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A Statistical Study of 166 Patients on Family Care Status Under the Chicago State Hospital Program : February, 1942--January 1, 1950

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A STATISTICAL STUDY OF 166 PATIENTS ON FAMILY CARE STATUS UNDER THE CHICAGO STATE HOSPITAL PROGRAM FEBRUARY, 1942--JANUARY 1, 1950

by

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CHAPTER I

THE FAMILY CARE PROGRAM

The present study is focused on the first eight years of the family care program at Chicago State Hospital. "Family care" is the designation used for programs involving mental hospital patients placed with private families and is an extension of hospital services, with the hospital retaining responsibility for the patients. For centuries this has been an acceptable method for providing mentally ill and mentally defective persons with some freedom from institutional care, permitting them to return to a more normal environment in the community.

In the sixth century in the village of Gheel, Belgium, a religious shrine gained fame as a refuge for the mentally ill and grew to such proportions that, in 1852, the national government placed the colony under medical supervision.[1] Two other systems of family care also developed in Europe. One of these was the "district system" which was developed in Germany in the eighteenth century. This was an arrangement for mental patients to be

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1 Hester B. Crutcher, Foster Home Care for Mental Patients, New York, 1944, 100.

placed together in groups, first in farming communities, and later in urban areas, with each institution responsible for the patients placed.[2] The other plan was the "dispersion system" which originated in Scotland in the middle of the nineteenth century. Under this system mental patients were placed with isolated families, and, after the placements were made, the institutions no longer retained any responsibility for the patients.[3]

The first family care program in the United States was initiated in Massachusetts in 1885, and was patterned after the Scotch plan.[4] The family care movement was slow in spreading, and the greatest development took place between 1930 and 1944, when eight states initiated such programs.[5] In Illinois the plan grew out of studies made at the state mental institutions.[6] These studies showed a need for relieving the overburdened hospitals and pointed up the need of providing for those patients who no longer needed institutional care, but who lacked the ability to make their own plans.[7] In an effort to meet this need,

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2 Horatio M. Pollock, Family Care of Mental Patients, Utica, New York, 1936, 136.

3 Crutcher, Foster Home Care, 108.

4 Pollock, Family Care, 35-36.

5 Crutcher, Foster Home Care, 181-192.

6 Margaret M. Platner, "Social Work in State Hospitals," The Welfare Bulletin, Springfield, Ill., 38, July, 1947, 35.

7 Florence Worthington, "Suggested Community Resources for Extensive Parole System for Mental Patients in Illinois," Smith College Studies in Social Work, June, 1933.

legislation[8] was enacted in 1935 enabling funds to be used by the state hospitals for these patients. In 1941 the Illinois Department of Public Welfare, with the assistance of the Illinois Society for Mental Hygiene, formulated a program for the state mental hospitals and schools.[9] The purpose of the program was described as follows:

> The outstanding purpose of this program is a therapeutic one to help improved patients again to become contributing, respected and self-respecting members of a normal community. . . . For some patients, development from the habit training level to a small degree of self reliance and social participation is all that can be expected. For others the goal may be full social and economic independence. . . . A secondary goal of this program would be to decrease the total state hospital population, thus making available more time for the medical staff to devote to therapeutic work with those patients who can benefit from active treatment. This conserves not only the work of the medical and nursing staff, but, also decreases the need for new buildings.[10]

In 1942 the program was put into effect in all the state hospitals and in the two schools for mental defectives at Lincoln and Dixon, Illinois. By February, 1942, the first patients were placed on family care from Chicago State Hospital.

The Department of Public Welfare published a Manual in 1942 setting up standards to be followed by the state hospitals in the selection, placement, and supervision of the patients on

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8 See Appendix I for revised law.

9 Platner, "Social Work in State Hospitals," 35.

10 Department of Public Welfare, Illinois State Hospitals Family Care Manual for Social Workers, April, 1942, 2.

family care." The procedures set forth in this Manual covered both the selection of the patient and the selection of the placement; the former became the responsibility of the hospital physician, and the latter, the responsibility of the social worker.

In selecting patients, the physicians were advised to review continually the hospital population in an attempt to determine whether or not the individual patient could adjust on family care.[11] In general, two types of patients were considered to be potential family care candidates. The first of these were the quiet, harmless patients who had been in the hospital for years and who had no relatives to take responsibility for their paroles, but who could be placed with families for supervision in a home. These were usually the aged, chronic patients who did not constitute a danger to themselves or to others, but who did require some degree of supervision. The second type were the patients who could benefit therapeutically from a more normal home environment. In many instances it was desirable to place the patient with a family in no way related to him. Such a family was not emotionally involved with the patient and offered him the "objective, sympathetic interest" which helped him on the road to recovery.

In general, according to the Manual, the patients to be

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11 Ibid., 4.

selected were those who have no available relatives or those whose relatives are considered incapable of giving good care.[12] Each physician was responsible for the patients in his wards. He evaluated the physical as well as the mental condition of the patient and included his recommendations as to needs in his referral to the Social Service Department.

In all cases the ward physician referred the patient to the Social Service Department for placement. In some instances, however, the question of suitability of a patient for placement was brought to the physician's attention from another source. According to the records of the patients in the study group, 117 of the 166 were found and referred by the ward physician. Of the remaining 49 patients, 5 were referred to the physician by the ward attendant, 3 by the social worker, 2 by the nurse, 2 by the industrial supervisor, and 1 by a patient already on family care. For the other 36 patients, it was not possible to determine who made the initial referral. Regardless of how the referral was initiated, the physician's approval was necessary.

Just as the selection of the patient rested primarily with the staff physician, the primary responsibility for the selection of the careholder, or foster home, rested with the social

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12 Ibid., 1-2.

worker. In this selection the social worker used the guide set forth in the Manual.

> With the aid of the psychiatrist, the social worker must develop a clear cut aim for each patient being placed. Either
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> a) the placement will be therapeutic, aiming toward preparing the patient for parole and eventually discharge, or
>
> b) the placement will be custodial, merely providing the patient with a more normal family life in which the patient may be happier than in a large institution.
>
> There will be instances where these aims overlap.[13]

The type of placement selected for the patient thus depended upon the purpose. For the patient who could benefit by a therapeutic placement, the social worker sought, usually, a placement where the patient would have a place to live and some type of employment. In many instances this was in a small institution where the patient was provided with living quarters as well as a salary. Other patients were placed in boarding homes and were employed in the community. For the older patients who needed custodial care, the worker sought boarding homes or nursing homes willing to accept mental patients for the amount permitted by the state boarding fund. Here the patients could have greater freedome and more individual attention without feeling the "stigma" of being in a mental institution.

Success in the selection of homes and institutions

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13 Ibid., 6.

depended partly upon the community's awareness and understanding of the program, and was made possible through the activities of church groups, public and private agencies, fraternal organizations, and other civic groups.[14] By utilizing all of these groups, and by their own personal efforts in following newspaper advertisements and information given by former patients and their friends, the social workers found homes and institutions which could be considered.

A form[15] was provided for the guidance of the social worker in her investigation of possible placements. This covered six main topics of information. The first included general identifying data, with specific questions on transportation between the home and the hospital. The second was a description of the neighborhood, including information regarding the type of neighborhood, recreational opportunities, and availability of churches, library, and parks. The third general topic was concerned with the physical aspects of the home. The physical standards were similar to those required for any boarding home by the Board of Health. The social worker looked for modern plumbing and adequate ventilation and heat, and for protection against fire. In addition, there must be separate beds for each patient and a

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14 Ibid., 4.

15 Ibid., 21.

storage space for his clothing and other belongings. More rigid standards were used for nursing homes.

The fourth topic involved a description of the personality of each member of the careholder's household, including his employment, his education, and his social background. The attitudes of each member of the family unit, or the working group, should not be characterized by any fear of mental illness. This was important since not only the careholder, but each person in the group, played a part in determining the success of the placement. For example, Anna, a family care patient, was placed in a small institution where the other employees were not aware that she had been a mental patient. This fact was discovered accidentally by one woman, who spread the information to the other employees. These other women were afraid and became hypercritical of Anna. Her few peculiar mannerisms intensified their feelings toward her, until the situation became intolerable. The institution finally asked the hospital to take Anna back as the other employees threatened to quit their jobs.

On the other hand, Jim, another family care patient placed in a working institution, made a successful adjustment due to the assistance of a co-worker. He was slow in learning and, on his first assignment, his supervisor became impatient with him and decided to return him to the hospital. One of the cooks defended him, and said he thought Jim could learn the job if some

one would work with him. This cook began helping him, and Jim progressed slowly but steadily, until he reached the point where he was able to take over the whole kitchen during the cook's absence. Jim's case shows the importance of an accepting attitude toward the patient on the part of all members of the family group or the working unit. It bears out the fact that the investigation made by the worker prior to placement should evaluate the family or institution in this respect, as well as in relation to the adequacy of the physical setup.

Each applicant for a family care patient was registered with the Social Service Exchange. This clearance comprised the information required for the fifth topic of the outline governing the investigation. The sixth point was the incorporation of all the letters of reference obtained on the applicant.

In selecting the type of placement to be used, the social worker had to consider the method of payment for room and board. For the patient who was employable she could select one of three types of placement: the patient could stay in a boarding homeand pay for his room and board by outside employment; he could stay in a home and work there for room and board plus a small additional wage; or he could be placed in a working institution, with room and board provided, and receive wages comparable to those of other employees. If the patient was unemployable, but with available resources, the worker sought a boarding

or nursing home that he could afford. If the patient was unemployable, and also without resources, the worker looked for a boarding or nursing home which could accept him for the amount paid by the public agencies or by the state boarding fund.

The present study of the family care program at Chicago State Hospital covers the program from its beginning in February, 1942, to January 1, 1950. By the conclusion of the period, the program was gaining impetus through encouragement from state officials who saw in it a means of relieving the acute overcrowding in state hospitals. One reason for a study at this time was the formulation by the Social Service Department, with the cooperation of the Clinical Director, of a new procedure for the selection of patients for family care. This plan was put into effect in March, 1950.

