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An evaluative study of foster home placement at the Veterans Administration Hospital, Northport, Long Island, New York

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AN EVALUATIVE STUDY OF FOSTER HOME PLACEMENT
AT THE VETERANS ADMINISTRATION HOSPITAL,
NORTHPORT, LONG ISLAND, NEW YORK

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY
VERNA LAZELLE WOODS

SCHOOL OF SOCIAL WORK
ATLANTA, GEORGIA
AUGUST 1968
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CHAPTER I

INTRODUCTION

Significance of the Study

The Community Placement Program at Northport Veterans Administration Hospital, has been in operation since 1953.¹ The Program is designed for patients who are ready to be returned to community living, but for various reasons are no longer able to live with their families. Foster homes are offered by the Northport Veterans Administration Hospital as part of their Community Placement Program. The program is designed to provide a rehabilitative environment for the patient and to help him resume his activities as a productive citizen within the community.²

The foster home program became an official part of Veterans Administration's rehabilitative program in 1947, with the issuance of a technical bulletin setting national policies of the program and making the program another source of treatment for the mentally ill.³

¹Community Placement Program Pamphlet, V. A. Hospital, Northport, New York. A. P. Dell Cort, M.D., Director, Northport V. A. Hospital, "Forward" (nd).


However, the official inception of the foster home program in Veteran Administration systems, came in 1951 after the success of pioneer programs in California, Alabama and Massachusetts Veteran Administration Hospitals. It was not until 1953 that the foster home program began at Northport Veterans Administration Hospital, as a part of the Community Placement Program.

The investigator's interest in the foster home placement segment of the Community Placement Program stems from having briefly worked with this program while on field placement at Northport Veterans Administration Hospital. The investigator's brief contact with the program stimulated interest in the value of the foster home program and the benefits the patients received from it. Having the experience of presenting a patient before the Community Placement Board for foster home placement and seeing the patient rejected, raised questions in the investigator's mind as to whether or not the patient was properly prepared for placement. This is not to say that the researcher's patient was the only patient not placed by this body, but many patients have the experience of this same misfortune.

The investigator realizes that the concepts of treatment for the mentally ill have undergone considerable changes in the past twenty-five to fifty years. There has been a shift from the asylum's custodial care to hospital care based on a more humane approach to treating the psychiatric patient as sick and needing treatment, rather than being mad and needing segregation from the community.
The new era in treatment of psychiatric patients focuses on therapy, rehabilitation and resocialization, instead of just permanent, regimented hospitalization. This permanent hospitalization has been refuted for the new "therapeutic community" approach. Modern treatment concepts foster atmospheres in which the patient is given the opportunity to test his ability to function independently. The "therapeutic community" involves use of a "therapeutic milieu" which utilizes every aspect of hospital life as therapy and integrates the hospital into the community. This atmosphere stimulates increased discharges of patients from the hospital into the community, which acts as a source of custodial care and rehabilitation.

With greater usage of the community as a therapeutic resource, programs such as: nursing homes, rest homes, domiciles, half-way houses, and foster homes are being utilized by neuropsychiatric hospitals, such as Northport Veterans Administration. Hester B. Cruther in her article, "Foster Home Care for Mental Patients," supports the usage of community therapeutic resources by stating:

Along with institutional care, family care increases the measure of human happiness by restoring to normal life, in a friendly world, and often to useful activity; people who the monotony and frustration of the institutional life have reduced at best to passive indulgence and at worst to bitterness and rebellion. The individual should have the opportunity to grow

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2 Rubleins, op. cit., p. 8.
and develop in an environment in which usual life experiences predominate.\textsuperscript{1}

Foster home or family care operates as an extension of Northport Veterans Administration Hospital's community therapy program.

The Community Placement Program functions for the benefit of patients who are discharged from the hospital, but still need a rehabilitative environment to help them resume normal living. However, for the mentally ill, discharge from the hospital into a foster home means many emotional demands are placed upon him as much of his fight to become a normal citizen is just beginning. If the patient is to remain in the intimate group setting of the home, he must be able to cope with the emotional demands imposed on him by the intimate family setting. The hospital must and does assume an important part of the responsibility for preparing the patient to meet these demands. In the hospital milieu, there is some indication of a surge of interest in preparing the patient for foster home placement by those directly involved. According to Cruther, there seems to be increasing requests for family care placements from both patients and staff of hospitals where open wards are used.\textsuperscript{2}

In 1955, the Veterans Administration system held three institutes for physicians, social workers, vocational counselors, and hospital registrars, stressing the objectives of placement of patients on trial visits, particularly in foster homes, indicating the need

\textsuperscript{1}Hester B. Cruther, "Foster Home Care for Mental Patients," \textit{American Journal of Psychiatry}, CXV, 115 (1954), p. 9.

