the family care program and this study are being carried out, is essential. The VA Hospital at Battle Creek is a 2,000 bed neuropsychiatric institution located six miles outside the city of Battle Creek on the Fort Custer Military Reservation. There are approximately 1,000 employees to serve the patients. The employees include doctors, social workers, nurses, psychologists, clergymen, occupational therapists, educational therapists, hospital aids, administrative personnel, and others. The resources of the Hospital are created for the patients in an attempt to rehabilitate those that can be rehabilitated, and so arranged that the patient can live wholly within the setting.

The patient population is largely psychotic and ranges from those patients who are regressed to the infantile level to those who are sufficiently recovered to reenter the larger community outside the hospital. The latter group are the patients with whom the family care program is primarily concerned. It is felt that not only the social service and medical staffs should share in the promotion of family care, but all personnel dealing directly with the patients. All personnel need to be aware of the program and its benefits for those patients that can qualify and help in the preparation of the patients for family care. This program is not a social service and/or medical program alone, but involves the total hospital personnel.

CHAPTER III

METHODOLOGY

The method used to carry out this study was that of grouping data gathered by four means: interviewing people dealing with patients involved in the family care program; observation of workers dealing with patients; personal experience; and a review of the literature on the topic. Statistical data were not used because the purpose of the study was to describe the family care plan, not to evaluate it or any of its component parts.

Interviews were conducted with members of the social service staff engaged in the family care plan. Members of the medical staff were also contacted concerning their role in the total program. The interviews were not carried out on a structured basis. A great deal of material came by casual conversation with social workers, doctors, and psychologists at times when they would meet and talk about the program informally.

Current thinking about family care was obtained not only from those dealing with the program on a full-time basis but from all social workers connected with the program to any degree. A schedule of specific questions was not used in the interviews because different infor-

mation was sought from the various workers depending on their role in the program.

Observation played a significant part in this study. The author had opportunities to accompany family care workers on field trips to family care homes in which there were patients residing. The author was able to talk to both patients and family care therapists about their feelings concerning the program, along with the problems which arose as a result of the patient being in the home. The visits provided an opportunity to observe the family care workers in their dealings with both patients and therapists, as well as a first hand account of some of the actual applications of social work skills in the family care program.

A portion of the material used in this study came as a result of the author's personal experience. The author is now working with three patients, preparing them to enter family care. With others, the author is attempting to introduce them to the plan and motivate them to consider it. In preparing the patients to leave the hospital for family care, the author has worked with other hospital departments and has had contact with the VA Regional Office. Interviews were held with the relatives of patients to explain the program and the reasons for placing the patient in family care, to try to gain their consent to place the patient and to enlist their help in planning for the patient's care.

The study of documents accounted for a large portion of the material used in this study. Documents were not only important as a major source of information but served to clarify questions that arose from the other sources of data. Reports and other written materials concerning family care were supplied by the Social Service Department at the hospital.

Documents used included office memorandums, papers prepared to describe duties of the workers in dealing with patients to prepare and motivate them for family care, reports to other VA offices, reports of meetings dealing with family care, and special VA forms used in the family care program. In addition, other material from the VA was used such as the Technical Bulletins and the Program Guides which spell out the policy for the entire VA system to follow in this program.

The author has attempted to marshal the facts gathered from each of the four sources. The data have been gathered from a wide variety of sources and focused toward one goal, that of describing the family care program in one VA hospital.

CHAPTER IV

SELECTION AND PREPARATION OF PATIENTS FOR FAMILY CARE

Patients selected for family care are usually those who have successfully moved through their treatment program in the hospital and are ready to try to live in the community under supervision. The patients may be free from the symptoms of their illness such as delusions or hallucinations, or have them under control to the extent that they will not be objectionable in a community. A patient must be able to care for his own physical needs before being considered for family care. Patients who are homicidal or suicidal, those showing alcoholic tendencies, or those showing signs of sexual deviation are not considered for family care. Patients that are noisy, disturbing, or overly agressive may not be considered because of the upsetting effect that they might have on the home and community in which they would be living.[1] The VA hospital selects the patients who will derive the greatest amount of therapeutic value from the program.

Family care is a type of trial visit under VA regu-

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[1]Crutcher, op. cit., chap. 4.

lations, thus only patients with psychotic diagnosis are eligible for the program. Trial visit is explicitly arranged for psychotics only, with non-psychotic patients receiving another kind of release from the hospital.

Patients who have made a good hospital adjustment and have responded to treatment well but cannot return to their homes, are often placed in family care. The reasons for not being able to return home fall into one of a number of categories. Some patients are placed in family care because they have no families to whom they may return or that are able to care for them. Others cannot return to their homes because their families do not want them; they may be afraid of the patient because they do not understand the illness. Still others are unable to return to their homes because their former family life had within it factors which helped to precipitate the patient's illness. To place the patient within the same environment might only serve to lessen or negate the benefits the patient received at the hospital. In the latter cases, the family sometimes wishes to have the patient return to the home. In such cases, interpretation of the family care program and its benefits for the patient is given to the family. They may fail to recognize that there are disturbing influences in their family relationships, upsetting to the patient. The worker may try to help them understand why the patient is

being placed in a family care home instead of returning him to his own home.

As patients move through their treatment program, the various members of the hospital staff are in a position to be on the lookout for possible family care candidates. Hospital staff members such as teacher, nurses, attendents, and social workers usually deal with patients more closely than the doctors do. This fact enables them to identify those patients that may be potential family care candidates. Staff members may bring to the attention of the ward physician those patients whom they feel would benefit from family care. They have an opportunity to observe the patients in their day to day life within the hospital and are able to give valuable information concerning the patients' adjustment to the hospital. The final decision concerning the selection of patients for family care rests with the ward physician. He compiles a list of potential family care candidates and submits it to the various hospital departments concerned with the preparation of candidates for placement.

