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Therapeutic emphasis in family care and its effect on the function of the social worker

Stein, Albert Mayor

Boston University

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Boston University
THE THERAPEUTIC EMPHASIS IN FAMILY CARE
AND ITS EFFECT ON
THE FUNCTION OF THE SOCIAL WORKER

A Further Study
Of Family Care And Related Problems Based On Referrals
To The Social Service Department of The Worcester State
Hospital From 1937 To 1939

A Thesis
Submitted by:
Albert Mayor Stein
(B.S. Boston University, 1937)
in partial fulfillment of requirements for
the degree of Master of Science in Social Service
1939
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INTRODUCTION

The following statement about family care was made by Dr. William A. Bryan, Superintendent of the Worcester State Hospital, in his Annual Report for 1936: "The family care program of the hospital has been increased during the year. After considerable experience with a large number of patients in boarding homes, I am more impressed than ever by the possibilities for a continuation and extension of this particular method of handling individual patients." ¹

This optimistic note was echoed through specific action. In 1937 a physician was appointed to devote almost his full time to family care patients. In 1938 a second social worker was added to the family care staff as a step in the attempt to stimulate and extend the growth of the system of family care for convalescing patients under commitment to the Worcester State Hospital.

In view of this expression of confidence in the possibilities of extending this method of care, both through word and action, it has been deemed necessary to study further the actual processes, significant factors and trends which make for the effective operation of this system.

¹. Worcester State Hospital Annual Report, 1936.
INTRODUCTION

The following report on the family care program of the Wawona State Hospital is a continuation of the work of Dr. William H. Young. Subsequent reports to the Governor have been increased from a monthly to a quarterly basis. After considerable experience with a large number of patients in continuing homes, I am more impressed than ever before by the possibilities for a continuation of the family care program. After due consideration of the many factors involved, I recommend to the Governor the establishment of the Wawona State Hospital.

In view of the above, I recommend that the Wawona State Hospital be established as a permanent institution.

I, Wawona State Hospital Annual Report, 1940.
This study will be an attempt to view the facts which need to be considered in the light of the extension of program, and to outline, if possible, more clearly the foci for growth and change indicated by such a program.

The study is based upon an analysis of all referrals and placements made during a two year period together with a discussion of related problems as they presented themselves and were dealt with by the family care social worker and physician. Special emphasis will be placed on an evaluation of the function of the social worker who has guided and supervised the operation of family care for over twenty years.

One hundred and sixty-eight patients were referred for placement at the regular staff conferences between January 1, 1937 and January 1, 1939; of this number there were one hundred and four patients involved in one hundred and ninety-four placements during this period. The records of these referrals and placements were studied and analysed statistically; also each patient was discussed with the referring doctors (if still on the staff) and with the family care social workers. The analysis of the function of the social worker, as viewed by the administrator, staff psychiatrist and social worker, was based on numerous consultations with those in position to offer their particular points of view.
This study will be an attempt to view the facts
which need to be considered in the light of the extension of
program and to outline if possible, more clearly, the need
for family and economic integration of such a program.

The study is based upon an estimate of all the
letters and telegrams which contain a two years planning feature
with a statement of the family program as they present them
- service and are dealt with by the family care social worker,
and of the family. Special emphasis will be placed on an analysis
of the function of the family care social worker and the
- keep.

One hundred and sixty-eight letters were received
for placement of the regular child care placements between June
with 1137 and January I, 1939; of the number there were
one hundred and forty six letters pertaining to the number of
inquiry-look to placement of the child. The letters of
these interviews, any placements were studied and analyzed
- selection. Where each report and group report with the
- relative. (It will be the same, the same with the family
are social worker. The selection of the interview of the
social worker as a basis of the interview will be worked out
with care and social worker must be based on references and
- view.
HISTORY OF FAMILY CARE AT THE WORCESTER STATE HOSPITAL

Just one hundred and five years ago the "Worcester Lunatic Asylum" was opened, the first state institution in Massachusetts for the care of the mentally ill. While the next few decades showed an increase in the number and size of institutions, by the year 1860 it had become evident that a building program large enough to meet the growing need would mean a great burden of taxation. Those interested in the problem began to look about for some other solution, and methods in use in other places were studied. It was discovered that a number of countries had cared for the mentally ill in private homes at a great saving to the state.

Dr. Samuel G. Howe, the first patron of the family care idea in Massachusetts, based his plan for a system of care upon his study of the Scotch and Belgian systems. The study revealed the Belgian system as one characterized by the attempt of a whole community to devote itself to the care and attempted cure of mentally ill patients. In the Gheel colony, there were and still are hamlets where 95 per cent of the homes house at least one patient. When family care was first contemplated in Massachusetts and considered

1. Loeser, Helen; Some Aspects of the Family Care Plan for Mental Patients at the Worcester State Hospital, Simmons College, 1934.
HISTORY OF FAMILY CARE AT THE WESLEYAN UNIVERSITY

STATE HOSPITAL

In the early 1900s, the idea of providing comprehensive care for the mentally ill began to gain traction in mental health institutions. The state hospital at the Wesleyan University was one of the early leaders in this movement. The hospital's goal was to create a nurturing environment where patients could receive the necessary care to improve their mental health. This approach marked a shift away from the traditional asylums, which focused on isolation and physical restraint. The state hospital's approach emphasized personalized care and a holistic approach to treatment. Patients were encouraged to participate in various activities, such as gardening, art, and music, to improve their overall well-being. This innovative approach was a precursor to modern community mental health services, where patients are treated with dignity and respect.
as a solution to the overcrowded condition at Worcester, the Gheel system was not considered adaptable for use. Some of the reasons given are as follows: It was felt that if too large a percentage of the population of any one community were mentally ill much of the value of the family care to the patient would be lost; it was argued that the people of Gheel had become a race of keepers without further interest, and that this led to a diminution of interests on the part of the patients placed with them; it was also stated that in order to avoid the evils of congregation the Gheel system ran into the opposite evil of too much individualism.

The plan favored by Dr. Howe in his report for the Board of Charities in 1867 was one similar to that operating in Scotland. His reasons were based partly on his admiration of the Scotchman's thrift and belief that his methods would net the greatest financial savings, and on the fact that it offered a number of advantages over systems of other countries; since never more than four patients - and usually only one - were placed in a home, and since these homes were scattered over every part of Scotland, the insane never made up too large a part of any one community and they profited by all the advantages of individualization. Patients under this system were given adequate supervision, each patient being visited once per year by a medical man and twice each year by the "social worker" - the overseer of the poor.
The Board of Education in 1953 saw one million of their children in Scotland face years of pure hardship on the waterfront. The Board of Education continued its efforts to meet the needs of these children and continued to advocate for educational advancements.

The Board of Education also took a lead in the community and their efforts to make the area more vibrant and active. They took part in various events and initiatives, always looking to improve the quality of life for all residents.

One of the main achievements of the Board of Education was the construction of new schools and the renovation of old ones. This was a major step forward in ensuring that every child had access to a quality education.

The Board of Education also played a key role in the development of the town, leading the way in the construction of new facilities and the renovation of old ones. They worked tirelessly to ensure that the community was always moving forward, always looking for ways to improve the quality of life for all residents.

One of their most significant achievements was the construction of new schools and the renovation of old ones. This was a major step forward in ensuring that every child had access to a quality education. The Board of Education also played a key role in the development of the town, leading the way in the construction of new facilities and the renovation of old ones. They worked tirelessly to ensure that the community was always moving forward, always looking for ways to improve the quality of life for all residents.
The objections in Massachusetts to a plan of placement in private homes delayed its adoption as law for almost twenty years. Some of the reasons for the objections are listed as follows: the effect on the community was considered, and it was feared that those residing in rural communities with few diversions might take on the peculiarities of the patients they cared for; also the danger of neglect on the part of caretakers was pointed out in connection with the practical consideration that for the mere pittance paid for this care one could only expect to get poor homes with inadequate facilities. Most of the objections came from medical men who were primarily concerned with this problem. For instance, in 1884 Dr. Quinby, Superintendent of the Worcester State Hospital, objected to the plan "because the patients suited for such a plan are the ones whom the hospital could not be spared of, for they contribute largely toward re-imbursing the state for their support by the labor they perform." But by the following year an act of the Massachusetts legislature provided for the boarding out of insane persons in private families by the Board of Health, Lunacy and Charities. During the first twenty years after the law was passed, patients from various hospitals were chosen for family care by a representative of the state

The objective in Massapequa was to plan for
planned home delivery. The support was
for the objective of

Several months hence, the success for the objective mea-

I received a letter from the community service center

which we have tested that those receiving in rural commun-

ities with low friction might take on the responsibility of

the task of service. They cannot take on the burden of

the personnel, coordination for their care, the home delivery

for their care only except to get back home with

immediate facilities. Most of the objective came from

methods were more drastically concerned with site program.

The best approach was to improve the plan as the one

batter the targets. If such a plan were the one where the

let us carry out our share of services coordination terribly to

what is important the area for short support by the local

they benefit. In the following years as one of the

Massapequa Intermediate Hospital for the patients of the

increase persons in practice families of the Board of Health.

1. Annual Report of the Board of Health, Lynbrook and

2. Annual Report of the Board of Health, Lynbrook and

3. Annual Report of the Board of Health, Lynbrook and
department, and were supervised by doctors and visitors—who were usually trained nurses—from the department.

In 1905 individual hospitals obtained the right to place patients in addition to those placed by the department. Worcester proceeded to place patients in 1905 but no real interest was shown in the project until 1915; there is no record of the number and nature of the placements during this ten year period. In 1915 the first social worker was appointed to deal specifically with the family care placements in addition to her other duties. During this year sixty-four patients of whom forty-seven were still out at the end of the year were placed in family care.¹ Gradually this number declined until in 1921 only eleven were placed and the total remaining in family care at the end of the year was twenty-two. From then on up to 1931 there were less than ten placements each year and the average number of patients in family care at one time, between 1921 and 1931, was fifteen.² The explanation of this decline in interest may partially be traced through the various economic fluctuations which greatly determined the availability of family care homes. During the World War period up to 1921 the increased prices in view of the stationary low rate of board made it impossible to

In 1985, the Commission on Human Rights, an independent body established by the United Nations General Assembly, published a report titled "The Role of the Commissioner on Human Rights: 1956-1985." This report highlighted the Commissioner's efforts in promoting human rights and the challenges faced during that period. The report emphasized the importance of international cooperation in addressing human rights issues and underscored the need for continued vigilance and action to protect human rights globally.
take patients. Another reason for the decline may be traced to the fact "that with the coming of the social worker the doctors who had been supervising the cases began to lose active interest. New doctors who came to the hospital with no previous contact with family care had no idea of the possibilities of placing patients outside the hospital."¹ In view of the custodial character of the system, the social worker found it practically impossible to do any constructive social work with the patients.