\textsuperscript{2}Hester B. Cruther, "Family Care," \textit{American Journal of Psychiatry}, CXVII (1960-61), p. 647.
for adequate advance preparation and planning for patients and their families.\textsuperscript{1} It is common knowledge that as the program operates, at Northport Veterans Administrations Hospital, the social worker assumes the responsibility of finding homes, selecting patients and placing patients in homes that best meet his needs.

Noted psychiatrist, W. E. Barton contends, that the hospital staff must seek out suitable patients for placement, while social workers are responsible for finding homes and out-patient supervision.\textsuperscript{2} Still other authorities assert that the responsibilities of the social worker is not to supervise the patient in the foster home but to prepare the patient for his placement in a foster home. It is the investigator's contention that all of these activities are the responsibility of the social worker as part of his obligation to his client. However, the investigator wishes to focus this study on the preparation given patients before their placements in foster homes.

Review of the Literature

Presently, there is a tremendous amount of literature written on foster care programs and their historical development, but few studies have been published that discussed the dynamic functions of the program. Studies have been done by Ullman and Berkman publishing findings to the effect that the environment in which the former mental patient lives when he leaves the hospital has a significant bearing

\textsuperscript{1}Burks, \textit{op. cit.}, pp. 24-25.

\textsuperscript{2}W. E. Barton, "Family Care and Out-Patient Psychiatry," \textit{American Journal of Psychiatry}, CXIX (1962-63), pp. 666-68.
on his ability to maintain a degree of adjustment, which permits him
to live in the community rather than return for further hospitaliza-
tion.\textsuperscript{1} This information was ascertained in their study "Types of
Outcomes in the Family Care Placement of Mental Patients." Lyle
and Trial in their research "A Study of Psychiatric Patients in
Foster Homes," brings out characteristic tendencies of patients in
Foster Homes. Their study indicated that withdrawal and regressiv-
eness decreases during foster home placement whether or not the patient
returns to the hospital or remains in the community.\textsuperscript{2} Currently
Northport Veterans Administration Hospital's Social Work Service
Department is conducting research on the effectiveness of its
Community Placement Program. There has been no indication of research
being done to ascertain more effective methods of preparing patients
for placement. There is no indication of research being done by
Northport Veterans Administration Hospital or any other researcher to
ascertain more effective methods of preparing patients for placement.
J. Mayone Stycos emphasizes in his study "Family Care: A Neglected
Area of Research," the need for research in family care of mental
patients. Stycos feels that research in this area is neglected and
that there is a need for expanded study.\textsuperscript{3}

\textsuperscript{1}Leonard Ullman and Virginia Berkman, "Types of Outcomes in
the Family Care of Mental Patients," Social Work, IV (April, 1959),
pp. 72-78.

\textsuperscript{2}Curtis Lyle and Olga Trial, "A Study of Psychiatric Patients

\textsuperscript{3}J. Mayone Stycos, "Family Care: A Neglected Area of Research,"
Some patients are ready for placement almost at the moment they decide to accept placement. These patients are usually physically and emotionally ready to leave the hospital. Their anxieties about entering the community have been calmed and are at a minimum. Yet, other patients are interested in foster homes, but must join preparatory groups or spend weeks in preparatory sessions with a social worker before they can accept any suggestions to enter a foster home.

The existing methods of preparing patients for foster home placement at Northport Veterans Administration Hospital is a combination of casework, group work and in many instances both techniques. The type of preparation given varies from patient to patient. Some need only individual support, while others need group motivation and support. For those patients whose problems evolving around placement demand more intensive help, both casework and group work services are given.

Due to the investigator's interest in the program as an effective service to patients and her desire to make a contribution to the hospital's program, this study was undertaken to evaluate the preparation of patients for foster home placement.

Definition of Terms

The following terms have been defined by the investigator so that the reader will have greater understanding of the research. The investigator used no specific source for defining these terms but created definitions and terms most pertinent to her research.

Group work method--A method of preparing patients, by the group process, for entering foster homes, through exploring,
developing and motivating the patient's interest in placement.

Casework method--A method of individually preparing patients, by casework techniques, for entering foster homes through exploration and motivation.

Bi-method--A method of preparing patients, both casework and group work techniques, for foster home placement by exploring, developing and motivating his interest in placement.

Readiness for Placement--The patient's preparedness to except placement in foster homes in terms of his physical, emotional, financial and familial approval.

Family Home Care--This term will be used interchangeably with family care. It denotes private homes which have been approved by the hospital for profiving after hospital care for patients who are sufficiently recovered to leave the hospital.

Community Placement Program--A service which provides selected patients with rehabilitative care in foster homes, half-way houses, special placements, rest homes, and nursing homes.