Under the new plan, the responsibilities of the Social Service Department were increased. The wards in the hospital were to be divided among the social workers, who were to consider each patient as a potential family care patient. The social worker was to accept the names of patients submitted by the ward attendant and then was to review the medical records. If she found no contraindications to placement, the worker then directed a memorandum to the Clinical Director, who reviewed the recommendations and in turn referred them to the ward physician. If the ward physician approved, the placement plans followed the same

procedure as before. This procedure is described in detail in Chapter III.

The present study was based on a review of the case histories of the total number of patients who were placed on family care from Chicago State Hospital from the beginning of the program in February, 1942, to January, 1950. This totalled 170, but four of the number were eliminated because necessary information was not available. The purpose of the review is to evaluate the program in terms of number and kinds of patients placed, and the length, type, and final disposition of each placement. Material was drawn from the case histories and other records available at the hospital, and from literature pertaining to the family care programs in general.

Identifying data were available in the medical and social service records, and a separate listing, maintained for patients who were placed on family care, facilitated locating these records. A schedule was used to assemble the facts for statistical presentation. Some difficulty was encountered in completing the schedules, as the information was not available in an accessible form in many of the records. It was possible to obtain the information relative to the number and kind of patients placed, and to the length, type, and final disposition of each placement. It was not possible, however, to determine, objectively, either the type of patient who made the best adjustment, or the type of

placement which was most effective. There were many factors involved in the dispositions of the placements which could not be treated statistically, and case summaries are used as a means of showing the bearing such factors had on the total placement problem.

CHAPTER II

SOCIAL AND MEDICAL FACTORS

The data presented in this chapter include the social and medical characteristics of the study group. The former cover sex, age, marital status, race, birthplace, religion, education, and occupation. The medical information includes the primary diagnosis, other medical problems, the number of commitments, the total time spent in institutions, and the length of the most recent hospitalization.

To obtain a picture of the composition of the study group, the material is presented according to the sources from which it was taken, that is, from the social and medical histories. Before presenting those data, however, information is given on the number of patients placed during each year of the period covered by this study. This gives, not only an idea of the development of the family care program at Chicago State Hospital, but also reflects the influence of community factors which may have hampered, to some extent, the growth of the program. The number of patients placed yearly by sex is presented in Table I.

TABLE I

DISTRIBUTION ACCORDING TO YEAR AND SEX OF 166 FAMILY CARE PATIENTS AT CHICAGO STATE HOSPITAL FEBRUARY, 1942--JANUARY 1, 1950

Year	Male	Female	Total	Per Cent of Total
Total	66	100	166	100.0
1942	8	20	28	16.8
1943	6	2	8	4.8
1944	21	9	31	18.1
1945	8	0	8	4.8
1946	2	2	4	2.4
1947	1	0	1	0.6
1948	14	28	42	25.3
1949	6	39	45	27.1

The study group of 166 patients was placed over a period of eight years. In the first three years, approximately 40 per cent, or 66 patients, were placed. The peak year of this period for placements was 1944, when 30 patients were placed. A marked decrease in the program followed, with only 8 per cent, or 13 patients, placed in the years 1945, 1946, and 1947. The year 1947 was the low point for the entire period, with only one patient released on family care. The program was revitalized in

1948 and 1949, and 87 patients, or 52 per cent, were placed during this two year period. This number constituted more than half the total study group.

These figures reflect conditions existing both in the community and in the hospital. As a result of the labor shortage during the war years, 1942 to 1945, it was possible to place many patients in small general hospitals and private sanitoria on working placements because these institutions paid low wages and, consequently, had difficulty maintaining an adequate staff. The family care patients were accustomed to the type of work required, and adjusted easily to the environment, as well as fulfilling certain needs within the institution.

The decline of the program in the years from 1945 to 1947 reflected two community problems. The curtailment of wartime industries and the return of servicemen, which made it possible for employers to select employees from a surplus market, caused a decline in the number of working placements available for the hospital patients. At the same time, with the critical housing shortage, there were no nursing or boarding homes available at rates authorized by the state boarding fund. The conditions existing in the hospital itself, which influenced the decline, were evaluated by Besser in 1947.[1] According to this

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1 Gwen Besser, A Review of Family Care Placements at Chicago State Hospital Through June of 1947, Chicago, Chicago Community Clinic, 1947.

writer, the shortage of staff, together with the consequent heavy case load, was probably one of the biggest factors in the decline in the program. Originally one social worker was responsible for all phases of it and had no other duties; thus she was able to devote the necessary time to locating placements. With the social workers carrying full case loads, they were unable to spend the necessary time locating new careholders. The writer also noted the shortage of help within the institution, which sometimes resulted in the doctors' reluctance to send good workers out of the hospital. In individual cases, however, many doctors gave considerable help in locating family care candidates.[2]

In 1948 new emphasis was placed on the family care program in all of the state hospitals and, at Chicago State Hospital, a social worker was assigned the task of locating family care placements. This worker contacted former patients to see if they knew of any friends or relatives who would accept family care patients. She was given leads by friends or relatives of the patients who were being placed; she found homes listed in newspapers; she contacted clergymen and sought information from other agencies. After developing possible placements, this worker made the information available to other caseworkers on the staff. They, in turn, completed the placements and supervised the

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2 Ibid., 8.

patients. Following this change, the number of placements increased.

Another trend evident from Table I was the shift, in 1948 and 1949, to the placement of more female than male patients. In the study group, 100 were women and 66 were men. Of the 79 patients placed in the first six years of the program, 46 were male and 33 were female. Of the 87 placed in the last two years of the period studied, however, only 20 were men and 67 were women. One reason for this was that, in the first years of the program, the majority of placements were working assignments. As these jobs were available principally due to the manpower shortage caused by the war, the majority of the openings were for men. On the other hand, the trend in 1948 and 1949, to boarding and nursing home placements, increased the number of women placed, as few of these homes would accept men.

A comparison was made of the ratio of men to women in the study group with the 1940 Census figures for the national mental hospital population. The study group contained 66 males per 100 females, while in the national mental hospital population the incidence was 116 males per 100 females.[3]

The social records for the 166 family care patients

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3 U. S. Department of Commerce, Bureau of the Census, "Characteristics of Inmates in Penal Institutions and in Institutions for the Delinquent, Defective and Dependent," 16th Census of the United States: 1940, Washington, 1943, 3.

were reviewed to obtain background information as to the type of patient selected, and included age, civil status, race, birthplace, religion, education, and occupation. Table II shows the distribution of patients according to age at the date of the first commitment to a mental institution.

TABLE II

DISTRIBUTION ACCORDING TO AGE AT THE TIME OF COMMITMENT OF 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Age Distribution	Number of Patients
Total	166
Under 20	11
20-30	27
30-40	27
40-50	26
50-60	20
60-70	16
70-80	29
80 and over	8
Unknown	2

Thirty-eight patients were under 30 years of age, while 37 patients were 70 or over. This meant that 75 patients, almost half the total group, were either in the youngest or the oldest

age groups. The largest number of patients in one age group were the 29 in the 70-80 group. The median age for the study group at the time of commitment to a mental hospital was 46.8 years.

Records also contained information pertaining to the patients' experiences prior to hospitalization, including place of birth. Table III shows the distribution of the patients according to national origin.

TABLE III

BIRTHPLACE OF 166 FAMILY CARE PATIENTS
FROM CHICAGO STATE HOSPITAL

Country of Origin	Number of Patients
Total	166
United States	112
Poland	8
Germany	7
Austria	5
Ireland	5
Russia	4
Brazil	3
Others	20
Unknown	2

*Two patients were from each of the following: China, Hungary, Italy, Greece; there was one patient from each of the following: Mexico, Sweden, England, Bohemia, Switzerland, Denmark, Yugoslavia, Scotland, Wales, Canada, Rumania, Finland.

Slightly more than two-thirds, or 112 patients, were native born, while approximately one-third, or 52 patients, were foreign born. The 1940 Census shows the percentage of foreign born in the national mental hospital population as only 18.5 per cent, while in the study group it was 31.3 per cent.[3] Of the 112 native born patients, 73 were women and 39, men. The foreign born patients were almost evenly divided, 27 men and 25 women. Of the 66 men on family care, approximately 40 per cent, or 2 out of 5, were from other countries; of the 100 women, 25 per cent, or only one out of four were foreign born.

The majority of the patients, 147, were white, 15 were negro, 2 belonged to the yellow race, and 2 were unclassified. In this racial distribution, the study group closely followed the ratio for the national population of mental hospitals. In the 1940 Census, 9.3 per cent[4] of this group fell into the non-white classification. In the study group the percentage was 10.2.

When classified according to marital status, the patients were listed as follows: Single, 62; married, 36; widowed, 32; separated, 17; divorced, 14; unknown, 5. The largest number, 62,

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3 Ibid., 3.

4 Ibid.

or 38.5 per cent of the 161 patients for whom the marital status was known, were in the single group. Of the 161 patients, however, 99 had at one time been married; thus the married group constituted 61.5 per cent of the group.

In addition to the birthplace, marital status, and race, the records contained information as to the religion of the patients. This information is shown in Table IV.

TABLE IV

RELIGIOUS AFFILIATION OF 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Religious Group	Number of Patients	Per Cent of Group
Total	166	100.0
Protestant	73	44.0
Catholic	56	33.7
Jewish	8	4.8
Christian Scientist	3	1.8
Greek Orthodox	2	1.2
None	3	1.8
Unknown	21	12.6

The table shows that 77.7 per cent of the 166 patients belonged to one of the two large religious groups, Protestant and

Catholic. Only 13 patients, 7.8 per cent, belonged to the other three religious groups. The information was unavailable for 21 patients, or one-eighth of the entire group. Of the 73 Protestant patients, 63 were native born and 10 were foreign born. In the Catholic group, however, 27 were native born, 27, foreign born, and the birthplace of two patients was unknown. The Jewish group was also divided evenly, with 4 in each group. Of the 73 Protestant patients, 53 were women and only 20 were men. The Catholic group, however, contained 35 women and 21 men.

There was no information in many of the records on the educational attainments of the patients. Table V shows the school grades completed by the patients for whom this information was available.

