Criteria for the selection of neuropsychiatric veterans for family care

Helene Wright West
Atlanta University

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CRITERIA FOR THE SELECTION OF NEUROPSYCHIATRIC VETERANS FOR FAMILY CARE

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

BY

HELENE WRIGHT WEST

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1958
DEDICATED TO

MY DAUGHTER

VERNITA JEAN WEST
ACKNOWLEDGEMENTS

The writer of this study wishes to acknowledge, with grateful appreciation, the invaluable assistance given by the Veterans' Administration Hospital, Battle Creek, Michigan in the construction of this project's Plan of Study and Schedule. Appreciation is acknowledged also to the Supervisor, Mr. Theodore Chavis and Miss Katharin den Blyker who provided information on the Family Care Program and made possible attendance at various Program functions. In the Construction of the Schedule, Dr. Stewart Armitage, Chief Psychologist and Dr. Norman Graff of the Psychology Department were most helpful.

Appreciation is extended to the members of the Screening Board Committee for their cooperation in the compilation of data on the Schedules.

Without the help of the Social Services Staff Members, who so graciously assisted with the collection of data for this study and extended psychological support to the writer, this project could not have been completed.

H.W.W.
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CHAPTER I

INTRODUCTION

Significance of the Study

Family Care for the mentally ill is only one of the broad aspects of the Family Care Program. It is used extensively for the placement of children, the aged, and the delinquent as well as the mentally ill.¹

Placement in Family Care is preferable to institutionalization because of the inability of the institution to meet the individual needs of individual persons. Institutions geared to handling hundreds and thousands, in some instances, cannot concentrate on individualized care. Some institutions have modified their program to the extent of introducing the Cottage plan. This is an improvement, but the entire orientation remains institutional.² As the years go on and more and better services are offered by the community, there are fewer compelling reasons for extensive institutional care.³

The use of Family Care for the mentally ill is one of many methods of treatment that have been utilized through the years in an effort to hasten recovery and complete rehabilitation. Many patients need this type of care because they have no homes of their own, their homes are inadequate, or because they need the experience as a bridge between the protective environment of the hospital and an eventual return to more independent living.

³ Ibid., p. 165.
Perhaps the strongest endorsement of Family Care came from Rosanoff who writes: "There is no doubt that at least 25 percent of the population of the average mental hospital can be maintained in extramural care with great advantage to all concerned."\(^1\) Another study regarding this approach states: "Since the home is the basic unit of society it is within this framework that man is happiest. It is to a home in the community, his own home or foster home, that the patient should be released to receive the benefits implicit in a home setting."\(^2\)

Foster Home Care in this country originated in Massachusetts in 1885, when the legislature permitted the State Board of Lunacy to place and supervise patients in approved families. Actually, it was not until 1905 that a statute was enacted by the legislature allowing State hospitals to place selected patients in family-care homes.\(^3\)

The purpose of Family Care has changed through the years as it has been evaluated and expanded.

In the beginning the main reason for adopting a Family Care plan was economic. Undoubtedly it is a less expensive method of maintaining the mentally ill, since it reduces the need for hospital beds, thus slowing up capital expenditure. However, experience with a well organized program demonstrates in fact that the first value of Family Care is that of patient therapy. It is therapeutic because it provides a special type of family life relieved of the emotional stresses so often present in the patient's own home....\(^4\)

Potential Family Care patients fall into two main groups: (1) those who are comfortable but chronically ill, and

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\(^1\) Aaron J. Rosenoff, "Extramural Care, Heredity and Genetics," American Journal of Psychiatry, CII (January, 1942), 509.


\(^3\) Department of Medicine and Surgery, Information Bulletin (Washington, October, 1952) IB 10-29, p. 25.

\(^4\) Family Care Program (The Ohio Department of Public Welfare), 1947, p. 1.
(2) those who need convalescent care before resuming their place in the community.¹

From the inception of the Family Care Program, there was an obvious need to select those patients who, it was believed, could benefit most from the experience of living in a family atmosphere. The object was to give the patients a new lease on life and a chance to be members in "good standing" of the community. It was hoped that such a program would be therapeutic even for those patients who had been hospitalized for a long period and retained some residuals of their illness.

Family Care in the Veterans Administration was officially instituted in 1951. An Official Bulletin establishing this program was issued on August 10, 1951. This bulletin set forth a need for a set of criteria for the selection of patients going into Family Care. In outlining and suggesting possible criteria, diagnosis was not felt to be important.²

The Veterans Administration's Family Care Program has proven successful because of the tremendous amount of careful planning involved in the selection of the home, preparing the care-taker for the patient, preparing the patient for the home, and the supervision of the patient while he is in the community.³

Family Care at the Hospital

The Setting.—Family Care as a therapeutic treatment plan for neuropsychiatric veterans at the Veterans Administration Hospital, Battle Creek,

¹ Ibid., p. 2.
Michigan, had its historic beginning in 1929 when the first veteran was placed in a home other than his own. This hospital is a 2055-bed neuropsychiatric hospital embracing 1600 acres six miles from the city of Battle Creek. Its services are maintained by 1241 employees. These employees are organized into various distinct, but coordinated services. Those most closely connected with the patients on a social planning basis are: (1) Medical Staff, (2) Physical Medicine Rehabilitation, (3) Special Services, (4) Finance, and (5) Registrar. The Chief of Professional Services is directly responsible to and under the direct supervision of the Manager of the hospital. He has under his direct supervision the physicians and the professional services.

The Medical Staff is made up of Psychiatrists, an Ophthalmologist, a Podiatrist, Dentists, Clinical Psychologists, Social Service, Nursing Service, Dietetic Service, Pharmaceutical Service, Laboratory Service and Radiological Service. Through these services, the medical needs of the patient are met. This staff prescribes and renders many treatments to the patients: Insulin Coma Therapy, Electroconvulsive Shock Therapy, Chemotherapy, Psychotherapy, and Family Care.

Physical Medicine and Rehabilitation is a form of treatment that utilizes certain types of activities to accomplish its aim. This type of

---

1 These figures, as of January 2, 1958, were secured from the Personnel office.
2 Know Your Veterans Hospital (Veterans Administration Hospital) Battle Creek, n.d., p. 2.
3 Information Handbook for Hospital Volunteers (Veterans' Administration Hospital), Battle Creek, 1957, p. 7.
4 Ibid., p. 8.
treatment is a direct outgrowth of the Army and Navy Hospital Rehabilitation programs adopted during World War II. "Psychiatrists have found that in all types of hospitals patients who are actually engaged in purposeful mental and physical activities tend to improve more rapidly than do inactive patients."¹

Special Services brings to the patient, the community way of life and is responsible for maintaining high morale among the hospitalized veterans. This ancillary treatment phase of the program is accomplished through the work of Recreation and Library. Voluntary Services are also rendered through this division.²

The Finance Service has among its duties the responsibility for maintaining a banking system for all patients' funds.³

