COMMUNITY IDENTIFICATION OF DISCHARGED MENTAL PATIENTS
RESIDING IN VANCOUVER CITY BOARDING HOMES

A Preliminary Study

by

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ABSTRACT

This study was designed to assess the community identification of discharged mental patients in community boarding homes—specifically, those patients discharged from the Riverview Mental Hospital and placed directly into Vancouver City boarding homes as part of a cooperative programme between the Social Service Department of the Riverview Hospital and the Medical Section of the City Social Service Department.

Community identification was defined in terms of three factors: physical presence in a geographic area; quality and quantity of social participation; and, relative opportunity for decision-making and independent functioning. Quantitative measurement of the latter two factors was attained through administering the Chapin Leisure Participation and Enjoyment Scale and the Vine­land Social Maturity Scale respectively. A qualitative measurement was attained by administering two questionnaires designed by the researchers—one to the boarding home operators, the other to the patients in the boarding homes.

The design of the study was initially that of a retrospective nature, comparing current data to data of previous performance obtained from hospital files. As this latter source proved inadequate, a longitudinal design was proposed, and a pretest of the research instruments was implemented with a boarding home sample and a comparative hospital sample.

The findings of the study thus pertain to the qualitative responses of the former patients in community boarding homes, and to qualitative comparisons of the responses of the community and hospital samples. The qualitative responses were generally of a positive nature indicating a satisfaction with community placement and an enjoyment of community life. The quantitative responses indicated a decrease of social participation, occupational activity and socialization skills following placement into the community boarding homes, but
an increase in the skill of self-direction and competency of locomotion. A comparison of the interviewers' ratings and the patients' ratings of significant impediments to social functioning indicated that the latter perceived this in financial terms while the former perceived it in psychological terms.

Conclusions of this study, necessarily limited because of its preliminary nature, relate primarily to the concept of community identification and to the difficulty of defining this concept in concrete terms. As the findings indicated that autonomy and independent decision-making were most closely related to subjective feelings of community identity, and that this increase in autonomy was related to increased feelings of dignity and self-worth, it was suggested that greater autonomy was the principal factor in the community identification of this population, and that this indicated a positive evaluation of the boarding home placement programme in that it led to the enhancement of the patients' feelings of dignity and self-worth. Recommendations for improvement of the programme include psychiatrically trained staff to supervise the patients, new regulations concerning finances, and provision of more activities and facilities designed to enhance the patients' feelings of self-worth.
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CHAPTER I

INTRODUCTION

As part of the rehabilitative services of Riverview Hospital, a boarding home programme is in operation in Vancouver and the Lower Fraser Valley area. One of the assumptions underlying the policy of placement in these homes is that this is a means of enhancing the patients' feelings of being a part of the community. The following is the preliminary phase of an evaluative study that is to be conducted in the City of Vancouver and that is designed to test whether or not this assumption is a valid one under the present programme. In other words, do the Riverview patients placed in boarding homes in the City of Vancouver feel more a part of a community than they did when they were still in the hospital?

Studies and articles written on the community care of former mental patients suggest that there is little correlation between the kind of care given and the name attached to it. Some programmes offer what they call "family care" while others apparently offer the same but call it "foster care". In one instance the term "boarding home placement" seems to describe the phenomenon that in another instance is called "multiple foster home placement". In still other instances, a "halfway house" is referred to. Although there is overlapping and confusion, two distinct purposes seem to be fulfilled by these entities and the purpose is not always explicit in the name. The one purpose is to offer a transitional kind of experience where the ultimate aim is relative independence and eventual reintegration into the community. The other purpose seems to be the provision of a residential facility that in many cases may become a permanent home offering varying degrees of supervision in a protective setting in the community for those people who will likely never function completely independently. In this study, we shall use the terms "boarding home"
and "boarding home placement" because these are the terms used by those involved in the programme.

DIFFERENTIAL USE OF BOARDING HOMES

In most cases, the Vancouver boarding homes are used as a resource to provide a permanent home for patients who likely will never become independent and self-supporting. While the intention may be for a permanent placement, frequently it is terminated or interrupted for any number of reasons including rehospitalization or the patient attempting to live on his own. In a limited number of instances, the boarding home may be used, either by intention or, occasionally, by happy accident, as a transitional residence for patients who require a sheltered environment before they can move from the protective existence of the hospital into the more demanding life of the community. For a small group, then, a boarding home may provide a halfway house kind of facility discussed by Weschler and by Sharpe as a sheltered social environment (64) providing a place where the patient can experiment and demonstrate his effectiveness as a person while receiving some protection from the stress of rapid integration with the community (53). Riverview Hospital does have two facilities, Vista and Venture, specifically designed for this purpose, but they are very small and inadequate to meet the demands of all patients leaving the hospital. For this reason the boarding homes in our study do have a dual function, although for the majority of former patients, they provide a relatively permanent home in the community, a place where they will be supervised and supported financially for an unlimited period of time.

THE BOARDING HOME PROGRAMME

Initially, the programme was instituted in 1959 as the result of the efforts of the Provincial Supervisor of Psychiatric Social Work and the Social Service Department of Riverview Hospital, together with the Administrators of the Field Service and Welfare Institutions Divisions of the Department of Social
Welfare (31, p. 2) with whom administrative arrangements were made. There are at present about 400 former patients living in boarding homes in the Fraser Valley, Lower Mainland and Vancouver areas. Some were placed from Valleyview Hospital and from The Woodlands School and Tranquille Training School for the retarded, institutions that more recently began to participate in the programme. Most, however, have been placed from Riverview Hospital which is an amalgamation of the Provincial Mental Hospital and Crease Clinic.

The population in the Vancouver boarding homes is somewhat fluid but at the present time there are approximately sixteen homes being utilized with a total capacity of about 120 patients. The number of patients per home varies from the largest with fifteen residents to the smallest with two. In many of the larger homes, the patient is not integrated as a family member but rather is one of a group of patient-boarders, giving the home the atmosphere of a small institution. In the occasional smaller home, the patient may participate in the activities of the home as if he were a family member.

With one or two exceptions, the boarding homes are privately operated homes licensed under the Welfare Institutions Act whose residents in most cases are former mental patients, and whose supervision is carried out by the Medical Section of the City Social Service Department. The boarding homes were almost all licensed originally for the purpose of providing homes for the elderly and in some instances there are elderly, as well as mentally and physically handicapped individuals being cared for. Latterly there has been a tendency towards greater segregation in placements so that the situation just described is becoming increasingly rare. There are a limited number of private patients in these boarding homes; that is, patients with private means who do not require financial assistance but who do require a protective environment. Those private patients in Vancouver homes are not supervised by the Public Health Nurses of the City Social Service Department.
and will not be part of our study.

THE POPULATION

The population will be defined more precisely in Chapter IV, but generally those patients placed in any of the boarding homes used by Riverview Hospital including the Vancouver ones, meet three criteria. First, they have received as much psychiatric treatment as there is available and there is no further need for them to be kept in custodial care in an institution. Secondly, no resources such as family or friends have been found either willing to or suitable for receiving the patient in their home. Thirdly, the patient is considered disabled to the point that he is not presently employable and may never be employable, and he is not capable of caring for all of his own needs without supervision. Many of the patients placed in Vancouver are without financial resources and so arrangements for social assistance to be paid are made prior to the move, by the Social Service Department of Riverview Hospital with the Vancouver City Social Service Department. For those few patients who are judged employable or potentially employable, the boarding home is seen as a rehabilitative resource. The plan is usually that when the patient does obtain work and is able, he will pay his own board to the operator. After a suitable period of time, he will move into a place of his own.

RATIONALE FOR POPULATION CHOICE

The residents of the boarding homes in Vancouver were chosen rather than those in other areas as the sole subjects for study for a number of reasons. One is that a metropolitan area like Vancouver does have a considerable variety of activities available for public use, allowing for participation in the community for those who so choose. Furthermore, there is a certain homogeneity in opportunities for recreation and employment and in accessibility to these. This is in contrast to boarding homes in more rural
areas in the Fraser Valley. By choosing just one area, we can standardize to some extent this availability of and accessibility to resources. At the same time the opportunity will then exist for further research to be done in other geographic areas for purposes of comparison. Finally, the patients in the Vancouver homes will be much more easily reached by the researchers than would patients residing in other areas in the Lower Mainland.