TABLE V

SCHOOL GRADES COMPLETED BY 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

School Grades Completed	Number of Patients
Total	166
No formal education	6
Grade School	
1-4	17
5-8	58
High School	
1-4	26
College	
1-4	10
Unknown	49

Six of the patients had no formal education and 75 had 8 years or less of grade school education. In the high school group there were 26 patients. Only ten patients had completed some years of college, and none had any graduate training. The median grade completed was 8.6. No school information was listed for forty-nine of the patients. According to the 1940 Census, the median was 8.4 school grades completed for the population of the United States as a whole, and 7.1 school grades completed for the national mental hospital population.[5] The median for the

5 Ibid., 5.

study group was higher than either of these.

In classifying the patients according to occupation for Table VI, the Federal Security Administration's occupational classifications[6] and occupational titles[7] were used. The table refers to the occupations of the patients prior to admission to the hospital.

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6 Federal Security Administration, Occupational Classifications, Vol. II of Dictionary of Occupational Titles, 2nd edition, Washington, 1949.

7 Federal Security Administration, Definitions of Titles, Vol. I of ibid.

TABLE VI

PREVIOUS OCCUPATIONS OF 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Occupational Classification	Number of Patients
Total	166
Service, Personal and Domestic	40
Clerical and Sales	23
Skilled Labor	19
Unclassified	18
Unskilled Labor	13
Professional and Managerial	8
Semi-skilled Labor	7
Agricultural, Fishery, Forestry	3
No occupation	17
Unknown	18

There was a variety of occupations listed for the study group. The largest single group was the service group, with 40 patients. Since many of the working placements available involved jobs in the service classifications, the patients with this work history fitted more easily into the available placements. The smallest group was the agriculture group, with only 3 patients, and the low figure may have been a reflection of the urban setting

of the hospital. Some of the more unusual occupations listed for the patients included an actress, a millwright, a kennelman, an interpreter, and a junkman.

The Medical Factors

The information included under social factors related to the patient's life prior to his hospitalization; that obtained from the medical records pertained to hospitalization and to his mental and physical condition. This latter covered the primary diagnoses, other medical problems or personal limitations, the number of admissions to mental hospitals, the total time spent in institutions, and the length of the most recent hospitalization.

Table VII shows distribution according to the diagnoses listed in the medical records. These diagnoses are divided into two general classifications, the organic and the functional, and records were examined to determine whether or not any organic changes were indicated.*

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* A psychiatrist at Chicago State Hospital assisted in the division of diagnoses according to organic and functional classifications.

TABLE VII

DIAGNOSES LISTED FOR 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Diagnostic Classification	Number of Patients
Total	166
Organic	88
Psychosis, Cerebral Arteriosclerosis	27
Senile Psychosis	25
Alcoholic Psychosis	16
Psychosis, with Syphilis and Meningo-Encephalitis	14
Psychosis, with Epilepsy	4
Post-Traumatic Psychosis	2
Functional	78
Schizophrenic	48
Manic-Depressive	7
Psychoneurosis	7
Involutional Psychosis	6
Psychopathic Personality	5
Mental Defective	4
Paranoia	1

The patients were divided rather evenly between the organic and the functional diagnoses, with 53 per cent falling in the organic classifications, and 47 per cent into the functional. The largest single group was schizophrenic, with 48 patients. The next two groups, in terms of size, were psychosis with cerebral arteriosclerosis, with 27 patients, and senile psychosis

with 25 patients. These three diagnoses totaled 100 patients, or 60 per cent of the study group.

The findings regarding diagnoses compared favorably with those in Crutcher's study, which stated that:

> A study of the mental diagnoses of patients who have been placed in family care in New York shows that the majority have dementia praecox,* probably because this is the group to which more than half the hospital population belong. The next most common diagnosis is mental disorder with cerebral arteriosclerosis. Here again, due to the increase of old people in the general population, this form of mental disease has the highest incidence, after dementia praecox, among hospital patients and offers the least hope of recovery because of the degenerative processes involved. Other diagnoses found among patients who have been placed in homes are: alcoholic psychosis, manic depressive, general paresis, with mental deficiency, senile psychosis, paranoid condition, traumatic psychosis, involutional melancholia, psychoneurosis, and psychosis with psychopathic personality. The important factor in selection is not the diagnosis, but the degree of disturbance and its effect on the patient and others.[8]

In both the New York study and the present study, schizophrenia was the largest diagnostic grouping, with cerebral arteriosclerosis as the next in order of frequency. Psychosis with syphilis and meningo-encephalitis, and psychosis with epilepsy were among those in the study group not found in Crutcher's group.

Before the patients were selected for family care, it was necessary to evaluate their physical as well as mental condition.

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* Dementia praecox is another name for schizophrenia.

8 Crutcher, Foster Home Care, 61-62.

The disabilities and diseases which were noted in the medical records are listed in Table VIII.

TABLE VIII

PHYSICAL ILLNESSES AND DISABILITIES FOUND IN THE FAMILY CARE GROUP FROM CHICAGO STATE HOSPITAL

Physical Diagnosis	Number of Patients
Total	166
No physical illness or disability noted	85
With physical illness or disability	81*
Cardiac, Coronary, Cardiovascular, Hypertension	21
Syphilis, Gonorrhea	18
Arthritis, Rheumatism	8
Asthma	7
Epilepsy	6
Eye Conditions	5
Varicosities	5
Deafness	4
Loss of Limb	4
Diabetes	3
Anemia	3
Cirrhosis (liver)	3
Others	10**

* 16 of these 81 patients had two of the diagnoses listed.

** These 10 included: tuberculosis, Parkinson's disease, ulcer, recurrent anal fissure, osteomyelitis, psychomotor retardation, tumor, and urethal stricture.

Many of the physical illnesses listed in Table VIII were contributory to the mental conditions. Others are common in persons of advanced age and had no apparent connection with the mental condition. Diseases that were contagious or infectious were either cured or arrested at the time of placement. The 81 patients who had one or more of the conditions listed in Table VIII represented 48.8 per cent of the study group.

Crutcher found that, "The physical diagnosis seems to be of as little importance as the mental in determining the fitness of patients for family care so long as the patient is free from acute infections, is up and about, able to take care of himself, and is not on a special diet."[9] In the present study group, although nearly half the total number had some physical illness or disability, these physical conditions did not put many limitations on the placements. Of the 166 placed, only 22 patients required continued medical care, 19 needed medications, 6 were unable to use the stairs, 6 required a special diet, and none required prosthetic devices.

The next three tables give information relative to the patients' hospital experience. Table IX shows distribution according to the number of admissions to mental institutions.

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9 Ibid., 62.

TABLE IX

DISTRIBUTION ACCORDING TO NUMBER OF ADMISSIONS OF 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Number of Admissions	Number of Patients
Total	166
1	95
2	33
3	21
4	7
5	4
6	2
7	1
8 or more	2
Unknown	1

Of the 165 patients for whom data on admissions were available, 95 had been admitted to mental hospitals only once. For the remaining 70 patients, 54 were admitted either 2 or 3 times, and 16 were admitted 4 or more times. The number of admissions seems to be related to the diagnostic classification. Of the 95 patients with only one admission to mental hospitals, 62 patients, or approximately two-thirds, had organic diagnoses. The ratio of organic to functional diagnoses was reversed for the

patients with 2 or more admissions. Of this number 44, or 63 per cent, had functional diagnoses. These figures indicated that the patients with functional disorders had a rate of readmission of two to one, compared with the patients in the organic classifications.

Table X shows the total time spent in institutions by the study group.

TABLE X

TOTAL TIME IN INSTITUTIONS FOR 166 FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Number of Years in Institutions	Number of Patients
Total	166
Less than 1	38
1-4	60
4-7	23
7-10	12
10-13	16
13-16	4
16-19	7
19-22	1
22-25	1
25 and over	3
Unknown	1

It would seem from Table X that the majority of the 166 patients were institutionalized for a comparatively short period of time. Of the study group, 98, or 58.8 per cent, were in the hospital for less than 4 years. While 133 patients were hospitalized for less than 10 years, 32 were in for 10 or more years. Of the 3 patients who had spent more than 25 years in mental hospitals, the first had been in for twenty-six and a half years, the second for thirty-two years, and the third for thirty-three and a half years. Although such patients made good adjustments on family care, it was difficult to persuade them to leave the protected environment of the hospital.

There was no significant difference in the time spent in institutions in terms of whether the diagnostic classifications were organic or functional. Of the 98 patients in institutions for less than four years, 57 patients were in the organic classifications, and 41 in the functional. Of the 67 hospitalized longer than 4 years, 31 patients had organic, and 36 patients functional, disturbances. The information was not available for one patient.

Table X shows the total time spent in institutions by the study group, while Table XI limits itself to the most recent hospitalization period.

TABLE XI

LENGTH OF HOSPITALIZATION PERIOD PRIOR TO PLACEMENT FOR 166 FAMILY CARE PATIENTS

Number of Years at CSH during Latest Hospitalization	Number of Patients
Total	166
Less than 1	69
1-4	49
4-7	19
7-10	7
10-13	8
13-16	4
16-19	5
19-22	1
22-25	2
25 and over	2
Unknown	1

In considering only the period of hospitalization prior to placement, an additional 31 patients, making a total of 69, were in the hospital for less than one year. One hundred and eighteen patients were in for less than 4 years, and 144 for less than 10 years, while only 21 patients were hospitalized for 10 or

more years.

These data from the social records showed a diversity of age, religion, occupation, and other pertinent social characteristics, while the medical records revealed the distribution of physical and mental illnesses. Though there was a predominance of certain groups, such as the number of aged patients, none was so prevalent that it could be considered conclusively characteristic of the whole group.

CHAPTER III

THE PLACEMENT PROCESS AND THE PATIENT AT THE TIME OF PLACEMENT

In addition to the selection of homes and institutions for family care placements, the social worker's part in the family care program embraced the preparation of the patient and the careholder and the supervision of the placement. This chapter covers the mechanics of the placement process, as well as information on the patient and on the type of placement.