Committee--This term is used by Northport Veterans Administration Hospital to describe a three man group which is appointed by the patient's estate or the hospital situations where the patient has no family.

Foster Home Program--A segment of Community Placement Program that uses privately owned and run homes for patients while they adjust to community living.

Purpose of the Study

This study evaluates the method of preparing patients for foster home placement at Northport Veterans Administration Hospital. Patients are prepared for placement by the use of casework, group work and in some instances by both methods. It is the intention of the researcher to evaluate these methods of preparation to determine which one most effectively prepares the patient for his placement.

Method of Procedure

A survey was taken of those patients who were placed in foster homes by the Community Placement Board of Northport Veterans
Administration Hospital, between September 1, 1966 and December 31, 1966. This survey showed that there were 62 patients placed during this period. The researcher divided the population into three groups--(1) casework, (2) group work, and (3) bi-method--for purposes of comparison. In selecting the sample for this study, the investigator discovered only six patients had been prepared by the bi-method. To keep the sample evenly distributed, the other two groups were limited to six patients each. The researcher divided the remaining population into two groups according to methods of preparation. Of the remaining 56 patients, 26 patients had been prepared by the group method and 31 had been prepared by the casework method. The investigator then random selected six patients in each of these categories. The selection, placed six patients in the group method and seven in the casework method. It was necessary to eliminate one of seven patients chosen in the casework group in order to keep the population evenly distributed.

To measure the effectiveness of preparation the following indices were used: (1) The length of time between the patient's acceptance for placement and his placement in a foster home; (2) interviews with social worker concerning their evaluations as to the patient's readiness for placement; (3) interviews with ward nurses concerning patient's readiness for placement; and (4) adjustment evaluations by foster home workers. Because of the commonality of jargon used by hospital staff in discussing patients, the same interview schedule was used for both social worker and nurses.

Historical data concerning the Community Placement Program was secured from books, articles describing the origin and development
of the program. Information describing Northport Veterans Administration Hospital and its foster home program was also ascertained through, (1) personal interviews with members of the social work staff, (2) observations, and (3) participation in the program.

Scope and Limitations

This study is limited to 18 patients who were placed in foster homes between September 1, 1966, and December 31, 1966. Further limitations of the study are: (1) the smallness of the sample, (2) the length of time allotted for the study, (3) the possibility of complications in placing the patient immediately after he has been approved for a placement such as no available foster homes or neither foster home worker has an opening on his caseload, (4) bias of these giving opinions about patients readiness, (5) the writer's limited experience in doing research.
CHAPTER II

DESCRIPTION OF AGENCY

Description and Location

The Veterans Administration Hospital located at Northport, Long Island, Suffolk County, New York, is the largest neuro-psychiatric hospital in the Veterans Administration system, with approximately 2,500 beds for male veterans. Employing nearly 1,500 staff members, the team approach is used in the treatment of its patients. Here the writer is referring to team approach in terms of collaboration of medical, psychiatric, psychological and social work professions, in addition to other personnel working with the patient.¹

Specifically the social worker with his knowledge and understanding of the patient's social behavior is able to help the medical staff become cognizant of social factors which confront the patient.²

At Northport Veterans Administration Hospital, social workers function as part of the team, however the medical staff acts as head of the team and is ultimately responsible for the patient while hospitalized.


Northport Veterans Administration Hospital offers Acute Intensive Treatment Service to patients who need immediate treatment and respond quickly, thus are hospitalized only a short time. Continual Treatment Service for those patients who are chronically ill, and need hospitalization over a longer duration. In addition to psychiatric treatment, the hospital is equipped to meet any type of medical, surgical, dental or tubercular problems. ¹

FUNCTIONS OF SOCIAL WORK SERVICE

Social Work Service functions as part of the hospital, team, giving direct casework and group work treatment, to the patient, helping family members work through difficulties they may be having as a result of the patient's illness and subsequent hospitalization. Velma Woods in her article, "Casework Practices in Mental Health Clinics", states much of the social workers job when working with mental patients and their families is giving support. ²

At Northport Veterans Administration Hospital, social workers are assigned by ward and have direct responsibility for the following:

(1) Helping the patient to most effectively utilize hospitalization through casework treatment directed toward his understanding and modifying his feelings and attitudes;
(2) assisting the family in handling their social and emotional problems which interfere with the patient's use of treatment;
(3) enabling the patient (and his family) through casework service to leave the hospital and move toward

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¹ Hopson, op. cit., p. 12.

rehabilitation in the community.¹

DESCRIPTION OF FOSTER HOME PROCEDURES

The foster home is of tremendous therapeutic value to the mentally ill patient. Many patients, who might otherwise have remained institutionalized the remainder of their lives are provided a most beneficial change of environment.² Foster homes were created to provide a means of wholesome family life. Patients who have been placed in these homes have been able to carry on more meaningful lives and recovered sufficiently to be freely discharged from the hospital.³

The individual patient, like everyone else, has his own special needs and aims, his own personality and characteristic way of reacting to people. So that the patient derives the most benefit possible from his experience, Social Work Service handles foster home placement with emphasis on each patient's requirement and rehabilitative needs. The social worker prepares the patient for placement, secures the proper home, visits the patient periodically while he is in the home and works with the foster home sponsor and the patient's family members toward more successful adjustment for the patient.