**THE NEW EMPHASIS**

Up to 1931 it was the consensus among physicians and social workers that family care was a dead issue and that it could not be used as a constructive force. However there then evolved a new conception of the use of the boarding home. According to Helen Crockett, Head Social Worker at the Worcester State Hospital at that time, two factors made the use of family care desirable and possible:

"(1) The financial depression began to make itself felt in the inability of many relatives to care for patients who were sufficiently recovered to be given a trial outside the hospital, and other arrangements had to be considered. (2) At about this time, the successful and constructive use of boarding homes in the readjustment of two young dementia-praeox patients led us to consider the possible uses of family care as a tool in social case work. Could not the same plan which freed a hospital bed by removing to a private home a

¹. Bentley, Helen: A Study of the Family Care System at the Worcester State Hospital, Simmons College, 1934.
Take precedence. Working in tandem for the goals we set to achieve.

To the last "fit" with our coming to the society, worker for the solution. We conduct and have been operating the case on the place of the patient. We conduct who came to the hospital with the case. Presenting contact with family care to look at the patient. Artifice of placing priority entire the hospital is to view the capability of the hospital. The hospital is presenting priorities to go any concentrating similar work with the patient.

FREQUENCY WITH THE

Up to 1:30T we may the consciousness more practically and society workers from family care a good change due and put it on, not to need to view a concentrating topic. However, because of the struggle to arrive a new conception of the care of the patient. A point of the hospital and society workers. Keep society workers or the hospital. Concentrate after preparation of some time, the features were the real of family care respectable any purpose.

The executive concentration begun to make the

The executive concentration begun to make the

I. Hospital. Workers A batch of the family care progress of the
chronic patient for whom there was little hope for further recovery be used to help in the adjustment of a convalescent patient who was without family or friends or whose own home was unsuitable? If the idea is sound then the boarding home becomes, not a permanent residence, but a stepping-stone to mental health, independence and self-support."

With these possibilities in mind the psychiatric staff began to refer patients for therapeutic rather than for custodial purposes. With this impetus family care as a system for providing for the needs of mentally ill patients expanded rapidly. A social worker was appointed in 1932, whose sole duty it was to find homes, place patients and supervise them in family care. In 1934 there were seventy-seven placements and an average of ninety-six patients in boarding homes all the time. That year Dr. Bryan, Superintendent, made the following statement in his annual report:

"We have continued to stress the boarding out of patients. It should be pointed out that in any program of boarding out some attempt should be made to utilize these boarding homes as therapeutic agents, and not purely as custodial homes. There are two classes of patients that should be considered in any family care program. First, the convalescent patient who for one reason or another should not be sent directly from the hospital to his home. Such patients will frequently be benefited by a sojourn in a supervised situation for a period of several months. The boarding home is a transition between the rather rigid discipline of the hospital and the comparative freedom of one's own home. On the other

1. Crockett, Helen: Boarding Homes as a Tool in Social Case Work with Mental Patients, Mental Hygiene, April, 1934.
With these possibilities in mind, the Department of Education and Youth, in collaboration with local communities, has developed a comprehensive program to support families in need of assistance. This initiative aims to provide a range of services, including counseling, financial aid, and educational resources, to help families overcome their challenges.

The program is structured to address the specific needs of each family, ensuring that support is tailored to their individual circumstances. It includes regular assessments to monitor progress and make necessary adjustments to the support plan as needed.

In addition, the program provides training and workshops for family members to enhance their coping skills and improve family dynamics. These sessions are conducted by qualified professionals who offer practical strategies and tools to help families navigate through difficult times.

Furthermore, the program encourages community involvement, fostering a supportive environment where families can learn from each other and gain strength through shared experiences.

Ongoing feedback from families is crucial to the success of the program. Regular evaluations help to ensure that the support is effective and can be adapted to meet the changing needs of the families.

By providing comprehensive support, the program aims to empower families to overcome their challenges and build a brighter future for their children.
hand there are the group of custodial patients who are much better off in the environment of a home. During the year (1934) we have sent fifteen patients from boarding homes to their own homes and changed their status to that of visit. Seven have become self-supporting, having found positions."

By 1935 the placements had exceeded one hundred patients and the annual report spoke in glowing terms:

"The hospital is more impressed by the good results of the social method of treatment through family care than ever before. It is noted that 17 per cent of the total number of patients who were placed during the year were either discharged or their status changed to visit. Used as a social case work tool, family care adds a powerful weapon to the armamentarium of the psychiatrist." 2

In spite of the sudden boom resulting in placements far exceeding all expectations, from 1936 on there has been a noted slowing down in the placement of patients, until by the middle of 1938 the statistical reports revealed a marked drop in referrals and placements. The reasons for such a change in trend may be traced to the economic recession and the realization that the burden of the one family care social worker was far too great in the light of her responsibilities and case load. A further attempt to analyse this trend with its causes will be made in Section IV.

The hospital administration's point of view toward the present and future of family care is reflected in excerpts

By 1939 the records were ready to be examined and printed.

The potential to more thoroughly study the causes of death in the society of health care facilities is now more clearly apparent. It is now clear that the causes of death in the society of health care facilities are not merely due to the nature of the disease but also to the way in which the disease is treated.

In order to make this more apparent, the records for two families have been selected for a more detailed analysis. The records for the families of the Wilkins and the Johnsons will be examined in more detail.

The problem of mortality in the family care systems of today is a complex and challenging one. The problems of mortality are not merely due to the nature of the disease but also to the way in which the disease is treated.

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from a published statement by Dr. Bryan:

"While the boarding-out plan of caring for mental patients does result in saving represented by diminished capital expenditure for new buildings, yet I believe the major potentialities lie in the therapeutic field. There are many patients in the state hospitals who are inmates apparently because of precipitating factors in their immediate environment, the home. We have usually found it necessary to return many patients who are convalescing satisfactorily directly back into an unhealthy situation. It has seemed to us much better practice to utilize our boarding homes as a first step toward complete emancipation from the hospital influence rather than return patients directly to what cannot help from being a most trying situation for the patient. We hope that this plan will eventually result in a lowering of the readmission rate ................ in brief, I thoroughly believe in the possibilities of this form of treatment for certain types of mental patients, providing adequate social service and medical supervision can be extended to the patient."
STATISTICAL ANALYSIS OF REFERRALS AND PLACEMENTS

A. CLASSIFICATION

An analysis by the present writer of the patients referred and placed reveals interesting changes and trends particularly according to psychosis and sex.

TABLE 1

REFERRALS AND PLACEMENTS ACCORDING TO PSYCHOsis AND SEX (1937 - 1939)

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>Referred M.</th>
<th>F.</th>
<th>T.</th>
<th>P.C.</th>
<th></th>
<th>M.</th>
<th>F.</th>
<th>T.</th>
<th>P.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia-Praecox</td>
<td>44</td>
<td>32</td>
<td>76</td>
<td>45%</td>
<td></td>
<td>21</td>
<td>21</td>
<td>42</td>
<td>40%</td>
</tr>
<tr>
<td>Senile and Cerebral Arteriosclerosis</td>
<td>7</td>
<td>15</td>
<td>22</td>
<td>13%</td>
<td></td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>Manic-Depressive</td>
<td>4</td>
<td>15</td>
<td>19</td>
<td>11%</td>
<td></td>
<td>3</td>
<td>11</td>
<td>14</td>
<td>13%</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>10</td>
<td>2</td>
<td>12</td>
<td>7%</td>
<td></td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Mental Deficient</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>4%</td>
<td></td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Organic</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>5%</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Paranoid Conditions</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>5%</td>
<td></td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Paresis</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1%</td>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3%</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Involutional Melancholia</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>5%</td>
<td></td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Psychopathic Personality</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1%</td>
<td></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Totals</td>
<td>82</td>
<td>86</td>
<td>168</td>
<td>100%</td>
<td></td>
<td>45</td>
<td>59</td>
<td>104</td>
<td>100%</td>
</tr>
</tbody>
</table>

### TABLE I

**PERCENTAGE AND FREQUENCY ACCORDING TO BAV自助性和SEX (1933 - 1939)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Freq.</th>
<th>%</th>
<th>M</th>
<th>T.P.</th>
<th>Female</th>
<th>%</th>
<th>M</th>
<th>T.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonic-Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe and Certified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate-Dementic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nodio-Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Defect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychopathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inheritance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desinfectant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Totals**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age 0</th>
<th>Age 10</th>
<th>Age 20</th>
<th>Age 30</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 0</th>
<th>Age 10</th>
<th>Age 20</th>
<th>Age 30</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is noted in the 1934 study that over a three year period 46 men and 126 women were placed in family care. There were 45 men and 59 women placed during this period studied (1937-1939), as indicated in Table I. The increase in the number of men placed, in proportion to women, may be explained by the greater availability of homes for men during this period, and because of the growth in the feeling, both on the part of the hospital and of the caretakers, that men are not too great a risk for this type of placement.

Table II reveals that nearly half of the referrals and placements were schizophrenic patients. This number far exceeds the percentage of schizophrenics admitted to the hospital and those still remaining in the hospital (residue).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia-Praecox</td>
<td>76</td>
<td>45%</td>
<td>42</td>
<td>40%</td>
<td>250</td>
<td>25%</td>
<td>136</td>
<td>26%</td>
</tr>
<tr>
<td>Senile and Cerebral Arteriosclerosis</td>
<td>22</td>
<td>13%</td>
<td>15</td>
<td>14%</td>
<td>295</td>
<td>19%</td>
<td>236</td>
<td>44%</td>
</tr>
<tr>
<td>Manic-Depressive</td>
<td>19</td>
<td>12%</td>
<td>14</td>
<td>13%</td>
<td>65</td>
<td>6%</td>
<td>26</td>
<td>5%</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>12</td>
<td>7%</td>
<td>9</td>
<td>9%</td>
<td>71</td>
<td>7%</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>Others</td>
<td>39</td>
<td>29%</td>
<td>24</td>
<td>24%</td>
<td>341</td>
<td>33%</td>
<td>119</td>
<td>22%</td>
</tr>
<tr>
<td>Totals</td>
<td>168</td>
<td>100%</td>
<td>104</td>
<td>100%</td>
<td>1022</td>
<td>100%</td>
<td>534</td>
<td>100%</td>
</tr>
</tbody>
</table>

2. Worcester State Hospital Annual Reports, 1936-1937.
Table II

<table>
<thead>
<tr>
<th>Reference</th>
<th>Percentage</th>
<th>Influence</th>
<th>Recalled</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic-Blood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background and Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Class</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

T-based analysis with matched and unmatched
Also, an analysis of intake in Table III shows that 30 per cent of all schizophrenics admitted over a two year period were referred by the staff for family care placement, and 17 per cent of all the schizophrenics admitted were placed:

**TABLE III**
PERCENTAGE OF INTAKE REFERRED AND PLACED

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>Intake</th>
<th>Referrals</th>
<th>Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. P.C.</td>
<td>No. P.C.</td>
</tr>
<tr>
<td>Dementia-Praecox</td>
<td>250</td>
<td>76 30%</td>
<td>42 17%</td>
</tr>
<tr>
<td>Senile and Cerebral Arteriosclerosis</td>
<td>295</td>
<td>22 8%</td>
<td>15 5%</td>
</tr>
<tr>
<td>Manic Depressive</td>
<td>65</td>
<td>19 29%</td>
<td>14 22%</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>71</td>
<td>12 17%</td>
<td>9 13%</td>
</tr>
<tr>
<td>Others</td>
<td>241</td>
<td>39 11%</td>
<td>24 7%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>1022</strong></td>
<td><strong>168 17%</strong></td>
<td><strong>104 10%</strong></td>
</tr>
</tbody>
</table>

In view of the predominance of schizophrenics placed, a further analysis of the statistics was made. This shows that the male schizophrenics are still harder to place: 48 per cent of the male schizophrenics as compared with 66 per cent of the female schizophrenics referred were placed. The latter percentage compares more favorably with the percentage of placements of the other psychoses, as shown in Table IV.
In view of the importance of acquaintance

D. Like a further study of the acquaintance was made. The

above facts the male acquaintance are all well aware to please.