Following receipt of the name of a patient recommended for family care, the worker reviews both the social and medical records. Before beginning placement procedure, she consults responsible relatives in order to secure their personal or financial participation in the plan, and to obtain their permission for the patient to live away from the hospital.[1] If the relative refuses this permission, it is the social worker's function to determine the reason for the refusal. If it seems to be based on a punitive attitude toward the patient, or a selfish motive on the part of the relative, the worker is permitted to go ahead with the

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1 Manual, 5.

plan as a therapeutic measure for the patient, regardless of the wishes of the relative. In one instance an elderly patient had an estate of her own, but relatives opposed her placement in a private nursing home. As the woman was quiet and needed only supervision and some nursing care, the worker completed the placement in a nursing home where the woman received the individual care and extra attention that she could afford.

In addition to relatives, there were frequently friends who were interested in planning for the patient. In some instances, after the worker had completed plans for family care, the relative or friend would decide to assume responsibility and, in that instance, the patient was then released on conditional discharge instead of family care. If the patient had a conservator, and, frequently, this was a relative, he was contacted to determine the patient's resources.

In the placement process, the social worker assembled data from many sources before talking directly with the patient. Reports were obtained from the physician, covering the present mental and physical condition; from the industrial supervisor, describing his adjustment on the job; and from the ward nurse, evaluating any peculiarities of personal habits.[2] The worker also secured information from the business office of the hospital

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2 See Appendices II, III, and IV for these forms.

about the patient's trust fund, to see what resources or personal property existed.[3] If possible, the first interview with the patient was held on the ward, and, in that interview, the worker discussed family care in general. At this time the patient was encouraged to tell what he desired and expected from the placement. In this way, he was given the feeling of actual participation in planning and was more inclined to cooperate in making the placement successful.

After evaluating particular needs and abilities, the worker consulted a resource file to determine what placements were available, and then discussed the plan further with the patient in order to secure his fullest cooperation. If the patient was unwilling to leave the institution, the worker had a series of interviews with him to prepare him for the placement. In some instances it was advisable to arrange an interview between the patient and his prospective careholder so that he could see his future living quarters. His clothing needs were also taken into consideration. The hospital set up definite specifications regarding the amount and type of clothing the patient should have in order that he might be comfortable at public gatherings, at church, and with the family group. When relatives, friends, or

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3 Manual, 5.

other resources did not meet this need, the new clothing was obtained from the hospital store.[4]

At the same time the social worker was preparing the patient for placement, she was preparing the careholder for his part in the placement. In this connection she interpreted the technicalities of family care status. The careholder was given the telephone number of the social worker, was instructed in calling the physician on duty in case of an emergency at night, and was given the names of two neighborhood doctors to call if emergency care was needed. If possible, the patient came back to the hospital for any necessary medical care, and, if extended care was indicated, he was returned to the hospital.[5]

The worker explained the patient's mental condition to the careholder, who was told what could be expected from such a person, and how he could be helped in adjusting to his new setting. Insofar as it was necessary, the patient's limitations, recreational interests, hobbies, and religious preferences were discussed. In explaining these factors, the worker also recognized the problems which might confront the careholder, who was given reassurance that the hospital was ready to cooperate in assuming responsibility for the patient at any time it became necessary to do so.[6]

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4 Ibid., 9.
5 Ibid., 8.
6 Ibid., 4-5.

Financial arrangements regarding wages or maintenance were discussed at this time. If the patient could not work, and was not eligible for public assistance or relief, the state boarding fund was used. In 1942 the amount provided was $22.50 per month, but, by 1949, it had been increased to $60.00. If the patient was without funds, a small personal allowance was included in the amount paid for board and room, and the careholder turned it over to him as the need arose.[7] If the patient was to work for all or part of his maintenance, the careholder had to list the tasks that would be assigned to him.

After these arrangements were completed, the tentative plan was submitted to the hospital physician for final approval.[8] Once this approval was obtained, the Chief Nurse was informed of the date of placement so that the patient and his clothing would be ready. If the patient had any money or personal belongings held for him in the business office, the social worker collected and signed for these the day he left the hospital. The family care status form[9] was given at this time to the Information Clerk to be incorporated into the permanent record. The worker then went to the patient's ward, signed for his belongings, and accompanied him in the hospital station wagon to his new home. The

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7 Ibid., 9.

8 Ibid.

9 See attached form in Appendix V.

men patients had been to the barber shop and the women to the beauty shop on the hospital grounds, so that they would look their best upon arrival.

If necessary, the social worker spent some time helping the patient familiarize himself with his surroundings, and this proved to be especially helpful to the older patients, who were apt to be confused by a strange environment. In one instance the social worker accompanied an elderly man, who, since he had been hospitalized many years, was apprehensive about going to a boarding home. The worker helped him to unpack and then took him for a tour of the neighborhood, which enabled him later to make short excursions alone to purchase cigarettes and other personal items. The worker noticed he stared at everyone they passed. Finally he remarked, "It sure is nice to see people who are smiling." When the worker took him back to the careholder, he was content to stay.

At this point in the placement process, it was difficult to determine accurately the ability of the careholder to provide for the needs of a particular patient. Supervision of the day-by-day living was required before the social worker could ascertain how adequately the patient's needs were being met in this regard, and the success of the placement depended upon continued and effective supervision.[10] The social worker planned her home

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10 Ibid., 7.

visits so that both the careholder and the patient could have individual interviews to discuss their respective problems. The former was to keep the worker informed of any changes in the patient's behavior, and the patient could register any complaints, whether about food, sleeping arrangements, or the careholder's treatment of him. Usually the first visit was made within a week after placement and, following that, visits were on a monthly schedule.[11] The amount of supervision, however, depended upon the individual patient and careholder. Reports of the worker's visits were incorporated in the patient's medical record and the social worker's recommendations determined the frequency with which the patient visited the outpatient clinic.

In Chapter II, the patient was considered as he appeared before and during his hospitalization; in this chapter, the focus is on the patient at the time of placement. The information includes his age, his relatives, the number of placements, the type of placements, the length of placement, and the method of support.

Table II, in Chapter II, gives the ages at the time of admission; Table XII shows the distribution according to age and sex at the time of placement.

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11 Ibid., 6.

TABLE XII

DISTRIBUTION OF FAMILY CARE PATIENTS ACCORDING TO SEX AND AGE AT TIME OF PLACEMENT

Age Group	Male	Female	Total
Total	66	100	166
Under 20	0	5	5
20-30	6	11	17
30-40	7	8	15
40-50	16	13	29
50-60	11	17	28
60-70	14	12	26
70-80	12	20	32
80 and over	0	13	13
Unknown	0	1	1

A majority of the patients placed were in the older age groups, and 71 patients, or 43.3 per cent, were sixty or over. The largest number, 32 patients, were in the 70-80 group. The table also shows that the male patients placed tended to be in the middle and older age groups. There were more women than men in both the youngest and oldest groups. The median age at the time of placement was 56.1, almost ten years older than the median age of 46.9 at the time of admission to a hospital.

For the purposes of this study, the term "relative" was

used to include only parents, siblings, or children. The social records showed that, at the time of admission, 132 of the 166 patients had relatives; 32 had no relatives; and there was no information in the records of 2 patients. There was no way of determining accurately how many of these relatives had died during the patients' hospitalization.

Of the 166 placements, 22 were replacements, and, of the 22, 15 were second placements, 6 were third placements, and one was a fourth placement. Additional information was obtained which includes the type of placement, the extent of replacements with careholders, the length of placement, and the method of support. There were four types of placements that were used, boarding homes, nursing homes, working homes, and working institutions. Table XIII shows the frequency with which each type of placement was used during the first eight years of the program.

TABLE XIII

DISTRIBUTION ACCORDING TO YEAR AND TYPE OF PLACEMENT OF FAMILY CARE PATIENTS FROM CHICAGO STATE HOSPITAL

Year	Type of Placement					Total
	Boarding Home	Nursing Home	Working Home	Working Institution	Unknown	
Total	66	20	20	57	3	166
1942	12	3	2	9	2	28
1943	3	3	0	1	1	8
1944	6	0	3	21	0	30
1945	1	0	1	6	0	8
1946	0	0	0	4	0	4
1947	0	0	1	0	0	1
1948	17	8	7	10	0	42
1949	27	6	6	6	0	45

One hundred and twenty-three of the 166 patients were placed in either boarding homes or working institutions; 66, or 39.8 per cent of the entire group were placed in boarding homes; 57, or 34.3 per cent, were in working institutions. Forty patients, or 24 per cent, were equally divided between nursing and working homes. Information was not available for 3 patients, or 1.8 per cent of the total group.

The table shows a trend away from the working placements in favor of boarding home placements during the later years of the program. Thirty-six patients were placed during the first two years of the program, and 15 of these, or 41.7 per cent, were placed in boarding homes, while only 9 patients, or 25 per cent, were placed in working institutions. The ratio was reversed in the years from 1941 to 1947, when 42 patients were placed. Of these, only 7, or 16.6 per cent, were placed in boarding homes, while 31 patients, or 73.8 per cent, were placed in working institutions. There was no significant change in the proportion of nursing or working homes used.

In this table the effect of community factors is shown again in the kinds of placements that were available. By the year 1944 there was an increasing shortage in the labor market, and landlords were able to get more money for their rooms from war workers than the hospital could allow for boarding placements. Following the war, the number of working placements, in proportion to the total program, decreased, but the acute housing shortage continued until 1948, when boarding and nursing homes again were available at boarding fund rates.

Boarding homes in which the patient was provided with room and board were used for two types of patients. One type of patient remained in the home all the time, in an arrangement similar to a nursing home except that no special care was needed.

These patients were usually free to leave the boarding home for short periods of time, although the careholder kept a close supervision of their activities. The other type of patient, however, was able to work at a regular job in the community and pay for his room and board from earnings, and had greater freedom of activity. The Y. home shows how the same boarding home could be used for both types of patients.