The Registrar's Division employs ward clerks, clothing room personnel, "valuable and incidental clerks." Even though these people are employed primarily for clerical or other duties, they come into direct contact with patients and often play a part in treatment.⁴

The Chaplaincy Service is another service which ministers directly to the patient. Supervision for this service is exercised by the Manager at field station level. It provides, through its chaplains, the opportunity for religious worship and individual ministrations. The patients are offered religious comfort and strength through the services of the Chaplain of

¹ Ibid., p. 18.
² Ibid., p. 21.
³ Know Your Veterans' Hospital (Veterans' Administration Hospital) Battle Creek, n.d., p. 2.
⁴ Ibid., p. 2.
their faith.¹

The type of treatment with which this study concerns itself is directly related to Social Services. Through it, the patients and members of their families are helped to utilize the many Veteran Administration benefits to which they have a right as well as their own community services available to them through public and private social welfare and health agencies. Social Services helps in clarifying the treatment and social facilities of the hospital to the patient so that he may make the best use of them. This may involve working with patients who have many personal and social problems such as (1) difficulties in getting along with their families or with other persons; (2) problems such as physical disabilities, cultural differences, occupational maladjustment, or economic need, and (3) problems related to their feelings and attitude regarding mental illness and treatment.²

Social workers attempt to know the patient and his family at the time of hospital admission. Thus, the "team's" knowledge of the patient is enhanced, thereby facilitating the patient's initial adjustment to the hospital. Emphasis is always on helping the patient use his own strengths, skills, and resources to rehabilitate himself.³

In trial visit planning and supervising the patient while on trial visit, it is necessary that the Social Worker know and utilize the social and health services in the patient's own community including his family and

¹ Information Handbook for Hospital Volunteers (Veterans' Administration Hospital), Battle Creek, 1957, p. 29.
² Ibid., p. 12.
³ Ibid.
and friends. This is done in order that the gains made by the patient while hospitalized can be sustained after his return to community living.¹

The Family Care Program.—The goals of the Family Care Program are: to improve the veteran’s happiness and adjustment, and to provide an interim experience toward discharge for those no longer acutely ill but not ready for discharge.²

The Family Care Program is a specialized way for patients to leave the hospital. This program is the combined responsibility of all hospital units. The Social Worker is the liaison person between the hospital, the patient, and the Family Care Sponsors.³ After consideration of administrative factors that render the patient eligible for placement, case work services become essential. The social worker’s role takes on more meaning to the patient. This function of social services involves interpretation of the Program to the patient. If he is motivated to go into the program, there is a need also to allay any anxiety that might be experienced by the patient in anticipation of his next move. If he is not motivated, an attempt is made to motivate him by helping him to understand certain benefits that he could derive from such a method of treatment. He is helped to see the value of a chance to become and accepted member of a family and a community; the opportunity offered, therein, to regain both self confidence and a renewed interest in life; the importance of someone being interested in his welfare.

¹ Ibid.
² Theodore Chavis, "Family Care Program" (Unpublished Paper, Veterans Administration Hospital, Battle Creek, 1957), p. 3.
³ Ibid.
and accepting him as he is; and giving support in his ability to accept the program as a plan toward more normal living.

As a result of the early placements in the Family Care Program, it was realized that long periods of hospitalization made it difficult for patients to adjust to community living without adequate preparation. It was felt that patients should be prepared to cope with problems of group living and social adaptation. As a result of this thinking, the Family Care Ward was established. The achievement of desired results was to be through the patients living in a group situation and interacting as a family while yet in the hospital. This program would allow for planned problem-solving situations which would give the patients opportunities to consider such matters as living in a family group, applying for work and going into social situations such as sports, recreation, and church groups. It could allow for early integration and an addition of treatment elements that become apparent from the problems and needs observed by the field workers in actual placement.¹

It was believed that a selected and well-indoctrinated staff would be a definite factor in establishing a social milieu and emotional tone which would prove helpful in the motivation of patients for placement. It would also serve to demonstrate an integrated, on-going ward team and intra-hospital participation in treatment.²

¹ Chavis, op. cit., p. 2.
² Ibid., p. 3.
The organization structure of the Family Care Program was composed of (1) The Steering Committee, which was invested with major administrative and policy making responsibilities, (2) The Program Coordinator, who had the responsibility for assessing program elements and integrating committee functions, (3) The Ward team, which had the responsibility for the evaluation, motivation, preparation and placement of patients, (4) The Screening Committee, which concerned itself with case finding and selection of candidates for the program.

An informal Steering Committee was established early in the program and later designated as permanent by the interdisciplinary group. This committee formulated and clarified the over-all aims and goals of the Program, selected the physical setting for the ward and designated staff. It participated in ongoing interpretation throughout the hospital toward fostering continuing acceptance. It considered and approved new aspects of the program and treatment as they related to the aims of the Family Care Program and the hospital's treatment philosophy.

The Program Coordinator provided leadership in integrating committee functions within the structure of the program. A non-ward team member was

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1 Letter from Social Services (Veterans' Administration, April 25, 1958).
2 Chavis, op. cit., p. 3.
chosen for this position who possessed a general knowledge of the hospital community, administrative ability, human relations skill, and acceptance of Family Care as a part of the hospital treatment program.¹

Regular weekly ward meetings were a function of the Ward Team. These meetings were used to clarify problems in working with veterans in groups and individually. On the basis of the evaluation in these meetings, the team determined when a veteran was ready to be placed in a home for the first time and formulated and evaluated goals for returnees.²

It was through a program such as has been described in this chapter that a patient passed as he progressed to the end result of the program which was actual placement. During this period, he was confronted with many problems that were similar to those "on the outside" and was able to evaluate his own strengths as the ward team evaluated him. It should be noted from the description of the ward that every patient who was placed on the ward was not placed in a home, either because he chose to remain in the hospital, or because the ward team felt that another type of planning would be more helpful for the patient at that particular time. There was an attempt to move the patient off the ward into actual placement, or to another ward after six months. Therefore, there is a regular turn-over on the ward at regular intervals.

The Screening Committee acted as an intake staff for the program. It studied, evaluated, accepted, and rejected patients recommended for Family Care. It determined whether the patients accepted should move to the Family Care Ward or go directly to the Trial Visit Board for approval of immediate

¹ Ibid., p. 4.
² Ibid., p. 7.
placement. Each member of the committee acted as a liaison person for referrals from personnel of his own service. An important function of this committee was the recording of findings and recommendations.\(^1\)

Since selection is one of the major factors to be considered in successful placement for the Family Care Program, it is hoped that this study will bring into focus the method of selection of veterans for the Family Care Program by factoring out elements which were considered by the Screening Board in their selection of patients. It may also point up therapeutic procedures necessary in the motivation and preparation of patients for the program as they relate to the criteria for selection.

In order to understand better the thinking of the Screening Committee, it is thought necessary at this point to describe the Family Care Ward. It is for the Family Care Ward that the immediate selection of patients is made by the Board.