Patients who have responded well to hospital treatment and are ready to leave the hospital are selected for this program. Because they cannot return to their own homes, they are given an opportunity to live in the community in homes selected by the hospital. The patients may

have made a fair adjustment to the hospital but improve even more outside, under hospital supervision. Thus they are placed in this program because they can be eased into the community instead of being forced into making a drastic change from the sheltered hospital environment to the competitive community life.

The social service department assumes a large share of the responsibility for the actual preparation of the patients chosen to leave the hospital. One of the early steps in this process is to complete a form entitled, "Recommendation for Trial Visit of Patient in Home Other Than His Own."[2] This form must be completed by the ward physician and registrar as well as the social worker. In most cases the social worker takes the initiative in this matter. The social worker is called on not only to complete his portion of the form but at times to assist the ward physician and the registrar with their sections of the form.

The doctor states why the patient is being referred for family care, the patient's diagnosis, his legal status, and the psychiatric or medical supervision needed. The registrar is asked to disclose facts about the patient's source of income and guardianship. Social service spells out the patient's hospitalization history, his readiness

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[2]See Appendix A for a copy of VA Form 10-2406, "Recommendation for Trial Visit of Patient in Home Other Than His Own."

to live outside the hospital, and the kind of home and family which would appear to best meet his needs. This form is then included in the patient's case record to be used as a source of information to help in planning for placement.

Soon after the doctor suggests that a patient be considered for family care, the social worker may ask the psychology department to test the patient. The test results help determine whether or not there are personality characteristics which must be considered before and after placement. An additional reason for referring a patient for testing is that the psychology department is carrying on a research project to determine if there are certain personality characteristics which may be necessary for a good family care adjustment.

The social worker helps the patient prepare to leave the hospital by attempting to motivate him to accept this change. Although this may begin at admission and run throughout the treatment process, it is intensified after the patient has been suggested for family care. The motivation of the patient may include a detailed explanation of the program and an opportunity for the patient to ask questions about it. The worker clarifies with the patient that he needs a minimum of $400 in his estate before he can be considered for this program and all payments for his

care must be paid from his own money. Hopefully, this has been explained to the patients before the doctor recommends them for family care.

The worker might also explain that the program is geared to those patients that have shown a good adjustment to the hospital and have responded well to their prescribed treatment. For those who have no family ties or are unable to return to their families, the worker might explain that this program is a way in which the recovering patient may leave the hospital on a trial visit. This means that he will receive supervision from the hospital staff and other hospital benefits such as access to the dental and medical facilities. If the patient feels unsure about being able to live on the outside, the fact that this program gives him an opportunity to leave the hospital and yet be under the supervision of both the family care therapist and hospital personnel may be a large factor in motivating him to leave. The examples of other patients who have used the plan to their benefit may be a good way of showing the patient that this is a plan which may hold some value for him.

The patient is helped to feel that he has a voice in all this planning. One way of accomplishing this is to have the patient go with the family care worker into the community to visit homes which have been approved by

the home finder. During the process of preparing a patient for family care an informal meeting is held to determine the type of home which might best meet the patient's needs from those available. This group, called the Family Care Board, is made up of the supervisor of family care, the home finder, the family care social worker and the patient's social worker. By reviewing what the patient needs in a home and those homes available, a decision is made that a patient might fit into one of two or three homes. Following this meeting, the patient is taken by the family care worker into the home to visit. He has an opportunity to see the home, meet the therapist and other family members, and then decide which of the homes he would prefer. If the therapist agrees that the patient will fit into the home, a big step in the preparation of the patient has been made. This also allows the worker to have a more realistic picture of what the patient wants and needs in the community and may give some signs of his willingness to leave the hospital. This information will be available when the patient is presented for the Trial Visit Board, as a rule.

The social worker may help the patient prepare to leave the hospital in still other ways. The VA requires that the patient have a physical examination including a chest X-ray, a dental examination, and completion of any needed dental work before the patient may

be placed. The social worker may be required to emphasize the need of these examinations and encourage the patient to keep all appointments in an effort to hasten the fulfillment of this requirement.

One important area to be covered in the preparation of a patient for family care is that of financial arrangements. The patient's funds may be handled by his guardian or by the hospital manager. The VA has an established policy concerning the financial arrangements for family care.[3] For those patients who do not have a guardian, the manager of the hospital cares for the patient's funds which are in an account at the hospital. Inasmuch as the payments for family care must come from the patient's funds, he should have sufficient savings, compensation or pension payments, income, or other estate to defray the cost of the program. If the hospital manager is responsible for the handling of the patient's funds, he sends a check for the cost of the patient's room, board, and laundry to the family care therapist. At the same time he will send a check to the patient for a monthly allotment to cover his incidental expenses. If it is in the best interest of the patient, the funds for all expenses will be sent directly to him, thus giving him the responsibility of making the actual payments to the therapist. One of the therapeutic aims of

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[3]Veterans Administration Technical Bulletin, op. cit., p. 3.

this program is to help the patient learn how to handle his funds himself.

In those cases in which a guardian has been appointed, all arrangements for family care are made with the guardian's consent. It is the guardian's responsibility to make all financial arrangements for the patient, subject to court approval. The guardian is to be advised by the hospital if the payments are to be made directly to the family care therapist, with a separate check to the patient for incidental costs, or if the total amount is to be sent to the patient. The VA regulations governing payments for family care do not allow the guardian or manager to make payments to the family care therapist, which include the patient's allotment for incidental costs. This gives the patient the freedom of having some funds for himself regardless of the arrangements made for the cost of maintenance. It is essential that the guardian understand that all payments must be made promptly and regularly. The hospital requests the services of the Chief Attorney of the VA Regional Office in making financial arrangements with guardians. The Chief Attorney may also be called upon to work with guardians as other matters may arise.