> The family group consisted of Mr. and Mrs. Y., both about 65 years of age, and their 22 year old daughter. There were 5 married children and 10 grandchildren, all living out of the home. This was a closely knit family group and the entire family gathered frequently to celebrate special occasions.
>
> Mrs. Y., the careholder, the dominant figure in the home, seemed to be motivated equally in this undertaking by her desire to 'do good' for religious reasons, by her interest in people, and by her wish to make money. She took two patients into her home and has been understanding with both. She has recognized their individual needs and acted accordingly, and has been able to use the social worker's supervision. Mr. Y., a driver for a delivery service, was a passive man who accepted his wife's plans for the group. The daughter had a warm friendly personality and treated the patients as members of the family.
>
> The home itself was a large, three-story house in a nice residential area, tastefully decorated and furnished with period furniture. Each patient had a large sunny bedroom and had access to the whole house. The patients were expected to join the family in the living room to watch the television shows. They were treated as members of the family, joined the family for all meals, and participated in all family activities. When special occasions arose, they were included in the planning, and the other family members always included them when gifts were given.
>
> The two patients had different needs which seemed to be met by this environment. The first patient to

be placed was Art, a senile man in his seventies. Art was very demanding of Mrs. Y's time, resenting the attention she gave to others. Mrs. Y. was tolerant of this and, to counteract it, encouraged Art to participate in outside activities, which included an Old Peoples' Group at the local community center and a religious group in which he was interested. This patient was never able to make friends easily and was inclined to rely on the Y. family for his social contacts. He was very fond of Mrs. Y. and called her 'mother.' After a few months, he was given a conditional discharge to Mrs. Y.

A few months after Art first came to the Y. home, a second patient, Bill, a paranoid schizophrenic in his middle thirties, was placed in this same home. He was a graduate engineer who obtained a good position and paid his own way in the Y. home. Many of Bill's difficulties had centered around his relationship with his mother. It was somewhat surprising that he made such a good adjustment in the placement, as Mrs. Y. resembled his mother in many ways, with the same type of personality. There was a great difference, however, in the manner in which Mrs. Y. responded to Bill's individual needs. His mother had refused to indulge his hobby for working on radio and television improvements, while Mrs. Y. encouraged him to bring his equipment into the basement and also suggested he might want to work in his own room. His mother had protested if he 'raided the ice box', but Mrs. Y. did not mind and even left things ready for his snacks. The doctor, at the time of Bill's placement, was doubtful of his ability to make a good adjustment, but, after one year in the Y. home, Bill was continuing to adapt himself to a normal family setting.

The Y. home is an example of the kind of home desired for family care patients where the patients are accepted as members of the family group. For this reason the home and the home atmosphere were described in greater detail than in the examples of the other three types of placement, the nursing home, the working home, and the working institution.

In nursing homes, patients were provided with room and board, with additional nursing services available. The careholders usually had nursing experience and had facilities for caring for patients with physical disabilities. In addition to medical care, many of the patients needed constant supervision. An example of this was the nursing home used for Marie, an aged, senile patient who had suffered for some time with a thrombosis.

> This nursing home was located in a nice residential section of a western suburb. As there was a lawn and garden, the patients had pleasant surroundings where they could get fresh air and sunshine. There were ten elderly women in this nursing home, each with her own room.
>
> Marie would frequently have recurrent attacks of her physical ailment, which would require her to have complete bed rest for two or three weeks. During this time she would have tray service for her meals, bed baths, and all the other care her condition required. This type of care was more expensive than ordinary boarding home care, but was possible for Marie because she had an estate of her own and was able to afford the entire cost from her own resources.

The third type of home used was the working home. In a working home placement, the patient was considered to be a member of the family group, but was accepted by the careholder for the express purpose of doing certain tasks around the home or on the premises. By working in this way, the patient usually earned his room and board plus a certain amount for spending money. Betty, a young patient, was accepted on this type of arrangement to take care of the careholder's mother.

> The B. home was in an apartment building in a fairly congested district of the city. The careholder lived

there alone with her elderly bedfast mother. This woman had a moderate income and did not work; however, she needed someone to stay with her mother whenever she left the apartment. For this reason she was willing to accept a family care patient in her home. Betty's job included dressing the invalid and giving her meals, in addition to helping with the lighter housework around the home. Betty seemed to enjoy her work with the elderly woman and came to look upon her as a mother. It was, therefore, a great blow to her when this woman died. The careholder had no further use for Betty's services and asked the social worker to make other arrangements for the girl. Betty was not only upset by losing her friend but also anticipated that the careholder would no longer keep her. Her behavior became peculiar and she began acting out some of her delusions. It was necessary to return her to the hospital.

The working institution was the fourth type of placement used in the family care program. According to this plan, patients were placed as regular workers in the institutions and received the same privileges and pay as the other employees. Usually room and board were provided and considered as part of the earnings. Mental hospital patients were considered to be esped ally fitted for this type of placement, since they were accustomed to institutional routine and work. At one suburban hospital, the personnel manager told the social worker that the family care patients were the "best employees" in the institution. An example of this type of placement was the one given to Rosemary, a young patient, who was placed on a working assignment in a hospital in a western suburb.

Rosemary was given a job working in the kitchen, with the personnel manager as her careholder. She had a room to herself in one of two frame buildings which were located in the rear of the hospital grounds and

which were used as dormitories for the female employees. Each building had a recreation room provided with radio and record player where the girls could spend their leisure time.

Informal activities such as card parties, picnics, and small parties were arranged for the employees by the careholder. Rosemary was inclined to lack initiative in social contacts so that it was helpful when the person in charge took an individual interest in all of the girls. She encouraged Rosemary to take part in the young people's groups in the local parish. As Rosemary could be difficult to manage, this person frequently called the social worker for interpretation and for suggestions.

These various placements are representative of the types of homes and working placements that were used. The amount of supervision which was required on the part of the social worker varied not so much from group to group as from patient to patient in each group. The worker decided upon the amount of supervision each patient and careholder might need and acted accordingly.

The social records were reviewed to determine the extent of replacements during the period covered by the study. In the eight years included, 97 different homes or institutions were used, and of this number, 77, or 79.4 per cent, were used for only one patient. This meant that 20 careholders, or 20.6 per cent, supervised the remaining 89 patients. Approximately one fifth of the careholders were responsible for more than half of the patients who were placed. Of these 20 careholders, 2 supervised 14 patients each, one supervised 9 patients, one supervised 7, and one supervised 5 patients. Two placements were used for 4

patients each, six for 3 each, and seven for 2 patients each. This may be significant, since it was possible that, as the care-holder experienced the satisfaction of caring for such patients, he would wish to continue working for the program and help extend it in the community.

In considering placement, one of the most important aspects was that of length. Because the period studied covered eight years, it was possible to determine with some validity the amount of time spent on placement. Two sets of figures are given in the following table, however, to show the results for the patients placed before 1949, as well as for the total group. This gives a more accurate picture regarding length of placement, since those which occurred within the last year of the study would necessarily be of short duration.

TABLE XIV

DISTRIBUTION ACCORDING TO LENGTH OF PLACEMENT FOR PATIENTS PLACED BEFORE 1949 AND FOR ENTIRE STUDY GROUP

Number of Months On Placement	Number of Patients Placed before 1949	Number of Patients In Study Group
Total	121	166
Under 1	15	22
1-3	15	29
3-6	19	36
6-9	17	21
9-12	12	15
12-15	16	16
15-18	6	6
18-21	5	5
21-24	1	1
24 and over	11	11
Unknown	4	4

Of the 45 patients placed in 1949, and not included in the first set of figures, 38 were in the intervals under 6 months and 7 were in the intervals between 6 and 12 months. Thus the median length of placement for the patients placed from 1942 through 1948, which is 7 months and 28 days, may be considered to

be more valid than the median length of placement for the entire study group, which was 5 months and 20 days. Both sets of figures show that the average family care placement was of short duration.

Of 121 placements prior to 1949, 78, or 64.4 per cent, were on placement less than one year, as compared with 74.1 per cent of the total group of 166 patients lasting less than one year. The figures for the patients on placement more than one year were the same for both groups. Twenty-eight patients were on placement between one and two years, eleven patients for two years or longer. Of these 11 patients, one had been on placement for a total of 90 months, while 4 others were on placement for over 40 months. Of the 4 listed as unknown, 3 were patients who had escaped some time between 1944 and 1948 when little supervision was possible because of staff shortage. It was not known how long these three patients remained on the placements.

The final aspect of placement considered was the method of support, which included special provision by the State for those who were without funds. According to this provision,

> The state boarding fund may be used where the patient is without resources and where there is no other governmental agency responsible for his support after he leaves the hospital. An indigent patient who returns to his legal residence is eligible for support from that locality and will usually not need support from the hospital. Patients meeting the eligibility requirements for those special categories of public assistance provided by federal and state funds such as OAA, ADC, [Old Age Assistance, Aid to Dependent Children] are eligible

in any part of the state and will not require boarding fund expenditure.[12]

Records indicated that boarding fund expenditures were made for patients eligible for Old Age Assistance during the time that these applications were pending. This, and other forms of support, are shown in Table XV.

TABLE XV

DISTRIBUTION OF FAMILY CARE PATIENTS ACCORDING TO METHOD OF FINANCIAL SUPPORT

Method of Support	Number of Patients
Total	166
Earnings	88
Boarding Fund	24
Income or Relatives	21
Boarding Fund Partial	20
Public or Private Agencies	8
Unknown	5

The 88 patients who were supported by their own earnings comprised 54.3 per cent of the total group. Twenty-four of the

12 Ibid., 11.

patients were supported by the state boarding fund, while 21 received support from that source, supplemented by other means such as income or earnings. These 44 patients comprised 26.5 per cent of the total group.

This table shows that there was a tendency to place those patients who were able to earn their own living. More than half the patients were self-supporting and about one-fourth were supported either entirely or partially by the institution. Some of these received support from the state boarding fund for only one or two months, or until their Old Age Assistance was authorized.

In order to get some idea of what the expenditures from the state boarding fund actually were for a given year, the records from the Business Office were studied for the year 1949. During that year, state boarding funds were made available for 24 patients, for either total or partial support. A total of $3,983.04 was paid out, or an average of $165.92 per patient. This amount was paid for 70 months of care, or approximately three months for each of the 24 patients.

The review of the activities involved in the placement process gives some indication of what had to be done with the patient and the careholder in the preparation for placement, and shows the social worker's function in the family care program. In addition, questions connected with special kinds of placements were brought out in case histories, and this information, combined with

the over-all activities, gives some indication of the variety of factors that affect the total process.

