1952

A study of family care as it operates currently at the Boston State Hospital.

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Boston University
A STUDY OF FAMILY CARE AS IT OPERATES CURRENTLY AT THE
BOSTON STATE HOSPITAL

A Thesis

Submitted by
Paul Joseph Michalowski
(B.S., Boston College, 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 home has always been the unit of society and the natural place for all who can live there. It is with this in mind that the writer undertakes the following study of "Family Care", which is the mental hospital's program for helping patients in a natural setting.

Purpose

This is a study of the family care program at Boston State Hospital to determine the following:

1. How do mental patients benefit from placement in private homes?

2. What type of patients are chosen for family care placement?

3. What are the advantages to the hospital in placing patients in family care?

4. How do social workers participate in the hospital family care program?
Scope and Sources of Data

All family care homes at the Boston State Hospital in use from September, 1950 to March, 1952 were included in this study. Data was obtained from case records of patients, case records of family care homes and individual conferences with the family care social worker. The writer also visited all the family care homes in use and obtained material from the family care mothers.

Method of Selection

For the overall study, all records of both family care patients and family care homes from September, 1950 to March, 1952 were used. Records for the case study were purposely chosen to show the difference between custodial placement and therapeutic placement.

Limitations of Study

This study is limited by the following:

1. The family care program at the Boston State Hospital is in the process of expansion and new factors concerning family care are constantly coming to light---i.e., various types of patients are being placed, with final results yet to show.
2. Some family care homes had both mother and father figures; others did not. This undoubtedly had an effect on the patient's adjustment which was not taken into account by the writer.
CHAPTER II

HISTORICAL DEVELOPMENT OF FAMILY CARE

The Colony at Gheel

The oldest family care system of record which is still in operation is that of Gheel Belgium. The early history of Gheel, of largely legendary character, indicates its establishment in the seventh century.

Briefly, the legend is to the effect that the daughter of a king, persecuted in a most unnatural manner by him, fled from her native country and took refuge at the place where Gheel now stands, the place where she found protection in the care of Father Gerebernus. Here, so the legend states, she abode serving God by fasting and prayer. Later, both priest and maiden were slain by the king and their bodies were buried by the people. Many people who later visited the graves of the martyrs were cured of all manner of diseases, bodily as well as mental but particularly of the latter. It was believed that the martyred maiden not only forgave her father, believing him to be insane, but also desired to alleviate a like madness in others. Pilgrims came, and many of them, especially those of unsound mind, were reported as being restored to health and reason. It became necessary to find boarding places in the neighborhood for the afflicted. Thus
was established the colony of Gheel.¹

The Church soon assumed the responsibility for the placement of these people; and the placement of these people expanded and became subject to local government regulations. In 1852 these semi-religious and semi-communal facilities became the nucleus of a state colony for mental patients. By the year 1930, there were three thousand of them cared for by families of Gheel and the surrounding towns. Scotland, Germany, and France took up family care in modified forms as early as 1857.

Development in Massachusetts

The earliest reference to family care in this country was in 1865, when Dr. Samuel Howe was made Chairman of the first State Board of Charities of Massachusetts. He felt that it was "better to separate the dependent classes than to congregate them", and "that we should avail ourselves of the existing agencies in society, the homes in particular". Following his visit to Gheel, he recommended a similar but modified system, patterned more nearly after that of Scotland. He felt also that no state hospital patient should remain longer in the institution than was absolutely necessary. Dr.

Howe did not live long enough to see his dream put into practice, but his ideals were carried on by Franklin B. Sanborn, Secretary of the Board of Charities, who also visited Cheel and Scotland. In 1885 he was successful in having laws passed by the legislature permitting the State Board of Charities to board private patients in private families. Five were placed in the first year. In 1898, the State Board of Insanity was created; in 1916, the Commission of Mental Diseases; in 1919, the Department of Mental Diseases; and in 1938, the name was changed to the Department of Mental Health.

Family care has continued to this day, under these various auspices, with quite marked success. From 1865 to 1905, all patients were placed by the Central Board. During the years 1901 to 1914, the Board employed a Medical Director and two social workers to place and supervise patients in family care. In 1915, the State Board discontinued its own selection and placement, transferring many to the supervision of the various state hospitals. In 1933, the Department of Mental Diseases transferred all remaining cases to the state hospitals for supervision as well as selection and investigation of the family care homes. Beginning with five patients in 1885, the peak load occurred in 1940, at which time there were 411 patients in family care in Massachusetts. Due to the war and other factors this number decreased to 197 patients in
family care as of March 1, 1950.²

There are three different types of family care at the present time. The Belgian, or concentration type, brings the patients together as a colony in a smaller district. The Scottish, or dispersion type, scatters the patients in small groups over a wide area without any connection with a hospital. The German, or adnex type, is an extension into the community of the hospital.³ The adnex type is characteristic of the family care program at the Boston State Hospital.

Development at the Boston State Hospital

Development of the boarding out plan at the Boston State Hospital began in 1922 at an occupational therapy center at Hopkinton, Massachusetts. The purpose of this center was to give convalescent care and therapeutic treatment to mental patients. This program was under the Department of Mental Diseases. It was for women patients who were not well enough to go home but were well enough to leave the hospital under special care. It gave them an opportunity to make a gradual adjustment from institutional life to life in the community.

² Personal communication with Dr. Robert H. Hamlin, Staff Consultant for the Massachusetts Special Commission on the Structure of the State Government (Baby Hoover Commission).

These patients also had an opportunity to look for work. It was considered an intermediary step and not a final haven for chronic or inferior patients. The number varied from time to time between seven and eleven. The age range of the patients was from seven to seventy years.4

All the state hospitals in Massachusetts were free to use this center although the Boston State Hospital was to supervise the program. This was regarded as a boarding out plan. The center was for those who were really too well to remain in the hospital and yet were not sufficiently recovered to take the complete step from the hospital into the community without something in between.