The Family Care Ward.—The Family Care Ward at the Veterans' Administration Hospital, Battle Creek, Michigan, is one of two wings on the first floor of a large Continuous Treatment Service Building. The ward maintains a separate office and bed capacity for 32 patients. Its operation and staffing pattern are on the basis of a separate treatment building. The geographic proximity of the Family Care Unit and the privileged unit, of that building, contribute to interaction among the two patient groups as well as among the personnel of the two units.\(^2\)

The purpose of the ward is to implement the over all Family Care Program by improving administrative procedures and communication; broadening

\(^1\) Ibid., p. 4.
\(^2\) Chavis, op. cit., p. 7.
interdisciplinary collaboration with a team approach to goal-solving; assessing veterans who return from placement and developing on-going community acceptance of mentally ill veterans.¹

The Family Care Ward served to demonstrate an integrated, ongoing ward team and intra-hospital participation in treatment. There was a concentration of operations and mechanics for the routine preparation of patients for placement in such a manner as would be time-saving and tension-relieving for the patient. Therefore, the ward program was organized to give patients experience in living outside the hospital. It was structured to prepare them for some of the changes in community living which would provide the opportunity to consider such matters as living in a family group, applying for work, and going into new social situations such as sports, recreation, and church groups. This allowed for early integration and addition of treatment elements that became apparent from the problems and needs observed by the field workers in actual placement.²

A nurse was not directly assigned to the ward since her role might conflict with the role of the female psychiatric aide who was the "mother of the ward" and had the responsibility of helping others develop a home-like atmosphere. A male aide is assigned at night since normally the "man of the house" would return at approximately that hour. During absence of an aide, there was no attempt to "hand-pick" a substitute since in any home situation there would be an occasion to use substitutes. In situations where a veteran's care involves a specific psycho-biological entity as in

¹ Ibid., p. 5.
² Ibid., p. 2.
the need for medication, he was sent off his ward to a nurse who administered to him.¹

The Ward Clerk was an important "family member". In addition, she performed clerical and administrative duties. She was in a unique position to observe veterans' behavior, needs and aspirations since it was to her that many of their tangible requests were expressed. Observations that she made were passed on to the team, evaluated, and integrated in treatment planning. The team assumed a reciprocating responsibility for her ongoing orientation, enabling her to identify special needs of veterans and to encourage them to make use of the services of the team members. The responsibilities of the ward clerk and the team as a whole represented a dynamic, coordinated team approach in treatment and planning for Family Care.²

Purpose of the Study

The purpose of this study was to determine what criteria were being used by the Screening Board in their acceptance or rejection of veterans for the Program. After determining what criteria were used, the next step was to determine how they were used. It was hoped that through this study, a workable set of criteria for the selection of patients for the Family Care Program might be developed.

Method of Procedure

The sample of this study consisted of 24 patients reviewed by the Screening Board from May, 1957 to February 15, 1958.³

¹Ibid., p. 6.
²Ibid.
³This period is being utilized since a structural Screening Board for the selection of patients for the Program has been in operation since May, 1957.
The following steps were utilized in the method of procedure: (1) Available literature on Family Care was read and criteria listed from these readings; (2) Ward team minutes were read and possible criteria listed from them; (3) Schedules were prepared for all patients in the sample. These schedules contained criteria obtained in steps 1 and 2 above; (4) Items considered as criteria in the Screening Board's decision were determined by individual interviews with members of the Screening Committee and recorded on the Schedule; (5) The schedules were analyzed to show how criteria were applied and which criteria were applied most frequently.

As background to the study, the social service staff and ward team members were consulted with regard to the necessary historical and administrative information.

Scope and Limitations

This study was limited to the Veterans of the Veterans' Administration Hospital at Battle Creek, Michigan, who appeared before the Screening Board between May, 1957 and February 15, 1958. It was not an attempt to study the entire Family Care Program but that element which concerned itself with the selection of veterans for the program.

This was not an attempt to evaluate the method of selection utilized by the Screening Board. It confined itself to an attempt to factor out elements in the method of selection of veterans for the Program and to determine those which were considered most important.
CHAPTER II

DESCRIPTION OF THE SAMPLE

The schedule used for this study was developed to discover the criteria utilized by the Screening Board of the Veterans' Administration Hospital at Battle Creek, Michigan, in its selection of veterans for the Family Care Program.

The sample for this study consisted of 24 male veterans. The age range was 22 to 57; the mean age was 39 years and 11 months, with a standard deviation of 8 years and 2 months.

TABLE 1

STUDY SAMPLE BY AGE

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 29</td>
<td>2</td>
</tr>
<tr>
<td>30 - 39</td>
<td>10</td>
</tr>
<tr>
<td>40 - 49</td>
<td>9</td>
</tr>
<tr>
<td>50 - 59</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

Twenty-two were white and 2 were Negro. Sixteen were Protestant and 7 Catholic. All the veterans were chronic, psychotic patients. The length of illness ranged from 3 years to 23 years, averaging 9 years and 6 months with a standard deviation of 4 years and 10 months.

The date of the first "known" hospitalization for mental illness was used to determine the apparent length of illness. The number of years
since the first hospitalization for mental illness ranged from 2 to 23; information was not given for one patient. The average length of hospitalization was 8 years, 11 months with a standard deviation of 4 years, 4 months.

TABLE 2
STUDY SAMPLE BY LENGTH OF ILLNESS

<table>
<thead>
<tr>
<th>Length of Illness in Years</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 - 5</td>
<td>7</td>
</tr>
<tr>
<td>6 - 9</td>
<td>4</td>
</tr>
<tr>
<td>10 - 13</td>
<td>10</td>
</tr>
<tr>
<td>14 - 17</td>
<td>3</td>
</tr>
<tr>
<td>18 - 21</td>
<td>0</td>
</tr>
<tr>
<td>22 - 25</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
</tr>
</tbody>
</table>

All but one had been previously hospitalized. The current hospitalizations ranged from 2 years to 16 years, averaging 5 years and 11 months with a standard deviation of 3 years and 10 months.
TABLE 3
STUDY SAMPLE BY LENGTH OF HOSPITALIZATION

<table>
<thead>
<tr>
<th>Length of Hospitalization</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - 23</td>
<td>1</td>
</tr>
<tr>
<td>19 - 20</td>
<td>0</td>
</tr>
<tr>
<td>17 - 18</td>
<td>0</td>
</tr>
<tr>
<td>15 - 16</td>
<td>1</td>
</tr>
<tr>
<td>13 - 14</td>
<td>1</td>
</tr>
<tr>
<td>11 - 12</td>
<td>5</td>
</tr>
<tr>
<td>9 - 10</td>
<td>5</td>
</tr>
<tr>
<td>7 - 8</td>
<td>3</td>
</tr>
<tr>
<td>5 - 6</td>
<td>3</td>
</tr>
<tr>
<td>3 - 4</td>
<td>3</td>
</tr>
<tr>
<td>1 - 2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>

This analysis differed from that of Ullman and Berkman whose sample included patients supervised in family care homes for a minimum of 18 months. While those included in this sample were from various wards within the hospital, however, even with these differences, some generalizations about criteria for placement may be made. Another

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1 Leonard P. Ullman and Virginia Conner Berkman, "Factors Related to Placement of Neuropsychiatric Patients in Family Care" (Unpublished paper, Veterans Administration Hospital, Palo Alto, 1957).
distinct difference was that this study used only the "known" hospitalizations of patients as they were recorded in the agency records, whereas the Ullman and Berkman study utilized the Veterans Administration Claim files and included "all" hospitalizations beginning with the first military hospitalization.