CHAPTER IV

THE DISPOSITION OF THE 166 PATIENTS THROUGH THE FAMILY CARE PROGRAM

In the preceding chapters, the family care program was examined in an attempt to obtain information about the type of patients selected for placement and about the placement process. The focus in the present chapter is on the disposition of the 166 patients, and brief case histories are included to show the six possible dispositions. These dispositions, with the exception of those instances in which the patient died, are considered in relation to the diagnosis, to the amount of time spent in institutions prior to placement, and to the type of placement. They include absolute discharge, conditional discharge, continued, died, escaped, and returned.

If the patients adjusted well enough to remain outside the hospital, the program was considered to be meeting, in some measure, the purpose of hospital administrators. This was accepted as a criterion since the program had a dual purpose--that of providing the patient with a more favorable environment and reducing the population of the overcrowded institutions. In the light of this purpose, satisfactory adjustment to family care was the only

objective criterion that could be applied to all of the placements. On the basis of it, the placement from which the patient was not returned to the hospital is, therefore, considered to be a satisfactory one. Before evaluating the disposition of the placements in terms of this criterion, the question of the number of months that patients were able to remain outside the institution is considered on the basis of economic savings to the hospital.

In his 1948 report the Deputy Director[1] of Mental Health Service made the point that the state of Illinois would save $7,400 in ten years for each patient boarded out. This represented the amount saved after deducting the cost of administering the family care program. The following table shows the distribution of patients according to the number of months on placement.

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1 Dr. G. Wiltrakis, in a report given at a Medical and Surgical Staff meeting of the Illinois Department of Public Welfare, January, 1948.

TABLE XVI

DISTRIBUTION OF FAMILY CARE PATIENTS ACCORDING TO NUMBER OF MONTHS ON PLACEMENT

Number of Months on Placement	Number of Patients
Total	166
Under 1	22
1-3	29
3-6	36
6-9	21
9-12	15
12-15	16
15-18	6
18-21	5
21-24	1
24 and over	11
Unknown	4

Of the 4 patients listed as unknown, 3 were recorded as escaped, and it was not known how long they remained on the placement before leaving without permission. The remaining 162 patients represented approximately 1,332 months, or 111 years of family care. According to the figures quoted, the state of Illinois saved a total of $82,146 on these patients. This does not show

the total time the patients remained outside the hospital, but only that period when they were carried on family care status before a final disposition was made.

An analysis of the 166 placements showed that dispositions fell into the six classifications which have already been listed. The absolute discharge, or permanent discharge from hospital supervision, could be given to the patient either as recovered, with his civil rights automatically restored, or as improved or unimproved. In the improved or unimproved groups, it was necessary for the patient to appear before the County Court to secure the restoration of civil rights. In contrast, the conditional discharge was a form of parole from the hospital in which the patient continued under a limited form of supervision, but with a relative or friend assuming responsibility for his activities. The term "continued" applied to those patients who were still on their placements as of January 1, 1950. The classification "died" pertained to patients who had died before they could be returned to the hospital. The disposition "escaped" was given to those patients who left their placements without the permission of the hospital. "Returned" applied to all patients who had to be returned to the hospital for any reason.

The following table shows the distribution of the 166 patients according to the final disposition of the placement.

TABLE XVII

DISTRIBUTION OF 166 FAMILY CARE PATIENTS ACCORDING TO THE FINAL DISPOSITION

Disposition	Number of Patients
Total	166
Returned	62
Absolute Discharge	45
Continued	24
Conditional Discharge	18
Escaped	12
Died	3
Unknown	2

This table shows that the largest number of patients in one group were the 62 returned. This was 37.4 per cent of the study group, and left 102 patients, or 63.2 per cent, distributed in the other five classifications. Of these patients, 45 received absolute discharges, while only 42 were in the two groups of "continued" and "conditional discharge." Patients in these groups required continued supervision.

Examples of the six categories are given, showing what type of arrangements were made in terminating the family care placements and giving some indication of the reasons for the type

of disposition made. The first disposition considered is "returned," which applied to 62 patients. Some of the reasons given for returning patients included the need of medical care, the request of the patient or of the careholder, and the request of relatives. One of the patients stated simply that he wanted to return to the hospital so that he could "sit under the trees." The following summary of the record of a patient who had to be returned gives some indication of the variety of factors that entered into this disposition.

> Josh, a 47 year old patient, had been hospitalized 11½ years before his placement in 1943. His diagnosis was "mental defective with alcoholism." He was a junkman before admission, and was separated from his wife. As he was quiet, good natured, and cheerful, Josh had been a favorite with both the patients and the hospital personnel. Because of his good work record, a job was obtained for him at a small hospital in the city where he was provided with living quarters.
>
> Josh was on placement four years before he was returned. In that time, there were three different persons supervising him, each of whom was impressed by his willingness to work. They reported that, when sober, Josh could do the work of two men; however, each was faced with the problem of his drinking. For the first few months, he was on his good behavior, but then he began spending his whole pay check on drinking and was unable to work for two or three days following pay day. He caused the hospital endless trouble taking care of him after these "sprees." The careholder reported that the original cause of his trouble was a group of women in the laundry who encouraged him to buy liquor for them. As he liked the attention, he tried to make a big "splurge" for them.
>
> Because Josh was a valuable employee when sober, the careholder was willing to make allowances for him. On several occasions he was returned to the hospital for aversion treatment, but the results lasted barely

a month at a time. For a while, the supervisor, with the social worker's permission, gave Josh only enough money from his salary to care for his immediate needs. With the remainder of the money she helped him to buy clothing and to accumulate savings. Finally in 1947, the social worker received a request to return Josh to the hospital. He had been intoxicated for three months and had set a fire in the neighborhood. As he was becoming a neighborhood nuisance, the careholder said she could no longer cope with him.

The second category in size was "absolute discharge," with forty-five patients. In determining whether or not the patients could receive this type of discharge, the psychiatrist considered, not only their mental condition as such, but also the amount and type of independent activity of which they seemed to be capable. Ray received an "absolute discharge" as recovered, only seven and one-half months after placement.

Ray was only 15 years old when first committed to the mental hospital. He was in grade school, in the seventh grade. His diagnosis was dementia praecox, hebephrenic, mental defective. He did not wish to return to his family because his own parents did not want him and he would have to return to his grandparents who were very elderly. His work record while in the hospital was good and it was possible to place him in a working institution.

At the time of placement, Ray was 24 years old. He was able to live at the small hospital where he was employed. After being at this hospital only a few months, he went to a distant suburb, on his day off, and obtained a job and a place to live. He explained this to the social worker by saying that he wanted to feel "he was being taken at face value and treated like everyone else."

This patient showed amazing independence considering the long period of hospitalization. When he returned to the out-patient clinic for routine examination by the clinic psychiatrist, it was recommended that Ray

receive an "absolute discharge" on the basis of his remarkable adjustment.

The third category of "continued" had 24 patients, and most of these were placed within the last year of the period covered by this study. One of these was Alice, who was placed in July, 1949.

> Alice was a 50 year old woman, separated from her husband. She had been hospitalized three times for a total of two years, and the diagnosis was manic depressive, manic state. Following a course of electro-shock treatment, she had recovered sufficiently to leave the hospital but was "not wanted" by her husband and had no other relatives. The ward physician recommended family care placement.
>
> A placement was made for Alice in a working home where she was to do the cooking and part of the housecleaning. The family group consisted of the careholder and her employed son. Alice seemed to be getting along fairly well until the careholder decided to marry a man with two children. As this meant that Alice would be cooking for five people, she decided this would be too much work for her. She found a room in a neighborhood hotel and obtained a job doing housekeeping work. The social worker approved the move, but thought that Alice needed continued supervision at this time. Consequently, the disposition was that of "continued."

The fourth category was "conditional discharge," and 18 patients were included in this group. These patients still needed supervision, but arrangements other than family care could be made for them. Ten of the 18 patients who received "conditional discharges" were eligible for Old Age Assistance, which they could not receive if they were on family care status. Four patients had recovered sufficiently so that relatives were willing to assume responsibility for them. The remaining four were

discharged to the careholder. The following excerpts show some of the difficulties that made it necessary to retain some form of supervision for some of these patients.

John, 78 years old, was diagnosed as psychosis with cerebral arteriosclerosis. He had no relatives to take care of him. He had been kind to a fellow patient, however, and when this man died his sister offered to take John into her home. The investigation of her home showed a seven room apartment which was clean and pleasant, with adequate plumbing, but situated in a poor neighborhood. The woman had unusual ideas about medical care, but she was warm, jovial, and interested in John. It was decided that, although the careholder (sister) was eccentric, she could provide the patient with a comfortable home.

At the time of his placement, the physician's report stated that John was on a salt free diet, was too old to work, and formerly assaulted other patients. He liked his new home, enjoyed Mrs. K's cooking, and helped her with the dishes and other errands. After he was there a few months, however, he began to complain that she was "picking up boy friends."

Application had been made for reinstatement of John's Old Age Assistance grant. When this was accepted, it was necessary to transfer John to the status of conditional discharge so that he would be eligible to receive the grant. In view of his complaints, whether realistic or not, the psychiatrist and the social worker decided to discharge John conditionally to the Social Service Department rather than to Mrs. K., as was originally planned.

Following that decision, John underwent an operation, and, following this, required much extra care. He could only be fed liquid food through a tube. However, Mrs. K. enjoyed caring for him and wanted to keep him as long as possible, as "he feels at home" with her. When the first year on conditional discharge was up, the psychiatrist said that John had not recovered sufficiently to receive an absolute discharge, yet he did not need to be returned to the hospital at that time. The psychiatrist, therefore, extended the conditional discharge for another year.

The fifth category is "escaped," and only 12 of the 166 patients were listed under this group. If a patient was missing for twenty-four hours without permission, he or she was listed on the hospital records as escaped. None of the twelve returned to their placements. In some instances, when the patients were not heard from again, and many years had passed, they were considered to be recovered and were discharged. Elsie was one of the patients who escaped, was eventually listed as such, and was never heard from.