There was a competent, trained occupational therapist hired to prescribe and supervise the patients' work. Some retraining in household tasks was prescribed for the patients who would eventually return to their own homes and those who looked forward to a post discharge period of self-supporting employment in the line of housework or restaurant work. Most of the work given to the patients was sewing, knitting, or crocheting. The finished articles produced by the patients were sold by private sales. The purpose of

4 Boston State Hospital Social Service Department, Report on the Occupational Therapy Center at Hopkinton, Massachusetts, 1929 (Typewritten; unpublished).
selling the articles was not for profit, but to pay the patients a fair amount for their work and to give them the feeling that what they could produce had a market value. The money realized from the sales was added to a special fund which went to the purchase of raw materials for future work. A certain amount of the proceeds of the sales was paid to the patients according to the work accomplished, thus giving them spending money for small personal needs.

On August 1, 1930, the occupational center moved to City Mills from Hopkinton, Massachusetts. The center was still under the same caretaker. The establishment of City Mills as a boarding home in which certain patients were placed under the status of family care as provided for by the Department of Mental Diseases was merely a change of residence from Hopkinton to City Mills. The board was paid from the boarding out allowance of the hospital.

The food, house, and other details of board and room were arranged by the caretaker, a pleasant woman of about sixty. The only financial transaction directly entered into by the State was the payment of $12.00 a week for the board of each patient. This was in 1937. From this money the occupational therapy worker was also paid.

This home at City Mills was under the supervision of the Head Social Worker at the Boston State Hospital. Her interest in family care was intense and a great deal of her
time was devoted to this work. Many of the suggestions have been used and the present program of the Boston State Hospital owes a great deal to this social worker who experimented with such a system. This has been beneficial to the patient, the hospital, and the State.

The City Mills project was discontinued in March, 1937, due to the slow movement of patients from the center into the community and the voluntary return of some patients from the community to the center. It was felt that this project was too costly for the State to maintain because of its questionable therapeutic value.
CHAPTER III

CONSIDERATION OF SPECIFIC ASPECTS OF THE FAMILY CARE PROGRAM

Definition and Purpose of Family Care

Family care consists of placing and supervising in selected homes (other than the patient’s home), mental patients who have reached a convalescent state and who no longer require full hospital care.

Family care offers a chance to make a limited social adjustment in uncomplicated surroundings for the patient who can benefit from such a placement. The family care home furnishes a sort of transitional socializational experience following improvement under hospital care and treatment. The fact that the patients placed in suitable families resume a measure of community life in a natural environment which makes possible more freedom than could be obtained in a hospital setting, renders the family an important adjuvant in the hospital’s treatment program.

Criteria for Selection of Patients and Contraindications

Patients are selected for family care in the process of providing the best form of care to meet their needs. The members of the psychiatric team recognize family care as a
tool of therapy. The psychiatrist who heads the team, is usually the one who recognizes the patient's need to leave the hospital; but he knows that to insure the best possible adjustment the patient needs an understanding home and a more or less protective environment.

Family care has been found desirable for the following cases:

The patient who is somewhat improved and has only slight symptoms.

The patient who is improved and has stationary symptoms, such as might be found among schizophrenics, and who will become institutionalized if confined too long.

The patient who is improved but a poor or inadequate home situation or no home at all.

The patient whose paranoid trends would make adjustment difficult among former friends.

The patient whose dissatisfaction with hospital treatment may diminish with family care.

The patient with senile or degenerative changes which may improve with individual attention.1

Many of the patients placed in family care are elderly patients, who, in most instances, have been residents of the hospital for many years. These are called custodial placements, and the aim of the change is not speedy recovery

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to fit them for life in the community but rather long term placement in a family setting outside the confines of the hospital. In recent years, however, therapeutic placements have been attempted for younger, more acute cases, who in general, have shorter periods of hospitalization and are being rehabilitated to return to life in the community.

It must be remembered, however, that not all families, or even all patients, agree to a family care placement. Many families fail to see the part that relationships in the home have played in the development of the patient's illness. They may be fearful that a foster family may succeed where they failed. On the other hand, some patients cannot gain enough insight into their illness to see the value of a trial placement in a foster home before the return to their own families. While many psychiatric social workers see the value of a foster home placement as a stepping stone between the hospital and the home the patient came from, the attitude of patients and their families often preclude the possibilities of such a pre-parole placement. As a result, the foster home placement has been used almost exclusively for patients who have no families and for patients whose families cannot, or will not, assume the responsibility for their care in their own homes.

Patients who have been in the hospital for a number of years seem to have a more difficult problem of adjustment
when placed in the community. Much of this stems from the so-called institutionalization of such patients—i.e., they live a very dependent life within the confines of the hospital, and when they find it necessary to make the change, they become filled with ambivalence. To become once again a part of the community has a strong attraction to the patient, but the protective atmosphere in the hospital cannot be put aside so easily. The individual patient is torn between the known and the unknown. The patient has a place to sleep, three meals a day, and the doctors, nurses, and attendants to care for him. The patient is apt to develop a spirit of dependency and become quite inactive. To become a part of the community again becomes a traumatic experience for the patient.

Prolonged hospitalization is not, of itself, a contradiction to successful placement, yet it has been shown that it often has a profound deleterious psychological effect on patients. It deprives the patients of their liberty; and becoming accustomed to having everything performed for them they become helpless and timid, lose initiative and interest in helping themselves and become passively irresponsible and dependent on others. The minds of patients who are on the road to recovery should be constantly oriented toward the advent of discharge to community life and they should be encouraged to assume responsibility for self-direction.
In placing patients in family care the important factor is the selection of the home and caretaker for the particular patient. The diagnosis is not as important as the personality and ability of the patient to adjust to an environmental situation. (See table on following page which is indicative of the range of diagnoses of patients in family care.)