Certain administrative factors were considered before each patient was presented to the Screening Board. Unlike State Hospitals, the Veterans Administration did not assume financial responsibility for a patient once he was placed in family care home. Therefore, it was necessary to know that the patient's source of funds was sufficient to maintain him outside the hospital. The normal monthly expense incurred in placement was $108.35 for room, board, and laundry. An additional personal allowance was also necessary to take care of the patient's personal and miscellaneous needs. Fifteen patients in the sample received 100% service-connected compensation which amounted to $225.00 monthly, and was ample to care for the patient while in a family care home. Four patients received a non-service connected disability pension in the amount of $66.15 monthly. Obviously, it was necessary for the latter group to secure employment while in placement to supplement the pension for maintenance unless they had a large reserve prior to placement. Some of the patients had funds of their own, and were not entirely dependent upon compensation. One of these was a non-service connected recipient, and the other 3 were service-connected.

It was of utmost importance that the patient and/or his guardian be willing to make funds available in order to maintain the patient in the program. This situation was clarified by Social Services and the Chief
Attorney, with the family and/or guardian in terms of the patient's needs toward gaining their acceptance. There was only one instance in which the guardian, who was a parent, refused to make funds available for this program. This was because of the family's rejection of the family care program; they were unable to understand that their home was not therapeutic for the patient's continued improvement.

Most of the patients had retained some residual of their illness. Only 9 were considered in "good" remission, while 9 had achieved a "moderate" degree of remission, four were in "fair" remission, and 2 remained in "poor" remission.

The diagnosis of the patient, as has been previously stated, was not considered important in Family Care planning for the patient. However, all the patients in this study were diagnosed as schizophrenic except one who was diagnosed as encephalopathy, traumatic, manifested by psychotic reaction, deteriorated type. Most prevalently seen were paranoid, catatonic, and hebephrenic types plus mixtures of two or more types contributing to "mixed type".

By definition, schizophrenia implies:

A severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusion formations, hallucinations, emotional disharmony, and regressive behavior.... The above types of schizophrenia are distinguished as follows:

Paranoid Type: Characterized predominantly by delusions of persecution and/or self-importance, wealth, or power.

Catatonic Type: Characterized by marked disturbances in activity, with either generalized inhibition or excessive activity.

Hebephrenic Type: Characterized by shallow inappropriate emotions and unpredictable and childish
behavior and mannerisms.  

The schizophrenic reaction according to Adolf Meyer's formulation, "...can best be understood as a habit disorganization resulting from a progressive maladaptation with an increasing use of substitute reactions instead of effective ones. The result is a disorganization of the personality and a final withdrawal from reality." The other type of illness represented is basically known as an infectious disease of the brain. The disease of this patient, however, was a direct result of gunshot wounds received in service.

The types of treatment received by these patients, as a whole included: Chemotherapy, Electro-Shock Therapy, Insulin-Coma Therapy, Lobotomy and/or Leucotomy, Psychotherapy, Physical-Medicine-Rehabilitation and/or Special Service activities.

Referrals to the program came from various hospital personnel. Those for this sample were made by physicians, social workers, and ward attendants. In other than this sample, the auxiliary therapies, such as Nursing, Physical-Medicine Rehabilitation, and Special Services had been sources of referral to the program.

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3 Ibid., p. 169.
CHAPTER III

CRITERIA FOR SELECTION

Careful selection of patients for Family Care was considered essential for successful placement. Therefore, the Screening Board evaluated each patient for movement into this program. Although criteria for selection were never outlined by the Board, each member had his own definite ideas about the types of patients that were feasible for the program. The criteria they used were secured from the schedules administered to the Board for that purpose. The criteria secured in this manner will be discussed in their order of importance as they related to the following general categories: motivation, medical progress, personality, hospital adjustment, family and home situation, employment situation, intelligence, appearance, previous adjustment, and visits.

TABLE 4
CRITERIA EMPLOYED BY SCREENING BOARD

<table>
<thead>
<tr>
<th>Factors</th>
<th>Number of Responses</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Personality</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Medical Progress</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>Motivation</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>Hospital Behavior</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Employment Situation</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Intelligence</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Appearance</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Family and Home Situation</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Need for Observation</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Adjustment in Previous Placement</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
Motivation

Motivation of the patient for considering Family Care was usually the responsibility of the psychiatrist and social worker of the ward he was assigned to at the time of Screening. This sometimes required several months of intensive case work activity with the patient and the family plus the use of key hospital personnel who had a positive relationship with him before he was "ready" to consider leaving the hospital for a home. Sometimes veterans were fearful of leaving the protective environment of the hospital. In such cases the social worker helped to allay the anxiety associated with going into the community. There were cases, however, wherein patients themselves initiated their consideration for the program. While Family Care is not a compulsory method of treatment for a veteran, it is necessary that he be motivated either of his own accord or by personnel before placement.

Of the 24 patients screened for the program, all indicated some acceptance of the program. Six were markedly ambivalent in their attitude. Their ambivalence usually revolved around their leaving the hospital which for some had become "home". One patient was unable to accept the program because of his family ties which represented security to him, although the home atmosphere was not conducive to his improvement. In one instance, the patient was fearful that he would not be able to cope with the complexities involved in extra-mural living. Even so, he wanted to go. Case 22 illustrates the manifestation of ambivalence in a patient toward Family Care.
Case No. 22

This is a 30 year-old, single, white, male, service-connected veteran of World War II who had a diagnosis of schizophrenic reaction unclassified. He presents a lifelong pattern of shyness, timidity, and difficulty in establishing relationships.

It was understood that he had a good relationship with his father and became quite disturbed and in need of hospitalization when his father died. He seemed to have strong feelings of being over-protected by his mother, stating that "she wanted to do everything for him".

At the time of his first placement, he had some awareness of his dependency but was unable to see how it related to his attitude toward hospitalization. He was able to verbalize some of his feelings but was unable to leave the "protectiveness" of the ward to go to activities. Following further treatment and medication, he was able to verbalize his dependency and relate some insight as to how his background and hospitalization had contributed to this. Through his acceptance of hospitalization and better understanding of it, he was able to plan and discuss transference of his dependency to a local physician as a means of aiding his extra-mural adjustment.