¹Social Work Service Folder, Veterans Administration Hospital, Northport, L. I., New York, p. 1.
³Community Placement Program Pamphlet, V. A. Hospital Northport, N. Y., A. P. Dell Cort M.D., Director Northport V. A. Hospital (N.D.).
Even though the procedures for foster home placement can be described in four words -- referral, preparation, presentation and placement -- the actual procedure is much more involved and detailed. Initially, ward social workers receive referrals from ward personnel, doctors, nurses, psychologists, and nursing assistants, for patients whom they feel have potentials for foster home placement. However in most instances the social worker is so well acquainted with his ward patients so that he is usually aware of which patients are potentials for placement. Still other patients refer themselves or their families refer them.

After receiving referrals, the social workers assess each patient to determine if he meets the criteria for foster home placement candidacy. Much of the social worker's assessment is done on the basis of the individual patient and his capabilities, in that what may be considered marginal functioning for one patient can be excellent for another. Each patient is assessed by the succeeding criteria: (1) How well his illness is remissed, (2) the patient's ego strength, (3) what his family and home life can offer in terms of rehabilitative environment, (4) his personal habits and hygiene, (5) his self-responsibility and need for supervision, (6) the therapeutic value the patient will receive from foster home placement, (7) his financial status and to what extent can he maintain his up-keep, and (8) his vocational potential.¹ In most instances vocational potential is a secondary consideration.

It is rare that a social worker is able to find patients who meet all the criteria for candidacy. Many patients are ready for placement in terms of the listed criteria, but are not emotionally ready to leave the hospital and resume their functioning in the outside world. For a majority of these patients Pre-Foster Home Groups are recommended and others are seen individually in one-to-one relationships. The Pre-Foster Home Group operates under the supervision of the ward social worker, exploring, developing and motivating the patient's interest in the Community Placement Program by the group process and method of treatment.\(^1\) The group discusses the patient's interest or lack of interest in entering the community. Group members examine problems to be encountered in the community and what a foster home has to offer them. On occasion some groups have patients who were former foster home patients and they share their positive and negative experiences with the group. Many patients move into foster home placement from these groups, others have extensive casework treatment in addition to their group experiences before entering the community.

The length of time between preparation and the social worker's presenting the patient before the Foster Home Board for placement consideration varies. This variance is caused by individual levels of patient readiness for placement. The pre-placement preparation may last from one to eleven months before the patient is ready for presentation. Preparation is geared toward emotional, physical,

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financial readiness and family acceptance of the patient's placement. It is the social worker who determines the patient's readiness and eventually presents him before the board.

Financial difficulties can cause a multitude of problems for the patient and social worker who are working toward placement. Those patients who have military service-connected disabilities and receive 100 per cent pension or compensation have little difficulty maintaining their up-keep while in foster homes. In June, 1966, a room and ward price list was established, setting monthly cost at $150 for single rooms, $135 for double room and $125 for a room with three or more men sharing it. For those men who received only partial service-connected compensations or are non-service connected, their pensions are relatively small and can not adequately cover the cost of up-keep. The Suffolk County Welfare Department has in a few instances supplemented these patients' incomes. However, this was only done after a six months successful adjustment to community living. Since no definite policy for supplementing patients' incomes has been established between the Veterans Administration Hospital and the Welfare Department, therefore, it is not possible to use that agency as a referral source. Therefore, many patients are often left with one course of supplement to their incomes. Consequently, some patients remain in the hospital, others stay in the community for only a short while or return to their families. For those patients who have committees, financial responsibilities are usually not difficult. These committees are often comprised of a banker or a lawyer or some other authorized

1Fields, op. cit.
agent who is responsible for the patient's well-being, when there are no family members. In these cases, decisions concerning the patient's welfare, whether financial or social are handled by this committee.

Emotional readiness is often a greater hinderance to patients' placement than any other factor. Frequently a patient's illness may be partially remissed; he may be in good contact and seems like a good prospect for placement, but in many instances the patient's anxieties about foster home living prevent his placement. At this point the social worker might continue to work with the patient individually, place him in a pre-foster home group or work with him in both methods. While activities are primarily carried on with the patient, relatives are also seen by the social worker. Not only is the patient assessed, but the family is also assessed. The family's attitudes toward the patient's hospitalization are studied and interpretations are made to the family as to how they can aid the patient during his rehabilitation.