Among the patients who should not be placed in family care are those who are bedridden, in need of constant medication or nursing care; patients who are disturbed, suicidal, violent or destructive; patients who are quarrelsome, contentious, or have pronounced delusions of persecution; patients with sex problems; patients who have severe convulsions; patients with infectious or contagious diseases; patients who are undergoing special medical or psychiatric treatments which would necessitate frequent trips back to the hospital.

Legal Requirements - Rules and Regulations

The term "family care" as used in the Massachusetts State Hospital implies the following provisions:

1. With the exception of the non-psychotic mental defective no patient is placed in a boarding home without having been first committed to the hospital responsible for his placement.

2. The boarding home is found and supervised by the social service department of the hospital.
<table>
<thead>
<tr>
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<tr>
<td>Paranoid</td>
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</tr>
<tr>
<td><strong>TOTAL</strong></td>
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3. The patient is retained as an active case, and is visited at stated intervals by a member of the medical staff as well as by the social worker.

4. No patient may be boarded with his own family at state expense.

5. The statutes of the State of Massachusetts provide for the payment of $14.00 a week for the patient placed in family care. The relatives of the patient, however, may prefer to assume the obligation of board expense privately. This is permitted if acceptable to the hospital, but the patient so placed continues under the supervision of the hospital just as all the others do.\(^2\)

The following rules and regulations are the legal standards for family care:

**Item 1 – General**

a. Subject to the sections of the law cited above, a patient may be placed at board in a private family. This is known as "Family Care" and commitment papers remain in force irrespective of time elapsed.

b. A person who is dangerous, or who is addicted to the intemperate use of narcotics or stimulants shall not be placed in family care.

c. Not more than a total of six patients may be placed in a single home. In the case of state schools for feeble-minded, the number may be increased to ten with the written approval of the Department.

d. The provisions of all regulations relating to patients actually in residence in the institution also govern patients in family care where applicable.

e. Only patients of the same sex shall be placed in a single home except with the approval of

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the Department.

Item 2 - Selection and Approval of the Home

a. A patient shall not be placed in family care in a home licensed by another department except by permission of the licensing agency.

b. Before acceptance of family care placement of patients, each home shall be investigated by a representative of the hospital and be approved by the superintendent.

Item 3 - Medical and General Care

a. So long as a patient remains in family care, the institution is responsible for supervision of all conditions of care.

b. A family care patient shall be visited by a representative of the institution at least four times yearly. He shall receive a mental and physical examination at least once yearly.

c. An attempt shall be made to provide a home-like atmosphere and reasonable opportunity for agreeable occupation and recreation.

d. A patient shall not be allowed to live above the second floor in a home except with written approval of the Department.

e. Each patient shall be furnished a single bed in sleeping quarters which are well ventilated and not crowded.

f. A patient shall not be left unsupervised for an undue period of time and shall not be restrained or locked in.

g. A patient shall be placed only in a building in which some member of the family actually resides.

h. Necessary clothing, medical and dental treatment and supplies may be furnished by the institution.
i. The caretaker shall immediately notify the hospital of any important developments of which the superintendent should have knowledge, such as illness or injury of the patient, escape, death, or exaggeration of mental symptoms, etc.

Item 4 - Fire Protection

a. Each family care home shall conform to standards of fire protection as established by the Department of Public Safety and shall be subject to inspection by representatives of the Department.

b. If all patients have their living and sleeping quarters on the first floor, adequate exits to the outside, at least two in number, shall be provided.

c. If two or more patients live or sleep on the second floor, at least two adequate exits to ground shall be provided, so spaced that a patient cannot be trapped by fire wherever located.

d. Means of fighting fire in the home shall include access to water in reasonable quantity and extinguishers of approved type.

e. Accumulation of inflammable material shall not be allowed.

Item 5 - Payment for Care

a. Not more than $14.00 per week may be paid for the board of state supported patients unless the maximum amount is subsequently changed by law.

b. Remuneration for privately supported patients is not subject to limitation and should be paid directly to the caretaker by the person representing the patient.

c. Bills for the payment of state supported patients will be scheduled for payment by the institution
at the end of each month.3

**The Role of the Social Worker and Procedure in the Placement of Patients**

At the Boston State Hospital, patients ready for family care are usually referred to the social workers in charge of this service by the psychiatrist. Also the social worker may suggest an individual for family care placement if the worker feels that this particular patient would benefit from such a program. Once a patient has been recommended for family care, and no other exit from the hospital is seen advisable, the individual patient is considered in detail. If approved, placement is broached to the patient and her family, if any; and when a vacancy exists in a suitable home, definite arrangements are made.

If the patient approaches the social worker or doctor and requests placement in family care, she usually has had a friend who has had a placement experience in a family care home and has recommended this as a desirable way to leave the hospital. In such instances, a brief explanation of family care is usually enough. However, sometimes it is necessary to clear up a few erroneous impressions and

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3 Handbook of the Massachusetts Department of Mental Health, Family Care with reference to General Laws 123, 16, 16A, 17, 18, and 31, p. 127, Regulation Number 11.
confusions, such as "one gets paid wages as well as having room and board", or "if you board out for a few months then you can get yourself a job anytime you want to and go where you want". The patient must realize that she must make no changes without the approval of the hospital staff through the social worker.

If, on the other hand, the patient has been recommended by some staff member, it is almost always wise for the social worker to explain family care in detail to her before she is considered for placement. Patients who have been in the hospital for a number of years often have a fear of leaving its security and if asked suddenly, "Would you like to go out to family care", will answer immediately, "I'd rather stay here". If, on the other hand, the patient has been told by the social worker of one of her former ward mates who is happy in a family where she is able to go to the library or store a few blocks away, her interest may be aroused and she, too, may wish to try living in a home away from the hospital. If there is a definite home available at the time the patient is being interviewed, its special attributes can be stressed, such as the location, recreational or community opportunities, some member of the family with whom she can share an interest or hobby.