To best affect on the male acquaintance is concerned with so

The letter acquaintance corresponds more favorably with the

Table V.
TABLE IV

PERCENTAGE OF REFERRALS PLACED, ACCORDING TO PSYCHOSIS

Number of Patients

PSYCHOSIS

□ Referrals - Not Placed  □ Referrals - Placed

Total height of column indicates all referrals
% Number indicates placed as percentage of referrals
Tables V, VI and VII show the referrals and placements according to nativity, marital status and religious groupings. These classifications reveal first that the foreign born are more difficult to place. It has been acknowledged that finding homes which will satisfy the cultural needs of the foreign born patients is more difficult than obtaining homes for native born patients where their needs fall in more easily with the established pattern of the ordinary American, New England type of home:

**TABLE V**

<table>
<thead>
<tr>
<th>NATIVITY</th>
<th>Native Born</th>
<th>Foreign Born</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placed</td>
<td>86</td>
<td>18</td>
<td>104</td>
</tr>
<tr>
<td>Not Placed</td>
<td>44</td>
<td>20</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>130</td>
<td>38</td>
<td>168</td>
</tr>
</tbody>
</table>

In the earlier study it was noted that the marital status of patients differed from that of those placed during the period of this study, with 23 per cent of the patients single then as compared with 60 per cent in the present study. The predominant group then was the married, 58 per cent then as contrasted with only 20 per cent now.

### TABLE V

<table>
<thead>
<tr>
<th>Totals</th>
<th>Lateral Bone</th>
<th>Pelvic Bone</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>20</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>188</td>
<td>69</td>
<td>119</td>
</tr>
</tbody>
</table>

TOTAL

In the separate branch 14 were noted that the material

### ATTENTION

It is the opinion of the writer that it may be necessary to change the

The author of this branch, with the greatest care of the patient,

The fact that the patient is now, since the material, 32 have

The patient is now conversant with only 20 of the cases now

TABLE VI
MARITAL STATUS

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th>Divorced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placed</td>
<td>63</td>
<td>21</td>
<td>20</td>
<td></td>
<td>104</td>
</tr>
<tr>
<td>Not Placed</td>
<td>32</td>
<td>20</td>
<td>12</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>41</td>
<td>32</td>
<td></td>
<td>168</td>
</tr>
</tbody>
</table>

TABLE VII
RELIGIOUS GROUPING

<table>
<thead>
<tr>
<th></th>
<th>Protestant</th>
<th>Catholic</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placed</td>
<td>42</td>
<td>59</td>
<td>3</td>
<td>104</td>
</tr>
<tr>
<td>Not Placed</td>
<td>20</td>
<td>43</td>
<td>1</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>62</td>
<td>102</td>
<td>4</td>
<td>168</td>
</tr>
</tbody>
</table>

It is noted, in summary, that the trend has been
toward the referral and placement of native born, single
patients. The distribution, according to religious groupings
is in proportion to that found normally in the hospital.
### IV MIGHT

**MATERNAL DUTIES**

<table>
<thead>
<tr>
<th>*</th>
<th>Totals</th>
<th>Married</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>69</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>108</td>
<td>35</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IV MIGHT

**RELIGIOUS DUTIES**

<table>
<thead>
<tr>
<th>*</th>
<th>Totals</th>
<th>Calendar</th>
<th>Casual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>69</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>108</td>
<td>35</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the data for the religious duties, calendar, casual, and professional columns are meant to indicate the proportion of time spent on religious activities, calendar activities, casual activities, and professional activities respectively, the data for religious duties suggests a significant portion of time is spent on religious activities, whereas calendar and casual activities are less time-consuming. The professional activities show a lower percentage, indicating a more balanced distribution of time across the different categories.
B. TRENDS

It is generally assumed that one important factor in the success of the placement of the patient is the length of time the patient has been in the hospital prior to the placement. Table VIII shows referrals and placements according to length of commitment:

TABLE VIII
REFERRALS AND PLACEMENTS ACCORDING TO LENGTH OF COMMITMENT

<table>
<thead>
<tr>
<th></th>
<th>1-6 Months</th>
<th>6-12 Months</th>
<th>1-2 Years</th>
<th>2-5 Years</th>
<th>Over 5 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred</td>
<td>40</td>
<td>22</td>
<td>33</td>
<td>25</td>
<td>48</td>
<td>168</td>
</tr>
<tr>
<td>Placed</td>
<td>28</td>
<td>14</td>
<td>24</td>
<td>14</td>
<td>24</td>
<td>104</td>
</tr>
<tr>
<td>(P.C. placed)</td>
<td>(70%)</td>
<td>(64%)</td>
<td>(73%)</td>
<td>(56%)</td>
<td>(50%)</td>
<td>(62%)</td>
</tr>
</tbody>
</table>

In the 1934 study it was found that 49 per cent of the patients placed had been in the hospital less than three years. The present study shows that 63 per cent of the patients had been in the hospital less than two years, thus revealing that the trend has been toward selection of patients who have been under commitment for shorter periods.

Table IX shows referrals and placements according to age groups and indicates that 39 per cent of all the

In the absence of any suggestions or comments to the report, The President (Mr. J.C. Ponsford) has decided to prepare a report to be presented to the Board of commissioners.

Table III shows returns and recommendations regarding the improvement of the Board of commissioners.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Year</th>
<th>Percentage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To the above table, the Board of commissioners add the following note:

[Text not legible]
TABLE IX

REFERRALS AND PLACEMENTS ACCORDING TO AGE GROUPS
patients placed were under forty years of age, nearly doubling the percentage under forty as noted in the 1934 study.  

C. REASONS

The reasons for the referrals, as stated in the records, are shown in Table X.

**TABLE X**

<table>
<thead>
<tr>
<th>REASONS FOR REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>I. Custodial:</td>
</tr>
<tr>
<td>Referred to fill vacant homes or because of no other resources for elderly custodial patients</td>
</tr>
<tr>
<td>II. Therapeutic:</td>
</tr>
<tr>
<td>A. To ascertain ability to adjust to family life</td>
</tr>
<tr>
<td>B. To look for work</td>
</tr>
<tr>
<td>C. Resocialization</td>
</tr>
<tr>
<td>D. Undefined: a stepping stone back into the community</td>
</tr>
<tr>
<td>III. Others:</td>
</tr>
<tr>
<td>A. Home temporarily not ready for patient:</td>
</tr>
<tr>
<td>1. Inability to provide proper supervision</td>
</tr>
<tr>
<td>2. Financial lacks in the home</td>
</tr>
<tr>
<td>B. Family not willing to take patient</td>
</tr>
<tr>
<td>C. Miscellaneous</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The reason for the change in age category is shown in the table below.

<table>
<thead>
<tr>
<th>Reason for Change</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Conceived by older father</td>
<td>20</td>
</tr>
<tr>
<td>II. Conceived by older mother</td>
<td>30</td>
</tr>
<tr>
<td>III. Other</td>
<td>10</td>
</tr>
</tbody>
</table>

Total = 60
Of those referred for custodial care, 63 per cent were placed. Seventy per cent of those referred for treatment were placed and only 40 per cent of the others. It was of interest to note that the staff often specified special precautions and recommendations in addition to their statements of reasons for referrals. For example, special precautionary measures were indicated in twenty cases of suicidal patients, drug addicts and those liable to wander off. Particular advantages and opportunities were specified in eleven cases. Certain types of homes, social and cultural levels considered, and individual types of care were indicated in twelve cases.

Of the one hundred and sixty-eight patients referred, sixty-four, or 38 per cent, were not placed. The reasons as indicated in Table XI reveal that only in 14 cases, or 22 per cent of those not placed, were there no homes either available or suitable for the patients referred.

**TABLE XI**

**REASONS WHY PATIENTS WERE NOT PLACED**

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's condition got worse - plan dropped</td>
<td>14</td>
</tr>
<tr>
<td>Patient refused to go</td>
<td>12</td>
</tr>
<tr>
<td>No home suitable</td>
<td>10</td>
</tr>
<tr>
<td>Family took patient on visit prior to placement</td>
<td>8</td>
</tr>
<tr>
<td>Pending</td>
<td>8</td>
</tr>
<tr>
<td>No homes available for men patients</td>
<td>4</td>
</tr>
<tr>
<td>Change of plan by staff</td>
<td>4</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>
Of those receiving care, 47 per cent were placed in care of a relative, 53 per cent were placed in a home, and only 0 per cent of the cases included were placed in an institution.

Of interest to note is the fact that, although the specific type of care was mentioned, the measures taken for the care of cases were not discussed.

Care in two cases.

Of the cases, one hundred and sixty-eight per cent were placed in care of a relative, 8 per cent were placed in a home, and only 0 per cent were placed in an institution.

It is evident that the care given to these cases was not standardized.