All of the patients placed in Vancouver are supervised by the Medical Section of the City Social Service Department and not by the Riverview Social Service Department as are the patients in Fraser Valley homes. The exception to this occurs when a discharged patient is seen at the After-Care Clinic in Burnaby by a member of the Riverview Social Service Department. Ongoing supervision of the homes and the patients, however, is carried out by the Public Health Nurses in the Medical Section. Furthermore, the patients' status with regard to the hospital is such that they are placed on boarding home leave for one month, although in some cases where the City Social Service Department requests it, leave may be extended for up to three, six or twelve months before formal discharge occurs. Patients in the Valley homes supervised by hospital staff are, on the other hand, carried on boarding home leave on a transfer basis for the entire duration of their boarding home residence. They are also visited periodically by a hospital psychiatrist so ties with the hospital are not severed nearly so completely as they are for those placed in Vancouver.

THE EXPERIENCE SURVEY

Rationale

In order to develop a broader understanding of the issues in the placement of mental hospital patients in Vancouver boarding homes, it was considered advisable to draw from and incorporate some of the knowledge and experience of a number of professional as well as lay personnel strategically
involved in the boarding home programme. These are the people with the practical everyday experience in the total boarding home programme. It was felt that they might provide some reflections on the relative effectiveness of various boarding home policies and procedures of placement and supervision, in achieving the objectives of the programme.

Method of Administration

The respondents interviewed for the experience survey were selectively chosen because of their first-hand experience with the various aspects of the boarding home programme. Those consulted were:

1. from Riverview Hospital - Social Services Supervisor, Boarding Home Coordinator, Treatment Unit Supervisor, and Boarding Home Social Workers
2. from Vancouver City Social Service - Medical Section Supervisor and Public Health Nurses who supervise the boarding homes
3. from Burnaby Mental Health Centre - Aftercare Unit Supervisor
4. from Vancouver Boarding Homes - Boarding Home Operators.

Three interview schedules of open-ended questions were designed to elicit views, feelings and facts from the respondents about the boarding home programme, its objectives, standard procedures, special problems and its effect on the patients participating in the programme. (See Appendices B, C, D)

Findings

The following findings were used to focus the study and to guide the researchers in the formulation of the research problem:

1. The boarding home programme was set up to provide a stable habilitation for patients who would otherwise remain
hospitalized.

2. Selected for boarding home placement are patients who appear to have benefitted as much as possible from available treatment resources and who are judged well enough to live in the community under supervision.

3. By way of preparation, patients are given basic information about the boarding home, the community and some of the opportunities available.

4. One of the major features of boarding home life seems to be the lack of activity. This appears to be related to the patients' lack of adequate financial resources, to the limited number of staff personnel or volunteers to stimulate the boarders and also to the heavy medication that many of the boarders take.

5. Most of the patients who go to boarding homes are schizophrenic, over the age of forty, separated, divorced or single, and dependent on social assistance.

6. In the homes, the patients apparently take care of most of their personal needs and sometimes help with a few household chores. Their activities are basically passive and solitary.

7. The patients are often reluctant to join into activities outside the home. This may be due to the nature of their illness, which often manifests itself in a desire for the security of the known, or perhaps due to self-consciousness about their status as former mental patients.
8. It appeared that there was a significant variation in the amount of encouragement to participate given the patients by the operators. This seemed to be an important factor in the amount of patient activity.
CHAPTER II

REVIEW OF THE LITERATURE

INTRODUCTION

In preparing to determine the direction of our study and to set the limits for it, a fairly extensive survey of the literature was undertaken. We discovered that very little of a specific nature has been reported and written on community participation and integration of mental patients in boarding homes. What we did gain from our survey were some general ideas about broad changes in the philosophy of the care of the mentally ill. Studies and descriptive articles about various programmes of community placement of the mentally ill were helpful because in many cases, even though the articles and studies differed in approach, the goals of placement they described were similar to those of Riverview Hospital. That is, a greater degree of community identification and integration was sought for the patients.

It is evident that the philosophy as well as the treatment of the mentally ill has changed drastically during the last two decades. Examples are recent developments in drug therapy and other physical therapies, and the extension of rehabilitative and social services that supplement the more traditional services found in hospitals for the mentally ill. Thomson is one of several professionals in the field who has expressed the idea that, in keeping with the goal of rehabilitating into the community, hospital treatment should only be one aspect of the larger treatment plan. (57) The point is also stressed in More for the Mind that services for the mentally ill should be organized to facilitate return to the community. (60)

There is a group of people, however, who became ill before the popular use of ataractic drugs, and another group who for some reason or other have not responded to any of the treatment methods available. They form a large percentage of patients occupying space in the chronic wards of mental
hospitals. Most of the patients in our population come from this group. For them, the philosophy that supports the idea of planning treatment with a view to return to the community is academic because they have already exhausted the existing treatment facilities. However, even if it is not always possible because of limitations in resources, the ideal is to rehabilitate them to the limit of their social, psychological and intellectual capacities. Thus another result of the change in philosophy and methods has been the emergence of programmes for community care of the chronically mentally ill in a protective setting. This type of programme seems to have had its significant beginnings after the war in the Veterans Administration Hospitals (hereafter referred to as V.A.H.) in various parts of the United States.

The change in attitudes toward care of the mentally ill, no doubt provided the atmosphere conducive to the development of community facilities. A currently prevalent belief in our society holds that institutionalization is undesirable if it can be avoided because it has a debilitating effect on the individual. Rehabilitation, according to Landy, involves the "process of socialization or resocialization---of learning and relearning ways of personal and interpersonal behaviour..." (35, p. 5) and it is felt that this is easier to achieve in the more nearly "normal" environment of the community. In addition, the chronic patient who is not able to take advantage of further treatment and who does not require custodial care is occupying a bed that might be used for a more acutely ill individual who does require in-hospital care.

Despite the rationales given to support the boarding home programmes, the one in existence in Vancouver for Riverview patients has never really been objectively evaluated to discover the effects of the placement on the patient. It is apparent that individuals who have grown accustomed to the secure routine of large institution over a period of years would have diffi-
culties adjusting to life in the community. This is especially true when a substantial residue of illness remains to inhibit full participation in community activities. The remainder of this chapter will be devoted to examining what various researchers have concluded were factors contributing to successful and unsuccessful adjustment in the community.

STUDIES AND DESCRIPTIONS OF PROGRAMMES REPORTED IN THE LITERATURE

Studies Describing Patient Post-Discharge Social Adjustment

Post-discharge studies generally compare the "successful" patients to the "unsuccessful" ones, success being defined as the patient's ability to remain in the community for a stated period of time. Although this criterion was useful in differentiating between the two groups of ex-patients, it has little application to our study which needs to define "success" on a much broader scope. Unfortunately, no previous studies have been done to measure the patients' degree and quality of community integration after discharge.

A study by H. L. Gordon, et al (26), enumerated the recreational activities of former schizophrenics following their return to the community. The findings indicated that this group definitely had fewer recreational activities than did a comparable group of "normal" male adults.

Another study by Leta A. Adler (1) measured the occupational, social and marital adjustment of former mental patients who were living at home at the time of the study. The findings showed that occupational adjustment fell below the norm of the general population as well as below the patients' pre-illness level. The level of social participation, measured by the extent of participation in informal groups, was also depressed, although "the proportion of released patients participating in organized groups was no smaller than the proportion found in most studies of the general population"
(1, p. 501). Marital and family adjustment were also below the norm. When the three separate areas of adjustment were combined into one measure of over-all adjustment, approximately two-thirds of the ex-patient population in this study fell below the standard of the general population.

Thus, although these patients in the above two studies were successful according to the criterion of remaining in the community, it is very apparent that they were quite unsuccessful in the various areas of adjustment which constitute "normal" community life. These post-discharge studies concerned patients who did not participate in particular community re-integration measures. Our study, however, will attempt to ascertain whether boarding home placement, as a re-integrating measure, facilitates community participation.