There are many ways of introducing family care to the patients, and they may be chosen according to the
individual. One patient may be interested in what she herself will gain, and another in what she can contribute. There are those who hesitate to leave the hospital and live with relatives who may be interested in placement in a family care home in order to make a gradual community adjustment. The chance to prove to herself and her family that she is now able to live outside the hospital will appeal to her. If a patient hesitates to consider family care placement, she may be invited to visit one of her friends in a family care home. Often seeing such a home and the contentment of patients there would make her anxious to have the same experience herself. Some patients may accept a "two week trial" when in doubt. The assurance that if at the end of that time she is not happy she may return to the hospital, may persuade her to agree to leave the hospital.

While there has been no regulation outlined by the Department of Mental Health regarding this matter, it has been the policy to ask the guardian or nearest relative to state approval of the patient's placement in family care. Some hospitals state in the letter which accompanies the blank for such a signature that permission from the relatives is not necessary but is being asked for as a matter of courtesy. In this latter is also included a brief explanation of family care status and the assurance that should any relative wish at a later date to apply for the patient
to make either a brief or indefinite visit to their home, the staff would be glad to give such a request consideration.

Those who have placed patients in family care homes or found employment for them know how often the patient and the home do not match or are not available at the same time. Many questions arise concerning the order of procedure. Should we have the boarding place available and then find a patient to fit? Or, should the patient be approved for placement and placed on a waiting list pending approval of a new home or a vacancy in an old one? Both methods have been used and have proven successful.

Both the stipulations made by the caretaker concerning preferences of age, religion, and "problems", and those drawn up by the staff concerning the type of home in which the individual patient should be placed, must first be kept in mind. Some caretakers are willing to have patients of any faith. Some patients are also willing to be in homes of any faith. However, if the patient wishes to attend her own church and is well enough to do so, she should be placed in a home within walking distance, or with a family who is willing to give her transportation.

If the patient is being placed with the hope that this will prove a stepping stone from the hospital to her own home, then the caretaker and her family should realize that this is to be a temporary placement. The caretakers
understanding and help in gradually including her in more home and community activities and encouraging her to take more responsibilities and make more decisions, will do much in helping with her rehabilitation. This is also true of a patient who hopes to go into a self-supporting status. This type of placement should be in easy reach of community advantages and activities.

On the other hand, the custodial patient who will have little interest in activities outside the family circle and immediate neighborhood can often be placed in a more rural or isolated home.

After a patient has been approved for family care and has been matched to a home, the date of placement is decided upon. Then there are several steps for arrangement of placement which must be taken into consideration. First the caretaker is contacted to be sure that it will be a convenient time for her to accept the patient. Then the ward doctor and supervisor are notified so that the physical and mental examinations may be made within the twenty-four hours required before the patient's release. The clothing supervisor is told in time to have the necessary supplies ready. The garage is notified so that a car is available. The social worker drives, a nurse or attendant accompanies the patient. It is the general policy for the social worker to have some other employee accompany him and not be alone with
the patient in case of accident or emergency. If any medi­
cation has been recommended by the ward doctor, prescriptions
are obtained so that supplies may be obtained ahead of time
from the pharmacy.

On the day the patient is placed, the treasurer's
office is given the name of the patient, caretaker and ad­
dress, so that bills may be made out by the office.

Patients in family care must, by law, be seen once
a year for a mental and physical examination by a physician
from the institution. In some institutions they are seen
twice a year. These examinations preferably take place at
the family care home. Chief among the reasons for this
course of action is the fact that patients often do not quite
understand the need for a mental or physical checkup when
they feel well and are apt to fear, if they are brought back
to the hospital for the examination, that they are really
being returned from family care. This causes unnecessary
anxiety, which can be avoided by examining the patients in
the homes. Patients are also seen by hospital physicians
when and as illnesses or injuries require their services. In
case of emergency, the caretaker may call a doctor in the
community to attend the patient. This doctor then bills the
state institution for his services to the patient. The
regularity with which family care patients are brought in to
the dentist varies with the institution involved. In some
instances patients are brought in routinely twice a year, while others are seen as the emergency arises or as recommended by the physician when he does the annual physical examination.

Also available to these patients are the services of the personal hygienist, chiropodist, physiotherapist, and laboratory technician; these specialists see the patients if and when advisable, either in the family care home or at the state institution.

Some of the most intensive supervision of the family care program is supplied by Social Service. A social worker is required by law to visit each home once every three months. Many homes are visited regularly once a month, and frequently workers go to homes even more often. Newly placed patients are sometimes telephoned the day after placement and are often seen once a week at first. Frequent contacts between caretakers, patients, and the social worker tend to create a better working relationship and make it possible to iron out small difficulties before they have a chance to become big problems.

Not only is the social worker responsible for seeing that the patient receives the services of the personal hygienist, chiropodist, etc. as needed, but he is also responsible for doing all in his power to rehabilitate the patient and expedite the latter's return to normal mental health. To
this end the social worker not only uses his own skills in helping the patient to solve her problem but also employs all the therapeutic aids the hospital and community afford. Occupational therapy projects are promoted. Some social workers regularly convey handwork of all sorts from the occupational therapy department to the family care home, supplying as nearly as possible requests of the patients for specific types of knitting, embroidery, etc.

**The Social Worker as a Home Finder**

The social worker has the task of finding new family care homes in the community, studying these homes, visiting the patients placed there, and interpreting to the patients what family care is and what it is for.

New homes are promoted to a great extent by the success of the existing ones. The caretakers who board out patients stimulate, by their satisfactions with their work others who could take on a like responsibility.