To further substantiate the importance of motivation in considering a veteran for Family Care, members of the Screening Board responded to this factor 27 times positively and twice negatively in determining if a patient would ever be placed in a home. This criterion was employed by the Screening Board in the case of 17 patients; fifteen were responded to positively and two, negatively.

Medical Progress

Medical progress was construed to take into consideration the stabilization of the patient including his "mood swings". Predictability could largely be determined by the medical progress a patient had made. For instance, if a patient was known to be cyclic in the manifestation of his illness, the social worker would be able to relate this fact to a sponsor who would watch for signs of regression. If a patient was
subject to seizures which were controlled to a great extent by anti-
convulsant medication, this could be related to the sponsor and the
patient urged to take this medication. Sometimes the maintenance of
stability was directly related to the patient's use of tranquilizing
medication. When the patient was adjusting well in all other areas, and
Family Care was to be used for therapeutic reasons, he was considered
ready to go, provided there were no adverse indications to the use of
medication while living in the community.

The degree of improvement that the patient had achieved had a great
bearing upon his readiness. It maybe impossible for a layman, by observa-
tion, to tell if a patient is ready for Family Care or not. With im-
provement, there may be a certain amount of conscious control exerted
by the patient over his instinctive impulses. Therefore, a patient
may have regressed but if he exerted conscious control, was harmless to
others and was stabilized, he was not denied consideration for the program.
It was felt that, in some instances, a family situation of feeling wanted
and accepted was all the patient needed to restore him to a level whereby
he could achieve an acceptable and satisfying adjustment.

In addition to the emotional illness of the patient, the physical
aspect was considered. While it was not necessary for him to be in per-
fected condition, he did need to be in good enough shape not to constitute
a nursing problem that would interfere with his adjustment.

It may be clearly seen from this factor that the acceptance of his
illness rendered the patient more amenable to the program. This acceptance
provided him with the necessary drive to conform to the medical decisions
of the Board.
Of the 24 veterans screened by the Board, nineteen were considered in "good" physical condition while 5 were considered "fair". None were in "poor" condition. It was felt that 14 had "good" stability of mood. An example of a good patient whose physical condition is considered "good" but whose stability of mood is considered "poor" is portrayed in Case 17.

Case No. 17

This veteran is a 32-year-old, white, single, Catholic male who was admitted in July, 1949 with a diagnosis of Encephalopathy, traumatic, manifested by psychotic reaction. Gunshot wounds in Service resulted in considerable mental deterioration with memory impairment, short interest span, and poor judgment, Jacksonian Seizures, low tolerance level for withstanding frustration, and inability to learn from experience. He is a personable, very friendly dependent type of individual, who is considered to be in fair to moderate remission. He is in good contact, communicates easily and is able to assume responsibility for his personal needs. His potential for having seizures has been controlled under anti-convulsant medication.

He was considered for Family Care after several attempts to adjust on regular trial visits with his family. This veteran was on trial visit in family care from March, 1955 to January 14, 1956, when he was returned to the hospital. During this time he was in four different homes. His return was precipitated by erratic behavior adjustment. He was replaced from March, 1956 to March, 1957 when a pattern of regular cycles of being more agitated and hyperactive necessitated his return. On several occasions he had driven cars that he purchased, which comprised a threat of danger to himself and others. Subsequent to his most recent return from family care, he was reconsidered for placement by the Screening Board in relationship to the above characteristics of his adjustment and his ability to make use of supervision to the extent

1 Data derived from case records and Screening Board minutes.
that it would be possible for him to achieve a satisfactory community adjustment.

There was a total of 13 positive and 15 negative responses. This criterion was employed by the Screening Board in 21 cases.

Personality

Personality, the sum total of the individual's internal and external patterns of adjustment to life, is generally conceived of as "all that makes a person what he is." Herein, the patient's method of handling himself in various situations is considered. While it is not completely necessary that he have an "appealing" personality, it is helpful if he is warm and accepting of relationships. He need not be aggressive as long as he is congenial and shows some interest in his surroundings.

In determining the personality factor, the Screening Board used such descriptive terms as "appealing", "affable", and "likeable", "the type that would fit into a home," or "the type that would appeal to some sponsor."

Case No. 4

This is a 44 year-old white, Catholic, single, service connected male who was diagnosed as Schizophrenic Reaction, with mixed paranoid and catatonic features, chronic severe. He was described as being unable to go home because his mother "upsets" him as soon as they meet. One of the factors in his being approved for the Program was that "he had a pleasant personality and a Sponsor would find it easy to respond to him.

On the negative side may be considered those who were unable to form relationships or were superficial in their relationships. Case No. 13 illustrates such a type.
Case No. 13

This is a 36 year-old, white, divorced, non-service connected World War II veteran who has a diagnosis of schizophrenic reaction, paranoid type manifested by paranoid, grandiose delusions and hallucinations.

Throughout his years of illness, three things form a pattern of return of illness; restlessness, change in employment, and drinking. The reason for his inability to adjust seems attributed to certain community pressures that inevitably result in psychotic episodes. He has interpersonal difficulties in employment and there is reason to believe he wishes to avoid people. He has difficulty in forming closer relationships and cannot relate on a give-and-take basis.

Sociability was considered under personality factors. It was usually a progressive factor unless it could be found to be a part of the patient's pattern of responses. This took into consideration the patient's acting out in any anti-social manner which might cause rejection of him by the community. The degree of personality integration was best evaluated through visits away from the hospital, especially if the patient had some questionable personality pattern. This factor was considered in the evaluation of 14 patients of the sample. In the evaluation of the patients using this factor, the Screening Board responded 39 times in their decision to approve or disapprove a veteran for the Program. It was used 27 times in approval and 12 times in disapproval. In determining if a patient would ever be placed in a home from the Family Care Ward, the Board responded 14 times, eleven of which were positive and 3 negative. This criterion was employed by the Screening Board in the case of 15 patients. Twelve were responded to positively and 3 negatively.

Hospital Adjustment

According to Hester B. Crutcher, a discussion of the veteran's hospital adjustment with ward personnel may reveal that, while a patient
is not seriously assaultive, he may have a habit of slapping, pushing, and shoving which makes him difficult to live with. Those who were noisy or obviously disturbed were not placed in homes, as were quiet patients, who had adjusted well to the hospital routine.\(^1\) The patient's participation in various hospital activities is considered and the degree of manifested comfort to which he relates in these areas. Extreme care must be taken in selecting those patients who are not dangerous to themselves or others. It was found that those making the best hospital adjustment were those who had accepted their hospitalization and were using it to their best advantage.

The ward adjustment of the patient was considered a part of the patient's hospital adjustment. His relationships with personnel and with other patients was evaluated. Closely related to this was his dependability in activities on or off the ward. This was considered essential, especially for the younger patients and for those who had expressed a desire to work in the community. It was generally felt that if the patient utilized his time to the best advantage while hospitalized, he would carry over his dependability into gainful employment.

Of the sample studied, 23 had made a "good" hospital adjustment and one had made a "fair" adjustment. Case 3 illustrates a "fair" adjustment.