Factors Associated With Successful Return To The Community

Studies have also been carried out to determine which factors are commonly associated with "success"—i.e. remaining in the community. M. M. Wessler and V.L. Kahn (65) did a follow-up study of 24 discharged chronic schizophrenics, 18 of whom were successful, 6 of whom were not. They found that there were three factors which generally enabled a long-time hospitalized patient to remain in the community. These factors were: one, a sustained family interest and tolerance of the patient's deviant behaviour; two, the continuance of drug therapy subsequent to discharge; and, three, the continued availability and use of psychiatric and social therapies during the period of discharge.

The importance of this latter factor has also been stressed by other studies. Wolkon and Tanaka (68) found that ex-patient involvement in a social rehabilitation centre after discharge was associated with a decreased rehospitalization rate. However, the evidence is not sufficient to demonstrate a causal relationship. Simpert, Sinnett and Wilkins (54) found that work
adjustment was the greatest problem for discharged acute patients, and fur­
ther that for many patients their lives were less rich in the community than
on an open ward in the hospital with an active treatment programme.

Although numerous studies (38, 49, 68) suggest that social partici­
pation, amongst other factors, is significant in determining whether a
discharged mental patient will make a "successful" re-adjustment to the com­

munity, a study by Freeman and Simmons (20), reported in The Mental Patient
Comes Home shows no such correlation with social participation, or other
variables such as family setting, work, follow-up treatment, or drug therapy.
Their study concludes that symptomatology is the only correlate with the
success or failure of the former mental patient to stay in the community.
This study throws considerable doubt upon the premise that social participa­
tion, as such, is a factor in determining the outcome of the patients tenure
in the community. Nevertheless, it can be conjectured that the amount and
nature of the patients' participation in various social activities in the
community will influence his identification with the community.

Studies Indicating The Need For Follow-Up Services

A number of writers recognize the difficulties inherent in the move
from the hospital to the community. David Landy (35), for example, speaks
of the cultural discontinuity which confronts the patient in this transition
and the patient's need to become resocialized to each different situation.
Richard Williams (67) adds that there are very basic differences between the
structure of the hospital and the structure of the social situation into which
the patient is discharged. He emphasizes the need for transitional rehabili­
tative services and half-way houses to bridge this gap. Brooks and Deane
(9) have demonstrated in a study of 269 severely disabled chronic ex-mental
patients that "success" is attainable only with "a good deal of contact and
support from the rehabilitation team over a period of many years" (9, p. 89).
A report on a programme in Nebraska for rehabilitating the mentally ill by Tunaken and Schaefer (59) stressed that their programme would not have been successful without the existence of a great number of after-care facilities either community or hospital based. Leveen and Priver (36), writing about their programme at Gateways Mental Health Centre in Los Angeles support this point saying "...the large number of successful cases indicate that a well-structured programme which fully exploits community resources has a vast potential for rehabilitation" (36, p. 561). And, finally, a study by Rodgers, Stephan and Whitelaw (51) suggests some of the inadequacies of the after-care services presently being offered to discharged Riverview patients. Thus, it is apparent that there is a general awareness of the problems the patient faces in returning to the community. The boarding home programme is a manifestation of this awareness in that it provides a protected environment for the patients who cannot live independently and for the few who need a transition period before independence.

Hospital Preparation for Community Placement

Despite the need for adequate after-care facilities, the post-hospital place of residence in rehabilitating mentally ill persons seems to be the most crucial factor. There are, in addition to community-based transitional facilities, programmes under which patients are given a transitional experience on the hospital grounds, in hospital-run facilities. The new Hillside Unit at Riverview Hospital provides this function for two groups of patients. For some it provides a learning experience before placement to a community boarding home, while for others it is preliminary to job-placement and independence. Mason and Tarpy (39) describe a similar facility that they call a "foster home preparation cottage". It provides a gradual transition for the chronic mental patient from the hospital to a community boarding home. Their claim is that 75% of those participating
in the programme's first five years of operation have made a satisfactory adjustment in the community. The authors see the cottage as a secure place where patients who are resistant to change can relearn lost social habits and "reestablish more normal behaviour patterns" (39, p. 220). However, the greatest percentage of the population to be considered in our study will be patients for whom placement is an end in itself.

Studies and Reports of the Benefits of Boarding Home Programmes

The literature on boarding home programmes similar to the one in Vancouver is scant, but there is general support for the philosophy of community placement programmes such as boarding homes and foster homes providing care and residence for chronic patients who are likely to remain dependent. The benefits of such programmes have been described by several writers. Lyle and Trail (38) studies a V.A.H. foster care programme in Washington, and rated the patients' participation in active sports, spectator events, hobbies, social activities and solitary activities. They concluded that the sustained improvement demonstrated by the patients in these areas of social participation, and their increased alertness and interest in the surroundings, more than justified the programme. It should be noted that this programme, like the one we shall study, did not have rehabilitation to independent living as its primary aim.

William Sculthorpe, (52) an administrator of the V.A.H. multiple placement programme in New York, expresses the opinion that the patients in these homes were likely to be stimulated to establish outside interests in the community. He justifies community placement in general by stating, "...foster home experience is nonetheless a more positive one than any other type of institutional living" (52, p. 522). (Sculthorpe's use of the term "foster home" corresponds to our use of the term "boarding home".) It may be added, that this is certainly one of the value assumptions which
underlies the Vancouver boarding home programme, and one of the basic assumptions to be evaluated in the course of this study.

Descriptions of Canadian Boarding Home Programmes

Descriptions of boarding home programmes on the Canadian scene, although limited, provide us with some indication of the success of this programme in this country. Beatrice Booth (6), who defined rehabilitation very broadly as the realization of physical, mental, social and vocational potential, concluded in her observations of 20 patients placed into foster homes from Riverview Mental Hospital that the programme did indeed facilitate patients reaching this goal. Her study, however, lacked statistical significance. H. Clifford (12) has reported on a family care programme functioning at the Alberta Hospital in Edmonton which placed over 130 people over a two year period. Fairly extensive follow-up was provided by the hospital through work projects supervised in the community on a daily basis. The success of this programme over the two year interval with 70 patients becoming independent and only 22 returning to the hospital, leads Clifford to conclude that "with adequate follow-up services, foster homes are a meaningful avenue for assisting the continuing development of a patient's independence" (12, p. 4).

R. F. Creasy (15) has described a community resettlement programme at the Selkirk Hospital of Mental Disease, which has placed nearly 300 patients into foster homes. Follow-up again is provided by hospital personnel and involves the referral to and participation of numerous community agencies such as vocational retraining and assessment centres, sheltered workshops, volunteer social groups, and individual volunteer association with patients aimed at "social rehabilitation". Although Creasy provides no statistical evidence regarding the outcome of this programme, he maintains that by utilizing a complex network of community agencies and organi-
zations, a programme has been established which provides both rehabilitation and activation for the patient in the community, thereby benefitting the patient, the hospital and the community.

And finally, N. Crawford (14) has reported on a limited boarding home programme sponsored by the Victoria Mental Health Centre which has placed 32 patients. The emphasis of this programme is on after-care provided by the Centre and on the encouragement of family involvement. No follow-up studies have been undertaken of this programme which has been operating for almost four years, but Crawford suggests that it has resulted in "patients who hurt less and feel included in the life process at long last" (14, p. 5).

SUGGESTED LIMITATIONS OF BOARDING HOME PROGRAMMES

Although there is general optimism about community care programmes for discharged mental patients, there are also some very definite limitations of this type of programme as it presently exists. Creasy (15) feels that in the Selkirk homes, dependency and regression were often fostered in that the patients' tendency to withdrawal and inappropriate behaviour would be gradually tolerated rather than any effort being made to change it. Crawford (14) speaks of the danger of the boarding homes becoming small institutions in themselves in that patients become so comfortable in the routine of the home that they resist efforts to move into and involve themselves in the community. And Booth (6) speaks of the social isolation which she observed among some of the occupants of a boarding home.

A study by J. Millette (42) of mildly retarded adults placed in boarding homes after years of institutional residence, demonstrates that these dangers are very real indeed. Social maturity as measured by the Vineland scale (see Appendix I) showed a considerable decrease in all of the 18 patients who had spent one year or more in boarding homes. Decreases
were most marked in the sub-scales measuring socialization and self-direction. Millette concludes that the lack of stimulation and increase in limits and restraints in the boarding homes are the primary factors in this deviation. That is, in his view, the institution provides greater stimulation and more freedom than a boarding home in the community. It would appear that chronic mental patients frequently function at a retarded intellectual level, and, therefore, these findings and conclusions can be applied with some reservation to the subjects of our study. One area of improvement which Millette noted was that of an increased sense of worth and dignity which the patients experienced as part of community living. However, there was no objective measure of this, but rather it represents the subjective impression of the psychologist.