The suitability of a home is dependent upon the caretaker who must be a well-adjusted person, who has much tolerance of the patient's vagaries. The home must give to the patient an opportunity to find in a wholesome family life an opportunity for more rapid recovery and more lasting emotional satisfaction than she has before known, so that her adjustment to the world of reality is a real one.
The motive for applying to the hospital to board patients is carefully investigated because the patients must not be exploited. The physical, social, and moral aspects of the home are considered as to how they meet the community standards. All possible precautions are taken to insure good care of the patients placed in family care homes.

Some caretakers find "problems" challenging, and prefer to have patients who, they feel, need special attention. Others wish only to have someone who can "become a member of the family and will enjoy being in a home". Some caretakers and their families enjoy being a family substitute for a patient who has no family of her own, and will do all in their power to give her a happy home.

Since family care is, in a sense, a unit of the institution employing it, the family caretaker's obligations for the care and supervision of the patient are the same as those of the institution. A list is given to caretakers who apply to board patients at the Boston State Hospital and each item is carefully explained by the social worker who does the home study. The list gives a clear idea of what is expected of the caretakers and what their attitude toward the patient should be. Briefly the caretaker, in addition to providing the patient with nourishing food, comfortable quarters and clean clothing, is responsible for constant supervision of the patient.
The Boston State Hospital recently conducted advertising campaigns in soliciting new homes by placing advertisements in the local papers. The response to these advertisements has been fair, but only a few of the applicants could be selected.

Ads were placed in thirteen newspapers, most of which had a relatively small distribution. The cost of these ads was approximately $46.00.

Twenty replies were received that were worthy of investigation. All twenty homes were investigated and eight were found acceptable and were opened as family care homes. These homes were able to take a total of twenty-one patients.

Out of the twenty applications only one was for male patients. Six men were placed at this home.

**Breakdown of Placements:**

- 4 of the new homes took one patient...
- 12 of the new homes took six patients...
- 3 of the new homes took three patients...
- 2 of the new homes took two patients...

21

The other twelve homes were not used for various reasons as follows:

- Four homes changed their minds after sending in the original application.
Two homes could not provide satisfactory references.

Four homes could not meet the requirements of state laws as to number of exits, sleeping above second floor, etc.

One home set such rigid requirements for the type of patients it wanted, that the worker was unable to comply—i.e., four Catholic girls between the ages of 20-24 who were so well behaved that they would have to be too normal to meet the homes requirements.

In one home the prospective family care mother was very neurotic and wanted a patient to care for her children while she worked nights.

**Reasons for Closing a Family Care Home**

Occasionally it becomes necessary to close a family care home. Such action may be at the request of the caretaker or the institution. A caretaker may move, wish to retire or seek gainful employment outside her home; she may find the income derived from the program inadequate for her needs, the work too confining, discover that her family is uncooperative, or have to give up because of health or for a myriad of other reasons. An institution may decide to close a home for any one or a combination of the following reasons:
The home may prove too inaccessible in some seasons of the year or too remotely located or physically unsatisfactory as a result of temporary or permanent changes (such as fires, floods, relatives of the caretaker moving in, etc.).

The caretaker may consistently refuse to meet her supervisory responsibilities, such as making sure that some adult is always present in the home, that food and clean clothing are adequate, that essential facts are reported, etc.

The caretaker may die or become too infirm, or the home atmosphere may become unsatisfactory.

In short, an institution may close a home for any reason or reasons which threaten the patients' mental and physical well-being.

When a home is closed, the patients involved should understand the action is not the result of anything they have done. As many as desire a continued family care life should be matched to new homes and transferred thence as soon as possible.

Value of Family Care

Over sixty years of family care experience in Massachusetts has proven the value of the program. It benefits the patient, the caretaker, the community, the mental
hospital, the state, and the psychiatric social service department.

To the partially recovered mental patient who has no home or family to which to return, family care is the natural bridge to discharge and self-sufficient community life. The family atmosphere, besides offering more freedom than the hospital, can in most cases, help to restore the patient to normal living better than the impersonal treatment so often prevailing in an institution with several thousand patients. It also saves the patient from the mental damage of prolonged institutionalization.4

If the home has suitable occupational therapy, it enables the patient to salvage her former work skills and if necessary to develop new ones by which she can eventually become financially independent. A period of foster care would prove beneficial to many patients who plan to return eventually to their own homes. It would preclude the necessity of their return immediately upon their release from the hospital to the situation which precipitated their illness. In the security of the knowledge that they were able to adjust successfully in one family situation, they

4 Stollfus, Grant, "Foster Home Care for the Mentally Ill," New Views, (National Mental Health Foundation), Series 2, No. 1, July, 1945, pp. 1-2.
would be better able to handle the difficulties of their own home situation. Also, a family that might hesitate because of fear to take the patient directly from the hospital would undoubtedly feel less compunction after the patient has adjusted satisfactorily in a family setting.

Family care offers many real benefits to the caretaker. It gives her a dependent person whom she can mother. The patient is a real outlet for the expression of maternal feelings and often takes the place of the foster mother's own children who have grown to adulthood. The patient also provides the caretaker with adult companionship. Care of the patient is a type of home employment for which monetary compensation is received. The income, although meager, is certain and dependable; and it is in cash which is often scarce. On farms and in homes where some produce is sent to market the patient provides a home market and thus saves the costs of selling the produce in open market. To the family that has extra living quarters, boarding a mental patient is the answer to converting these facilities into cash. If additional help is needed in the home or on the farm, a work placement will probably meet the need.

