Not one mother has left the hospital against medical advice since homemaker services were provided in a Texas county.

Hidalgo County Homemaker Program

HOWARD JUSTISS

HIDALGO COUNTY'S public welfare agency in its child welfare work has the distinction of being the first to provide homemaker services in Texas. We feel these services answer a vital need in our county. Actually, there are some parts of our homemaker service which we do not like but cannot change immediately because of our financial situation. I want to tell you about some of the weak points as well as the strong; the good and the bad.

Imagine yourself in the southernmost city of Texas, Brownsville at the mouth of the Rio Grande. Travel up the river about 75 miles, turn directly north, and go another 20 miles. You will find yourself in Edinburg, the county seat of Hidalgo County. There are about 16,000 people in Edinburg when all the migrant workers have returned from the north, which usually happens in December. There are about 200,000 people in Hidalgo County. It is a large county and much more thickly populated than some counties I know of in Texas. The chamber of commerce would prefer that I tell you only the attractive things about the region, such as the good, tree-ripened citrus fruits, the beautiful palm trees, the many oil and gas wells, the fine cattle, and the warm winter vacationland; but I feel that you should know more than these facts because there are some which influence our child welfare homemaker program.

We have a population of 75,000 children, many of them from large families whose parents are poorly paid farm laborers. Wages are from $4 to $5 per day when they work.

Because of inadequate diet, lack of medical care, overwork, and poor health standards, incidence of tuberculosis is extremely high. In the South Texas State Tuberculosis Hospital, located in the adjoining county, there were 473 patients on August 31, 1959. Of that number 205, or 43 percent, were from Hidalgo County.

There are great social and cultural differences. Seventy percent of the residents are Latin-American, or Spanish-speaking; others are those who have settled there from the colder regions "up north."

Our child welfare agency is charged with the responsibility of providing protective services to children who are "dependent" and "neglected," as defined by our State laws. This includes the usual provisions for foster-home boarding care, casework services, and adoptions. Homemaker service came to be a part of our program as a result of an experiment with two family situations. I would like to tell you briefly about these two families before we discuss other features of the work.

On a visit to the home of Mr. G in Edinburg, Tex., we might see a family of two girls and three boys getting ready for school. We would be in a small frame house with two bedrooms, a kitchen, and an outdoor toilet. It is a very modest house, but what you would

Mr. Justiss is regional service supervisor, State Department of Public Welfare, Hidalgo County Child Welfare Unit, Edinburg, Tex. *This paper was delivered at the Round Table Conference on Homemaker Service of the American Public Welfare Association in Washington, D.C., December 4, 1959.*

expect for a rent of $25 per month. The youngest child, a boy 6 years old, probably would be asking the 50-year-old lady in the house, whom he calls "Tia" or aunt, to brush his hair. Or this same motherly lady, dressed in a plain, striped seersucker uniform, might be helping 12-year-old Mary pack her school lunch. The father, Mr. G, is not there because he left about 7 a.m. to do odd jobs on a ranch nearby. He is 65 years old but he likes to supplement his Aid to Dependent Children check of $96 per month by helping his "patron" repair fences, oil windmills, repair cattle guards (that's the kind of gate you run over the top rather than get out of a car and open), or anything else there is to be done. He does these odd jobs for $4 or $5 per day. The lady helping the children get off to school is our first homemaker. She has served continuously in this same home since January 24, 1955.

The situation of the G family came to the attention of the child welfare department in October 1953, when the mother became mentally ill and we had to place the children in foster-home boarding care. The mother was hospitalized, diagnosed as schizophrenic reaction, catatonic type with mental deficiency. With the prognosis poor, we decided it was unfair to keep the children in foster-home boarding care. Arrangements were made to return them to the father, Mr. G, who could use his ADC check of $96 to pay a housekeeper to help him with the children, who were then aged 2, 5, 8, 10, and 11. This was a poor arrangement: Mr. G offered only $1 a day to this helper. There was no washing machine. She complained of the two-burner kerosene stove and the fact there was no food except beans. She knew that this was not what a 2-year-old child needed. Mr. G fired her, only to find the next one just as complaining and disagreeable. When he did find someone to suit him, she quit because Mr. G did not want to pay her. "After all, I am furnishing the food," he said.