> Elsie, a 56 year old, single, white patient, had a diagnosis of psychosis, syphilis with meningo-encephalitis. She had been traveling through Chicago on her way to California when she applied for help from Travelers Aid. Because of her psychotic behavior, she was hospitalized.
>
> Elsie was treated for syphilis. She worked on the ward and was very cooperative. When brought before the medical staff for consideration for discharge, she was declared to be improved enough to leave the hospital, and the doctors recommended a family care placement. The social worker arranged to have Elsie released to the Salvation Army and to work at a local hospital which did not have living quarters for its employees.
>
> Elsie was very excited about leaving and was confident she would "make good." After placement, she showed great independence, adjusted well, and was neither timid nor fearful. Her supervisor at the local hospital liked her very much and managed to get her a room in the nurses' home. Elsie did a good job and looked forward to receiving an absolute discharge on her first visit to the outpatient clinic. This was not granted, and Salvation Army continued to be responsible.
>
> It was following this visit to the clinic that Elsie disappeared. The supervisor reported to the

social worker that Elsie had been very upset about not receiving her absolute discharge and had cried constantly after her return to the clinic. Suddenly she had packed her belongings and left. She told a friend that she was going "to California or New York" where she would have "someone to laugh with." She was listed as "escaped," and was never heard from. It was assumed that she had carried out her plans to go to her friends.

The sixth and final category was "died." Only three of the patients died while on placement, of whom one was Arthur.

Arthur was a 67 year old patient, diagnosed post traumatic psychosis, with post traumatic enfeeblement. When he recovered from the psychosis, there was no place for him to go. His only relative was a brother, an Old Age Assistance recipient, who was unable to help Arthur, although he was interested in him.

This brother helped the social worker find a room for Arthur within a block of his own apartment. This made it possible for Arthur to take many of his meals with his brother and to visit with him whenever he was lonesome. When the brother died after six months, Arthur was very despondent and was removed to a nursing home where he could receive additional care. He enjoyed taking walks and sitting in the nearby park. One summer day, after taking a long walk, he returned to the nursing home, complaining of a pain in his heart. He died within a few minutes.

These excerpts give some indication of the variety of factors that are involved in the individual dispositions. In regard to the study group as a whole, however, the dispositions are considered in relation to the diagnoses, the length of time in institutions before placement, and the type of placement.

The dispositions of the 166 placements are shown in Table XVIII according to diagnostic classifications, which are divided into two major groups, the organic and the functional disturbances.

TABLE XVIII

THE DISTRIBUTION OF 166 FAMILY CARE PATIENTS ACCORDING TO DISPOSITION AND DIAGNOSIS

Diagnosis	Disposition							Total
	Ret.	AD	Cont.	CD	Esc.	Died	Unk.	
Total	62	45	24	18	12	3	2	166
Organic	36	15	16	13	4	2	2	88
Psychosis, Cerebral Arteriosclerosis	12	3	4	5	1	1	1	27
Senile Psychosis	10	3	8	4	0	0	0	25
Alcoholic Psychosis	8	6	1	0	1	0	0	16
Psychosis, Syphilis	5	2	1	3	2	0	1	14
Psychosis, Epilepsy	1	1	1	1	0	0	0	4
Post-Traumatic Psychosis	0	0	1	0	0	1	0	2
Functional	26	30	8	5	8	1	0	78
Schizophrenia	15	19	5	2	6	1	0	48
Manic Depressive	1	4	1	0	1	0	0	7
Psychoneurosis	1	3	2	1	0	0	0	7
Involutional Psychosis	2	2	0	2	0	0	0	6
Psychopathic Personality	3	1	0	0	1	0	0	5
Mental Defective	4	0	0	0	0	0	0	4
Paranoia	0	1	0	0	0	0	0	1

The patients in the organic classifications had a slightly higher rate of return than those in the functional groups. Of the organic patients, 40.9 per cent were returned, while of the functional patients, 32.9 per cent were returned. There was a more significant difference between the organic and the functional

groups in the other five categories or dispositions. More than twice as many from the functional classifications were given "absolute discharges" as from the organic groups.

For the patients who required continued supervision with the dispositions, "continued" or "conditional discharge," the ratio was reversed. There were more than twice as many organic as functional patients with one of these dispositions. The reason for this distribution lay in the need of the organic patients for continued supervision, since patients in this group do not respond to environmental changes in the way that patients suffering from functional disturbances frequently do. These figures seem to indicate that, if patients with functional disorders did adjust well enough to remain out of the hospital, they usually were able to secure an "absolute discharge."

Table XIX shows the dispositions in relation to the number of years in institutions prior to placement.

TABLE XIX

DISTRIBUTION OF 166 FAMILY CARE PATIENTS ACCORDING TO DISPOSITION AND TIME SPENT IN INSTITUTIONS

Number of Years in Institutions	Disposition							Total
	Ret.	A.D.	Cont.	C.D.	Esc.	Died	Unk.	
Total	62	45	24	18	12	3	2	166
Under 1	12	9	5	7	3	0	1	37
1-3	16	12	14	5	4	0	1	52
3-6	17	5	3	0	3	0	0	28
6-9	6	7	0	2	0	1	0	16
9-12	9	2	0	2	1	0	0	14
12-15	1	5	1	0	0	0	0	7
15-18	1	2	0	0	1	0	0	4
18-21	0	1	1	1	0	0	0	3
21-24	0	0	0	1	0	0	0	1
24 and over	0	2	0	0	0	1	0	3
Unknown	0	0	0	0	0	1	0	1

The median time spent in institutions by the family care patients was 2 years, 9⅛ months. This table shows that more than half of the patients (89) had been hospitalized for less than 3 years, and that 117 patients, or 70.3 per cent of the study group, were hospitalized for less than 6 years. Of these 117 patients,

45, or 38.4 per cent, were returned to the hospital. The 48 patients who had been hospitalized longer than 6 years had a slightly better average of satisfactory placements, with 17 patients, or 35.3 per cent, being returned to the hospital.

Although longer periods of hospitalization have been considered detrimental to the patient's ability to adjust outside the institution, this did not hold true for the study group. Eighteen of the 166 patients had been in the hospital for 12 or more years. Of these, only 2 were returned to the hospital. Half of the 18 patients had a diagnosis of schizophrenia. These nine had a rather remarkable record, 7 receiving absolute discharges, one, a conditional discharge, and one being listed as escaped.

The classifications in Table XIX which had the largest ratio of unsatisfactory placements were the groups of patients who had been in institutions from 9 to 12 and from 3 to 6 years. In the 9 to 12 year group, nine of 14 patients placed, or 64.3 per cent, were returned, while in the 3 to 6 year group, seventeen of the 28 patients, or 60.7 per cent, were returned to the hospital.

In addition to the diagnosis and the length of time in the hospital, another factor considered was the type of placement that was used. Table XX shows the distribution of the patients according to the disposition and type of placement.

TABLE XX

DISTRIBUTION OF 166 FAMILY CARE PATIENTS ACCORDING TO DISPOSITION AND TYPE OF PLACEMENT

Type of Placement	Disposition							Total
	Ret.	A.D.	Cont.	C.D.	Esc.	Died	Unk.	
Total	62	45	24	18	12	3	2	166
Boarding Home	20	14	16	10	3	3	0	66
Working Institution	23	25	3	1	5	0	0	57
Nursing Home	11	2	4	3	0	0	0	20
Working Home	7	4	1	4	4	0	0	20
Unknown	1	0	0	0	0	0	2	3

The group of patients placed in boarding homes had the smallest per cent returned to the hospital, with 20 of the 66 patients, or 30.3 per cent, returned. Of these 20, 12 patients had organic and 8 had functional disorders. Fifty-five per cent of the twenty patients who were placed in nursing homes returned; of the eleven patients in this group, ten had organic diagnoses. The group placed in working institutions also had a high percentage returned, with 23 of the 57 patients, or 40.3 per cent. In the working homes, 7 of the 20 patients, or 35 per cent, had to be returned.

The patients in the working institutions had the largest number of patients receiving "absolute discharges;" 25 patients, or 43.9 per cent, were given this discharge. Thirteen, or slightly more than half of this number, had the diagnosis of schizophrenia, and ten of these had been hospitalized for more than eight years prior to placement. The patients in the nursing homes, with the highest percentage of returns, also had the smallest percentage (10 per cent) of absolute discharges.

Of the 24 patients who were still on family care placements, two-thirds were in boarding homes. Half of the 24 patients were either senile or were suffering from cerebral arteriosclerosis and 19 had been hospitalized for less than 3 years. More than half of the patients receiving "conditional discharges" were in boarding homes, and 13 of the 18 patients had organic disorders. Seven patients in this group had been hospitalized less than one year, while 12 were hospitalized less than 3 years. As for the patients listed as "escaped," 9 of the 12 were on working assignments, and 8 of the 12 patients had functional disturbances.

The placements were considered in regard to the disposition of each. There were many factors in each placement which could not be treated statistically and to indicate some of these, case examples were included. These showed some of the difficulties involved in an objective consideration of the results of the placements.

CONCLUSIONS

Analysis of the 166 cases comprising the study group showed that successful placement of patients depended upon careful selection of both the patient and the placement. Selection of the former rested with the physician, and of the latter, with the social worker. In general, two types of patients were placed, those who needed merely custodial care, and those who could benefit therapeutically from contact with family life. The homes selected had to meet, not only certain physical requirements, but also had to meet the emotional needs of persons who were mentally ill. For this reason, the attitudes of members of the household toward mental illness had to receive major consideration.

During the first years of the program more men were placed than women; however, there was a shift in 1948 and 1949, when three times as many women as men were placed. This shift appeared to be related to the overall economic picture, for the earlier assignments were predominantly working assignments, while the trend later was toward boarding homes which preferred women patients.

Data obtained from the social histories gave a composite picture of the social characteristics of the study group. The

median age of the group was 47, but the majority of the patients (99) were over 50 years of age. More than two-thirds of the group was native born and the majority were white. The largest religious group was Protestant, while the next largest was Catholic. In regard to marital status, the largest number (62) belonged to the "single" group; however, of the 161 patients for whom the marital status was known, 61.5 per cent, or 99 patients, had at one time been married. The occupations included a large variety of jobs, but the largest single group was the service group. This group best fitted the job placements which were available.

Medical information showed that the 166 patients were divided rather evenly between the organic and functional diagnoses, with 53 per cent falling in the organic, and 47 per cent, in the functional, classifications. Three diagnoses accounted for 100 of the patients: schizophrenia, 48; psychosis with cerebral arteriosclerosis, 27; senile psychosis, 25. Less than half of the patients had physical illnesses or disabilities; many of these conditions were contributory to the mental illnesses, while others were common in persons of advanced age and had no apparent connection with the mental condition.