5 Pollock, Horatio M., "Family Care of Mental Patients", Utica, New York, State Hospital Press, p. 48, 1936.
People have always looked with fear and trepidation at "insane" persons, spoken of them in hushed, swed tones, and conscientiously avoided association with them. All too often former mental patients find the attitude and ignorance of the community a serious handicap in their social and occupation adjustment. Gradually, through public education, people are coming to realize that a discharged mental patient is not as apt to be dangerous as an undiagnosed and untreated case. The fear is slowly being overcome by understanding of mental illness and of the place a recovered or partially recovered mental patient may hold in the community.

The advantages of family care are myriad and accrue to the patients, the caretakers, the hospital, and the community. The following fifteen points are illustrations of these advantages:

1. Foster-family care is the most natural and the freest form of the placing of mental patients.

2. Foster-family care saves the patient from the mental damage done by prolonged institutionalization.

3. Foster-family care results in a quicker social readjustment of patients.

4. Foster-family care is for many patients a successful form of treatment.

5. Foster-family care guarantees individual psychotherapeutic treatment because it is obliged to individualize; institutional treatment is preponderantly mass therapy.

6. Foster-family care makes it much easier to
give the patient change of environment and home conditions.

7. Many patients receive great psychotherapeutic benefits from being surrounded by persons of a different sex, by children and by animal pets.

8. Foster-family care offers the patient numerous occupational possibilities, unequalled in naturalness and therapeutic value.

9. Foster-family care is the natural bridge to parole and discharge.

10. Foster-family care is an indispensable means for unhampered "early discharge" and for parole. All patients who for some reason cannot be placed in their own families should be put in foster families.

11. Foster-family care is the natural bending link between institution and parole, each facilitating the other establishment and development.

12. Foster-family care is the cheapest treatment in the world. Every boarding patient makes the providing of a bed in the institution unnecessary. Also the numbers of nurses needed can be reduced.

13. Foster-family care is an excellent means of popularizing psychiatric endeavors and of propagating mental hygiene knowledge.

14. Foster-family care of all three types can be introduced in all countries. It is also possible to have it in large cities.

15. Foster-family care is applicable for almost all types of patients.

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CHAPTER IV

CASE HISTORIES

In this chapter two cases are presented in detail to illustrate the two types of family care placements. The first case is representative of a therapeutic placement—i.e., the patient was able to resume her place in the community. The second case is a chronic patient who requires little supervision and who can live in a controlled community. This patient is representative of a custodial placement.

Case I

The patient, a young woman of thirty-five was admitted to Boston State Hospital in 1949 in a highly nervous state. No evidence of delusions or hallucinations were evident, although patient was over-excited, over-talkative, and over-active. Her diagnosis was Manic depressive, Manic type.

Her family background revealed that she was the third child of four children. The other three children had met with untimely deaths while still children and the patient was the only child who had lived. Her home life was an unhappy one because her father and mother were constantly fighting with each other. The mother disliked the patient and blamed her for starting arguments between the mother and father, although the patient was actually torn with conflict because of her parent's difficulties. The patient's childhood was a very unhappy one and she never knew a "normal" home life.
Educational Background

Patient received a good education, graduating from college at the age of 22. Patient lived at home while attending college.

Work History

After graduation the patient went right to work for a business concern and worked for them for fourteen years as an office worker. She was working for this concern at the time of her breakdown.

Shortly after she started working, patient left home and lived with a girlfriend in an apartment. This life was an unhappy one also as the girlfriend was too bossy (similar to her mother).

Sex Life

Patient while living with this girlfriend had several affairs with various men and at the age of 27 she contracted syphilis. This experience caused her to refrain from further sexual contact.

The patient received a series of shock treatments while at the hospital which improved her condition a great deal. At this time the patient did not wish to return to her former work and expressed fear about returning to work at any job. At a staff conference it was felt that it would not be good for the patient to live with her mother. The doctor suggested that the patient be tried in family care to see if a more normal home would help to rebuild her confidence. The case was then referred to Social Service.

The social worker saw the patient several times before the patient was willing to try a home in a rural area.
The placement was made in the spring of 1950.

At the family care home the patient's progress was at first quite slow, but the strong, sincere interest of the family care mother finally rebuilt the patient's confidence. The patient was also visited constantly by the hospital social worker who helped the family care mother understand the nature of the patient's illness so that the family care mother's work could be more effective. After a period of months at the family care home the patient began to make contacts in the community. The patient had been in the family care home one year when she was successful in finding work at a large nursing home as an attendant to the nursing home patients. At the present time she is working at this home and is adjusting very well. She writes consistently to the family care mother and visits whenever she has a chance. Her relations with her own mother are still strained and they do not go near one another, but the patient is able to get a great deal of feeling from her foster mother which will help assure her continued adjustment.

Case II

The patient, an elderly woman of fifty-nine years, was admitted to the Boston State Hospital in a confused and disoriented condition. She had delusional fears that policemen were after her and that she would be electrocuted. Her diagnosis was Schizophrenia, paranoid type.
Her family background revealed that she was an only child. Little is known about her early life or childhood. When she was sixteen years of age her mother was committed to the Danvers State Hospital where she died some years later. The patient did not get along well with her father and got married at the age of twenty as a means of leaving home.

Her married life was considered reasonably happy. There were no children and the patient got along well with her husband until he became ill with pneumonia in the spring of 1950. Shortly after her husband became ill, the patient became depressed and worried. These symptoms enlarged into the delusional fears explained above and led to her commitment to this hospital. Shortly after she was committed here the patient's husband died.

Work History

No work history is known other than that of housewife.

Educational Background

As far as is known, the patient only went through grammar school.

Sex Life

No information available.

After her admission to the hospital, the patient was given a series of shock treatments which caused her delusions to disappear. The patient, however, was fearful about returning to the community and to help restore her confidence she was started on industrial therapy in the sewing room of the hospital.
She remained at this work for approximately one year before she was finally staffed. This resulted in her being referred to social service for possible family care placement, in an effort to help her get back into the community.