Payments for family care are $25 per week or $108 per month. Inasmuch as the payments are made in advance, the first month's payment must come from the veteran's

funds at the hospital. The guardian or the manager will be notified as to the date on which the payments are due. If a guardian is handling a patient's funds the hospital will turn over what funds remain in the hospital account to the guardian when the patient goes into family care.

It is customary for the social worker to write to the Chief Attorney in cases where a committed patient is to go into family care, stating that the patient has been recommended for family care by a member of the medical staff. The purpose of this contact is to determine the extent of the veteran's estate and sources of income. The Chief Attorney's office may also be requested to notify the patient's guardian of the plan for possible placement and ask his cooperation in matters pertaining to the placement and continuance of the patient in the family care program.

When it has been determined that the patient is ready to be placed in family care, the doctor who recommended him will schedule the case for presentation before the Trial Visit Board. Notification is given to the hospital departments concerned, including social service, two weeks before the case is presented so the departments may prepare whatever material they may have to present to this Board.[4]

The Trial Visit Board is made up of the Chief of

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[4]Suggested Procedure for Presenting Patients for Trial Visit, Battle Creek, Michigan. VA Hospital, 1955.

Intensive Service or the Chief of Continuous Service, the patient's doctor and one additional doctor, the social worker, a psychologist, a representative from the registrar's office and the nurse and attendent from the patient's ward. Each of the above mentioned personnel is asked to give information about the patient which would be helpful to the Board in carrying out its function. Personnel from the Physical Medicine Rehabilitation Service including manual arts therapist, occupation therapists, educational therapists, and others of this service who have dealt with the patient submit written memoranda to the Board concerning their contacts with the patient. At times, these representatives may be asked to attend the meeting of the Board in order to present their information. In addition to those mentioned, a stenographer is present to record the discussion and recommendations.

The social worker is asked to evaluate the patient's home situation, his relationship with his family, and the family's attitude toward the patient leaving the hospital. It is necessary for the social worker to obtain information from the family either by personal interview or by correspondence. The social worker ought to be prepared to tell the Board if consent has been given by the family for the placement. The social worker is also asked to evaluate the economic status and/or needs of the patient and his family.

Local community social agencies that are available to supervise and give support to the patient and family are evaluated, and the information obtained presented to the Board to help them make their evaluation. In his recommendations the social worker may state that in the light of the above facts about the patient and his family, it is advisable that the patient be placed in a family care home.

The physician presenting the patient is called upon to give a brief history of the events leading up to the admission of the patient to the hospital, his diagnosis, the treatment prescribed, the adjustment to the hospital, and the doctor's recommendation which, in the case of a patient being prepared for family care, would be to place the patient in one of the hospital's family care homes. The registrar will make the patient's clinical record available to the Board and will have information concerning the patient's legal status and financial situation. Representatives of the other hospital services may be called on to add information about the patient not covered by the reports given by the doctor, social worker or registrar, and which might have a bearing on the patient's adjustment outside the hospital. The patient is then interviewed before the Board by the physician presenting the case. The interview will be focused on bringing out the patient's contact with reality, the presence or absence of delusions,

his hostile attitudes, and the patient's thinking which might indicate whether or not he is suicidal or homicidal. The physician helps the patient express his understanding of the meaning of the placement, his plans while in family care, and his attitudes toward returning to the hospital if the placement is not successful. Following the interview with the patient the Board determines if he should be placed in a family care home or if he requires a longer period of hospitalization.

As soon as possible after a patient has been approved for family care by the Trial Visit Board, arrangements are made to place the patient in the home selected. Usually by the time the patient is presented to the Trial Visit Board he will have had his physical examination, his dental work will have been completed, and he will have his clothing and valuables available so he can move into his new home as soon as possible. Final arrangements are made by notifying the family care therapist that the patient will soon be coming to the home. At the time the patient is placed, the family care therapist signs an "Agreement to Provide Home Care for Patient" and the patient signs "Patient's Agreement with Hospital in Relation to a Home Other Than His Own."[5]

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[5]See Appendix B for a copy of VA Form 10-2409, "Patient's Agreement With Hospital in Relation to a Home Other Than His Own," and Appendix C for a copy of VA Form 10-2410, "Agreement to Provide Home Care For Patients."

The role of the social worker in the preparation of a patient for family care is chiefly that of motivating him and giving support, so that he will be able to go through with placement planning. The worker also contacts outside resources for assistance in this planning. The family care program and the reasons for placing a patient in family care are interpreted to the patient and his family. The social worker acts as a member of a team which is preparing the patient to leave the hospital. Usually the team relationship is quite informal. The social worker may be called upon at times to help the doctor, registrar, or others concerned with preparing the patient for leaving the hospital. On the more structured level, the team relationship is seen in the Trial Visit Board in which the representatives of the various departments must present their material and reach a definite conclusion.

Some of the social work skills involved are interviewing, recording, interpretation of policy and plans, and motivation of the patient toward leaving the hospital. In the interview the worker may help the patient bring out his thinking and attitudes, both favorable and unfavorable, toward the proposed plan. In the interview situation, the worker may be able to help the patient explore the adjustments that he may have to make in the community. Recording is important to the worker inasmuch as it shows

the direction that the contact with the patient has been taking over a period of time. It is also valuable if the patient's social worker transfers the case to a family care worker, by showing the new worker the progress that has been made in preparing the patient for family care and the direction that the contact with the patient has taken. A careful interpretation of the family care program and the reasons for placement is given to the patient, his family and/or guardian and other interested people including those dealing with the patient in the hospital. This is done to elicit full cooperation from all concerned with the placement. Motivation of the patient often requires that the worker be patient and understanding in his efforts to help the veteran accept the plan as one which is believed to have value for him. The worker must accept the patient where he is in his thinking about the possible placement, allowing him to set the pace in the planning for family care. The worker needs to allow the patient the freedom of questioning any part of the program or the preparatory work involved, and to be willing to answer all questions promptly and truthfully. This helps to show the patient that the worker respects him as a person, and gives him a sense of participation in the planning.