SUMMARY OF THE FINDINGS IN THE LITERATURE

Although the literature abounds in discussions of the philosophy of community placement and the desirability of boarding homes for former mental patients, there are virtually no studies which attempt to evaluate the degree of community integration of patients in such a programme. Evaluative studies have been done on the over-all ability of mental patients to remain in the community and several studies point out the importance of social participation and the need for facilities to promote such activities among the patients. However, even though these studies have some bearing on our current investigation, it is generally difficult to determine the reliability of the findings and to compare the findings of one study to those of another in that the experimentors were often the administrators of the programmes, and frequently the study design was not specified. Also, these studies often resulted in very different, and often, contradictory findings. Furthermore, such factors as the characteristics of the board-
ing home, its location and its operator, which we consider as important variables in this current study, have not been commented upon in the literature we surveyed.

Having made the above observations, it should be apparent that the literature should be viewed skeptically as it pertains to this study. Although great claims have been made for community placement programmes, including boarding home placement, the evaluative studies to substantiate these claims are largely non-existent. The value of the literature, however, lies in the fact that it delineates the areas to be explored and suggests the manner in which these explorations should be charted. That is, it provides the guideline and the background for our study.
CHAPTER III

THE PROBLEM FORMULATION

PURPOSE OF STUDY

The purpose of this study in its entirety is: one, to explore the value of Vancouver City boarding home placements as a therapeutic resource in the rehabilitation of former mental hospital patients discharged from Riverview Hospital, two, to examine the validity of the theoretical assumptions underlying the policy of the programme and three, to assess the patients' sense of community identification.

In this preliminary study, our purpose is to pretest the instruments for reliability, validity, and suitability with the sample, and to make recommendations concerning the design for further study.

One of the basic questions guiding this enquiry is whether or not this programme does in fact meet its stated objectives and purposes. According to the literature, boarding home placements were generally initiated on the assumption that this would foster social and emotional rehabilitation and result in substantial savings of public funds. In discussing this question with chosen representatives in the field, we found that the specific programme we are studying was originally set up in 1959 to provide "stable habitation" for chronic patients who would otherwise remain hospitalized. The objectives of this programme have subsequently been modified to include a more therapeutic goal such as the one mentioned above. Implicit in these objectives is the desire to enhance the patient's sense of being part of the community. Does the programme achieve its goal? If not, is it just an administrative maneuver to discharge patients in order to facilitate the ever increasing number of admissions?
THE SOCIAL WORK PROBLEM

Our first concern stems from the fact that more and more patients are being discharged to the community due to recent changes in treatment methods, more 'enlightened' community attitudes toward mental illness, and rising rates of admissions.

Secondly, since the survey of the literature has indicated a paucity of research on the integration of mental patients discharged to community boarding homes, we feel the need for evaluative research to substantiate the many claims to success. (See Chapter II).

As social workers, we will be confronted with these patients on two different levels. First of all, we will be directly responsible for them in terms of meeting their immediate social, economic, and psychological needs. The patients in our study receive social assistance which covers their basic needs such as shelter and personal requirements. The patient returning to the community is often faced with the stigma of mental illness. Extended periods of hospitalization foster an atrophy of social and physical skills which further removes him from normal participation in the community. Changes in medication prior to or accompanying discharge, as well as the adjustment to boarding home living, often require the attention of Hospital and/or After Care Workers.

Secondly, social work must be concerned with long range planning for the integration of these patients into the community and must help implement community action towards this end. It is hoped that an examination of basic assumptions underlying this programme and an evaluation of its merits will yield data that will enrich future planning and programming in this field.

STATEMENT OF HYPOTHESIS

On the basis of the assumptions inherent in the broad objectives
of the existing boarding home programme in Vancouver we hypothesize that:

Placement of mental hospital patients in community boarding homes increases their identification with the community.

OPERATIONAL DEFINITIONS

Community Identification

A sense of community identification is subjectively perceived, but we assume that this perception is influenced by such objective factors as the patient's: one, physical presence in a geographical area, two, his social participation, and three, the relative opportunities he has for decision-making and independent functioning.

It is the quantitative and qualitative aspects of the second dimension and one variable of the third dimension that we will attempt to measure.

Our Community Defined

For purposes of this study, the community is the City of Vancouver, a large metropolitan area with a population of 409,000. The patients are discharged to boarding homes in this city and are expected to conform to the accepted norms of the community. The city itself, covering 43.3 square miles, is bounded on three sides by water and an adjoining suburb to the east.

This urban setting is in direct contrast to the mental hospital which is situated some twenty miles beyond the city limits. The hospital itself, an isolated complex of buildings, provides care for some 6,000 patients during the year. In many respects it is similar to a small city but on the other hand it is isolated from the mainstream of community life. This building up of an "artificial" community, with its multiplicity of services, creates many problems of reintegration into and identification with the larger society.
ASSUMPTIONS

Value Assumptions

1. Man is basically a social being who needs association with friends and relatives and participation in community activities to foster growth and development.

2. One of the dominant values in our North American culture is that of self-reliance. This leads us to strive for independence in all areas of our functioning.

3. Because mental hospitals tend to create dependence rather than independence, and because institutionalization is debilitating to the individual, it is advantageous to return the patient to the community as soon as possible.

Operational Assumptions

1. Physical presence in the community is assumed to be self-explanatory and does not require further consideration.

2. Social participation would normally include the individual's total involvement in community affairs. In this study, however, we will limit the activities involved to leisure time activities on an individual or group basis and to relationships with family, neighbours, and friends. Employment is excluded because one of the criteria for the patient's selection for boarding home placement is that he be "unemployable". Participation in community activities by members of the "normal" community is lower than commonly thought (19) but we assume it to be higher than that of the discharged mental patient.

3. We assume that social maturity is one index of the person's capacity to make decisions and function in-
dependently. If the individual does not have within himself the potential to grow and learn, he will not be able to function on his own regardless of the opportunities that are available.

4. Boarding home placement is a good means of rehabilitation for this group of patients, for whom no more active treatment is useful and for whom employment is unrealistic.

5. We assume that there are some opportunities for decision-making and independent functioning despite the relatively sheltered environment of the boarding home.

6. We assume that an urban area contributes more than a rural area to the achievement of a sense of community identification, although this is not necessarily a correct assumption in our modern society with its anomic nature.

VARIABLES

Patient Characteristics

The patients placed in Vancouver City boarding homes at the present time are schizophrenics, generally and the majority of them receive social assistance. The nature and duration of their illness, the length of hospitalization, their age and marital status, their limited finances, and the amount of medication they take will have some effect on their social participation.

Relative Opportunities in Hospital and Boarding Home for Decision-Making and Independent Functioning

The relative opportunities in the hospital and in the community for involvement in social activities and independent decision-making are appreciably different. As the hospital is isolated and there are few trips
to the city, the patient does not feel a part of that community. However, as the hospital provides a broad variety of activities and programmes for the patient such as Occupational Therapy, Recreational Therapy (including such activities as ball games, bowling, swimming, dancing, movies, and parties), and work placements, it is not unreasonable to assume that some patients feel a strong sense of belonging to a community, albeit the hospital one. With respect to decision-making, this is virtually nonexistent in a large institution, where all areas of life are routinized, and where even the decision to participate in a certain activity might have been staff recommendation to comply with the treatment plan.

In the community there are many avenues open for social participation, but they are not all equally accessible with respect to distance or cost. The element of choice to participate is relatively open in the non-hospital environment. However, here again the patient is expected to conform to the rules of the boarding home with respect to hours, permission to leave the boarding home and involvement in specific activities.