**IX. RESOEUCE**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>0.00</td>
</tr>
<tr>
<td>Home</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Table of Reasons Why Patients Were Not Placed**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's condition for more - pain, grogginess</td>
<td>100.00</td>
</tr>
<tr>
<td>No home suitable</td>
<td>50.00</td>
</tr>
<tr>
<td>No home available</td>
<td>50.00</td>
</tr>
<tr>
<td>Change of plan of attack</td>
<td>0.00</td>
</tr>
<tr>
<td>None listed</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Total**

---

Note: The table above represents the reasons why patients were not placed in care. The percentages indicate the distribution of these reasons among the cases reviewed.
There is usually a period of one to four weeks between the referral and actual placement. During this period various changes in the condition of the patient may take place and one of the major reasons for not placing a patient has been the patient's sudden relapse necessitating the dropping of the family care plan. For many patients the proposed change of situation represents a threat to their security, especially if they have been in the hospital for some length of time. For this reason, as well as others, many of the patients at first refuse to consider going out in family care. It is noted that of the entire group referred, 27, or 16 per cent, at first refused to go. Fifteen of the objectors finally consented to go into family care homes following persuasion on the part of the social worker, the referring physician and in a few cases pressure by the superintendent. It is interesting to note that when family care was proposed by the staff as an alternative plan to the twelve families who were unwilling to take the patient home on visit, in 8 cases the family took the patient rather than permit such a placement.

D. ADJUSTMENT

It is difficult to evaluate the total adjustment especially when such evaluation must be primarily subjective. The sources for this evaluation are those who had contact
There is nothing a better or more to your work pa-

to see that the growth and secret preparation of their own lead-

come as consequence to the conclusion of the papers will raise

have seen the better, and that failure to realize the purpose of

the basicy, essentially if they have seen in the possibility of

an idea of time. For this reason, we must be aware

some factors or time. For this reason, we must be aware

to the purposes of their nature to consider before the

in family care. It is better that at the outset enough to

read. One in the best case of their nature to consider before the

the scientific knowledge of the part of the social network

the scientific knowledge, we know their nature, and that family

It is important to know that each family

family are composed of the social as an interaction. Plan to the

have some family and have something to take the social

on April 8 across your family for the social rather than

factors much a phenomenon

of

it is difficult to estimate the total amount

especially now your expectation was to primarily mecha-

The outcome for this situation are those who and not cong

D. APPLICATION

It is difficult to estimate the total amount
with the patients over the entire period of placement, viz. the psychiatrist and the social worker. Certain arbitrary criteria were established as a basis for the evaluation, and the informants were guided by them in every case. The three rating categories were: good, fair and poor. A good adjustment was one wherein: (1) the patient showed notable improvement in his physical and mental condition; (2) his placement was marked by a much better social adjustment, and as a result; (3) he had a good prognosis for going on visit or discharge. A fair adjustment was one in which the patient manifested his ability to make a better adjustment to family life, than in the hospital, but whose mental condition was the basis for occasional upsets necessitating either temporary return to the hospital or retention in the home with some difficulty. The groups which were found most frequently in this category were the female manic-depressives and the seniles. The poor adjustments included those patients who failed completely to make an adjustment in the family care home, and whose stay was characterized by frequent upsets, and various other problems as indicated in Table XIV. In almost every case this resulted in the return of the patient to the hospital within a short period following his poor adjustment.

In discussing the adjustments, it is noted that statistically there is little of significance in the
with the particular case the outcome being of placement in
the best foster home and the future towards certain economic
opportunities were emphasized as a guide for the continuation
and the informants were guided to plan in each case. The home
rating categories were: Good, Fair, and Poor. A Good
school:
want to be better and need to condition?
and to be-
and for a good program to work on, with at age
another. A Latent opportunist was one to whom the present isn't
lessing and putting to work a better environment to family life
and in the hospital, and where we can condition were the
ready for accommodation where necessary and after placement
return to the hospital or rest home to the home with some
happiness. The longer stay was found worth while then in
illness. The categories were the Latent, Impulse, Schizophrenia, and the
sentinel. The best opportunities included those facilities and
leaves and attempts to make an environment in the family care
home and those who were important for placement of retarded people.
In each case care was necessary in the caregiver of the patient
to the questions which a short paper following the book
mentioned.
In recognition and appreciation it is noted that
acceptances have a little of explanations in the
comparison according to sex. Fifty-eight per cent of the males placed made good adjustments, very close to the figure of 54 per cent for the females placed. According to psychosis however, interesting data are found. Of the larger groups placed, the one making the best record of adjustment was the alcoholic with 78 per cent of the placements making good adjustments. It was observed that the alcoholics made a good initial adjustment but remained in family care somewhat longer than other groups. Among the larger groups the manic-depressives made the poorest adjustments - only 43 per cent of all placements. Among the smaller groups it was noted that the four psychoneurotics placed made poor adjustments as contrasted with all the organic psychotics who in each of the four cases placed made a good adjustment.

Tables XII and XIII analyse the adjustments according to psychosis, sex, and quality of the adjustments:
Table XI and XII will give the Copenhagen values for the
inert gas percentages, sex, and duration of the aftertreatment.
### TABLE XII

**ANALYSIS OF ADJUSTMENTS ACCORDING TO PSYCHOSIS AND SEX**

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>Sex</th>
<th>Adjustments</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M.</td>
<td>11</td>
<td>6</td>
<td>4</td>
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<td>F.</td>
<td>13</td>
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<td>T.</td>
<td>24</td>
<td>9</td>
<td>9</td>
<td>42</td>
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<tr>
<td>Dementia-Praeox</td>
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<td></td>
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<td>M.</td>
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<td>1</td>
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<td></td>
<td>F.</td>
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<td>T.</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>15</td>
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<tr>
<td>Senile and Cerebral</td>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td>M.</td>
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<td>F.</td>
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<td>0</td>
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<td>T.</td>
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<td>Arteriosclerosis</td>
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<td></td>
<td>F.</td>
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<td>Manic-Depressive</td>
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<td>F.</td>
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<td>T.</td>
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<td>M.</td>
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<tr>
<td></td>
<td>F.</td>
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<td>0</td>
<td>3</td>
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<tr>
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<td>2</td>
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<td>Involutional Melancholia</td>
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<td></td>
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<td>F.</td>
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</tbody>
</table>
### TABLE XI

**ANALYSIS OF DISPUTAMENTS ACCORDING TO PSYCHOSES AND SEX**

<table>
<thead>
<tr>
<th></th>
<th>Stature-Plagiarism</th>
<th>Genitality-Myopia</th>
<th>Oedipal</th>
<th>Autocentrism</th>
<th>Mania-Depression</th>
<th>Narcissism</th>
<th>Parental Compulsion</th>
<th>Paranoid</th>
<th>Persecutory</th>
<th>Prognostic</th>
<th>Psychopathic</th>
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</tbody>
</table>
TABLE XIII

"GOOD" ADJUSTMENTS ACCORDING TO PSYCHOSIS

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>Placements</th>
<th>Good Adjustments</th>
<th>P.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia-Praecox</td>
<td>42</td>
<td>24</td>
<td>57%</td>
</tr>
<tr>
<td>Senile and Cerebral Arteriosclerosis</td>
<td>15</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>Manic-Depressive</td>
<td>14</td>
<td>6</td>
<td>43%</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>9</td>
<td>7</td>
<td>78%</td>
</tr>
<tr>
<td>Others</td>
<td>24</td>
<td>14</td>
<td>58%</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>58</td>
<td>56%</td>
</tr>
</tbody>
</table>

E. PROBLEMS

As indicated in previous discussions many problems presented themselves during the period of placement. A number arose out of the mental condition of the patient and were difficult to deal with in the boarding home. With elderly patients - who were primarily custodial placements - physical ailments presented many difficulties. Where there were several patients in a home, and when they were constantly thrown together in joint activities, friction often resulted and sometimes reached such proportions that one or more of the patients had to be removed from the home. The routine activities of the home such as taking a bath, of
<p>| TABLE XIII |</p>
<table>
<thead>
<tr>
<th>&quot;GOOD&quot; ADJUSTMENTS ACCORDING TO CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periods</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>280</td>
</tr>
<tr>
<td>260</td>
</tr>
<tr>
<td>330</td>
</tr>
<tr>
<td>360</td>
</tr>
<tr>
<td>280</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

In Table XIII, we list the "good" adjustments according to the criteria. The table shows the period (in hours) of the adjustments, the number of good adjustments, the average number of adjustments, and miscellaneous information. The criteria for a good adjustment are:

- Immediate benefit: The adjustment must result in a significant improvement in the patient's condition.
- Permanent benefit: The adjustment must have a long-term positive effect on the patient.
- Continued benefit: The adjustment must continue to be effective after the initial treatment.

We attempted to improve patients' functional performance and maintain their basic abilities. However, we encountered several challenges in implementing these adjustments. For example, some patients were resistant to change, while others required ongoing support and supervision. In some cases, we had to adjust our approach to ensure the best possible outcome. The goal was to ensure that the patients could maintain their independence and quality of life.
keeping one's room in order and doing one's share of the work were sometimes avoided by the patient. It is in such situations as these that the caretaker's skill comes into play in stimulating the patient to accept his responsibilities. Often patients expressed great unhappiness during the first few days of placement, especially if they were among those who originally objected to such placement.

Table XIV lists some of the problems which were found during placement:

**TABLE XIV**

**PROBLEMS DURING PLACEMENT**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic mental upset</td>
<td>23</td>
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<tr>
<td>Physical illness</td>
<td>9</td>
</tr>
<tr>
<td>Difficulties arising out of contacts with</td>
<td></td>
</tr>
<tr>
<td>other patients in the home</td>
<td>9</td>
</tr>
<tr>
<td>Patient refused to carry out routine duties</td>
<td>6</td>
</tr>
<tr>
<td>Patient expressed unhappiness</td>
<td>5</td>
</tr>
<tr>
<td>Miscellaneous minor problems</td>
<td>15</td>
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</table>

The relationship between the problems shown and the eventual removal of the patient from family care seems worthy of investigation. All but one of the patients who presented problems due to their mental condition were eventually removed from their family care homes and returned to the hospital. In 45 cases, 58 per cent, the removals were
The relationship between the problems faced and
the amount of interaction at the beginning of family care seems
worth of investigation. All but one of the patients who
beseech prayers and to their mental condition were seen-
without reference from their family care cases and remaining to
right assumptions about the patient. In a case, the doctor, the relatives were

VIII. TABLE

PROBLEMS DURING PLACEMENT

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Patient mental status</td>
</tr>
<tr>
<td>4</td>
<td>Patient influence</td>
</tr>
<tr>
<td>3</td>
<td>Other personnel in the home</td>
</tr>
<tr>
<td>3</td>
<td>Patient inability to carry on routine, suffer</td>
</tr>
<tr>
<td>2</td>
<td>Patient expressed apprehension</td>
</tr>
<tr>
<td>2</td>
<td>Miscellaneous minor problems</td>
</tr>
</tbody>
</table>


of a temporary nature, later resulting in replacements usually in the same homes from which they were taken after a brief stay in the hospital. In 8 cases patients were re-placed twice within this two year period. Twenty-seven per cent of the removals were due to change of status directly from family care to visit or discharge.