When the patient is ready to be presented for placement, the social worker notifies relatives by a letter to tell them of the program and the patient's interest in it. In reply, relatives either give their approval or rejection of the plans to present the patient. If the family objects to the program and all those involved in the patient's treatment feel that this program is strongly needed, the social worker attempts, through activities with the family to show the therapeutic benefits the patient can receive from the program. In the event this method fails to stimulate, a positive response from the family, a "ten-day letter" is used to notify the relatives
of the patient's pending placement.¹

As the program operates at Northport Veterans Administration Hospital, the final decision as to the patient's readiness for placement is made by the medical staff. When the social worker feels the patient is ready for placement, he presents the patient before the ward staff. At this ward staffing, in which the assistant hospital director, chief ward physician, chief nurse, social worker and nursing attendants participate, the patient is presented by the social worker, interviewed by the participants and final recommendations are made by the ward physician. If the group agrees that the patient is ready for foster home placement the social worker presents the patient before the Foster Home Board.

The Foster Home Board is comprised of (1) the chief of Social Work Service, (2) four foster home workers, and (3) the presenting ward social worker.² Once the patient is accepted by the board, a foster home worker is appointed and the patient is evaluated again in terms of what is available for this particular patient. The foster home worker evaluates the patient in much the same way as does the social worker, his focus being the patient's feeling about placement possibilities of remission of illness, financial status and the type of home which best suits the individual. However, once again the length of time between a patient's acceptance by the Foster Home Board and placement may vary. Factors such as, the lack of a suitable

¹Social Work Service Foster Home Care Handbook, Veterans Administration Hospital, Northport, New York, A. P. Dell Cort, M.D., Hospital Director (M.D.), pp. 4-5.

²Ibid., pp. 3-4.
home for the patient at the time, objections by family members or limited finances often hinder immediate placement.

When an appropriate home is located, the patient is discharged from the hospital on trial-visit and placed in a home by the foster home worker. Trial-visit begins with discharge and last for six months, during which time the foster home worker makes periodical visits to the home. At that time, the foster home worker visits with the patient and his sponsor, evaluating the patient's adjustment to community living. At the end of the trial-visit period, if the patient's adjustment has been satisfactory, it is recommended that the patient be discharged from hospital care. Upon his discharge, the patient may remain in the home or secure some other living arrangement.
CHAPTER III

ANALYSIS OF DATA

The data used in this study was obtained through a variety of methods: Personal interviews, observations and a survey of case materials. This data was incorporated into the tables which will be analyzed and discussed in the content of this chapter. The data obtained was placed in the following tables: (1) Characteristics of patients; (2) social workers evaluations of patients readiness for placement; (3) nurses evaluations of patients readiness for placement; (4) length of time between acceptance and placement; (5) foster home workers evaluations of patients adjustment; and (6) recidivism of patients.

Characteristics of Patients

Characteristics of the patients describe the distinguishing features of patients included in this study. It includes those factors that describe the patients served by the Northport Veterans Administration Hospital.

The data in Table 1 shows that the 18 patients studied were diagnosed as Schizophrenic Reactions, with secondary diagnoses. Of the 18 patients studied their secondary diagnoses showed that 7 patients or 39 percent were hebephrenic, 5 patients or 28 percent were paranoid, 3 patients or 16 percent were undifferentiated, 2
patients or 11 percent were catatonic, and 1 patient or 6 percent were alcoholic. Sixteen percent were service connected, while 6 percent were non-service connected. The study showed that the mean age of the patients was forty-nine. Sixty-one percent or 11 of the patients in the study were in the Armed Forces during World War II, while 28 percent or 5 patients served in the Korean-Conflict and only 11 percent or 2 patients were peace-time veterans. It was also revealed that 11 or 62 percent of the patients in the study were long-term patients, 22 percent or 4 were long-term chronic patients and 16 percent or 3 patients were short-term.

Social Workers Evaluations of Patients' Readiness for Placement

Social worker evaluations of the patients' readiness for placement discusses the factors that ward social workers consider when assessing patients readiness for placement in a foster home.