Characteristics of Boarding Home Operators

One of the major variables that we feel is important is the personality and qualities of the individual boarding home operator. Generally, in our experience survey, we found the operators to be warm-hearted and sincere but there is a large degree of variation in their approach to and understanding of the patients. They seemed to be lacking in direction. For example, most of the operators were cognizant of the fact that the patients were apathetic and inactive, but did not know that these discharged patients need prolonged encouragement and support and even someone to take them out to various activities. This, of course, reflects their lack of training and the lack of supervision of these homes by qualified psychiatric personnel.
Another aspect of the above is the degree to which the operator is dependent upon the boarding home rate of $95.00 a month per patient. If this is the operator's sole source of income, he may not be able to employ outside help and may thereby be limited in the amount of time and energy he can give to the patients. Also this may be a stress factor if he has vacancies that cannot be filled immediately.

Financial Resources

The amount of the patient's comforts allowance will be a factor to consider as some patients receive $10.00, others $16.00. Apparently the larger amount is given to patients who go out a lot and require more for transportation. However, if the patient does not seem to need this extra amount, he is not given it.

PEOPLE CONCERNED WITH THIS STUDY

The City Social Service Department

This department is responsible under legislation to administer social assistance to needy persons and to supervise boarding and nursing homes. Under a policy arrangement made in 1959, the Medical Services Section agreed to undertake the responsibility for discharged mental patients on social assistance who resided in city boarding homes. The Medical Services Section is composed of Public Health Nurses, who are directly responsible for supervision of these patients.

Many problems occur for this agency with regard to the supervision of these patients. First of all, there are few resources available for such patients and it is difficult to find suitable homes for them. Secondly, the letters of referral do not always contain the necessary information regarding financial eligibility or pertinent facts concerning the patient's background. For example, a previous history of child molesting is not always revealed. Thirdly, the major problem seems to be the tedious process
of readmitting the patient to hospital if he should have a recurrence of
symptoms. The fourth problem is related to the large caseloads carried
by the Public Health Nurses and their lack of specific training in handling
psychiatric problems. All of these difficulties are time and energy con-
suming and leave the nurses with little or no time for direct supervision
of these patients. They are forced to deal with them pretty much on an
"emergency" basis.

Riverview Hospital and The After-Care Clinic

The hospital provides psychiatric treatment for the patient as well
as many other services to facilitate his recovery from mental illness. In
conjunction with the Department of Social Welfare the hospital is responsible
for the administration of this particular programme and for referral of pa-
tients to the City Social Service Department. The After-Care Clinic sees
patients who are referred to them by either agency.

Several problems can be cited with respect to the role of the hos-
pital. First of all, there are realistic pressures to get patients out of
the hospital as admission rates are on the increase. Secondly, the Social
Service Department is not always aware of the patient's characteristic be-
haviour and may make a poor assessment. If the patient is placed premature-
ly, the worker may have to spend a great deal of time helping the patient
to adjust. This whole area of responsibility concerning supervision of the
patient needs to be more clearly defined. On the whole, the hospital feels
the community should assume more responsibility for the care of boarding
home patients.

Boarding Home Operators

In Vancouver, some 16 people operate licensed boarding homes for
patients from Riverview Hospital. Their task is a formidable one for they
must assume twenty-four hour responsibility for the patients, whose behaviour is often unpredictable and demanding. Often the time-consuming role of cook, housekeeper, nurse, and confidante is beyond the capacity of the operators who must also be compassionate and tolerant towards their patients.

The particular problems they must deal with include problems of medication, the difficult period of adjustment, and the patient who displays symptoms of illness. These problems may arise at any time during the day or night and often the operator must face them without the aid of professional guidance. Another problem is that of "making ends meet" with the low boarding home rates and the high cost of living. Patients often damage household furniture or utensils and may break machinery, thereby adding to the operator's expenses.

Canadian Mental Health Association

This voluntary, community group provides activities for patients in and returning to the community. However, for some reason they have found it difficult to cope with the boarding home patients and their programme is directed more toward the needs of patients who are becoming fully integrated into the community.

The particular problems involved here are the rapid changeover of staff and the inability of some volunteers to handle the more manipulative and demanding patients. The volunteers need a lot of support and direction that is not always forthcoming.

School of Social Work at U.B.C.

The Research Department is concerned with evaluative research of existing community programmes and their policies. This study is being undertaken by five students, one who has had considerable experience in a similar boarding home programme, two who have been acquainted with a boarding home
programme for retarded people, and the remainder of the group who have had no experience in this field. All are interested in the boarding home programme and its functions.

The Boarding Home Patients

There are 116 patients currently residing in Vancouver boarding homes. These homes are often unattractive, older homes that were designed for the care of elderly people. The patients must contend with problems of adjustment to a new way of life and to, in many cases, an "alien" community. They often face boredom after diverse activities in the hospital. They have specific needs that must be met if we are to help them function in the community.
CHAPTER IV

DATA COLLECTION AND DESIGN

REVIEW OF THE VARIABLES

The major concern of this study is community identification of mental patients discharged to city boarding homes. Before choosing the design model and research instruments, we considered what aspects of our operational definition lent themselves to objective measurement. We chose the quantitative and qualitative dimensions of social participation as our major variable, thinking that it would be relatively easy to obtain information from various sources regarding the patients' leisure time activities. We selected social maturity as our second variable as we felt that this was one aspect of independent functioning that could be measured objectively. We also hoped to obtain subjective data and impressions about these two variables. The study design was chosen to give us reliable data in an efficient manner; the instruments, to measure the specific variables that we considered to be an integral part of the concept of community identification.

STUDY DESIGN

Design Considerations

Initially, we considered several approaches to our study concentrating mainly on one aspect of community identification, namely social participation. The first was a retrospective before and after study done through the use of hospital records and discussions with members of the nursing staff who knew the patients prior to discharge. This was felt to be unreliable due to the lack of suitable information in the files and to the fact that we would have had to rely on staff memory concerning specific patients who might have been discharged several years ago. Secondly, we considered doing a comparative study using matched groups of patients in the hospital and in the
community. This method would be too tedious and difficult for purposes of this study and it was not possible to control intervening variables. Thirdly, we thought of measuring two groups of patients in the community with respect to the amount of their social participation, to see if the group who participated most did, in fact, feel a greater sense of community identification. Our last consideration was a longitudinal study on a group of patients before and after discharge to boarding home to evaluate the effect of placement. However, this was not feasible for this year as more time would be required to do this type of study and suitable people would have to be recruited to interview and test the patients. This approach would, in the researchers' opinion, be ideal and will be recommended for use in the future. With respect to the time, resources, and knowledge of the group, we decided to make this a preliminary study to pretest the instruments on a small sample with a view to doing a longitudinal study.

Sampling Design

The population from which the sample for this study was drawn was defined according to three criteria:

First, it was to consist of former Riverview patients who are currently resident in Vancouver boarding homes, and who have been placed there directly from Riverview Hospital. The population was restricted to the Vancouver boarding homes because of the accessibility of these homes, the availability of information about patients in these homes, the almost unlimited opportunities for social participation in this community, and because the homogeneity of the urban centre allows for more accurate comparisons with other such centres. The decision to include only patients placed directly from hospital was made to exclude the variables associated with other types of intermediate residence.

Secondly, the population was to consist only of those patients
supervised by the Public Health Nurses of the City Social Service Department. This restriction was necessary due to the lack of information on unsupervised patients. The result of this was that only patients in receipt of social assistance were included in the population, and patients with independent incomes were excluded. As income is assumed to be a fairly significant variable in the extent and type of social activity feasible for a patient, this restriction tends to bias the sample.

Thirdly, the population was restricted to those patients discharged from hospital between the dates of January 1, 1959 and September 1, 1966. The first cut-off date represents the approximate date when the placement of patients in community boarding homes was incorporated into the discharge policy of the hospital. The second cut-off date was chosen to ensure that all patients would have had at least six months to adjust to the community and settle into relatively stable behaviour patterns.

Having defined the population according to the above criteria two alternative methods of sampling seemed appropriate - random sampling, or stratified sampling. The latter was suggested by the findings of the experience survey which indicated that certain variables associated with each boarding home, such as size of home, interest of operator, and so on, might be important factors in determining a patient's social participation. However, due to the extremely uneven distribution of patients in the various homes as well as the relatively small size of the entire population it became apparent that this method was not feasible. Therefore, the simple random sampling method was adopted. In using this method, the assumption is made that patients are assigned to the various homes on a random basis. However, there is some question as to whether this actually happens since there is often an effort made to match the patient's needs with the resources and facilities of the home. Thus, there may be correlations between the type of home and
the characteristics of the patients therein which are not taken into account in the sampling method. As the control of this variable is not feasible under the present study, allowance for this will be made in the interpretation of findings.