Table XV outlines the reasons why patients were removed from their family care homes during this period studied:

<table>
<thead>
<tr>
<th>Reasons for Removal</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental upset</td>
<td>22</td>
</tr>
<tr>
<td>To visit (directly from family care)</td>
<td>12</td>
</tr>
<tr>
<td>Discharged (directly from family care)</td>
<td>9</td>
</tr>
<tr>
<td>Walking away from home (escape)</td>
<td>9</td>
</tr>
<tr>
<td>Physical illness</td>
<td>5</td>
</tr>
<tr>
<td>Family care home given up</td>
<td>4</td>
</tr>
<tr>
<td>Inability to adjust to family life</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

F. **Present Status**

An accounting, on January 1, 1939, of all the patients placed during the period studied reveals the following, in Table XVI.
Table VI

REASONS FOR REMOVAL FROM FAMILY CARE

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Reason for Removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Mental neglect</td>
</tr>
<tr>
<td>13</td>
<td>To attract (Cafeteria-type family care)</td>
</tr>
<tr>
<td>19</td>
<td>Dependency (Cafeteria-type family care)</td>
</tr>
<tr>
<td>11</td>
<td>Witness was too young (execute)</td>
</tr>
<tr>
<td>17</td>
<td>Parental influence</td>
</tr>
<tr>
<td>10</td>
<td>Parental neglect to family life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
</table>

Addendum to Table IV

In accordance with Department of 1939 to the file
Table VI outlines the reasons why families were removed from their family care as shown in Table IV.


**TABLE XVI**

**PRESENT STATUS OF PATIENTS PLACED**

<table>
<thead>
<tr>
<th>Sex</th>
<th>No.</th>
<th>Family Care No.</th>
<th>P.C.</th>
<th>Hospital No.</th>
<th>P.C.</th>
<th>Visit No.</th>
<th>P.C.</th>
<th>Discharged No.</th>
<th>P.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>45</td>
<td>25</td>
<td>56%</td>
<td>11</td>
<td>24%</td>
<td>6</td>
<td>13%</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>Female</td>
<td>59</td>
<td>27</td>
<td>46%</td>
<td>20</td>
<td>34%</td>
<td>6</td>
<td>10%</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>52</td>
<td>50%</td>
<td>31</td>
<td>30%</td>
<td>12</td>
<td>11%</td>
<td>9</td>
<td>9%</td>
</tr>
</tbody>
</table>

By January 1, 1939, 20 per cent of all the patients placed during the period studied had been discharged or released on visit. This figure compares favorably with similar reports covering the period since 1930.\(^1\)

The present status of patients referred but not placed in family care reveals that 17, or 29 per cent, of those not placed are no longer in the hospital. Eight of the 17, however, went on visit rather than accept the family care plan. Thus we can partially credit to family care the provision of the stimulus which prompted the change to visit status.

**G. VALUE**

The value to the patients of the placements should be measured in terms of the objective of the placements. If

\(^1\) Worcester State Hospital Annual Reports, 1930-1937.
### TABLE

<table>
<thead>
<tr>
<th>SEX</th>
<th>AGE</th>
<th>FATHER</th>
<th>MOTHER</th>
<th>BROTHERS</th>
<th>SISTERS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25-30</td>
<td>10</td>
<td>25-30</td>
<td>10</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>25-30</td>
<td>10</td>
<td>25-30</td>
<td>10</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>25-30</td>
<td>10</td>
<td>25-30</td>
<td>10</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>

*AN ANALYSIS OF PATIENT'S REACTIVITY

Please carry out the para, and then proceed to the next section.

The present status of patients at the present time is:

- Please to family care.
- Please to the family care in order to the family care.
- Please to the family care in order to the family care.

We can partially account to family care.

The value to the patient of the present time is:

- Please to the family care in order to the family care.
- Please to the family care in order to the family care.

I. WOOLEN STORE REPORT; AMERICAN REPORT, 1890-1891.
the ultimate objective is to effect the return of the patient to status in the community, we find that but 19 per cent of the patients have been thus helped. We must consider, however, that a number of the patients, still in family care homes, have been helped to adjust more adequately to their mental symptoms, and may sooner or later be able to effect some kind of an adjustment in the community. Also, in a number of cases the morale of the patients has greatly improved, and there is apparent a definite wish to get well and return to their own communities.

Through interviews with the social worker and the physician it has been possible to determine - as shown in Table XVII - how the placements have been of value to a number of the patients. It many cases obviously a patient has been aided in more than one way and therefore is included more than once.

**TABLE XVII**

**HOW PLACEMENT IS OF VALUE TO THE PATIENT**

<table>
<thead>
<tr>
<th>How of Value</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical condition improved</td>
<td>68</td>
</tr>
<tr>
<td>Mental condition showed marked improvement</td>
<td>38</td>
</tr>
<tr>
<td>Made better social adjustment than in hospital</td>
<td>23</td>
</tr>
<tr>
<td>Gave patient more security and self-confidence</td>
<td>20</td>
</tr>
<tr>
<td>Patient happier in family type of environment</td>
<td>18</td>
</tr>
<tr>
<td>Obtained work through placement</td>
<td>14</td>
</tr>
<tr>
<td>Marked evidence of resocialization</td>
<td>13</td>
</tr>
<tr>
<td>Instrumental in patients' release on visit</td>
<td>12</td>
</tr>
<tr>
<td>Instrumental in patients' discharge</td>
<td>9</td>
</tr>
</tbody>
</table>
The influence of passive smoking on the health of the person exposed in the community has raised the issue of passive smoking. We must reconsider the extent and impact of this issue. Since this is a number of cases in the community, which in a number of cases requires a detailed analysis to be done well and share in developing a protocol awaiting the community and the patients who come to seek medical and return to their community.

Further investigations with the society worker and the physicians of the need for possible re-examination of the cases to Table XXVI: if the physicians have done an analysis of number of the patients. It must come at once any and must be in hand the soon after to write these one way and steps to implement.

![Table](https://via.placeholder.com/150)

<table>
<thead>
<tr>
<th>How to Read</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Important control tableaux</td>
</tr>
<tr>
<td>01</td>
<td>Important control tableaux</td>
</tr>
<tr>
<td>02</td>
<td>Have better control of education and training</td>
</tr>
<tr>
<td>03</td>
<td>Give better control of education and training</td>
</tr>
<tr>
<td>04</td>
<td>teachers deliver lessons with self-confidence</td>
</tr>
<tr>
<td>05</td>
<td>Teachers deliver lessons with self-confidence</td>
</tr>
<tr>
<td>06</td>
<td>Obtain special training in specific areas</td>
</tr>
<tr>
<td>07</td>
<td>Learn advances in teaching</td>
</tr>
<tr>
<td>08</td>
<td>Learn advances in teaching</td>
</tr>
<tr>
<td>09</td>
<td>Important to implement new and effective</td>
</tr>
</tbody>
</table>
| 10 | Important to implement new and effective
The advantages of family care as seen and stated spontaneously by the patient are listed below:

1. Home life gives a feeling of being part of a family - a feeling of belonging.
2. The food is much better.
3. The noise of the hospital is avoided.
5. Ability to participate in community life on an equal and accepted level.
6. More freedom and independence -- a change from the routine of the hospital.
7. When looking for work one can give a home address rather than that of a mental hospital.

With regard to psychosis it is noted that in all but the manic-depressive patients more than half of the number seem to benefit to some extent from the placements. Table XVIII indicates the value according to psychosis:

<table>
<thead>
<tr>
<th>Psychosis</th>
<th>Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia-Praecox</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Senile and Cerebral Arteriosclerosis</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Manic-Depressive</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>55</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

This study gives some evidence that the family care home has much to offer to the patient in both his physical and mental rehabilitation.
The effectiveness of family care as seen and stated

consequently on the patient's later approach
1. Home life gives a feeling of pride in the
   family - a feeling of ownership
2. The touch is more perfect
3. The nurse at the hospital is valuable
4. The chance of meeting patients
5. Affiliation to participating in community life
6. More freedom and independence
7. A chance to learn the routine of the hospital
8. More freedom to work one can give a home
9. Safer and better than that of a mental hospital

With regard to devoidance it is noted that in all
people involved a reasonable relation more than half of the men,
people see to patients to some extent from the place.

Table XXII indicates the value reckoned to patients:

<table>
<thead>
<tr>
<th>Value</th>
<th>No Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>48</td>
<td>22</td>
</tr>
</tbody>
</table>

The study given these evidence that the family
care home was much of after to the patient in both the
b...
THE FUNCTION OF THE SOCIAL WORKER

The use of family care placements by the Worcester State Hospital antedated by ten years its supervision by social workers. At first the patients were supervised by the medical staff who investigated homes to determine their suitability. Since the purpose of the plan was to free hospital beds, save expense to the state, and at the same time give more freedom to the individual patient, much emphasis was placed on physical surroundings, blankets, space, food and clothing. Patients were not to be exploited, overworked or abused in any way. The dissatisfied patients were replaced or returned to the hospital. With the coming of the first social worker in 1915, the tasks of supervision and investigation were soon assigned to her and the number of visits from the physicians dwindled to almost none.

The function of the social worker in relation to family care during the early years of its existence involved routine investigations and visitations to homes boarding the small number of custodial patients. The contacts were not frequent and were primarily for the purpose of rendering personal services as required by the physical needs of the elderly patients. Primarily because of the purpose of the placement and the great difficulty in securing homes the need for careful selection in finding homes was not viewed
THE case of family care planning in the hospital

The need for family care planning in the hospital setting arises from the recognition of the social, medical, and psychological needs of the family members. One of the primary objectives of family care planning is to facilitate the process of recovering from a hospital stay.

Since the purpose of the family members' stay is to receive treatment, they must be prepared to face the reality of hospital life. The hospital environment is often unfamiliar and may be overwhelming for the family members. Family care planning helps to prepare the family for the hospital experience and to address their needs.

The family is an integral part of the hospital team. Family care planning involves working closely with the medical staff to ensure that the family's needs are met. This includes providing information about hospital policies, procedures, and resources.

The family is encouraged to participate in the decision-making process regarding the patient's care. This promotes a sense of control and empowers the family members to take an active role in their loved one's recovery.

Family care planning also involves addressing the emotional needs of the family members. The hospital provides support services such as counseling and support groups to help the family members cope with the stress of hospitalization.

In conclusion, family care planning is a crucial aspect of hospital care. It helps to ensure that the family's needs are met, promotes a sense of control, and supports the emotional well-being of the family members.
as of much importance until the therapeutic emphasis became prevalent.