The social worker talked with the patient about her feelings toward returning to the community and the patient expressed great fear about leaving the hospital and having to make her own way on the outside. She had never worked at any job other than housework and felt that she was much too old to start learning a job now. The only relation the patient had was an aunt who steadfastly refused to take the patient into her home.

The social worker then talked the situation over with the doctor who suggested that the patient be placed in a family care home until she reached the age of sixty-five when she could be placed on old age assistance. This plan was then discussed with the patient, who after learning that there would be no pressure in family care, said she would be willing to try it.

Several months ago the patient was placed in a family care home in a rural setting. At the present time the patient is adjusting extremely well. The family care mother likes the patient very much and the patient is well pleased in her new home. The patient now feels that when she
reaches the eligible age for old age assistance she would like to stay in her present setting. If things go along as they are now, that is the arrangement that will eventually be made.
CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

This study of the family care program at Boston State Hospital was undertaken to answer the following questions:

1. How do mental patients benefit from placement in private homes?

2. What type of patients are chosen for family care placement?

3. What are the advantages to the hospital in placing patients in family care?

4. How do social workers participate in the hospital family care program?

The investigation was carried out by studying the records of family care patients, and family care homes in order to answer the questions asked above.

A descriptive study of family care in general and family care as practiced at the Boston State Hospital was given as background information on family care, and also to
show the administrative role of the social worker in a family care program.

A case study of two types of family care placement used at Boston State Hospital was also shown:

1. Therapeutic
2. Custodial

Conclusions

1. How do mental patients benefit from placement in private homes?
   a. The case studies reveal that family care provides mental patients with the opportunity to live in a family setting and to provide them with a normal mother and father figure, some for the first time.
   b. The family care setting enables a patient to rebuild lost confidence and helps to prepare some of them to return to the community in a self-supporting role.
   c. Family care removes the patient from the hospital which is a great aid in keeping patients from becoming institutionalized.
   d. Family care allows mental patients to live in a family setting when their own homes would be detrimental to their recovery.
2. What type of patients are chosen for family care placement?

As has been indicated by the table on Medical Diagnoses of the Patients in Family Care, no patient is barred from family care because of the peculiar nature of his or her mental illness. This table shows that patients with almost all known types of mental illness have been placed in family care.

3. What are the advantages to the hospital in placing patients in family care?

a. Family care means substantial financial savings for the state. Under the recently increased rates, the state pays $14.00 per week, or $728.00 per year for the board of each patient. Added to this is the cost of clothing, medication and social work supervision. One social worker can supervise approximately fifty patients. The average total cost might run as high as $850.00 per year, while the maintenance cost per patient in a hospital averages about $1,000.00 per year. In addition, the capital outlay involved in housing these patients is avoided and a substantial contribution may be made toward reducing the serious overcrowding which exists in most of the hospitals. Further, for every four patients who recover enough to become self-supporting,
the entire cost of a social worker's salary ($3600-$4200) is saved.

b. Overcrowded state hospitals cannot give all their patients individual attention. Family care provides a means whereby the patients so placed can receive the extra attention that often means the difference between continued hospitalization and a return to a self-supporting life in the community.

c. Family care homes in the community offer the hospital an excellent chance for interpreting mental illness to the community. This in turn helps to relieve the stigma and shame attached to mental illness and makes the patient's eventual adjustment in the community much easier.

4. How do social workers participate in the hospital family care program?

Family care from its very inception in this country has almost always been supervised primarily by social workers. Social workers at the Boston State Hospital have the job of finding the family care homes, investigating them and supervising the patients after they are placed in family care.

In many cases the original referrals are made by the doctor to place certain patients in homes, but after the referral is made, it is the function of the social worker to
effect the placement. This involves preparing a patient to leave the hospital sometimes after the patient has been there for several years and is very reluctant to leave. The social worker in many instances has to stimulate the patient's interest and acceptance of the home, and in other instances to bring about a positive attitude for the home by the patient's relatives. There are many instances in which the worker has to explain tactfully to relatives that the patient's former home situation is not beneficial for him and that he will be better aided by a family care placement.

In many instances the community objects to the placement of mental patients in their midst, and it is then up to the social worker to clarify the nature of mental illness to the community and promote an attitude of helping mental patients toward recovery.

After the patients are placed in the community, it is oftentimes the worker's function to find work placements for patients who are ready to try employment again.

As mentioned previously, the family care program at Boston State Hospital is being expanded and is having its growing pains. This expansion will probably continue until approximately 75 to 100 patients are out in family care. This expansion program will provide a fertile area for some future study in answer to questions such as:

1. Whether or not patients are returned to
self-sufficient community living more quickly from rural or urban areas.

2. Whether greater emphasis should be placed on custodial placements or therapeutic placements.

Answers to questions such as these would provide great help to family care workers of the future.

Approved:

Richard K. Conant
Dean
Appendix I

Tables

Instructions to caretakers

Questionnaire to be filled out by boarding home applicants
# TABLE I

AGES OF PATIENTS IN FAMILY CARE AS OF MARCH, 1952

<table>
<thead>
<tr>
<th>Ages</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 24 years</td>
<td>2</td>
</tr>
<tr>
<td>25 - 29</td>
<td>1</td>
</tr>
<tr>
<td>30 - 34</td>
<td>3</td>
</tr>
<tr>
<td>35 - 39</td>
<td>3</td>
</tr>
<tr>
<td>40 - 44</td>
<td>1</td>
</tr>
<tr>
<td>45 - 49</td>
<td>2</td>
</tr>
<tr>
<td>50 - 54</td>
<td>8</td>
</tr>
<tr>
<td>55 - 59</td>
<td>5</td>
</tr>
<tr>
<td>60 - 64</td>
<td>9</td>
</tr>
<tr>
<td>65 - 69</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