Four types of placements were used: boarding homes, nursing homes, working homes, and working institutions. The type selected depended upon whether the purpose of placement was custodial or therapeutic. The majority of the patients were placed

in either boarding homes or working institutions. In the last two years of the period studied, the trend has been toward placement in boarding homes. Of the 97 careholders used during the eight years, 77 were used for only one patient, while the remaining 20 careholders supervised 89 of the patients. The placements were of short duration, with 74.1 per cent lasting less than one year. The median time of placement was 5 months and 28 days; however, excluding the 45 patients placed in 1949, the median time on placement was 7 months and 28 days. More than half of the patients earned all or part of their support, while a little more than one-fourth were supported either totally or partially by the state boarding fund.

If the patient was able to remain outside of the hospital, the placement was considered to be satisfactory for the purpose of this study. Using this criterion and considering the type of placement, the best results seemed to be attained in the boarding homes, with only 30 per cent of the 66 patients being returned to the hospital. Thirty-five of the 20 patients in working homes were returned; forty per cent of the 57 patients in working institutions were returned; fifty-five per cent, the largest percentage, of the 20 patients in nursing homes were returned. There was no significant difference in the number returned in terms of diagnostic classification, that is, whether the disorder was organic or functional. Twice as many patients

receiving absolute discharges had functional diagnoses as had organic disorders. On the other hand, of the 42 patients with "continued" and "conditional discharge" dispositions, more than twice as many suffered from organic as from functional disturbances.

It is difficult to state definitely what type of patient made a satisfactory adjustment, since there were many intangible factors, such as the patient's own feeling of security or insecurity and his ability to find satisfaction in personal relationships, which had to be taken into consideration. In general, however, patients with organic diagnoses had a slightly higher rate of return than patients with functional disturbances. In regard to type of placements, nursing homes had the highest percentage of returns, while boarding homes had the lowest.

Correspondence between the Chief of Social Service in Institutions and the Chief Social Worker, relative to the progress of the program, was made available to the writer. This correspondence indicated that the program had not expanded as much as was originally anticipated, during the period studied. This slowing up was probably due, at least in part, to the disruption of family life that accompanied the war and post-war periods. Industry's demand for labor meant that many women who might under other circumstances have been interested in patients were themselves employed. For others, the housing shortage made it impossible for them to take an extra person into their homes,

even though they were interested in doing so. The correspondence also indicated that plans were being formulated, at the end of the eight year period, to increase the extent and effectiveness of the program.

In the meantime, some adjustments in procedure were indicated by the study. There would be practical help in the inclusion, in each social history, of a specific concrete evaluation of the careholder. This should include his attitude toward patients, his methods of handling problems, and the ways in which he was of help to the social worker. Such information would be valuable in relation to replacements.

The Social Service Department could also make a significant contribution to the total program if it could work out some system which would prevent patients from being "lost" in the institution, simply because there is no one to press for their discharge. Jaffary[1] discusses this problem and refers to a plan used at the Kankakee Hospital in 1933, according to which:

> With the purpose of discharging every improved patient who was parolable, a card file was set up in which a card was placed on the patient's admission, to be reviewed three months later. This automatic review of cases brought to attention those who were recovered but not paroled, and directed effort toward their parole. . . .

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1 Stuart K. Jaffary, Mentally Ill in Illinois, Chicago, 1942, 134.

If some method, such as this, of reaching all patients could be developed, patients might be prevented from becoming so "institutionalized" that it is difficult, and sometimes impossible, to persuade them to leave the hospital, even when they are ready for placement and when placement is available to them.

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APPENDIX I

Illinois Revised Statutes, 1939
Chapter 23 - Section 26

Insane patients or inmates or patients of charitable institutions may be boarded out.

Any insane patient in any State hospital for the insane, any inmate of the St. Charles School for Boys or the State Training School for Girls except inmates committed by any Court of the United States or any inmate or patient of any State charitable institution may be placed at board in a suitable family home by the Department of Public Welfare if said department considers such course expedient. The cost to the State of the maintenance of any such boarded out patient shall not exceed the average per capita cost of maintenance in the institution from which such patient is boarded out. Bills for the support of a patient so boarded out shall be payable monthly out of the proper maintenance funds and shall be audited as are other accounts of the department. The department shall cause all persons who are boarded out by it in family homes at public expense to be visited at least once each three months. Upon the complaint of any boarded out patient or of any responsible citizen or member of the household where such patient is boarded out, the department immediately shall investigate, and, if needful, such patient shall be removed at once to the institution of which he was an inmate or patient before he was boarded out or to another boarding place. Where there is no complaint, the department shall cause to be removed as above, any patient, who, upon visitation, is found to be abused, neglected, or improperly cared for when boarded out in a family home. The department may permit any boarder temporarily to leave custody as an insane person in charge of his guardian, relatives, friends, or by himself, for a period not exceeding one year, and may receive him again into such custody when

returned by any such guardian, relative or friend, or upon his own application, within such period, without any further order of commitment and may, during such temporary absence, assist in his maintenance to an amount not exceeding the rate paid for his board when boarded out in a family home by the Department.

In placing any child under this Act, the department shall place such child as far as possible in the care and custody of some individual holding the same religious belief as the parents of the child, or with some child welfare agency which is controlled by persons of like religious faith as the patients of such child.

(As amended by act approved July 6, 1935. L 1935, p.251.)

APPENDIX II

PHYSICIAN'S EVALUATION

For Patients to be Considered for Family Care Placement

Name _____ Hosp.No._____ Ward_____ Date_____

Diagnosis _____

Anti-social tendencies exhibited at present time:

Assaultive _____ Sex delinquency_____ Incontinent___
Homicidal _____ Wandering or escape _____ Others _____
Suicidal _____ Fainting spells or fits__

What physical disease does patient have?

Are there any psychosomatic complaints:
Will any continued medical care be necessary?
Any medication?
Is a special diet recommended:
Does patient have any physical defects?
Will he need any prosthetic appliances?
Is patient able to go up and down stairs?

PRESENT MENTAL STATE:
(check if defective) Describe if checked as abnormal.

Behavior _____
Speech _____
Mood _____
Delusions _____
Hallucinations _____
Abnormal ideas _____
Orientation _____
Memory _____

Is patient suitable for Nursing Home? Boarding Home? Working Placement? If latter - Light Work? Heavy Work?

When possible placement is found for patient social worker will confer with physician for approval of placement and any further details regarding patient's condition and needs.

REMARKS:

Signed _____ M.D.

APPENDIX III

NURSING SERVICE EVALUATION

Name _____ Hosp.No. _____ Ward _____ Date _____

1.	Unclean and takes no interest in personal appearance.	Yes ___	No ___
2.	Idle and will not help with ward work.	Yes ___	No ___
3.	Cooperative and friendly. Interested in helping with ward routine.	Yes ___	No ___
4.	Interested in social activities.	Yes ___	No ___
5.	Appetite poor.	Yes ___	No ___
6.	Unusual table habits.	Yes ___	No ___
7.	Sleeps poorly.	Yes ___	No ___
8.	Talks to self.	Yes ___	No ___
*9.	Shows peculiar behavior.	Yes ___	No ___
10.	Seems sad.	Yes ___	No ___
11.	Over-active.	Yes ___	No ___
12.	Over-talkative.	Yes ___	No ___
13.	Destructive.	Yes ___	No ___
14.	Irritable; not able to get along with others.	Yes ___	No ___
15.	Has fainting spells, fits?	Yes ___	No ___
16.	Untidy bladder and bowel habits - a) at night	Yes ___	No ___
	b) during the day	Yes ___	No ___
17.	Up, but has difficulty in performing ordinary routine.	Yes ___	No ___
18.	Has ordinary energy.	Yes ___	No ___
19.	Unusually vigorous for age.	Yes ___	No ___
20.	Bed Patient.	Yes ___	No ___
21.	Tendency to wander.	Yes ___	No ___
22.	Tendency to escape.	Yes ___	No ___
*23.	Unusual sex habits.	Yes ___	No ___
24.	Talks of suicide or tries to harm self	Yes ___	No ___
25.	Assaultive to other patients.	Yes ___	No ___
26.	Assaultive to attendants.	Yes ___	No ___
27.	Does patient have visitors?	Yes ___	No ___

*Remarks: Give specific data on items starred on back of page. Elaborate on any you think necessary.

APPENDIX IV

CHICAGO STATE HOSPITAL

INDUSTRIAL DEPARTMENT

Name _____ Hosp. No. _____ Ward _____ Date _____

Type of Work Assignment _____ Place _____

Quality of Work:	Good	Fair	Poor
Supervision Needed:	Minimum	Partial	Maximum
Appearance:	Neat	Careless	Untidy
Attitude Toward Others:			
Toward Supervisor	Cooperative	Irritable	Uncooperative
Toward Fellow Workers	Cooperative	Irritable	Uncooperative
Attitude Toward Work:	Has Initiative	Follows Orders	Cannot Follow
Ability to Accept Suggestions:	Accepts	Resents	Refuses
Adjustment on Assignment:	Good	Fair	Poor
Improvement:	Great	Some	None
CHARACTERISTICS	Sociable	Indifferent	Withdrawn
	Dependable		Unpredictable
	Alert		Dull

Does Patient Work Better: Alone With Others

What Kinds of Work Placement Has Patient Had in Hospital:

Why Was Patient's Job Changed:

Can do heavy work Can do light work Can do only routine tasks

Has trade, skill or profession

Remarks: (Include Unusual Work Habits or Tendencies) (Use Other Side)

APPENDIX V

CHICAGO STATE HOSPITAL

FAMILY CARE STATUS

DEPARTMENT OF PUBLIC WELFARE

Date _____

Name of patient placed _____ Hosp. No. _____

Name of persons with whom patient is to be placed _____

Residence _____

TYPE OF PLACEMENT

Strike Inapplicable (State Support
(Self Support
(Agency Support

Describe Arrangements _____

Reason for placement _____

Condition of patient
at time of placement _____

Where patient is to be
taken at time of placement _____

Recommended by _____ Physician

Approved _____ Superintendent