Case No. 3

This veteran was a 43 year-old, white, Catholic, male who was divorced and 100% service-connected. He was diagnosed as schizophrenic reaction, paranoid type,

\(^{1}\) Hester B. Crutcher, *Foster Home Care for Mental Patients* (New York, 1944), p. 46.
chronic severe. He was lobotomized and had seizures which possibly contributed to the instability of his moods.

He had been hospitalized 8 years during which time there had been no visits away from the hospital. Family Care was recommended for this patient because his relatives felt they were unable to supervise him in his present state.

He got along well with others most of the time, and was in good contact occasionally. His behavior on the ward was unpredictable, as he was prone to become impatient with routine. During these times he became assaultive and tense. He was always neat and clean, needed very little supervision in the performance of activities, assumed leadership and was quite active in the ward government and in promoting activities for groups of patients.

It was felt that the recovery he had made would render him amenable to Family Care and that this might be the only way he could leave the hospital since he had no home to which to return.

It was further revealed that 19 were dependable, three were "fairly" dependable, while two were not dependable. This criterion was employed by the Screening Board in the case of 12 patients. Nine patients received positive responses and 3 negative responses. This factor was also used in determining the appropriate placement for the individual.

There were 16 responses to the hospital adjustment factor by Screening Board members, thirteen positive and 3 negative. This criterion was employed by the Screening Board in the case of 12 patients. Nine received positive responses and 3 negative responses.

*Family and Home Situation*

It must be understood that it was not absolutely essential that the hospital have full cooperation and acceptance by the families of the Family Care Program as long as there were no other deterrents to prevent the patient's going and he was motivated. However, an effort was made to integrate the veteran within his own family group before Family Care
became a method of treatment. ¹

Wide selection for therapeutic placement depends entirely upon the individual and his needs, it has been found that the patient who benefits most from such placement is one whose needs are not adequately understood or met by his own family or one who has no family ties... If the family has feelings of guilt about the patient, which may be the basis of its attitude toward him, the greatest care must be taken not to intensify this feeling in working out a family care placement. ²

There was an attempt, made by Social Service prior to screening, to know the veteran's family situation in each case. If there were an interested family, an attempt was made to share with them the extra-mural planning for and with the patient. An investigation of the family situation revealed the desirability of the patient's living at home from the hospital's point of view. The family and/or home situation was measured in terms of what it could offer the patient in his present state.

Of the 24 patients screened, ten were found to have "no home," seven had "unacceptable homes," and seven had homes that would be "acceptable when the patient is more improved." An "unacceptable home" was viewed from the patient's and/or the hospital's point of view as one not offering a therapeutic environment conducive to the patient's rehabilitation. An example of such is seen in Case No. 6.

Case No. 6

This is the case of a 22 year-old, single, male, Negro, Protestant veteran who had been admitted on two

¹ Theodore Chavis, op. cit., p. 5.
occasions. He was approved for the program because of the overprotectiveness of his home environment. He was ambivalent toward the program, as he was not sure how his mother would feel about his going into a foster home. He was incapable of making any decisions for himself because of his immaturity. There was a question of his social adjustment since he never adjusted well in his home prior to his illness. In spite of his deep dependency upon his family, he was unable to live in harmony with them.

A patient's home that is considered "acceptable when he is more improved" was measured in terms of the family's acceptance of the patient and his readiness to go to them. An example of such a home is exemplified in Case No. 14.

Case No. 14

This is a 22 year-old, single, white, Protestant, male veteran of peacetime service. He was diagnosed as schizophrenic reaction, unclassified; incompetent. This patient's condition was possibly precipitated by head injuries at the ages of 8 and 11 years and meningitis at the age of 17.

The mother and father were interested in Family Care as a step in rehabilitating the patient for community living. They were willing to accept him at home only when "he is a new man and able to assume his role as an adult." They seemed to have no understanding of the patient's illness and felt that he would benefit from living in a family situation with people to whom he is not related. They wanted him to "test" his ability to adjust to a family situation before returning home.

In the Screening Board's decision to approve or disapprove a veteran for placement in the Family Care Program, the Family and Home Situation was considered a total of 31 times, with 7 positive and 24 negative responses. This criterion was employed by the Screening Board in the case of 15 patients. Three patients received positive responses, while 12 received negative responses. In determining whether or not he would ever be placed in a home from the Family Care Ward, this factor was considered a total of 9 times, with all the responses being negative.
Employment Situation

The employability of the patient was not of primary concern in considering a patient for placement. It was felt, however, that if a patient were employable and willing to work, he might become more easily integrated into the community. This was felt especially true of the younger patients. This idea is contrary to the original theory in foster home placement, that one should be able to "carry a share of the work". There were instances, however, in which patients would of necessity, have to work to maintain themselves outside the hospital. In such cases an effort was made to know the capacity of the patient to maintain himself in gainful employment. Some of the veterans were able to perform chores in and around the home that compensated for their room and board. Some were able to move into industrial employment, while others were not able to work or had no desire to do so.

The patient's employability was determined by his use of leisure time while at the hospital. If he participated regularly and conscientiously in some activities every day and was not content to be idle, he was considered to be a good prospect for employment. If he had an interest in hobbies, it was believed that he would keep himself occupied and might become well integrated into the community.

Of the total screened, fifteen were scored as "motivated to seek employment," eight were "fairly motivated," and one was "not motivated at all."

Case No. 13 is used again to illustrate the case of a veteran who needed

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to work to maintain himself in the community. Although he has been in
the Program previously, it was felt that he would be able to integrate
himself into the community.

This 36 year-old veteran was active and dependable. He appeared interested in his work which included farm
detail and dietetics helper. In addition to his work, he attended regular classes in Educational Therapy. He
had hobbies that he enthusiastically pursued, especially oil painting. There was an awareness of his limitations
and some insight which possibly precipitated his going into Educational classes that would better quality him
for work.

The readiness of this veteran to go into Family Care
appears to be substantiated by the above. The fact that
he was a "very fine person" who was greatly motivated to
help himself and realized his limitations was influential
in the Board's decision to accept him.

Members of the Screening Board considered the employment situation 17
times. Twelve of these were positive responses and 5 were negative. In
determining if a veteran would ever be placed in a home from the Family
Care Ward, employability was considered a total of 5 times; four times
positively and once negatively. This criterion was employed by the
Screening Board in the case of 12 patients. Seven patients received
positive responses, and five received negative responses.

Intelligence

Intelligence is related to the individual's capacity to assess reality
and exert control. There are some decisions the patient must be able to
make even if it is nothing more than putting on a coat before going into
cold, rainy weather. If his intelligence was impaired, he was not con-
sidered "ready" for the Program. There was a need for the patient to be
able, with preparation, to adapt himself to new and different situations.
Above all, there was a need for him to assume some responsibility for
himself.