It is up to the worker to prepare the patient if his case is to be transferred to another worker. Some re-

gression in the patient's progress might appear because of the breaking of one patient-worker relationship and the necessity to establish another.

The patient should also be prepared to leave the sheltered environment of the hospital for the more competitive life in the community. Even in a family care home in which the patient is under the supervision of the hospital and the family care therapist, he will face more community competition and demands than were required of him in the hospital. It is up to the social worker to help the patient face this reality.

At times it may be necessary to manipulate the patient's hospital environment, in an effort to stimulate his willingness to enter into family care. It is sometimes necessary to move a patient into a ward in which the ward personnel are more inclined to work with patients in preparing them for family care and in pointing out the values of this program. It may be wise at times to place a patient who does not show a great deal of motivation to leave the hospital in a ward where there are other patients who are being prepared to go into family care and who show an enthusiasm for this plan. At the present time a special ward has been set up for patients being prepared for family care. The doctor in charge of the ward is active in helping patients enter into family care. The ward personnel are

selected for their interest in the program and given training concerning family care. The need for a family care ward was underlined by the shortage of social workers to deal with this program, the diversification of thought towards the plan and because of a need to motivate the patients by group methods.[6]

At times it may be necessary to change a patient's work assignment or assign him a job at the hospital, as well as change the ward on which he lives. It may also be necessary to take a patient from one work assignment and place him on another. If a patient is a good worker on his job and the person for whom he is working is more interested in the job than in the rehabilitation of the patient, it would be justifiable to change the patient's work assignment.

In the social worker's role as a member of the hospital team, he needs to cope with the patient's feelings, attitudes, fears and questions about the placement. He also deals with the feelings of family members and other interested persons, trying to point out the rehabilitative values of the program. Finally, the worker uses whatever community resources are needed to make the patient's adjustment in the community as successful as possible. The worker

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[6]Semi-Annual Narrative Report On Social Services, October 1, 1955 to March 31, 1956, Battle Creek, Michigan, VA Hospital, 1956, pp. 5-7.

attempts to interpret the program to the community at every opportunity, in an effort to help the community accept and better understand the patients who are being placed in their midst. Careful selection of patients for family care is essential at this early stage in the use of the program in this country. While the community is learning to accept these patients the social worker, along with other hospital personnel, needs to be particularly careful in choosing patients who, by their ability to adjust to the community, will help establish this program as a valuable part of the treatment of emotionally ill persons.

CHAPTER V

SELECTION OF FAMILY CARE HOMES

The selection of patients for family care is a co-operative effort in which a number of hospital personnel work together. The selection of homes to be used in the family care program, however, is the responsibility of the social service department.[1]

The ground work for the selection of homes is done some time before the home is actually needed. This requires that the community be shown the value of the program. The program is interpreted to influential individuals and groups within the community in order to elicit their support. Prejudices and resistance toward mental illness need to be overcome before the program can become successful. Successful placement of patients helps to educate the community as to the value of the family care program.

Methods of obtaining applications from prospective family care therapists can be placed into three groups: conferences and meetings, publications, and personal contacts.[2]

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[1]Veterans Administration Technical Bulletin, op. cit., p. 2.

[2]Dorothea K. Hunter, Home Finding. Unpublished report prepared for use by Social Service Department, VA Hospital, Battle Creek, Michigan, no date.

Conferences and meetings include meetings with child and adult placing agencies; meetings with hospital doctors, nurses, clergymen, attendants, volunteers and others; and community meetings with veterans' service groups, church groups, Family Service Agencies, PTA groups, and Bureaus of Social Aid. To these groups, representatives point out the family care program and the needs for homes to carry out the program successfully.

Publications, as a means of soliciting possible homes, include blind newspaper advertisements requesting homes for patients, personal advertisements and inquiries made by patients, feature stories about family care in the nearby city newspapers, and newspaper reports of meetings such as the quarterly family care therapists' meetings.

Personal contacts made by family care therapists with their friends and acquaintances, is a third method of obtaining prospective family care homes.

It has been found that the requests for homes made through newspaper advertisements have resulted in a large number of applications. However, many of these applications had to be turned down if the standards of the program were to be maintained. As a result, this aspect of the program has been discontinued. The most successful means of finding possible family care homes has been through personal contact made by family care therapists. The other

method cited has been mildly successful, accounting for a small number of the homes now available.

When a person shows an interest in providing care in his home for a patient, he is asked to fill out an application form and submit it to the home finder in the Social Service Department. The form, "Application For Consideration of Home in the Trial Visit Program,"[3] asks for a description of the home, an outline of the members of the household, and a listing of the domestic and other hired help on the premises. Some specific questions include the marital status of the householder and family members; church attendence; distance of the home from the hospital; whether or not the family has ever cared for a mental patient and, if so, the patient's relationship with the family; the willingness of the family members to have a patient in the home; and reasons for taking a patient into the home.

The VA has listed some of the factors to be considered by the home finder in evaluation the applications for consideration as a family care home: the understanding, help and interest that the family can provide for the patient; the effects of the patient on family members, especially small children; the reasons for wanting the

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[3]See Appendix D for a copy of VA Form 10-2407, "Application For Consideration of Home in the Trial Visit Program."

patient in the home; the adequacy of the family income, so that it is not dependent on the monthly payments received for care of a patient; the cultural background of the family; the social and recreational activities available; physical standards of the home and the physical conditions of the family members.