Sample size was determined somewhat arbitrarily. A pretest sample of 10 patients was chosen - this representing approximately one-tenth of the total population which was established as consisting of 116 patients. For a full scale study, a sample size of one half the population would be considered necessary in that individual differences are a significant factor in social participation and therefore a large sample is necessary to determine significant trends.

In addition to the above-mentioned sample, a further sample of 10 potential boarding home candidates was selected from Riverview Hospital for the purpose of testing the applicability of the research instruments to patients still in hospital. On the recommendations of Social Service staff, four patients were chosen from both East and West Lawn Units and two were chosen from Crease Unit. The instruments were tested with this purposive sample with a view toward a proposed longitudinal study.

STANDARD INSTRUMENTS USED

We attempted to locate already formulated and tested instruments that would measure the characteristics we are concerned with in this study. Two things had to be kept in mind. One was that the instruments have validity for the trait that we wanted to measure. The other was that it be usable with our sample of mental patients and former mental patients who are impaired to the point where they cannot function independently in the community. It was thought that the sample would likely include severely, moderately and minimally impaired individuals and for this reason, the items of the instruments would have to be phrased in simple and fairly concrete terms. We
eventually chose two standard tests, the Vineland Social Maturity Scale and F. Stuart Chapin's Leisure Participation and Enjoyment Scale.

**Vineland Social Maturity Scale**

The Vineland Scale (See Appendix I) is made up of a list of items which are arranged in order of increasing average difficulty and represent progressive maturation in self-help, self-direction, locomotion, occupation, communication, and social relations. (16) It was felt that this scale, measuring maturation in social independence, could be used to provide an index of the patients' actual current capacity for independent functioning. The scoring of the scale takes into account the individual who may now have or who may have had in the past the capacity to do a particular task but who does not now have the opportunity to do it. Since it provides a standard schedule of normal development, scores can be expressed as a Social Quotient.

The scale has been used with many different groups of individuals and with the same groups many times and the consistent returns indicate that it has a high degree of reliability and a low probability of error. The correlation between estimated and obtained scores for normal subjects was extremely high and for normal subjects in several sample groups it ranged from $r = .85$ to $r = .95$. (16, pp. 318 and 433) The Vineland's major use is with mentally retarded individuals as a measure of their social competence in relation to population norms.

This scale can be administered to a variety of informants and also to the subject himself. We chose the latter approach because we felt the patients had sufficient intellectual capacity to answer the questions reliably. A study done in 1940 demonstrated that it could be used successfully with mentally disturbed patients. (16, p. 560) The items are not complex and little time is required for administration. We limited the scale to those items between 76 and 100 inclusive with the exception of items
83, 95, and 96. The lower limit was a somewhat arbitrary choice, the upper limit and the items deleted were based on no opportunity.

Chapin Leisure Participation and Enjoyment Scale

The decision to limit the measure of social participation to leisure time activities meant that the Chapin Leisure Participation and Enjoyment Scale (See Appendix F) could be used. We chose this aspect of our second variable because the sample design excludes anyone who is supporting himself. Therefore most of the patients' time is "leisure" in a sense. The scale provides a quantitative index of the subject's leisure activities and a qualitative measure of his enjoyment. Each is scored simply on a five-point scale. The forty-seven items are relatively concrete and unambiguous.

Unfortunately, the reliability of the scale itself has not been standardized although a limited check on reliability will be possible through a crosscheck with another questionnaire specifically devised to administer to the subjects of this study. Validity has been determined with respect to three characteristics. With income, \( r = .019 \), with sociocivic activities, \( r = .40 \) and with cultural status, \( r = .039 \). The only normative data available is for 1925 and 1929 studies of college students and graduates. The usefulness of these scores as a basis for comparison for any current study would be limited because of the selected sample used and the inevitable changes in availability and kinds of leisure activities in the past forty years. (41, p. 213)

This pretest is intended to indicate the workability of this instrument for our group of subjects. However, because of the limitations in opportunities for some kinds of leisure activities in the hospital and boarding home settings, eleven items (Numbers 1, 4, 7, 20, 28, 38, 39, 41, 42, 45 and 47) were deleted before administering the test. The criterion for deletion was that there was thought to be no opportunity for engaging in this
activity either in the hospital or in the boarding home or in either of the two. This, of course, means that any scores obtained by this method could not properly be compared to normative data obtained where all 47 items were used. Nevertheless, comparisons will be made between the groups tested with the revised scale.

A Measure of Alienation

An attempt was made to locate a feasible instrument to test the opposite of feelings of community identification, that is, alienation from the community. We were not able to find one that we felt was on a sufficiently concrete level for our subjects to consistently comprehend.

INSTRUMENTS DEVISED FOR THIS STUDY

We devised three instruments to provide: one, statistical data about the sample, two, additional information about the qualitative nature of the patients' social participation, and, three, the subjective feelings of the patient towards his social life and his perception of himself as part of the community.

Statistical Data Sheet

This instrument was designed to provide a structure for the information to be collected from agency and hospital records. The 13 items included were variables that might affect social participation. This information was first collected from the files at the City Social Service Department and was then crosschecked with the files at Riverview Hospital. Two additional items were included to obtain information regarding the patients' work and social activities in the hospital. Initially, we planned to do a before and after study retrospectively and this information might have provided valuable data for comparative purposes. Currently, we are using this information to substantiate our variables.
Questionnaire for Boarding Home Operators

The second instrument was to be administered to the boarding home operators to: verify the information collected from the patients, give some indication of the quality of the patients' relationships with others, and obtain the operators' perception of the capacity and opportunities that the patient has to participate in community activities. Furthermore, we wanted to get some idea of the boarding home operators' interest in and encouragement of the patients to be active as we felt that this was an important variable. Eleven simple questions were posed to the operator mostly focused on the patients so as to be non-threatening to the individual operator. The last item on this questionnaire asked for the interviewer's assessment of the boarding home operator's interest in the particular patient.

Questionnaire for the Boarding Home Patients

The third research instrument was developed to elicit the patients' subjective feelings about life in a boarding home as compared to life in the hospital, to obtain their perception of the reasons for their limited social participation, and to obtain the interviewer's assessment of the patient's capacity to relate and participate. This questionnaire was composed of ten questions for the patient and three for the interviewer. Some of the questions were open-ended and some were rated on a scale. The questionnaire was purposely kept short as the attention-span of schizophrenic patients is relatively limited. There was also some attempt to arrange the questions in a non-threatening way.

MAJOR SOURCES OF DATA

Agency and Hospital Files

Originally, we considered files to be our main source of data, especially for the retrospective information regarding the patients' activi-
ties in the hospital. However, this proved an unreliable source of information as the records were either not specific enough or were inaccurate. We did however, make use of the files for specific data such as age, marital status, length of hospitalization, and attempted to ensure reliability by providing a cross-check between agency and hospital files.

Boarding Home Operators

We felt that the boarding home operators would be a reliable source of information for they would know the patient best. For this reason, we interviewed the operators to verify information already obtained and to ascertain their perception of the patient. We attempted to make an independent assessment of the operators so that their involvement with the patient would not give us a biased response.

Patients

We felt that the patients themselves could provide the best answers regarding their subjective thoughts and feelings. However, we realize the limitations in their intelligence and perception due to residual symptoms, limited ability to relate to others as a result of their illness and hospitalization, and present medication. We, therefore, attempted to make an assessment of these factors.

ADMINISTRATION OF SCALES AND QUESTIONNAIRES

This study took the form of a pretest of instruments. All were tested on our sample of boarding home patients and the two standard scales were tested on the hospital sample of patients awaiting boarding home placement. Our main concern was to test whether these instruments were suited for use with the population and whether they yielded the data they were intended to yield.
Administration to Discharged Patients

It was decided that each member of the research group would interview two subjects and would administer all of the tests to them rather than four people administering one schedule each to ten different patients. We considered that it was probably more important for reliability that the patients only be confronted with one individual. Further, it was decided, in view of the fact that chronically ill mental patients (particularly schizophrenics) have notably short concentration spans, to make two short visits rather than one more lengthy one. On two different days within the same week all of the schedules were administered. The one exception occurred when one of the interviewers was not able to obtain the cooperation of an operator of a home where two of our subjects resided.