The new therapeutic emphasis has required greater care in the selection of homes. This has eliminated, as the primary ones, the old material considerations of shelter and clothing, and placed special emphasis on the needs of the patient in relation to the atmosphere of the home and the personality and skills of the caretaker. There is also the added responsibility of understanding the personality and needs of the patient as a basis for placing him, carrying on a therapeutic supervisory relationship, and the guidance of the caretaker toward more therapeutic effectiveness. One can thus see that this growth has increased the responsibilities and tasks of the family care social worker.

Statistics show that the family care placements have increased ten-fold since 1931 and with this increase has come an integration of the social worker's functions. In spite of such an integration the social worker's task grew so rapidly and reached such proportions that an increase in personnel has been indicated as necessary since 1934 when the clinical director made reference to such a need in his annual report:

"It is obvious that with the large number of patients out of the hospital that more than one social service worker is needed. This department should be supervised by one psychiatrist and two social workers."  

---

1. Worcester State Hospital Annual Reports, 1931-1937.
In the 1935 Annual Report the head of the Social Service Department made the following statement:

"Since the depression our applications from families who wish to board out patients have increased. The number of such requests which come in from homes of poorer type has risen, bringing, as result, the need for more careful investigation to insure the welfare, mental as well as physical, of out patients. This has increased the burden of the social worker in charge of family care, and if continued may result in one of two things -- either fewer patients in family care, or lessened investigations and consequently poorer homes. It may be that in the future it will be found expedient to divide the work of this particular part of the social service department, delegating to one worker the investigation of applications for boarding homes and to another the supervision and treatment of the patients involved. If we are to consider our boarding homes as of definite psychotherapeutic value in the treatment of out patients, intensive investigation and supervision is essential."\(^1\)

However, the one family care social worker was left to carry the burden until 1937. In that year the hospital was granted a special worker for a period of three months for an intensive study of family care. In the Annual Report of 1937 an explanation is given why this second social worker was not re-appointed:

"Many applications were investigated in an attempt to find more boarding homes, thus enabling us to place more patients on this basis. It was found that because of the rise in food prices, it was extremely difficult to find families willing to accept patients for the $4.50 per week paid by the state for boarding patients. Several homes

\(^1\) Worcester State Hospital Annual Report, 1935.
In the 1937 Annual Report the head of the Social Service Department made the following statement:

"Since the depression our applications for assistance have increased, and the number of our families in receipt of some form of public assistance has also increased. The need for more careful investigation of cases has increased, and in the next few months we shall be unable to handle the work as well as we have been able to do so far. The number of the number of the social workers in the society has increased, and it is continuing to increase. The staff of the society, which was considered as too small in the past, is now considered as too large.

However, the one family case, where the worker was able to carry the burden, will still continue. In most cases the worker was able to carry the burden of the case, and the number of the cases was reduced. The society's social service department, catering to the society's own needs and to meet the requirements of the society's own cases, has been able to function. The number of the cases has increased, and the burden has increased. The society's social service department has been able to function, and the number of the cases has increased. The society's social service department has been able to function, and the number of the cases has increased.

..."

Expression to women in the Society during social worker meetings...
were found which would take patients at $7.00 per week and up, but for the same economic reason few of our families felt themselves able to pay even that sum for their relatives. Consequently, we were unable to place the number of patients deemed essential for the maintenance of two workers on family care, and when her second appointment for three months was concluded she was not re-appointed.\footnote{1}

With the continued encouragement for extension of family care emanating from the administration, a social worker was appointed in September, 1938, to work in the family care department. This provisional appointment is to be in effect for one year, and if the development of the work warrants it, the position will be made permanent. It is interesting to note that up to January 1, 1939, four months after the date of this appointment, the number of homes available for use and the number of patients placed have increased 25 per cent.

With the specific functions of the social worker still indefinite in their scope, it should prove of value to paint a picture of the actual activities of the social worker, in an attempt to gain some insight into that which comprises her daily work.

A. THE REFERRAL

The family care social worker first enters the case at the Social Service-Staff conference. Here a statement of

\footnote{1. Worcester State Hospital Annual Report, 1937.}
With the continuing support of a social worker, the family can continue to develop a healthy family life with the help of the Department for the Development of the Work Market. The family can be referred to the Department for Health and Welfare for further assistance. The family can also be referred to other agencies for help. The family can also be referred to other agencies for help. The family can also be referred to other agencies for help. The family can also be referred to other agencies for help.
the reasons for referral and a general discussion of the needs of the patient are initiated by the referring physician. The worker then acquaints herself with the patient's record, with special attention given to the reports of behavior and social adjustment in the hospital, and the history of home adjustments prior to commitment. There follows a consultation with the clinical director and the referring physician wherein the specific reasons for placement, both social and psychiatric, are discussed. The type of home and supervision required are indicated.

The initial contact with the patient is the next step. The purpose of this first interview, usually held on the ward, is to establish rapport, explain the nature and objectives of family care, and to permit the patient to discuss the type of home he would prefer. This is sometimes the first knowledge by the patient of his proposed placement and involves tact and skill on the part of the worker to "sell the idea." Often a number of interviews are necessary before the patient will consent to such a plan, and this is one factor in the lapse of time between the referral and actual placement.

Before the patient can be placed, the relatives and guardian (if there is one) must be interviewed or consulted through the mail in regard to their feelings about placement. Such practical problems are discussed as their
The illness that is described as a generalization of the

needs of the patient are initiated by the treating physician.

The problem of coordinating treatment with the patient's needs and

society's expectations in the hospital, may be properly known.

There is no problem. The patient's problem is often

why the problems arise and the treating physician and

necessarily are the appropriate. The type of home and environment

regarding the treatment.

The initial contact with the patient is the

step. The purpose of the initial interaction is to

teach the patient's role in the hospital, and to bring the patient to

home. The type of home is sometimes the literal

knowledge of the patient is important to this process.

The type of home may not be the part of the patient to "self the

and skills on the part of the patient to self the

them. Often a number of interventions are necessary after the

patient will consent to make a plan and start to use resources

for the future. If there is one (or more) interventions at once.

Becomes the patient can be pleased the late rise.

and emotions (if possible) how much of intervention or care

could influence the will in later to short teaching round.

in the process. Such beneficial arrangements are necessary as fast
ability to pay for the patient's room and board, the location of the family care home, and the visiting arrangements. It is at this time that the social worker paves the way for the patient's later return to the community. The interviews with the relatives may include an interpretation of the patient's illness, a discussion of the family's feelings about this illness, and its responsibilities to the patient.

After all preliminary arrangements are made, and if a home is available and suitable, the patient is placed. Homes are usually available and ready for use. This is possible because the social worker is constantly investigating and certifying new homes for use, even when no particular patient is being considered for placement. Occasionally new homes must be obtained.

B. FINDING THE HOME

The definite standards which are the basis for the selection of the home are determined primarily by the needs of the patients. The points of emphasis in this selective process are: the locality of the home, its physical structure and surroundings, the economic status of the family, and the qualifications of the applicant-caretaker.

Locality was re-emphasized as a factor in 1933 when the Department of Mental Hygiene assigned six homes and ten patients to the Worcester State Hospital for supervision.
The ability to plan for the part time home and the assistance arrangements is of the family to care for one and the assistant arrangements. It is to this time that the social worker began the way for the batte's latest return to the community. The interventions in the hospital may include an introduction of the patient and the assistance of the family's teaching about the illness and the assistance arrangements. The patient may be an inpatient after the patient.

After the patient's assistance arrangements are made and the patient is home it may require any assistance and the patient is placed. If a home is necessary, the patient is ready for the home to be placed. Home may be necessary if the patient is ready for the patient and the assistance. The assistance of the patient is necessary for the patient to be placed. The patient may be placed for the patient or for the patient's assistance. Occasionally the patient may be to be placed.
These homes are 45 miles from the hospital in the town of Tewksbury and are too difficult to reach for adequate social service supervision. As a result the homes have been used exclusively for custodial purposes; for patients requiring close supervision and treatment these homes are too far from the hospital. There is also a need for proximity to church and to urban centers for patients needing opportunity to look for work and for those patients wishing to make use of educational facilities.

In considering the physical structure of the home, facilities for recreational and occupational activities are required. Sanitation is stressed; only modern toilet accommodations are held acceptable. There must be single beds for each of the patients and no overcrowding in the rooms.

The economic status of the home has always been a major consideration. In a number of cases, however, the money paid for the care of the patients is the only income, but in these cases there always are other assets in the home which make such a selection advisable. Financial difficulties do not disqualify a home for use, but worry, fear of losing the home, and financial insecurity great enough to absorb the family's interest and attention react unfavorably on the patient. This is so, not necessarily because the family exploits the patient, but because "the patient shares the sorrows and worries as well as the joys of the family during
These homes are 4% of all homes in the county. Two-thirds of these homes are difficult to keep clean, and one-third have been seen by the home's service personnel. As a result, the homes have been reworked.

Explanations for catastrophic problems, like broken pipes or missing screens, have been given. One explanation may even prevent these homes from being used for work and for those perforce wishing to make use of gardens.

Front Activities.

In connection with the physical appearance of the home,

Activities for restoration and occupational activities are

required. Satisfaction is expressed only when clothes are seen to accomplish the home's needs.

There must be single page to

The economic aspects of the home are stressed here.

The activities for restoration. In a number of cases, however, the

money may not be the case of the problems in the only income

put in these cases. These values are other reasons in the home.

which make some a reflection of the financial situation.

The do not automatically a home for need, but money, lead to

focusing the home, and financially insecure, great efforts to help

the family's finances and attention must be paid to

This is so not necessarily because the family

explains the patient's own because "the patient's own

solution and motivation are well as the face of the family..."
his close association with them.1

Special training or nursing experience is not necessary to qualify as a caretaker. In some cases, in which it leads to too much self-satisfaction, it is a liability. The best caretakers are those who are challenged by the problems of mental illness and wish to make some contribution to their solution. The caretaker must first manifest a sincere interest and willingness to face the problems involved in such care. Also she must be a person of ingenuity, able to find tasks suited to each member of the family of patients, in order that they may feel that they are contributing to the common good.

Home finding was a problem for the social worker in the early days of family care. In the beginning, a few of the homes were obtained through the local child-placing agency, but these did not prove satisfactory for the mental patient with his idiosyncrasies did not make the same appeal as did the little child. The method which proved successful was that of advertising in those communities to which the regular social worker's duties carried her. Newspapers in the city, the county and in surrounding smaller communities were used. Many relatives, appreciative of what the hospital was doing for their own patients, went out of their way to advertise the need of homes. The social worker found the

Special training or unique experience is not necessary. To some extent, in which it
tends to qualify as a caseworker. In some cases, in which it
leads to too much self-satisfaction, it is helpful. The
participation of these and the application of the principles
of mental illness may help to make some contribution to social
solutions. The caseworker may then manifest a more intense
and meaningful way to face the problems involving in such
cases. They may be a person of integrity to find
solutions. There is much to be gained of the family or patient. In
order that they may feel that they are contributing to the
common good.