The home finder reviews the applications received and, if any are disapproved, the applicants are notified with an explanation for the disapproval. Remaining applicants are visited by the home finder for further evaluation. The home finder uses an "Outline For Obtaining Information as to the Suitability of Homes Other Than Patient's Own,"[4] to aid in reaching a decision as to the value of the potential home in light of the over-all program. Three factors must be considered: the personalities of the family members, the resources of the community, and the physical setting of the home. The form lists questions to be answered concerning the physical attributes of the home and its positive and negative aspects concerning the care of patients, the home finder's summary of interviews with references given by the applicant, the standing of the applicant and family in the community, the favorable and unfavorable interpersonal relationships in the family, and the general type

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[4]See Appendix E for a copy of VA Form 10-2408, "Outline For Obtaining Information as to the Suitability of Home Other Than Patient's Own."

of patient who could use the home to best advantage.

The information obtained from the visit to the home is reviewed and those not meeting the standards of the program are rejected. The homes approved are kept on file to be used as patients are placed in family care homes. Rejected applicants receive an explanation in which the worker points out why their home would not fit into the program. This is an area which calls for skill in public relations on the part of the social worker. Those homes approved are chosen because the favorable points in them outweigh the unfavorable points. Whether or not a home is used after approval depends on the needs and desires of the individual patients being considered for family care.

Homes are selected to meet, as fully as possible, the various needs of the patient. This requires both rural and urban homes, homes with and without children, a large range of ages of therapists and family members, various religious faiths, a wide range of nationality and racial backgrounds, and various social, educational, and employment levels.

The home finder's activities go far beyond the mere selection of homes. While a patient is being prepared for family care, the home finder meets with other social service personnel comprising the Family Care Board, to help select a home for the patient. The home finder

is able, by virtue of her knowledge of the home, to point out the values of the available homes. Of those available, the Family Care Board narrows the number to a few homes which appear to possess the desired qualities. The home finder or another family care worker then takes the patient to visit the homes and observes him with the family members. The home finder or other social worker may be able to help the patient choose the home in which he would like to live and at the same time determine if the family members feel that they would like to have the patient in their home.

Before a patient is finally placed the social worker may be called on to explain the patient's illness, his needs, and possible ways of working with him to the members of the family with which he is going to live. The patient and worker work together closely to clear up questions that the patient may have about the family, the community, what is expected of him in the home, and other questions that may arise around the move from the hospital.

Since the home finder carries a small caseload of patients being prepared for family care, she also performs the same duties as other social workers in preparing patients for family care.

In home finding, the social worker must be skilled in interpreting this plan to individuals and groups in the community to stimulate community interest in the program.

In the selection of homes she needs to judge the values of a home quickly so a decision can be made whether to accept or reject it. She may also be called upon to motivate families to accept patients in their homes.

The home finder must possess the same skills and techniques used by the social workers dealing with the preparation of patients, in addition to the added skills of being able to work in the community. The home finder must not only be skilled as a caseworker but also as a community organizer, so as to be able to mobilize the resources of the community to help meet the needs of a special group of citizens.

CHAPTER VI

SUPERVISION OF PATIENTS IN FAMILY CARE HOMES

The placement of a patient in a family care home does not mean that social service contacts with him are at an end. Supervision of both the patient and family care therapist must continue until the patient leaves the home. Supervision of the patient to help him adjust adequately to the community is of equal importance to the selection and preparation of the patient for placement.

Supervision of a patient in a family care home might be thought of as help given to the patient and family with which he is living, to make the adjustment that is involved as a result of the placement. This supervision may be given by the supervisor of family care, the home finder, the family care social worker or, in some cases, by a member of the general social service staff. In supervising a patient in a home the social worker works largely independent of direct supervision and without the support

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[1]The greatest part of the data in this chapter was gathered from the United States Civil Service Commission Position Description, for Social Worker (Psychiatric)-Family Care, February 10, 1956 and Supervisory Social Worker (Psychiatric) February 10, 1956.

of the hospital environment. Although the social worker may consult with psychiatrists and supervisors concerning possible ways of dealing with patients and family care therapists, there are occasions which call for the worker's independent judgment. Problems concerning the patient's adjustment or those which may arise between the patient and the family and/or community may require immediate action by the worker in the field. The social worker must be able to set limits for the patient and try to help the family and community accept and live with the patient.

In direct supervision of the patient, the worker confers with him concerning his feelings and behavior during his adjustment to the home and the community. The worker may try to help the patient transfer his dependency from the hospital to the family care therapist, and eventually to become self-dependent. At the same time, he attempts to help the patient to redirect his energy toward independent activities such as greater use of recreational facilities, participation in community affairs and, later, toward employment. Full-time employment is usually not encouraged at the outset; rather, it is felt that it is to the patient's advantage to start with a part-time job and work toward full-time employment.

The social worker may confer with psychiatrists about the patient's progress, the need to transfer a patient

from one home to another, and the final disposition of the case. Independent thinking is necessary, however, on the part of the social worker in making decisions in these matters. He may also wish to confer with the psychiatrist about awarding the patient an extension of his trial visit, or to discharge him from the hospital. The social worker is the key person in these matters because he is the one with the opportunity to observe the patient in the home and community. When the patient is first placed in the family care home the social worker visits him on a weekly basis. As the patient makes the adjustment to the home and community in a satisfactory manner the visits are reduced to one a month. If the patient is transferred from one home to another the visits would be on a weekly basis until he makes a satisfactory adjustment to the new home.

The social worker must deal directly with the family care therapist as well as with the patient. This is to evaluate the effects of family life on the patient and also to help the family develop ways of meeting the patient's needs. To help the family do this, the social worker may be called upon to give the therapist and other family members support and encouragement by suggesting ways of dealing with the patient and by interpreting his illness. At times it may be necessary for the social worker to deal with the problems of the therapist so that the therapist may be able

to work with the patient more effectively.