On January 24, 1955, the department employed a warm, motherly widow to work with Mr. G and his children during the days only. The children knew her because she had lived in the immediate neighborhood. Also, she knew the children's mother and was able to help them understand and talk about what had happened. Each year the mother returns from the hospital on furlough to visit her family, but each time her peculiar behavior makes it evident to the children, the homemaker, and to Mr. G that she is too ill to remain at home.

In the meantime, our homemaker has taught the oldest girl how to cook, to sew, and to keep house. Plans are for this girl to take over the responsibilities of the home and to close the case during 1960, after 5 years of continuous service.

Our second homemaker was hired in October 1955, in an effort to protect five children, aged 2 through 15 years, from exposure to tuberculosis from their mother. Mrs. B, the mother, resisted hospitalization. Even though she went to the hospital several times, she would return home each time against medical advice. Enforced isolation of the mother in her own home, with a homemaker to care for the children, was the only alternative to foster-home boarding care for the children. When Mrs. B began hemorrhaging, she agreed to return to the hospital. Even then, she came home in 6 months for an "unauthorized" visit just to "see how the children were getting along."

The homemaker was able to give continuous 24-hour care to these children for 6 days each week, but not without problems. The father had always depended upon his wife to discipline the children, but he resented the homemaker doing it and he could not do this himself. As a day laborer in the fields, his income was insufficient even with ADC and this eventually was denied on the basis that a caretaker was supplied by the department. The homemaker was an excellent cook but, as a result of the ADC denial, there were times when there was little or nothing to cook. The homemaker accused the father of making "advances."

These issues were settled skillfully by the caseworker.

This same homemaker remained in the home of Mr. B's family until the mother was discharged after 3 years in the hospital.

Our program has grown and improved since those first few months of blundering and experimenting. At one time in 1959, we had 14 homemakers caring for 14 such families. In the past 4 years we have used a total of 57 home-

makers to care for 48 families including 236 children. Most of these children would have required boarding care for long periods of time in foster homes had this arrangement not been available. I need not point out the advantages to each child of remaining in his own home, but another factor made sense to our commissioners—the homemaker services cost less than foster-home boarding care. Homemaker services for the G family for 5 years have cost the county about $6,240. Foster care for these five children for the same length of time would have cost about $12,000, and would have included no help for Mr. G himself.

We pay our homemakers $20 to $25 per week. Usually they are widows with no family responsibilities, neighbors to the family in distress, and acquainted with the children. They love children and accept willingly the household duties required in caring for them. Also they are familiar with financial deprivation and can manage well on limited incomes, inadequate housing, and few facilities. (One homemaker, who was required to live with a family of small children in a house with only one bedroom, slept on an Army cot in the lean-to kitchen every night for several months.)

And they are interesting people. For example, one lady is in this country on a passport. She was brought up on a ranch in Mexico, lived several years in Laredo, Tex., where her father was a merchant, and later became a professional dancer and actress in this country. She came to Texas from Mexico a few years ago to earn money for the care of her invalid husband. He was a professional bullfighter who was gored by a bull. He now lives with his mother in Monterrey, Mexico, while his wife works for us as a homemaker to support him. She is the "life of the group" at our regular meetings for in-service training.

One caseworker assumes responsibility for all families receiving homemaker services. For 2 years now, we have held regularly scheduled meetings of our caseworkers, to add to their training and insight in helping these families. We use our home demonstration agent, the chief county health nurse, and our own staff in teaching such subjects as general child care practices, recognition and care of childhood diseases, preparing balanced meals on low-income budget, mending clothes and sewing, budgeting and buying both foods and clothing, and personnel policies.