Median Age: 54 years

Sex Distribution:
- Female: 30
- Male: 6
### TABLE II

**Duration of Hospitalization Before Date of Family Care Placement**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
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</tr>
<tr>
<td>1 - 2 years</td>
<td>5</td>
</tr>
<tr>
<td>3 - 4 years</td>
<td>5</td>
</tr>
<tr>
<td>5 - 9 years</td>
<td>10</td>
</tr>
<tr>
<td>10 - 14 years</td>
<td>5</td>
</tr>
<tr>
<td>15 - 19 years</td>
<td>3</td>
</tr>
<tr>
<td>20 - 29 years</td>
<td>4</td>
</tr>
<tr>
<td>30 - 39 years</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>
TABLE III

YEARLY AVERAGE OF PATIENTS IN FAMILY CARE

FOR THE PAST SIX YEARS

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
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<td>10</td>
</tr>
<tr>
<td>1948</td>
<td>13</td>
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</tr>
<tr>
<td>1951</td>
<td>17</td>
</tr>
<tr>
<td>1952</td>
<td>37</td>
</tr>
</tbody>
</table>
INSTRUCTIONS TO CARETAKERS

1. Your patients should be treated as members of your family and made to feel at home so far as possible.

2. Study the dispositions of your patients, but do not discuss or encourage their peculiarities or fancies. Their habits should be observed and any wrong tendencies discouraged.

3. Keep careful oversight of your patients. Some responsible person must always be with them.

4. Never threaten your patients or lock them in their rooms. Every form of punishment is strictly prohibited under all circumstances.

5. Patient's failure to eat enough should be reported at once, unless good reason is obvious. Take notice whether they are gaining or losing weight - see that patient's bowels move daily.

6. More than one patient must never be allowed to sleep in one bed, nor should sleeping rooms be above the second floor unless special permission be obtained.

7. Patients should be encouraged to do suitable work, according to their strength, but never beyond it. Light out-door occupation such as gardening, caring for hens, and so forth, is suitable for women patients.

8. All clothing must be kept clean and in good repair and subject to the inspection of the visitor. When patients are removed, all clothing belonging to them must be taken with them.

9. Patients should have a thorough bath at least once each week.

10. For State Boarding Patients. Payments for board are made monthly as soon after the first of the month as bills can be approved. Bills are made up to the beginning of the month, and not up to the time when you receive payment. Private patients will be paid for according to agreement with relatives.

11. No bills, except in emergencies, should be contracted or expenditures made without authority from the superintendent.

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK
LIBRARY
12. Be self-reliant in dealing with emergencies; act promptly in accordance with your best judgment as you would for yourself, and then report as soon as possible to the hospital. Do not allow a continuance of anything which seems wrong to you without calling it to the attention of the Visitor from the Hospital. Try to foresee difficulties and seek advice beforehand.

13. If a patient is ill, report this at once to the hospital. Ask for a social worker, but if you are unable to get one, explain to the operator that you are one of our caretakers, and ask for the Assistant Superintendent. In case of death, telephone or telegraph to the hospital. In an emergency, call a local physician, and then the hospital.

14. If a patient escaped, search for her. If she cannot be found immediately, notify the local police and the Superintendent.

15. If a patient becomes dangerous or unmanageable, notify the hospital at once. If necessary, in order to care for her safely, call on the local authorities to assist you until the hospital responds.

16. Patients must not visit friends at a distance without permission from the Superintendent. They must not be removed to another house, family, or town without approval from the Superintendent.

17. Visitors of the hospital will expect to see each patient alone, to inspect her room and clothing thoroughly, and to make such other examination as may be necessary. Please do not be sensitive, nor regard this as any reflection on you or your care of the patient. The Visitor is required to do it as a part of her duty in all cases.

18. Record in ink any important information, especially dates of visit of friends or of the patient to friends. Note change of habits, and of mental or physical condition of the patient.

19. We must be kept informed of any additions to the boarding family - i.e., if they take any convalescent cases from other hospitals, especially general hospitals, if they take children to board, etc. It would be better if we knew about these matters before the actual changes took place, as the Department does not generally approve of
mixing mental with other types of patients.

20. These patients will from time to time be seen by a physician from the hospital.
QUESTIONNAIRE TO BE FILLED OUT

BY BOARDING HOME APPLICANTS

and returned to the

SOCIAL SERVICE DEPARTMENT, BOSTON STATE HOSPITAL

Dorchester Center Station, Boston, Mass.

DATE:

Name

Maiden Name

Address

How may we reach you by telephone?

Give full directions for reaching your home, if starting from

Boston by automobile.

By bus

How long have you lived in town?

Do you own your home?

Describe it briefly as to:- number of rooms

heating system modern bath

Is the house private tenement farm

On what floor do you live?

On what floor do you plan to have patients sleep?

How many bedrooms do you have available for patients?
First name and age of each member of your family?
1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  

What is the occupation of each working member of your family?

Are all members of your family in good health? If not, state disability.

Have you at any season of the year hired help? If so, of what age: sex: nationality: character:

Have you at any time of the year boarders? If so, of what age: sex: nationality: character:

Note your preference on the following facts regarding the patients you wish to take:

Number of patients: Sex:
Age: Nationality: Religion:

Have you ever taken patients or children before, and if so, when: from whom: and how long did they stay?

Would payments of patients be your only income?

How much money would you expect for each patient?

What work would be required of a patient?
Do you drive an automobile?  

Own a radio?  

What papers and periodicals do you take?  

Have you any house pets?  

Give name and address of family physician.  

What church do you attend?  

Name and address of your pastor.  

How far is your home from church?  

From school:  

What other social opportunities are available in the community?  

Please give names and addresses of three persons who are not related, who have known you for at least a year, to whom we may write for references.  

1.  

2.  

3.
APPENDIX II

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BIBLIOGRAPHY


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