If the home is one in which the patient is not able to adjust, it may be necessary to terminate its use for that particular patient. In such cases, the worker would interpret the reasons for the action to the family care therapist. The factors in the family care home which are not conducive to the best interests of the patient are pointed out so the therapist will understand the reasons for the action.

The family care therapists are helped to understand their duties and responsibilities to the patient by attending the quarterly family care therapist meetings at the hospital. In these meetings, they are given an opportunity to talk to doctors and social workers, as well as to other family care therapists in order to gain more knowledge of mental illness and how to work with patients suffering from mental illness. In addition, the therapists are helped to feel that they are a part of the total treatment plan for the patients and to identify with the hospital.

In addition to supervising the patient and the family care therapist, the worker is active with the patient's family and guardian. The guardian is informed of the original financial agreement and of any changes in the patient's family care home or in the financial requirements. If a patient is changed from one home to another or

returned to the hospital, the guardian is notified to stop payments being made to the family care therapist or to change to the new therapist. The same procedure holds for those patients without guardians whose funds are being handled by the hospital manager.

The social worker deals with the patient's family concerning its feelings about the patient and his placement. Although it may not be to the patient's advantage to return to his own home, the family might not understand this and might feel some resentment toward the patient for wanting to live in a strange home. The worker may be called upon to evaluate the patient's progress for the family and, if it is necessary to change homes, the need for this must also be explained. The social worker may try to enlist the aid of the family in making plans for the patient, both while he is in the hospital and while he is in family care.

The family care worker who supervises the patient in the family care home is occasionally required to work with patients who must return to the hospital. The worker may be able to help the patient return to the hospital through the casework relationship that was established while the patient was in family care.

CHAPTER VII

SUMMARY

This study has attempted to show how a family care program is carried out in one VA hospital, focusing on the role of the social worker. If the family care program is to function successfully, then the work of the social service department in the hospital is essential.

The social worker assumes an important position in the hospital team. A large share of the work of making a successful placement centers around helping the patient to accept a placement as being in his best interest, to help him make an adequate adjustment in the home and community, obtaining suitable homes, and interpretations of the program to the community. Many of the obstacles that must be overcome are social work rather than medical problems. These problems range from the patient's unwillingness to accept placement, to the attitudes of the patient's family and community toward the patient leaving the hospital.

If family care is to be of value as a step in the total plan to rehabilitate the individual patient, much of the success of the placement will depend upon how adequately the patient was prepared for placement and how well he is supervised in the home. He needs not only to be treated

by the medical staff so as to be on his way toward recovery, but to have been motivated and prepared to leave the hospital. The social worker is responsible for a great amount of the work involved in preparing a patient for family care, yet the need for a team relationship remains strong. Family care thus is visualized as a program involving many of the hospital services, and requiring effective working relationships. The social worker may be called on at times to initiate action which may involve other hospital services, or to coordinate the activities of the various services. Despite the social worker's apparent large responsibility in this plan, the use of other services and of the team relationships are basic.

In order for the family care program to be successful, the patient and his needs must be the primary objective of consideration. There needs to be a respect for the person's desires and wishes and a recognition that he is entitled to have a voice in the planning for his future care. The worker begins with the patient at his level of understanding of the family care program and his willingness to try this type of treatment. The social worker then attempts, in the main, to motivate the patient to accept this plan as something which is felt to have value for him.

It would seem that if these two basic social work principles were overlooked the placement might not be

successful. A placement made against the patient's will or without his full understanding could set him back in his recovery, perhaps requiring a further period of hospital treatment.

In the family care program the social worker must use not only the resources of the hospital to help prepare the patient, but also those of the community. The nature of this program demands the support of the individuals and families in the community as well as that of the social agencies and social groups. Without their support, this program could not survive. The community may need to be educated about mental illness and how it may aid in the treatment of the mentally ill by providing care for patients in their homes. This community education is necessary if families are to be willing to open their homes to patients.

The family care social workers have a responsibility to assist in the planning for a patient from the time he is recommended for family care by a member of the medical staff until final termination of the case. The representatives of the other hospital services such as doctors, nurses and psychologists, are chiefly concerned with the treatment and preparation of the patient to enter family care. The social worker is not only concerned with this treatment and preparation but is responsible for the additional task of finding homes in which the patients may

receive help in making an adequate community adjustment, and for the supervision of the patient in the home and community. The homes need to be chosen with a great deal of care, to be of the greatest possible therapeutic value to the patient. The social worker must be capable of giving skilled supervision to both the patient and the family care therapist in an effort to help the patient achieve a state of recovery from his illness which will enable him to be discharged from the hospital and to re-establish himself as a useful and productive member of society.

APPENDICES

RECOMMENDATION FOR TRIAL VISIT OF PATIENT IN HOME OTHER THAN HIS OWN

(Summary of Psychiatric, Medical, and Social Data)

1. NAME OF VA STATION	2. ADDRESS	3. DATE

4. VETERAN'S LAST NAME - FIRST NAME - MIDDLE INITIAL	5. DATE OF BIRTH	6. REGISTER NO.	7. CLAIM NO. C-	8. WARD NO.

9. VETERAN'S HOME ADDRESS	10. RELIGION

PART I *(To be completed by ward physician)*

11. REASON FOR REFERRAL *(Composition and attitude of family, and reason for not placing patient with them)*

12. DIAGNOSIS *(Psychiatric and medical)*

13. DESCRIPTION OF PATIENT *(Physical appearance, personality, behavior, moods, etc.)*

14. IS PATIENT MEDICALLY CONSIDERED ABLE TO HANDLE OWN FUNDS?	15. LEGAL STATUS
☐ YES ☐ NO	☐ COMPETENT ☐ INCOMPETENT ☐ GUARDIANSHIP PROCEEDINGS UNDERWAY ☐ COMMITTED