Before each visit, all of the interviewers met in order to standardize, as much as possible, their approaches. A preliminary explanation of the purpose of the study and the kinds of information desired was generally agreed upon by the group before interviewing both the patient and the boarding home operator. As well, the group went over the schedules item by item, to clarify and note the meaning of any unclear or ambiguous terminology or questions. Each interviewer studied the Manual of Directions for the Vineland Scale. The ten subjects were assigned two to each interviewer mainly on the basis of geographic convenience for the interviewer.

Each interviewer contacted the City Social Service Department Medical Section nurse for the area or areas in which his subjects lived. The nurse was asked to telephone the boarding home operators concerned to explain our request and finally the interviewer telephoned the operator to explain in greater detail our plan and to arrange a convenient time to interview the patient and the operator. On arrival at the home, an explanation in general terms about the aims of the study was made to the patient and his help re-
quested. The Chapin Leisure Activity and Enjoyment Scale was administered to the patient on the first visit because it was felt to be least threatening, easiest to answer and most likely to ensure continued cooperation. The questionnaire for the operators was also administered on this occasion. The Vineland Social Maturity Scale and the study questionnaire for the patients were administered on the second and last visit. Where required, explanation of the study's purpose was given again on the second visit. With one exception all schedules were administered orally with the interviewer asking questions of the subject and noting the responses immediately. One interviewer had to write and sometimes rewrite the questions for an elderly deaf Chinese man whose understanding of English was limited.

Administration to Riverview Patients

In order to assess the suitability of the two standard tests for patients within the hospital, each interviewer administered both tests to two patients who are presently in hospital. Essentially the same explanation of the study's purpose was given to the patients in hospital as was given the patients in the boarding home. Both the Chapin and the Vineland Scales were administered on one occasion.

DATA ANALYSIS DESIGN

In analyzing the material collected, we plan to consider each instrument separately according to what it was designed to measure and to relate items, which were categorized, to each other and to the variables.

Statistical Data Sheet

The items will be tabulated for frequency and significant differences will be noted, especially with regard to our variables.

Chapin Leisure Participation and Enjoyment Scale

The total score of the 36 items will be obtained for both the acti-
vity and enjoyment scales. The items were classified according to: one, individual and group activities and two, place of occurrence, that is, inside or outside home or hospital ward. The items that were scored 4 or 5 on the enjoyment and 1 and 2 on the activity scales will be analyzed. We will determine the frequency of each of these items and will group them according to the above categories. The percentage of possible activities done by each patient and boarder will be computed and the averages of these for each group will be compared to a similar figure obtained regarding individual items. The same thing will be done for the items regarding place of occurrence preferred. This will be done to see if there is any correlation between the patients actual and preferred type and place of activity.

The Vineland Social Maturity Scale

The 18 scales will be scored to ascertain the social ages and to note any trends regarding the various categories. The two samples will be compared with respect to the above and significant differences will be reported in the findings.

Questionnaire for the Boarding Home Operators

The items in this questionnaire will be divided into four categories: one, patient opportunity, two, patient capacity, three, frequency, and four, boarding home operators' characteristics. The items (See Appendix G for specific items in each category) will be tabulated for frequency and considered in the above categories.

Questionnaire for Boarding Home Patients

Again, the items will be classified according to patient opportunity, capacity, and frequency. The items will be tabulated to note significant factors about the patients' subjective feelings about their life in the boarding home and in the community.
CHAPTER V

STUDY FINDINGS

INTRODUCTION

Statistical data (see Appendix E) for the random sample of ten boarding home patients were obtained from each patient's hospital record and from the City Social Service Department files. Although the original sample consisted of ten patients in eight Vancouver boarding homes, we were unable to elicit the participation of two patients and one boarding home operator for the administration of the scales and questionnaires. Consequently, those findings are based on the responses of the remaining eight patients and seven operators. The Leisure Participation and Enjoyment Scale and the Vineland Social Maturity Scale were administered to a sample of ten patients presently in hospital and the findings were then compared with those of the boarding home patients.

An additional difficulty arose in that four patients did not come directly from the hospital to the boarding home. Due to the small sample involved however, we did not give further consideration to this factor.

DESCRIPTIVE DATA

As stated earlier, we felt there might be considerable variation in social participation with regard to such factors as age, sex, diagnosis, education, length of hospitalization, medication and so forth. While the sample is too small to draw far-reaching conclusions, the following observations may be pertinent.

1. Half of the sample of seven men and three women are in the 46 to 55 year old age group. This may be significant in that it raises the question with regard to the kind and amount of social participation of the normal population in this age category. It might be suggested that people...
in this age group are normally less active in their participation.

2. Eight of the ten patients in the sample have a diagnosis of schizophrenia. The tendency to withdraw from social situations associated with this diagnosis would certainly be an important factor in their social participation.

3. Half of the patients have been ill for over ten years and over half have had more than two hospitalizations. This finding also reflects the extent of their illness and the extensive debilitative effects of such a long-term illness.

4. Half of the patients have only completed school from grade seven to ten. This educational handicap might limit the range and variety of social participation and influence their enjoyment of various activities.

5. Upon leaving hospital, four patients were rated as legally capable (to assume financial responsibility) whereas five were rated as incapable; the legal status of the other one was unknown. If such a large proportion of "incapables" was indeed representative of the total population, one might anticipate considerable variation in the social participation of the two groups.

6. All of the boarding home patients participated in some of the following hospital work activities before discharge: ward chores, laundry, kitchen or gardening and such social activities as table tennis, cards, television viewing and pool.

7. Six of the boarding home patients go to the after care clinic for medication. Half of these are on reduced medication since discharge. We are fairly certain that three others who do not go regularly to the after care clinic are on medication from another source such as a private doctor, and one goes to the Alcoholism Foundation. Generally, the patients are on a sustaining dosage of medication which might have some effect on
their participation in social activities. However, as this is such a small sample, it is difficult to be conclusive about this.

LEISURE PARTICIPATION AND ENJOYMENT SCALE

Average raw scores (see Appendix F) were obtained from the eight boarding home patients and compared with those of ten patients presently in the hospital.

1. The boarding home patients scored an average of 71 on their activity rating and an average of 124 on their enjoyment of these activities.

2. The hospital patients scored a higher average of 82 on their activity rating and an average of 129 on enjoyment of these activities.

Little significance can be attached to these scores by themselves due to the small sample and the absence of any normative data for comparative purposes. Ideally, our scores should be compared with average scores from a normal population but in the absence of such data, we can only compare the two groups of patients involved. It is interesting to note, therefore, that the hospital patients scored higher on both activity and enjoyment of activity than the boarding home patients. (see Appendix L). In both groups there was greater participation in individual activities than in group activities. Similarly, both groups showed greater participation in activities performed inside the boarding home or hospital ward than outside the home or hospital ward. (see Appendix M)

<table>
<thead>
<tr>
<th>TABLE I</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE PERCENTAGES OF ACTIVITIES PERFORMED OUT OF THE TOTAL NUMBER POSSIBLE IN EACH CATEGORY</td>
</tr>
<tr>
<td>Group Activities</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Boarding Home Patients</td>
</tr>
<tr>
<td>Hospital Patients</td>
</tr>
</tbody>
</table>
In order to determine which activities both groups of patients did not perform but would prefer to do, those items marked 1 or 2 (never or rarely performed) on the activity scale and 4 or 5 (like or like very much) on the enjoyment scale were noted. Items scored in this way by five or more respondents were then singled out and examined. The boarding home patients indicated that they rarely or never: have conversation with family; participate in indoor team recreation or sports; read magazines for pleasure; and participate in outdoor team sports, but would like or like very much to participate in these activities. The hospital patients rarely or never: attend small social entertainment; entertain at home; have informal contacts with friends; participate in indoor recreation or sports; participate in outdoor team sports; attend symphony or concerts; or go camping, but would like or like very much to participate in these activities.