We have used a total of 57 homemakers in 48 different family groups. The family situations which required homemaker services were:

- In 24, or 50 percent, the mother was hospitalized because of tuberculosis. In two of these homes, both parents were hospitalized at the same time, and the homemaker lived with the children on a 24 hours a day, 7 days a week, basis.
- In four homes, the mother was mentally ill. In most cases, she was hospitalized.
- In four homes, the mother had died. In one of these, the father had also passed away, so the homemaker lived with the children until permanent provision could be made for them.
- In four homes, the mother had cancer.
- In 12 homes, either there were other illnesses, the mother had abandoned the children, or other circumstances required the mother's absence for long periods of time.

The average length of stay of the homemaker to aid these 48 families has been 7 months.

Our homemaker program has certain unique features. Homemakers are selected usually from the immediate neighborhood or town where the family lives. In many instances, she is known to the children and is a friend of the parents. Hidalgo County is a large county, and even though the northern section is ranch country and sparsely settled, other sections, covered by small citrus groves, are thickly settled. There are 10 small towns or distinct communities with populations of from 3,000 to 30,000. Because many homemakers refuse to work in an adjoining community which may be 5, 10, 15, or 25 miles distant from their own homes, each homemaker is employed for the duration of a specific case. We have been able to persuade some, however, to take other cases, even if it meant travel.

Homemakers are not employed by the month or by the year or permanently, but for the duration of need in a particular family. The first one employed is in the same home after nearly 5 years; others remain 6 months to 1 year.

We do not use homemakers for very short periods, such as a brief hospital stay of a mother. I think we should, but it takes so long

to recruit, get social security cards and health certificates, and to get to know the new homemaker, the mother is back at home before the homemaker is ready to work.

Homemakers are used primarily in situations where there are several children who would be dependent, neglected, and require boarding care in a foster home if homemaker service were not available.

We see this type of care for family groups as better for the children. First of all, it eliminates at least some of the trauma of separation. It keeps the father involved with his children's care at least at night and on weekends. The children need at least one parent and a closer family relationship than would be possible with boarding care.

It provides a type of care which the ill mother can accept more readily and thus it permits her to accept hospitalization. Many mothers have told us that they would stay in their home and die, rather than see their children "sent away" to some stranger's home. Of course, many factors encourage this attitude such as fear of the hospital—the unknown, and fear of the risk of leaving the husband.

We might mention a mistake we made early in the program. We hired some young, unmarried women who were alert and quite attractive. You can see how this failed. Even if things did go well at home, the ill mother in the hospital became jealous and left against medical advice in order to protect her place in the family. Now we seldom employ a homemaker who is not already a grandmother, and, as pointed out previously, one who is known and accepted by the mother. (Incidentally, the average age is 50 years.) We have given status to our homemakers in the eyes of the community and the children they serve by supplying each homemaker with plain striped seersucker uniforms with insignia. The insignia have "Child Welfare" at the top and "Homemaker" at the bottom. In the center is embroidered the face of a child. The insignia were handmade by a group of nuns in Mexico.

To justify the use of uniforms at county expense, I thought my best argument, stated briefly, was: "This uniform, like that of a nurse, sets these neighborly ladies aside as being officially in the home and not just another woman who has taken the place of the mother who is ill."

Casework services are provided when a homemaker is used. The caseworker has the difficult task of helping the father keep his place as head of the house by providing the groceries as well as giving the love and care he should to the children. She must also help the children to understand what has happened to the family. She keeps the hospitalized mother informed about the children with visits, letters, and pictures. There has not been a single instance of a mother returning home from a hospital against medical advice since our homemaker program has become well established. The homemaker, in planning the budget and in working through disciplinary problems with the father, has the aid and support of the caseworker. The welfare worker is, in a sense, the homemaker's employer, yet she must look to the father as the head of the house who provides the funds (usually ADC) for the children.

Our homemaker program is far from perfect, but it is serving a definite purpose for us in Texas by preserving families and saving them from having to go to foster homes. We experimented with needful families and found a partial solution in homemaker service. I hope others might be able, not to duplicate our program, but to apply those parts of it which might enable them to serve children better in their States and communities.