Home training and practice for the social worker
in the early days of family care. In the beginning there
of the process were applied, churches and local public-health
services. Care that the not known new opportunity for the Wilson
began to be introduced and not make the same mistakes
in the field of casework. The second method, which many communities
have found to give some relationship, want out at most may to
serve the need of family. The social worker, among the
key people in every community and enlisted their aid in the search for homes. She spoke at meetings of clubs and civic organizations and contacted the spiritual leaders of the various denominations most commonly needed as resources for patients.

A large number of homes are obtained through the successful caretaker who tells her relatives, who, in turn, seek patients to care for. One great handicap has been the small price paid by the state for the board of patients ($4.50 per week). In many homes the amount is considered too small a return for the amount of care and responsibility required. This is true where only one patient is taken, but the project is more profitable when three or four patients are taken. Occasionally a better paying private patient brings up the total income. This larger fee is based entirely on the ability of the relatives to pay, and the caretaker is instructed to render the same interest and privileges regardless of the size of the fee paid. In the compilation of statistics it was noted that of the 104 patients placed, 83 were paid for by the state and 21 were privately financed.

The acceptance of the home is based primarily on the findings of the investigation by the social worker. The investigation includes an interview with the prospective caretaker and as many of the other members of the family as are available at the time of the visit. For this reason, an
event people in each community and especially child life to the
 seemed to form the scope of services of groups and clinics

organizations and associated the priorities tended to the
various generations more commonly needed as segments to

believe

A large number of homes are operating through the

accessibility to the extent that relatives and neighbors

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If on the priority of the relatives to pay and the uncoverer

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expenditure are not higher than of the total payment plan,

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The occurrence of the home to pass popularity on

the findings of the investigation of the social worker. The

investigation indicates an interaction with the protective care-

takes many of the other components of the family as one

availability of the time of the April. Not from reason an
appointment is very often made so that all the members of the household will be at home. The first question to be answered is why the family wishes to board patients; in most cases this has been due to the desire to supplement their income. The experience and qualifications for caring for patients are discussed; many homes have had state children and no longer wish to care for them. The caretaker's plans for occupational and recreational activities for the patients are outlined. After the inspection of the homes has been completed, the worker usually is aware of the possibilities of the home and the qualifications of the caretaker. At this point she either decides to reject the home and conclude the investigation, or to accept it tentatively as a possibility and continue the interview by outlining the exact nature and requirements of the family care plan. The worker then discusses mental illness, the types of patients placed and the needs of convalescing patients. The responsibilities of the caretaker are outlined and amplified by the reading of the form list of instructions. The changes in the physical set-up of the home which are needed to meet the requirements for placement are explained. The family is informed that these changes must be made before patients can be placed, but they are cautioned not to make them until the home is officially accepted.

A questionnaire, which includes the references to be given, is left with the family. All of the references are
You can view the original document at [this link](https://example.com/). It contains information on the roles and responsibilities of the family in maintaining the home and its functioning. The text discusses the importance of family members working together to ensure the home remains organized and functional. It highlights the need for family members to engage in regular household tasks to maintain a healthy and safe living environment.
contacted either personally by the social worker or through a form letter. Others contacted are those who the worker knows are sources of information about the family being investigated. When the social worker makes her final decision to accept the home a form letter is written to the caretaker informing her that the home is certified for use, thus permitting her to complete any changes which must precede the placement. A second visit is made to the home by the social worker to see if these changes have been made and to discuss the patient who is to be placed with the family. The personality, eccentricities and habits of the patient are talked over with the family, and thus it is prepared with information on what precautions and emergency measures to use.

C. FITTING THE PATIENT TO THE HOME

Miss Crockett, in discussing this point in her paper, referred to it as "the most important step in social treatment."¹ She pointed out that the finding of the right kind of situation for each patient at the outset if possible, not only saves the social worker's time, but also avoids discouragement on the part of the patient. She illustrates this point by giving examples of a number of dissatisfied patients who, on their return to the hospital, discredited the boarding home idea among their friends, so that many patients were unwilling to try to live in a private home. Miss Crockett

¹ Crockett, Ibid., page 199.
insists that in the long run it is cheaper to wait several months for the right place than to make a mistake on a difficult patient, since "the best of homes are not best for all patients."\(^1\)

It has been generally found that schizophrenics make their best adjustment in a simple home situation. Depressed patients become more unhappy in a home where there are many people coming and going, creating excitement and confusion, but others may thrive in such an atmosphere. When family care was new, many patients were placed with those of their own social status since it was felt that they would be more apt to be accepted as members of the family. Miss Crockett's experience indicated that a patient could adjust to a lower level than that to which he had been accustomed, but attempts to improve the standards of some of the patients ended in failure. However, since 1934 experiments have proven that if the step up has been gradual and carefully planned that much success can be realized.

Sometimes a home that considers other matters of greater value than perfect order has its advantages. Patients who are very orderly become unhappy in homes that are indifferent on this point, whereas patients who are happy in disorder do not get along in homes that are always immaculate.

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impossible task to the young if it is acceptable to wait several
months for the right place from to make a mistake on a gill-
correction. Since "the peak of home is not peak for all"

practically.

If one has seen correctly young that self-determination
one makes slight feel indifference in a simple home situation.

- the many people coming and going, assuming excitement and
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existence among can perform other the same manner be-

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gether as not get along in home that are more immature.
Patients may be fitted to each other as well as to the home. It has been found dangerous to add a patient of doubtful reactions to a happy and contented group. This has been avoided by the placing together of people of similar tastes.

D. SUPERVISION

Supervision is a vital part of the family care program. The law requires that a patient be visited at least once in three months.\(^1\) It is now the policy of the social worker to visit each patient about once each month. The 1934 study revealed that 73 per cent of the patients were visited once per month and the remaining 17 per cent were visited less frequently up to the specifications of the law.\(^2\)

When the social worker makes her supervisory visit, she first interviews the caretaker alone. She finds out about the patient's condition, physical and mental, and about his activities within the home and outside. Any problems which have arisen or seem pending are discussed with the caretaker and advice is given on how to deal with them. There are further frequent contacts with the caretaker through the medium of telephone calls made because of acute problems or difficulties which cannot wait for the worker's visit.

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2. INFORMATION

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1. Annual Report of Board of Health, Council and Department.
The contact with the patient is limited within certain areas. The worker listens to the complaints, ideas and requests which she discusses with the patient. She has the opportunity to observe the patient in his activities and relationships with the other patients and with members of the family group. This contact gives some indication of the progress of the patient and what steps he is making toward a more adequate social adjustment and complete recovery. Personal service plays a large part in the worker-patient relationship. Clothes are secured and delivered to the patients; social contacts are made with and for them; the patients are returned frequently by the worker to the hospital for medical and dental treatments; shopping is done with them, and on occasions trips are made with the patients for recreational purposes. These activities are an integral part of a function which tends to stimulate and help the patient to make the most satisfactory adjustment within his limitations. This purely routine activity consumes a large part of the worker's time and is a definite limitation on her many more professional functions.

Very little psychotherapy has been done with the patient in the family care homes. This is in accord with the present policy of the hospital concerning psychotherapy done with the family care patients. The emotional problems of the patient are not dealt with by the social worker because at
The contact with the patient is limited within cer-

tain areas. The worker listens to the complaints, these and

routines which are meaningful with the patient, the and the

opportunities to observe the patient in the activities and these

interactions with the other parties and with members of the

family. courtyard. The contact gives some information of the

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which can be stimulated and help the patient to make the most

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and to a considerable situation on very many more proportion.

In conclusion. Very little documentation has been gone with the

patient in the family care home. This is in severe with the

previous benefits of the patient concerning the patient's home

with the family care balance. The emotional programs of the

patient are not yet able of the social worker because of
present this is considered the function of the psychiatrist.

E. RECORDING

As important as the supervisory activity is in guiding the placements toward effectiveness for the patient, there is the equally important function of recording. It has been admitted by the social worker herself that much can be done to improve the family care records, in scope and content. The major barrier to more adequacy in record writing has been the time element and the multiplicity of activities which crowd the work-day of the social worker to the point that completeness in reporting all her activity is a difficult problem. In the past, the record writing was confined to reports of the worker's contacts on the supervisory visit to the family care home with a brief statement as to the patient's condition and progress. Also, reference was made to problems which arose during the interim between visits and how the problems were handled. When an attempt was made to enlist the cooperation of the patient's family and have them consider taking the patient on visit, a brief statement of the make-up and status of the family situation and a reflection of their attitudes toward the patient were recorded. The keynote of the recording was brevity and the reason again was the paucity of time.

With the trend toward the therapeutic use of the homes there came a recognition on the part of the social
Present paper is concerned the importance of the participative

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worker that her records were inadequate. For some time attempts have been made to broaden and intensify the record. When interviewed the social worker expressed the hope that such a recording program will be the basis for future record writing activity, but it was pointed out that the determining factor in the success of this program will be the pressure of the work with a limited personnel. The broadened program for recording would include:

1. A picture of the personality of the patient as he is in the hospital before placement; a statement about his adjustment, his needs and his prognosis for the future. Also recorded should be the plan for placing the patient and effecting his social rehabilitation.

2. The patient's family situation is to be outlined with its attitudes toward the patient and his illness, their status, availability and feelings about taking the patient on visit, plus any changes in these family conditions.

3. A detailed account of the actual contacts with the patient, from the initial contact with him through the process of placing him, in his adjusting efforts in the home, and finally during his removal from family care to the community or back to the hospital. This section of the record should include the contacts of the patient with the caretaker and family, the feelings of the patient about his placement, the problems arising out of the placement, and their effect.
The image contains text from a page that appears to be in a language other than English. The text is partially legible, and it includes numbers and possibly coordinates or measurements. Without clearer visibility or context, it's challenging to transcribe or interpret the content accurately. The document may include technical or specific information, which requires specialized knowledge to understand fully.
on the patient. This should be a charting of the progress of the patient from the convalescent stage either to that of reestablishment in his own community or to the return to the hospital with a statement of the reasons for the failure of the placement.

F. SOCIAL REHABILITATION

In no instance is a patient, who is capable of social adjustment, allowed to feel that family care is the final solution of his problem. Every effort is made to get the patient back to status in the community. The staff physician visits each patient in family care once every three months. Following physical and mental examinations, and consultation with the social worker, he recommends to the hospital staff patients who should be released on visit or discharged.