The data in Table 2 reveals that emotional readiness is determined by the remission of the patients illness. Seventy-eight percent or 10 were in partial remission. Familial approval was not given in 55 percent or 10 of the cases, in 22 percent or 5 of the cases the family approved foster home placement, while in 16 percent or 3 of the cases the family made no reply to correspondence concerning the patient's placement. A majority of 78 percent or 14 of the patients had sufficient funds to cover their stay in the community and 22 percent or 4 had insufficient funds. All of the patients in the sample study were considered to have been in good physical condition. The social workers considered 50 percent or 9 of the patients were very well prepared for their placement and 50 percent or 9 of the patients
## Table 1

### Characteristics of Patients Included in the Study

<table>
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<th>Method of Preparation</th>
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<th>Tour of Service Duty</th>
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**Key**
- **Diagnosis**
  - Heb. -- Hebephrenic
  - Para. -- Paranoid
  - Und. -- Undifferentiated
  - Cata. -- Catatonic
  - Alco. -- Alcoholic
- **Service Connection**
  - N.S.C. -- Non-Service Connected
  - S.C. -- Service Connected
- **Tour of Service Duty**
  - WWII -- World War II
  - K-C -- Korean Conflict
  - P-T -- Peace-Time
### TABLE 2
SOCIAL WORKERS EVALUATIONS OF PATIENTS READINESS FOR PLACEMENT

<table>
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<th>Method of Preparation</th>
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<td>5</td>
<td>10</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>
were satisfactorily prepared.

**TABLE 3**

**NURSES EVALUATION OF PATIENT READINESS FOR PLACEMENT**

<table>
<thead>
<tr>
<th>Method of Preparation</th>
<th>Number of Patients</th>
<th>Fair</th>
<th>Satisfactorily</th>
<th>Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casework</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Group Work</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>B1 Method</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
</tbody>
</table>

The data in Table 3 indicated that the nurses evaluated 8 percent of the patients based as fairly prepared, 12 percent or 3 patients as satisfactorily prepared and 80 percent or 14 patients as being very well prepared for their placements.
TABLE 4
LENGTH OF TIME BETWEEN ACCEPTANCE AND PLACEMENT

<table>
<thead>
<tr>
<th>Method of Preparation</th>
<th>Number of Patients</th>
<th>Time Span</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>one-two weeks</td>
</tr>
<tr>
<td>Casework</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Group Work</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Bi Method</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>10</td>
</tr>
</tbody>
</table>

The data in Table 4 revealed that 56 percent or 10 of the patients in the study were placed in one to two weeks, 28 percent or 5 were placed in two weeks to one month, while 16 percent or 3 were placed in foster homes in one month to two months.

Foster Home Workers Evaluations of Patients Adjustment

Foster home workers evaluations of patients adjustment describes the adjustment made by patients during their six months trial placement.

The data in Table 5 showed that 50 percent or 9 of the patients took their medication voluntarily and 50 percent or 9 patients took their medication under supervision. Fifty-six percent or 10 of
<table>
<thead>
<tr>
<th>Method of Preparation</th>
<th>Number of Patients</th>
<th>Physical Appearance</th>
<th>Medication</th>
<th>Management of Funds</th>
<th>Social Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tidy</td>
<td>Untidy</td>
<td>Voluntary</td>
<td>Supervised</td>
</tr>
<tr>
<td>Casework</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Group Work</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Bi Method</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>
The patients kept their physical appearance tidy as compared to 44 percent or 8 patients who were untidy. Fifty-one percent or 9 of the patients were capable of managing their funds, 33 percent or 6 patients managed their funds satisfactorily, and 16 percent or 3 managed their funds poorly. In 44 percent or 8 of the cases, patients were socially well adjusted, but in 7 percent or 1 case the patient was passive and withdrawn, while in 32 percent or 4 cases they were unable to function, in only 16 percent or 2 cases the patients were hostile and anxious, and in 16 percent or 2 cases their social adjustment was fair.

**TABLE 6**

**RECIDIVISM OF PATIENTS PLACED IN FOSTER HOMES**

<table>
<thead>
<tr>
<th>Method of Preparation</th>
<th>Number of Patients Who Returned to VAR</th>
<th>Number of Patients Who Remained in Foster Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casework</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Group Work</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Bi Method</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>

The data in Table 6 showed that 73 percent of the patients remained in foster homes, 27 percent of the patients returned to the hospital, and that 100 percent of the group work patients remained in foster homes.
Summary of Analyzed Data

Chapter III showed that four patients receiving group work preparation were placed in foster homes in one to two weeks after acceptance by the Foster Home Board and two patients were placed within two weeks to one month. Three of the patients prepared by the casework method were placed within one to two weeks, one was placed within two weeks to one month and two were placed within one month to two months. Of the patients prepared by the bi-method, three were placed in one to two weeks, two were placed in two weeks to one month and one was placed in one month to two months.

The study showed that the foster home workers evaluations of the patients social adjustment while in foster homes revealed that of those patients receiving casework services two adjusted very well, one was passive and withdrawn, one was hostile and anxious, one adjusted fair and one was unable to function. The patients who were prepared by group work showed in their evaluations that four patients adjusted very well, one was hostile and anxious and one adjusted fair. Two bi-method patients adjusted very well, two were hostile and anxious, one adjusted fair and one was unable to function.