16. WHAT PSYCHIATRIC OR MEDICAL SUPERVISION IS REQUIRED?

17. WHAT MEDICATION IS NEEDED?

18. WHAT DIET IS RECOMMENDED?

19. SIGNATURE OF PHYSICIAN	20. DATE

PART II *(To be completed by the Registrar)*

21. NAME OF GUARDIAN	22. ADDRESS

23. NAME OF NEAREST RELATIVE	24. ADDRESS	25. RELATIONSHIP

PATIENT'S SOURCE OF INCOME

26. VA COMPENSATION	27. PENSION	28. MILITARY RETIREMENT	29. INSURANCE	30. OTHER
$	$	$	$	$

31. HAS AID AND ATTENDANCE BEEN AWARDED?	32. AMOUNT OF INSTITUTIONAL AWARD	33. AMOUNT OF ESTATE HELD AT HOSPITAL	34. AMOUNT HELD ELSEWHERE
☐ YES ☐ NO	$	$	$

MILITARY SERVICE

35. BRANCH OF SERVICE	36. LENGTH OF SERVICE	37. HIGHEST RANK OR GRADE	38. DATE OF LAST DISCHARGE	39. COMBAT ACTION
				☐ YES ☐ NO

PART III *(To be completed by social worker)*

HOSPITAL AND EMPLOYMENT HISTORY

40. LENGTH OF HOSPITALIZATION PRIOR TO AND DURING MILITARY SERVICE	41. LENGTH OF HOSPITALIZATION SINCE DISCHARGE FROM MILITARY SERVICE	42. TYPE OF HOSPITALIZATION OTHER THAN VA
		☐ PRIVATE ☐ STATE ☐ NONE

43. BRIEF HISTORY OF EMPLOYMENT PRIOR TO AND AFTER DISCHARGE FROM MILITARY SERVICE

PATIENT'S READINESS FOR PLACEMENT

44. PATIENT'S AND RELATIVES' ATTITUDE TOWARD HIS PLACEMENT

45. PATIENT'S WORK ASSIGNMENTS, HOBBIES, AND OTHER REHABILITATION ACTIVITIES

46. ABILITY OF PATIENT TO ASSIST WITH HOUSEHOLD TASKS

47. CLUB MEMBERSHIPS AND OTHER ASSOCIATIONS

48. PRESENT AND PAST CHURCH ACTIVITIES

49. NAMES OF PERSONAL FRIENDS INTERESTED IN THE PATIENT	50. ADDRESSES

51. PATIENT'S SPECIAL NEEDS, CAPACITIES, PROBLEMS, ETC.

52. TYPE OF HOME AND COMMUNITY DESIRED

53. KIND OF SUPERVISION AND PERSONAL ATTENTION REQUIRED BY PATIENT IN THE HOME

54. DESIRABLE QUALITIES IN THE PERSON ASSUMING RESPONSIBILITY FOR THE PATIENT	55. PREFERRED AGE RANGE

56. RECOMMEND PLACEMENT OF VETERAN IN	57. SHOULD EMPLOYMENT IN THE NEIGHBORHOOD BE ENCOURAGED?
☐ RURAL AREA ☐ URBAN AREA	☐ YES ☐ NO

58. SIGNATURE OF SOCIAL WORKER	59. DATE

PATIENT'S AGREEMENT WITH HOSPITAL IN RELATION TO A HOME OTHER THAN HIS OWN

1. NAME OF VA STATION	2. ADDRESS		3. TELEPHONE NO.
4. NAME OF VETERAN	5. REGISTER NO.	6. CLAIM NO. C-	7. AGREE TO PAY MONTHLY $
8. NAME OF PAYEE	9. ADDRESS		10. TELEPHONE NO.
11. NAME OF SOCIAL WORKER			

AGREEMENT: I agree to pay monthly the amount specified in Item No. 7 to the Payee named in Item No. 8 for room, board, laundry, and attention to my welfare. I further agree to discuss any matter of concern to me that arises during the course of this agreement with the Payee and with the Social Worker named above before I make any change in this agreement.

12. SIGNATURE OF VETERAN	13. DATE
14. SIGNATURE OF SOCIAL WORKER *(Witness)*	15. DATE

V A FORM APR 1953 **10-2409**

VA DC 160215

AGREEMENT TO PROVIDE HOME CARE FOR PATIENT

1. NAME OF VA STATION	2. ADDRESS	3. TELEPHONE NO.

4. NAME OF PATIENT	5. REGISTER NO.	6. CLAIM NO. C.

7. NAME OF PATIENT'S PHYSICIAN	8. NAME OF SOCIAL WORKER

9. AGREE TO CARE FOR THE PATIENT AT THE MONTHLY RATE OF $	10. DATE WILL ACCEPT THE PATIENT INTO MY HOME

AGREEMENT: I, the undersigned, agree to accept the above named patient into my home on the date indicated in Item No. 10 at the monthly rate shown in Item No. 9. I will provide the patient with room, board, laundry service, and look after his personal welfare.

I understand that the patient will be on trial visit status during his stay in my home and will be visited at regular intervals by a member of the Social Service Staff from the hospital.

I agree to notify the patient's physician or the social worker at the hospital, name and telephone No. listed above, at once if there is any change for the worse in the patient's condition, either physical or mental, or if the patient absents himself from my home for any period of time without my knowledge or consent.

I further agree to notify a social worker or physician at the hospital, if my address is changed or if any other person becomes a member of my household. I have been informed that I have the right to request the patient's return to the hospital at any time, if he does not make a reasonable adjustment.