Of the total patients screened only ten were rated in regard to their intelligence. Of this number, six were rated negatively. The intelligence factor was considered by the Board a total of 20 times in their decision to approve or disapprove veterans for the Program. Of this number, 11 were positive responses and nine were negative. In determining if he would ever be placed in a home from the ward, intelligence was considered a total of eight times; five positively, and three negatively. This criterion was employed by the Screening Board in the case of 14 patients. Six were rated positively and 8 negatively.

Appearance

"Our society sets great store on physical appearance...,"¹ says Havighurst. Therefore, the goal for each individual may well be to become proud, or at least tolerant of one's body; to use and protect one's body with personal satisfaction.²

A patient who was neat and clean and showed an interest in his personal appearance as well as personal hygiene seemed to be desirable. It did not matter if he was confused, and had residuals of his illness. Poor appearance seemed to be a symptom of illness. Usually as the patient improved, he became increasingly aware of his personal appearance.

Case No. 16 will be used to illustrate how the appearance of a patient affected the decision of at least two members of the Board in their

²Ibid., p. 39.
acceptance of him for the Program.

Case No. 16

This veteran was a 33 year-old, service-connected, white Greek Catholic, single, male. He was diagnosed as schizophrenic, paranoid type. He had been hospitalized 12 years and his illness was characterized by negativistic behavior, belligerence, carelessness in appearance, foul language, and bizarre motions. He had exposed himself sexually to his mother and his sister which precipitated their fears of him.

He cannot live at home because his father was unwilling to accept responsibility for what he may do to himself or others while away from the hospital.

This patient was considered by the Board because he requested family care. He was accepted because his bizarre motions had disappeared, he had become very helpful, considerate and reliable, and had become more neat and clean in appearance. Even though accepted for the Program, there was question in the minds of some of the Board members who felt his acceptance should have been conditional.

In considering a patient for approval or disapproval in the Program, appearance was raised 10 times with one negative response. In determining if he would ever be placed in a home from the Family Care Ward, it was considered only once, positively. This criterion was employed by the Screening Board in the case of 7 patients, six were rated positively and one negatively.

Previous Adjustment

Previous adjustment of the patient within the Program was of interest, if he had ever been placed in a home. It was generally felt that a good evaluation of the patient could be made once he had been observed in the Program.

An example will be presented to show a patient who was considered for replacement and accepted by the Board. It is interesting, however, to note that even though the patient was considered by the individual
members of the Board as being a poor risk, he was accepted in the program and his predictability was considered good. It was felt by two members of the Board that his going would relieve some of the pressure he exerted on the staff; one felt he should be given another chance, and another agreed with the decision of the Board for "research purposes" only.

This case was a good example of the many facets that must be considered in determining whether a patient should be replaced in a Family Care Home or not.

Case No. 12

Patient is a 39 year-old white, divorced, post-lobotomy, non-service connected veteran who was admitted in 1948. He had previously been treated for catatonic schizophrenia. In 1938 he was hospitalized for psychiatric treatment as a result of a suicidal attempt. He is presently diagnosed as: Schizophrenic Reaction, unclassified.

He had two enlistments in military service, the first of which was very successful and the second resulting in his hospitalization. This patient was placed in a foster home under the Family Care Program but was returned after about a month because of leaving the home without the knowledge of his Sponsor, during which time he experienced a seizure. It was felt that the shock of the seizure contributed to his long recovery.

During the time away from the hospital, this patient had no difficulty obtaining employment but invariably chose a job which was dangerous in regard to his seizure condition, possibly because of his inability to accept the fact that he had seizures.

At the time of Screening the patient had requested Family Care and felt he had a better appreciation of the program. He was more accepting of the program and willing to respond positively to supervision which was one of his problems before.

The Screening Board responded only twice to the previous adjustment factor in their decision to approve or disapprove patients for the program. There were no negative responses. In their determination of whether he
would ever be placed in a home from the Family Care Ward, there were six positive responses and one negative.

When members of the Screening Board were asked if they thought a veteran would ever be placed in a home from the Family Care Ward, there were six who qualified their "yes" with this factor and one who qualified his "no" with it. Some felt that having been previously placed in a home the patient would make a better adjustment. More had been learned by the team about the patient, in some instances, and thus the social worker was better able to determine the extent of the patient's needs. Through this type of study, the social worker could relate whatever was necessary to another sponsor in helping her to understand the needs of the patient. The ability of the patient to accept supervision was of utmost importance in this area. Usually, if the social worker was in constant, weekly contact with the patient, he was able to tell when stress was mounting within the patient and return him to the hospital before he experienced an exacerbation. This criterion was employed by the Screening Board in the case of 4 patients. Three were rated positively and one negatively.

Visits

All patients in the sample, except six, had visits away from the hospital. Visits were encouraged when a patient was being considered for Family Care placement. This allowed the patient to test himself in the community living. It also allowed hospital personnel to evaluate his use of time and his attitude toward extra-mural life.

Behavior and use of time away from the hospital was scored on 19 patients. Seven had made "adequate" use of their time while away from
the hospital, six had made "fair" use of their time away, and six had made "poor" use of time away. Of the latter group, there had been evidence of fighting and drinking. The remaining five had not had any visits away from the hospital. Following was a case that illustrated "poor" use of time while away from the hospital.

Case No. 2

This is a 32 year-old, single, white, service-connected Catholic veteran diagnosed as Schizophrenic Reactions, unclassified, chronic, moderate. He is competent. He comes from a rather refined family although probably a controlling one. He felt people were laughing at him and talking about him when he had those "uncontrollable spells."

During a period away from the hospital he became violent and fought his sister and her husband. He threw household utensils and threatened to get a gun and "find out about things." He also used alcohol excessively which probably precipitated the violence.

Eleven of the total group were "very" motivated toward visits away from the hospital. It would appear that at least four who made a less adequate adjustment on visits were more eager to go than those making an adequate adjustment. There were six who were moderately motivated to leave and seven who were not motivated to go. Of the seven who were not motivated to go, some had visited outside several years before, and their visits had either been unpleasant experiences, or since, that time they had been rejected by their families and had no place to visit. Some had become so institutionalized that they were fearful of venturing outside the hospital boundaries.

This criterion was employed by the Screening Board in the case of 3 patients. Two were rated positively and one negatively.
CHAPTER IV
SUMMARY AND CONCLUSIONS

The writer of this study set out to determine what criteria were used by the Screening Board in their evaluation of veterans for the program, to determine how these criteria were used, and to contribute to a set of criteria for such a program. Although Family Care has been a method treatment used by this facility since 1949, there was no written statement of their criteria. There were administrative factors written and adhered to but no personal characteristics used by which to measure patients for this program.

The following criteria have been determined by factoring out elements which were considered in Family Care Screening Board decisions. These general categories describe what the Board used as criteria: motivation, medical progress, personality, hospital adjustment, family and home situation, employment situation, intelligence, appearance, previous adjustment, and visits.

As the Family Care program progressed, more emphasis was placed upon a need of criteria for selection. The Veterans' Administration recognized this need when it officially instituted the program in 1951.