Recidivism of patients who were placed in foster homes revealed that four casework patients remained in the community and two returned to the hospital. Three bi-method patients remained in the community while three returned to the hospital. All six of the group work patients made successful adjustments and remained in the community.
CHAPTER IV

READINESS OF PATIENTS AS PERCEIVED BY SOCIAL WORKERS AND NURSES

As in any multidisciplinary agency, Northport Veterans Administration Hospital utilizes the professional opinion of its staff when making decisions about the welfare of the patients. This chapter reports the evaluations given by the social workers and nurses involved with patients who were placed in foster homes. These narrative evaluations give insight into the kind of preparation given patients before foster home placement.

Social Workers Evaluations

The investigator wishes to state that the six group work patients used in the study were long-term patients. It is assumed that they would need more intensive treatment and that this fact could possibly have some effect on their readiness for placement. The six social workers involved in the study responded in the following verbatim statements.

Social Worker U:

Our ward handles short-term intensive treatment and this usually means out patients are only with us for a brief period. Therefore, most of our service is only [sic.] through brief-contacts. We feel that our patients get the best we have to offer, but the briefness of our relationship may hamper the effectiveness of our services.
Social Worker V:

We've found that because of our working with patients in Pre-Foster Homes groups prior to placement, our patients are usually more ready to face community living. There is some evidence that, more of an opportunity for patients to move at their own pace is guaranteed by the group process and when patients are really ready they will let you know. The group seems to give tremendous support and motivation to the patients. Fewer of our group work patients have returned to the hospital than those we've prepared by casework. We couldn't possibly contribute all the success we have to groups—the group work method—but there is some apparent favorable results coming from the use of this process.

Social Worker W:

Most of our patients are long-term chronic schizophrenics, who at best, function on minimal levels. These patients whom we've placed in foster homes, were placed after long periods of intensive preparation. We see to it that all arrangements are taken care of before presentation, but this does not insure successful adjustment during placement. The patients get the best preparation we can give but this is not assurance enough that they are ready to meet the demands of community living.

Social Worker X:

We think that we prepare our patients very well for placement, but I found that giving support so that they may meet the challenge of foster home living just isn't enough. Patients' fears of having to intimately live with a family can not always be met. This kind of fear begins and continues when the experience actually begins.

Social Worker Y:

I think we do a good job of getting our patients ready for placement. However, the patients on our ward lack the motivation to want to join this program. This is the focus of our difficulty, motivating patients toward wanting to leave the security of the hospital's environment and entering the outside world. The Pre-Foster Home group has been very effective, but it doesn't reach everybody. We need something more if our patients are to be best benefited by the Community Placement Program.
Social Worker Z:

We like to think our patients are well prepared for foster home placement. We see to it that matters such as, family consent, finances and emotional readiness are worked out before our patients are presented before the Foster Home Board. We've discovered that this cuts down on the frustrations and anxieties of pre-placement activities, giving the patients more energy to direct toward adjustment to his placement.

Summary of Social Workers Evaluations

In evaluating patients readiness for placement in foster homes, the six social workers involved felt that they had adequately prepared their patients for placement. At least two of the social workers used in this study felt they could not completely prepare their patients for the demands of day to day family living. Preparation through the group work method seemed most effective for two of the social workers involved, because of the support and motivation patients gave each other. They felt, however, that not every patient benefits from this kind of preparation.

There is also some feeling among the social workers that the type contacts (whether long-term or brief) affect the patients' adjustment in the community. Some patients can benefit from only brief contacts whereas other patients do not adjust to foster homes after long intensive care. One of the social workers felt that if all the details such as finances, family consent and emotional readiness were worked out, the patient's energy would and could be directed toward his adjustment to the community.

When evaluating the patient's readiness for placement the social workers dealing with patients via casework method, considered
one patient out of six very well prepared, three out of six patients prepared by the bi-method were considered very well prepared, while five out of six group work patients were considered very well prepared.

**Nurses Evaluations**

In discussing the actual preparation process that patients are exposed to on their ward before placement, the six nurses involved in this study gave the following verbatim statements.

**Nurse O:**

Because patients who leave this ward usually have all their discharge details completed and they are fully aware of what type of place they’ll be living in; I feel they are very well prepared. The social workers on the ward usually work the patients up for placement and we assist in whatever manner we can.

**Nurse P:**

We usually don’t have too many fellows who leave the ward for a foster home, but those that I have seen placed were satisfactorily prepared. They seemed anxious to go and looked forward to the experience. We have two excellent social workers on our ward and we really look-out for our boys. Not only are discharge details worked out but the patients seem emotionally ready too.