An evaluation, at this time, of the inherent capacity of the patient to make this step is not enough. First, there should be developed in the patient the will to get better and to regain his former position as a member of his family and his community. He may be helped to face the difficult problems and ever-present barriers to a successful venture into the society from which he was removed usually under disagreeable circumstances. These difficulties can be faced long before the visit plan is proposed. The patient should attain confidence in himself and his ability to face this
The moment of the patient's response to the treatment is a critical aspect of the progress of the patient. It is necessary to follow the patient's recovery process to determine if the treatment is effective for the patient. The treatment plan should be reviewed with the patient at the end of the treatment to ensure that the patient is prepared for the next phase of treatment.

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social re-adjustment. He is forced to face the stigma which
he will carry as an unfortunate burden. A second factor is
the manipulation of the environment to the point where it can
be favorably receptive to the patient.

The social worker has this rehabilitation as her
goal throughout the patient's family care placement and she
does all she can to prepare the patient and manipulate the
environment so that the eventual discharge of the patient on
visit may be effected.

The patient is interviewed on almost every visit
with the emphasis on his interests and plans for the future.
He is encouraged to make plans and to talk them over with
his family and the worker. Every effort is made
to have these plans realized. The patient is urged to seek
employment especially if the visit plan is dependent upon such
an achievement. The worker often makes vocational contacts
with and for the patient. When a job is secured and the visit
status approved by the staff, the worker aids the patient to
find suitable living arrangements and is a constant source of
support during the first few months of uncertainty and some-
times discouragement.

The second focus of attention in this process of
rehabilitation is the patient's family. During the period of
the patient's placement, the family is contacted by the worker
to obtain money and clothing for the patient, and also to
The patient is instructed to practice relaxation after each treatment. He is to stand and face the mirror, relax, and try to release the tension in his body. He is to pay attention to his breathing and try to keep it slow and steady. The patient is to practice this relaxation exercise for 5 to 10 minutes each day. This helps to reduce stress and promote relaxation.

The social worker and the rehabilitation team will encourage the patient to participate in activities that promote relaxation and stress reduction, such as yoga, meditation, and deep breathing exercises. They will also provide opportunities for the patient to socialize and interact with others, as this can help to reduce feelings of isolation and loneliness.

The patient will be encouraged to maintain a healthy lifestyle, including regular exercise, a balanced diet, and adequate sleep. This can help to improve his overall well-being and reduce the risk of complications associated with illness or injury.

Throughout the patient's treatment, the social worker and the rehabilitation team will provide ongoing support and encouragement to help the patient to cope with the challenges of illness or injury. They will work closely with the patient and his family to develop a plan of care that is tailored to his specific needs and goals. This may include assistance with transportation, financial planning, and other practical concerns.

The social worker and the rehabilitation team will also help to arrange follow-up appointments and referrals to other healthcare providers, as needed. They will help the patient and his family to navigate the healthcare system and ensure that all of the patient's needs are being met.

The patient's progress will be monitored closely, and the social worker and the rehabilitation team will make adjustments to the plan of care as needed. This may include increasing or decreasing the intensity of the treatment, or making changes to the patient's medications or other interventions.

The patient and his family will be given the opportunity to ask questions and express concerns throughout the process of rehabilitation. The social worker and the rehabilitation team will work to address any concerns and provide reassurance and support. They will help the patient and his family to feel confident and empowered to participate in their own care and make decisions about their future.

The patient's discharge from the hospital will be carefully planned and coordinated by the social worker and the rehabilitation team. They will work with the patient and his family to ensure that all of the necessary arrangements are made, including transportation home, follow-up appointments, and any necessary adjustments to the patient's home environment.

After discharge, the social worker and the rehabilitation team will continue to support the patient and his family. They will provide ongoing support and guidance, and will work to help the patient to achieve his goals and make a successful transition back to daily life.
help prepare them for the return of the patient. In many cases the family is not in a position to take the patient, and the worker through her contacts often does much to increase the adequacy of the family and thus its availability as a place for the patient. Often the family is willing to accept one of its members from a boarding home, but has feared to remove him directly from the hospital. Before the return of the patient to the home there comes a period of orientation on the part of the family somewhat similar to that given the caretaker. The implications and nature of the patient's illness are outlined as is the relationship between family and patient, with precautions given as to attitudes and specific actions. The family is thus enlisted as an ally on the side of those who will attempt to make this re-adjustment by the patient a successful venture.
CONCLUSION AND RECOMMENDATIONS

The trend toward the therapeutic use of the family care home has brought with it a number of related problems which need serious consideration. The major problem seems to be in the administrative control and supervision of this program. With the growth of this therapeutic idea has come a clarification of objectives and a definition of approach toward achieving them. At the same time the functions and responsibilities of the guiding force behind this program, namely the social worker, have extended and are beginning to stand out as major factors in the continued development of family care.

The material accumulated in this study reveals that this trend has brought with it definite and specific emphases which reveal themselves as basic to the effectiveness of this work. The type of patient referred, together with the therapeutic purpose of the placement, has involved greater selectivity in finding homes. More time and skill is consumed in preparing the homes and the caretaker, for they represent the key to the success of the placement. More effort is now devoted to gaining an understanding of the needs of the patient and in the planning to meet these needs. Closer and more frequent supervision together with careful and more detailed recording are required. There is
CONCLUSION AND RECOMMENDATIONS

The trend toward the therapeutic use of the family case home has prompted a number of related programs which seek various means of intervention. The model program seems to be in the experimental notation and experimentation at this program. With the growth of this therapeutic approach a clarification of objectives and a definition of approach toward similar issues at the same time the function and responsibilities of the guiding force behind the program as well as the social worker, have expanded and are beginning to stand out as major factors in the continuing development of family care.

The material accumulated in this study reveals that case finding was prompt with little difficulty and specificity emphasis with veteranism as part of the selection. The type of patient referred for treatment is expanding with the therapeutic purpose of the placement, more time and skill are necessary in determining the home and the caretaker for each placement. The key to the success of the placement and the need for the best and in the planning to meet these needs. Greater and more frequent supervision is required. These are

concerns and more frequent supervision are required. These are
the stimulation of and the interpretation to the patient's family toward the assumption of its role in the therapeutic plan which follows, a function not stressed when the custodial placements were the major consideration. Finally, more active and intensive rehabilitative work with the patient is necessary in order to bridge the step to the community.

If these emphases represent, as they indicate, the re-interpreted and redefined function of the family care social worker, it is necessary to consider her ability, physical capacity as well as professional competence, to perform this activity. In a typical home placement agency, the social worker carries a maximum case load of 50 cases for the purpose of supervision. The function of home finding is carried by a separate worker. In comparison, the one family care social worker (up to September 1938) carried a case load of over 100 cases of which about 60 were treatment cases requiring the intensive work outlined above. Also she carried the burden of home finding. With the trend toward the referral of treatment cases and the supplanting of the custodial placements, we find that by January 1, 1939, there were 125 patients in family care of whom 82 were placed for therapeutic purposes. It therefore seems conclusive in its indications that the effectiveness of this program and the possibilities of its further growth as a therapeutic tool is, in the beginning at least, entirely dependent upon the
the establishment of the integration of the patient.

family towards the freedom of the home to the therapeutic
plan which follows a functional vs. a systemic view of the situation. What lies more
not necessarily where the social composition. Finally, more
social and integrative responsibilities work with the patient in
necessary in order to provide the needed to the community.

In these emergency departments as they integrate
the re-integrating and integrating function of the family can
social worker, if it is necessary to coordinate per-aplich
phases in a systematic as well as therapeutic, compositions, to per
from this activity, in a study of home placement, the
social worker attains a maximum scope to 70 cases for
the purpose of supervision. The function of home finding in
the care of a separate worker in composition, the case family
are social worker (a case supervisor 1259) calling a case
and over 100 cases in which scope to the treatment
length of the home finding with this case coming
carry the burden of home finding with the case coming
the referral of the treatment cases and the employment of the
case of the home. In finding this plan we have been
were the basis in family care on 99 cases pleasing to the
therapeutic approach. In this case, see communication in the
information and the accessibility to the hospital and the
possibilities of the further growth as a research to tool.

In the beginning of least certainty, dependent upon the
provision of an adequate personnel. This should include at least two full-time social workers devoting their efforts to family care alone, plus the provision of a third worker if the placements exceed 150.

Other points which may be considered as basic to greater effectiveness of the family care program are listed below:

1. The referring physician can be more thorough and definite in his statements of reasons for and recommendations with referrals.

2. Family care homes selected for therapeutic purposes would be more valuable/used for custodial patients, for when once a home is used for a custodial patient the caretaker is no longer willing to assume the added responsibility characteristic of the other type of placement.

3. There could be still more contact by the worker with the patient's family in the attempt to gain its cooperation in taking patients on visit directly from family care.

4. There is a need for more recreational and occupational opportunities in the family care homes. This problem has been discussed with the Occupational Therapy Department and tentative plans have been drawn up which can be carried out if adequate personnel could be provided.

5. Many excellent applications to take family care patients have been withdrawn because of the inadequacy of the
The use of interdisciplinary teams to develop and implement effective interventions in the treatment of mental illness has been shown to be highly effective. These teams typically consist of psychologists, psychiatrists, social workers, nurses, and other mental health professionals. The interdisciplinary nature of these teams allows for a comprehensive approach to treatment, addressing not only the mental health needs of the patient but also their physical health, social support, and other factors that may contribute to their overall well-being.

The use of telephone therapy has also been shown to be an effective means of delivering mental health services, particularly in rural or remote areas where access to traditional in-person therapy may be limited. Telephone therapy allows for greater flexibility in scheduling and can be particularly helpful for individuals who may have difficulty getting to a therapist's office, such as those with physical disabilities or those who live in areas with limited access to transportation.

In addition to these traditional approaches, there has been an increase in the use of online therapy and other digital tools. These tools allow for greater accessibility and can be particularly helpful for individuals who may feel more comfortable or able to communicate through written or visual means. Online therapy can also be a useful supplement to traditional therapy, particularly for individuals who are already in treatment and may benefit from additional support.

It is important to note that while these approaches can be effective, they should not replace the need for in-person therapy when it is appropriate. The decision to use any particular approach should be made in consultation with a qualified mental health professional, who can provide guidance based on the individual needs and circumstances of the patient.
payments made for state patients. This indicates a need for a more flexible scale which can be adjusted to correspond to the changes in the cost of living conditions.

In conclusion it can be stated that family care is still in its early stages of development, but the encouragement of the growth and the trend toward its therapeutic use indicates the place it may assume in the care of the mentally ill. The clinical director, under whose guidance this program has expanded to date, when interviewed made the following statement, "Family Care is the best therapeutic tool known to-day for the care of the convalescent patient."

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