11. SIGNATURE OF APPLICANT	12. ADDRESS	13. DATE

V A FORM APR 1953 **10-2410**

VA DC 160214

Form Approved
Budget Bureau No. 76-R354

VETERANS ADMINISTRATION

APPLICATION FOR CONSIDERATION OF HOME IN THE TRIAL VISIT PROGRAM

1. NAME OF VA STATION	2. ADDRESS

DESCRIPTION OF HOME OFFERED

3. NAME OF PERSON TO BE RESPONSIBLE FOR PATIENT'S CARE	4. DATE OF BIRTH	5. RACE	6. OCCUPATION

7. ADDRESS *(Number, street, city or town, and State)*	8. HOW LONG HAVE YOU LIVED IN THIS COMMUNITY?

9. MARITAL STATUS *(Check)*

☐ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

10. DO YOU LIVE IN *(Check)*	11. HOW MANY ROOMS HAVE YOU?
☐ OWN HOME ☐ RENTED HOME ☐ APARTMENT ☐ OTHER	

12. HAVE YOU A TELEPHONE?	13. IF ITEM NO. 12 IS "NO," IS THERE ONE AVAILABLE TO YOU?	14. HOW FAR IS TELEPHONE FROM YOUR HOME?
☐ YES ☐ NO *(If "Yes," give number)*	☐ YES ☐ NO *(If "Yes," give number)*	

15. IF ITEM NO. 13 IS "YES," GIVE NAME OF SUBSCRIBER	16. ADDRESS

17. DO YOU ATTEND CHURCH?	18. ADDRESS
☐ YES ☐ NO *(If "Yes," name of church)*	

19. ARE YOU A MEMBER OF THAT CHURCH?	20. WHAT IS YOUR RELIGION?	21. CAN YOU ARRANGE FOR PATIENT TO ATTEND CHURCH REGULARLY?
☐ YES ☐ NO		☐ YES ☐ NO

22. NAME OF NEAREST RAILROAD STATION TO YOUR HOME	23. NAME OF NEAREST BUS STOP

24. GIVE DISTANCE AND DIRECTIONS FOR REACHING YOUR HOME BY AUTOMOBILE FROM VA STATION LISTED IN ITEM NO. 1

25. NAME OF SPOUSE	26. DATE OF BIRTH	27. RACE	28. RELIGION

29. MEMBERS OF HOUSEHOLD *(Family and others)*

A. NAME	B. AGE	C. SEX	D. RELATIONSHIP	E. OCCUPATION

30. IS ANY MEMBER OF YOUR HOUSEHOLD AN INVALID OR UNDER MEDICAL CARE?

☐ YES ☐ NO *(If "Yes," what is the nature of the illness)*

31. DOMESTIC AND OTHER HIRED HELP ON THE PREMISES

A. SEX	B. RACE	C. AGE	D. DUTIES

32. DO ANY OF THE HELP LIVE IN YOUR HOME AND EAT WITH THE FAMILY?	33. DO YOU HAVE BOARDERS OR LODGERS?	34. ARE ALL MEMBERS OF YOUR HOUSEHOLD WILLING TO HAVE A PATIENT LIVE IN YOUR HOME?	35. WHAT IS APPROXIMATE AGE AND SEX OF PATIENT DESIRED?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

36. HAVE YOU EVER CARED FOR A MENTAL PATIENT IN YOUR HOME BEFORE?	37. WHAT WAS THE PATIENTS RELATIONSHIP TO YOU?
☐ YES ☐ NO *(If "Yes," give name)*	

38. REFERENCES *(Give name and address of two persons not related to you. Also, name of your Doctor and Minister)*

A. NAME	B. ADDRESS

39. WATER SUPPLY SOURCE AND PLUMBING FACILITIES

☐ CITY WATER SUPPLY ☐ PRIVATE WATER SUPPLY ☐ INSIDE TOILET ☐ OUTSIDE TOILET ☐ TUB BATH ☐ SHOWER BATH

40. LIGHTING AND HEATING EQUIPMENT

☐ ELECTRIC LIGHTS ☐ FURNACE-PIPED STEAM OR HOT WATER ☐ FURNACE-WARM AIR ☐ STOVES OR ROOM HEATERS

41. HEATING FUEL

☐ COAL ☐ WOOD ☐ LIQUID FUEL ☐ UTILITY GAS ☐ BOTTLED GAS ☐ ELECTRICITY

42. DOMESTIC ANIMALS AND FOWLS

☐ HORSES ☐ COWS ☐ POULTRY ☐ PIGS ☐ DOGS ☐ CATS

43. AMUSEMENTS AND ENTERTAINMENT ITEMS

☐ AUTOMOBILE ☐ RADIO ☐ PHONOGRAPH ☐ TELEVISION ☐ DAILY PAPER ☐ MAGAZINES

44. OTHER FACILITIES FOR CARE, ENTERTAINMENT, AND INTEREST OF PATIENT

45. WHAT RECREATIONAL OPPORTUNITIES ARE AVAILABLE IN THE COMMUNITY?

46. WHAT IS YOUR REASON FOR WISHING TO TAKE ONE OF OUR PATIENTS INTO YOUR HOME?

47. DATE	48. SIGNATURE OF APPLICANT

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VE INISTRATION

APPLICATION FOR CONSIDERA F HOME IN T AL VISIT PROGRAM

31. DOMESTIC IRED HELP ON S

A. SEX	B. RACE	C. AGE

32. DO ANY OF TH YOUR HOME AND EA LY?

☐ YES ☐ N

33. DO YO WILL OR L OME?

☐ Y

HAT IS APPROXIMATE AGE AND SEX OF PATIENT DESIRED?

36. HAVE YOU EV ENTAL PA

☐ YES ☐

IENTS RELATIONSHIP TO YOU?

38. REFERR

your Doctor and Minister)

DDRESS

APPENDIX E

Form Approved
Budget Bureau No. 76-R355
OUTLINE FOR OBTAINING INFO
OTHER TH
ON AS TO
ENT'S O
ILITY OF HOME
48. DESCRIBE THE INTER-PERSONAL
A. FAVORABLE
THE PATIENT

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