In the analysis of data for this study, motivation of the patient seemed to be of foremost concern to the members of the Board. Medical progress, personality, and hospital adjustment rated next in order of preference. The employability of the patient was considered by some as a criterion while intelligence, appearance and previous adjustment in the program were also rated in varying degrees. The patient's use of time while he was away on visits was used to determine the patient's use of self control. While the
TABLE 4
CRITERIA EMPLOYED BY SCREENING BOARD

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<th>Number of Patients</th>
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Family-home situation was considered and received a number of responses, mostly negative, it was not a major determinant in selection of the patient for the program. Whether a patient had a family or not was not the important thing considered but rather the feelings of the family members toward the patient.

It was of interest that the criterion of age, most frequently referred to in relation to the predictability of a patient in the Program, was used only once in considering patients for the program. It was of further interest that while the agency had determined that patients of age 40 and above do better in the Program, twelve were screened who were less than 40
years old. Two of these 12 were as young as 22 years old.

It was surprising that more emphasis was not placed upon the employ-
ability of a patient in the determination of whether he would ever be placed
in a home from the ward or not. This is of special significance since half
the men were under age forty.

It appeared that the patient's appearance would have received more con-
sideration in the Board's decision to approve or disapprove a patient for
the program. This factor is the first one that a layman would probably
observe. The patient's interest in his appearance is surely indicative of
his improvement.

From examination of the data, it also appears that while the decision
of the members of the Board was unanimous in each case, there were instances
where there was not wholehearted agreement with the decision by all members
of the Board. There were varying degrees of acceptance by members which
might indicate a need to clarify the function of the Board members. The
significance of ambivalence among members of the Board may be a point that
necessitates discussion among the members.

The criteria set forth in this study indicate the need for clarifica-
tion of "what the Board looks for in a patient" for the Program, in terms
of what he could offer the program as well as what the program could offer
him.
APPENDIX
I. IDENTIFYING INFORMATION ON PATIENT

Name ______________________, Birthdate ________.
Age_______, Race________, Religion__________________.
Marital status: Married____, Single____, Divorced____, Separated____, Widowed______.

II. ADMINISTRATIVE FACTORS AFFECTING FAMILY CARE CONSIDERATION.

a. Source of funds: Service connected compensation____, Non-Service connected pension______, Other______, None______.

b. Guardian? Yes____, No______.

c. Committed? Yes______, No______.

d. Family Situation: No home____, Unacceptable home____, Acceptable when patient is more improved______.

e. Casework planning with family for Family Care? Yes______, No______.

f. Attitude of family toward Family Care? Accepting______, Ambivalent ______, Non-Accepting______.

g. Casework planning with patient for Family Care? Yes______, No______.

h. Attitude of patient toward Family Care? Accepting______, Ambivalent ______ Non-accepting______.

i. Referral to Family Care by: Self______, Hospital Personnel______, Family______, Other______.

j. Willingness of patient and/or Guardian to make funds available for Family Care? Yes______, No______.

k. Diagnosis: ____________________________________________________________
III. HISTORICAL DATA ON PATIENT.

a. Characteristics prior to illness: __________, __________, __________, __________, __________, __________, __________.
b. Characteristics in the onset and severity of illness: __________.
c. Degree of external precipitating stress: None, Mild, Minimal, Moderate, Severe.
d. Degree of Psychiatric impairment: None, Mild, Minimal, Moderate, Severe.
e. Date of first known hospitalization for Mental Illness: __________.
f. Total length of hospitalizations: ____________________________.
g. Number of hospitalizations: ____________________________.
h. Length of Illness: ____________________________.
i. Date of current admission: ____________________________.
j. Length of time hospitalized since current admission: __________.
k. Current admission status: First, Readmission, Transfer.
l. Types of treatment received: Chemotherapy, Electro-Shock Therapy, Insulin-Coma Therapy, Lobotomy and/or Leucotomy, Service activities (specify).
m. Current visits from the hospital:

<table>
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<th>Type</th>
<th>Yes</th>
<th>No</th>
<th>Number</th>
<th>Average Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Passes</td>
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<td>(2) LOA</td>
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<tr>
<td>(3) Trial Visits</td>
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</table>

IV. PRESENT HOSPITAL ADJUSTMENT.

a. Present behavior characteristics: ____________________________
b. Degree of remission: Good____, Moderate____, Fair____, Poor____
c. Religions interest___________, Special interests or skills____
d. Attitude toward hospitalization: Accepting____, Ambivalent___________, Rejecting___________
e. Friends and other community ties________________________
f. Ward adjustment: Good____, Fair____, Poor____
g. Dependability in activities: Good____, Fair____, Poor____, No activity____
h. Sociability: Good____, Fair____, Poor____
i. Use of funds: Frugal____, Adequate____, Excessive____
j. Behavior and use of time while away on visits: Adequate____, Fair____, Poor____
k. Motivation toward visits: Very____, Moderate____, None____
l. Motivation to seek employment: Good____, Fair____, Poor____
m. Recognition of dependency: Good____, Overly____, Rejecting____
n. Stability of mood: Good____, Fair____, Poor____
o. Physical condition: Good____, Fair____, Poor____
p. Ability to care for self: Good____, Fair____, Poor____

V. ACTION OF THE SCREENING BOARD.
   a. Date____________
   b. Accepted____, Conditionally accepted____, Deferred____, Rejected____
   c. Predictability: Good____, Fair____, Poor____

VI. INTERVIEW WITH SCREENING BOARD REPRESENTATIVE.
   A. How do you feel about this man's referral to the Screening Board?
1. Should have been stopped at Ward referral level and not scheduled for Board: Yes____, No______.

2. Should have had more casework planning: Yes____, No______.

3. Was an excellent recommendation: Yes____, No______.
   a. What were your feelings about Screening of this veteran in relation to the items you checked?______________________________

B. Did you agree with the decision of the Screening Board? Yes____, No______.

C. What factors contributed to your decision to approve or disapprove this patient for Family Care? List in order of importance______________________________

D. Do you feel he will ever be placed in a home from the Family Care Ward? Yes______, No______.
   1. What factors went into your decision?______________________________

E. What was your level of confidence in this man?
   1. Do you think he can be placed in Family Care Home within 2 months____, After 3 months____, or after a more extensive period of preparation______.
   a. What were your reasons for feeling he can be placed in the period of time you designated?______________________________
2. Can he maintain himself with weekly____, Monthly_____, Quarterly____, or with practically no supervision_____?
   a. On what basis did you determine his requirements for supervision?

3. How long do you think he can remain out of the hospital?
   0____ 6 months, 6 months____1 year, 1 year or longer_____.
   If not more than 6 months, what do you think will bring him back

4. How definite do you feel about your decision? Without reservation____, Some uncertainty____, Unsure____, Felt forced ______.
   a. What factors in the veteran's situation influenced you in this decision?
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Miscellaneous Material


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