**Nurse Q:**

Our ward cares for the chronic more regressed patients who often permanently remain in the hospital. Those patients who have left us to go into a foster home have needed a great deal of motivation to take such a step. In most instances the social workers have provided the motivating impetus for these patients. I feel that the preparation that these patients have received has been satisfactory but it has not been enough to sustain our patients in the community. Many have returned to the hospital. I don’t hold the social workers totally responsible for this return, but perhaps some other methods of preparation other than just casework treatment might be tried.
Nurse R:

I feel that the social worker on our ward does a very good job and most of our patients are very well prepared for their placements. Much of the success we've had with placements of our patients is due to the efforts of our social worker. Many fears and inhibitions have been removed from the patients' hesitations about foster homes through shared group experiences. The staff on our ward refers patients whom we feel have potential for foster home placement. Most of these patients are asked to join our Pre-Foster Home group and others are seen individually. Of those patients who were in groups we've seen some tremendous results. We feel that when our patients leave this ward they are really ready for a stay in the community.

Nurse S:

Since most of the patients on this ward are long-term hospitalizations and adjust best in structured environments, such as the hospital we have few patients being placed in foster homes. Any trying to change these patients' comfortable mode of living has a difficult time. The social worker on the ward works hard to motivate these patients. When one is ready his placement is very well worked out. I feel the patients are satisfactorily prepared for placement.

Nurse T:

It has been my experience, to find that even though details for placement have been arranged by the social worker, patients are still hesitant about placement. I don't know whether this can be attributed to the patients' illness or a lack of preparation the patient receives. I feel that the preparation given patients is only fair.

Summary of Nurses Evaluations

Nurses evaluating the patients readiness for foster home placement felt that five of the patients receiving casework services were very well prepared, three receiving bi-method preparation were very well prepared, and all six of the patients receiving group work
services were very well prepared.

It was agreed among the nurses that the social workers had well prepared the patients for placement. One nurse felt that more than casework was needed to get patients ready for community living. Still another nurse felt that the preparation given patients was inadequate. Those patients seen in groups were best prepared and ready for community living reported one nurse.
CHAPTER V

SUMMARY AND CONCLUSION

This study was undertaken to determine which of the three methods -- casework, group work, or bi-method -- used for preparing patients for foster home placement was the most effective. The findings indicate that those patients prepared by the group work method had more successful adjustments in foster homes and remained in the community throughout the six months of trial placement.

The investigator hypothesized at the outset of this study that those patients who had received group work and bi-method preparation were better prepared for foster home placement than those patients prepared by the casework method. The data collected suggests that this hypothesis has some validity. However, the investigator feels that this study was not extensive enough to draw any final conclusions.

It was revealed by these findings that those patients whose waiting period between acceptance and actual placement was more than two weeks had a higher recidivist rate than those patients who were placed within two weeks after acceptance. This fact could be evidence of lack of preparation or not enough preparation.

There was no indication that characteristics shared by the patients in the study differed to any great degree from group to group.
However, the six group work patients were all long-term patients and may have had the opportunity to have received longer more intensive preparation than other patients in the study.

Since the length of time patients remained in the community is proof of successful adjustment, then those patients prepared by the group work method had the most favorable results. None of the six that were in this category were returned to the hospital after their six months trial-visit release.

It is felt by the investigator that the results obtained in this study were found for the following reasons: (1) The group work method as used by Northport Veterans Administration Hospital, allows the patient to receive support from the social worker involved and fellow patients who share similar feelings; (2) those patients prepared by the group method were long-term patients and these patients have longer, more intensive preparation for placement; and (3) participation in groups may also help to prepare the patient for the kinds of close inter-relationship he would share with a foster family.

Even though the study does suggest that those patients who were prepared by the group work method were better prepared for placement, the investigator feels that the size of the sample used in this research was too small to make any valid inferences as to the most effective method of preparation. This study was also subject to many variables that would affect its outcome. For instance, the study covered only a four month period of the year's Community Placement program, the sample used was not a representative
sample since the investigator was forced to use the only six patients prepared by the bi-method, the availability of foster homes and foster home workers was not always certain, thus sometimes causing delays in immediate placement, and although the social workers and nurses used for personal interviews gave honest opinions, there might be some hesitation to openly be critical of one's own programs and co-workers.

The researcher does recommend that the Social Work Service Staff do a more extensive study with a much larger sample with regard to its Foster Home Program. It was generally agreed among the professional staff interviewed in this study that the preparation given patients for placement was good, but needs to be extended to meet the many demands the patient faces when living in foster homes. Since this study does point up some success in patients who were involved with group work, the investigator would recommend that the Social Service staff extend its present Pre-Foster Homes groups and create new kinds of group experiences for those patients interested in foster homes.
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