**TABLE II**

**ACTIVITIES PATIENTS RARELY OR NEVER PERFORM**
**BUT WOULD LIKE OR LIKE VERY MUCH TO PERFORM**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boarding Home</td>
<td>- have conversation with family</td>
</tr>
<tr>
<td>Patients</td>
<td>- indoor team recreation or sports</td>
</tr>
<tr>
<td></td>
<td>- magazine reading for pleasure</td>
</tr>
<tr>
<td></td>
<td>- outdoor team sports</td>
</tr>
<tr>
<td>Hospital</td>
<td>- small social entertainment</td>
</tr>
<tr>
<td>Patients</td>
<td>- entertain at home</td>
</tr>
<tr>
<td></td>
<td>- informal contacts with friends</td>
</tr>
<tr>
<td></td>
<td>- indoor team recreation and sports</td>
</tr>
<tr>
<td></td>
<td>- attend symphony or concerts</td>
</tr>
<tr>
<td></td>
<td>- go camping</td>
</tr>
</tbody>
</table>

These findings suggest that even though both groups participate
in more individual than group activities and in more activities in the boarding home or hospital ward than outside, they would actually prefer more group than individual activities and more activities outside the home or hospital ward than inside.

VINELAND SOCIAL MATURITY SCALE

Social Ages

The mean social age for the boarding home sample was 14.5 years and 15.3 years for the hospital sample. The distribution ranged from 10.4 to 19.2 years.

As the mean and the distribution of the social ages of the two samples were very similar, the assumption can be made that the two groups were roughly matched vis-a-vis their social competency. (See Appendix J)

As the distribution of ages appears to cluster about the 15 year age level with diminishing frequencies on either side of this, it could be hypothesized that the population forms a normal distribution about this mean.

Social Skills

Only items up to the 18 year old level were counted, since only a few positive scores were elicited above this, and by counting the negatives the self-direction and occupation categories would have been unfairly weighted.

The boarding home group appears to be superior in the skills of self-direction and locomotion. Largely this reflects the difference in the level of restriction in the two environments, for example the hospital patients' confinement to hospital grounds and the constant supervision by staff.

Categories of socialization and occupation appear to be superior in the hospital group. Again, opportunity appears to be a major factor as, for example, accessibility to workshops in the hospital and the encourage-
ment given by staff to indulge in social activities.

Categories of communication and self-help dressing showed rather small differences which could not be considered significant in view of the small sample. (See Appendix K)

| TABLE III |
|-----------------|-------------|-------------|
| PERCENTAGE OF PLUS SCORES IN EACH CATEGORY OF THE VINELAND SCALE |

<table>
<thead>
<tr>
<th>Scale</th>
<th>Boarding Home %</th>
<th>Hospital %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-direction</td>
<td>91</td>
<td>77</td>
</tr>
<tr>
<td>Locomotion</td>
<td>87</td>
<td>62</td>
</tr>
<tr>
<td>Communication</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>Occupation</td>
<td>37</td>
<td>73</td>
</tr>
<tr>
<td>Self-help-dressing</td>
<td>87</td>
<td>100</td>
</tr>
<tr>
<td>Socialization</td>
<td>37</td>
<td>67</td>
</tr>
</tbody>
</table>

| TABLE IV |
|-----------------|-------------|-------------|
| ITEMS ON THE VINELAND SCALE SHOWING GREATEST DISCREPANCIES |

<table>
<thead>
<tr>
<th>Item</th>
<th>Boarding Home %</th>
<th>Hospital %</th>
</tr>
</thead>
<tbody>
<tr>
<td>87. (SD) Buys own clothing accessories</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>92. (L) Goes to nearby places alone</td>
<td>87</td>
<td>50</td>
</tr>
<tr>
<td>82. (O) Does simple creative work</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>89. (O) Performs responsible routine chores</td>
<td>31</td>
<td>85</td>
</tr>
<tr>
<td>85. (S) Plays difficult games</td>
<td>44</td>
<td>80</td>
</tr>
<tr>
<td>88. (S) Engages in adolescent activities</td>
<td>31</td>
<td>55</td>
</tr>
</tbody>
</table>

The discrepancies on the first two items may, at least in part, be accounted for in opportunities available to the two groups. The hospital patients simply do not have the chance to purchase clothing and leave the premises unsupervised to the extent that boarding home patients are able to.
The discrepancies in the remaining four items may be due to the fact that the hospital environment is more structured than the boarding home and consequently the patients here may feel more compelled to engage in these activities than boarding home patients. The implication appears to be that the opportunities afforded by the patients' environment is a crucial determinant of the activities they will undertake.

**QUESTIONNAIRE FOR BOARDING HOME OPERATORS**

This twelve item questionnaire (see Appendix G) was administered to the seven boarding home operators associated with the patient sample. The following findings were made:

**Capacity For Socialization**

In respect to the patient's capacity for socialization, the boarding home operators, with the exception of one, felt that the patients got along well with the other boarders. In contrast to this, the operators expressed less certainty about the patient's ability to get along with other people in the neighbourhood. Three patients were rated as getting along "well", two as "fair", one as "poor", and two as "not known". This rating is similar to the operator's judgment of the patient's ability to mix socially with others in which one was scored "very good", four as "good", one as "fair", one as "poor", and one as "very poor". In general, we might infer from comparing these items that the patient's capacity for socialization is less with people outside the boarding home than within the boarding home.

**Opportunity For Socialization**

Looking at the patient's opportunities for socialization, the boarding home operators, with the exception of one, considered their homes as conveniently located for the patient to get to community facilities such
as community centres, movies, and public transportation. They permitted six of the eight patients to handle their own comforts allowance. The comforts allowance consisted of $10.00 for three patients and $16.00 for five patients. The boarding home operators differed in their opinion about the financial resources of their patients to take advantage of community facilities rating two as "good", three as "fair", and three as "very poor". No relationship was found between the amount of the allowance and the boarding home operator's rating of the patient's socialization. Half of the patients however, gave financial reasons as the predominant obstacle to participating in activities. This variation suggests that the operators rate the patient's financial resources in terms of their present utilization of community facilities rather than their potential use of these facilities with adequate allowance.

Level of Socialization

The boarding home operators reported that five of the eight patients did not participate at all in various community activities. Six of the operators reported that they attempted sporadically, a few times each year, to encourage five patients in the sample to participate in community activities. Two operators stated that they did not encourage the other three patients in the sample at all to participate in community activities. We did not find a relationship between the degree of encouragement a patient received and the amount of social participation. According to the operators, other people, such as the public health nurses and volunteers, encouraged the eight patients to participate in community activities on a very minimal basis. Consequently, we might infer that the patients in this sample tend not to participate in community activities and receive little or no encouragement from the operator or others to do so. Despite this, the boarding home oper-
ators of six patients were rated by the interviewers as being interested in the patients. This rating was based on the interviewer's overall evaluation of the operator's responses in the interview.

In general, the operators reported that the patients had limited contact with relatives, friends, and acquaintances. No distinction was made as to whether the patient sample saw these people at the boarding home or elsewhere. Also, no attempt was made to differentiate who had initiated these visits - the patient or the visitor. On the basis of the information obtained, we might infer that the patients in the sample had relatively less frequent contact with friends and acquaintances than with relatives.

TABLE V
BOARDING HOME PATIENTS CONTACT WITH OTHERS

<table>
<thead>
<tr>
<th></th>
<th>Relatives</th>
<th>Friends</th>
<th>Acquaintances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over once a week</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Once a week</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Once a month</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sporadically</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Not at all</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Not known</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

8 8 8

obtained, we might infer that the patients in the sample had relatively less frequent contact with friends and acquaintances than with relatives.

QUESTIONNAIRE FOR BOARDING HOME PATIENTS

This ten item questionnaire (see Appendix HI) was administered to the eight boarding home patients. The following findings were made:

Level of Activity

Five of the patients felt that they would generally like to be more active. The other three patients said that they wished to remain the same. In respect to social activities that they would like to do more of, the patients expressed the following desires: four for movies; three for odd jobs; two to visit friends; and one each for reading, walking, outdoor
sports, concerts, and live theatre. Two of the patients said that they would prefer to do less sitting around the boarding home. In terms of activity preferences, these responses appear to correspond to the patient's responses on the Leisure Participation and Enjoyment Scale noted earlier.

The patients were asked where they had more to do in the hospital or the boarding home. They differed almost evenly in their reply with three patients designating the hospital, three the boarding home, and two no difference. In reply to where they enjoyed life more, six patients chose the boarding home rather than the hospital; attributing their preference to the increased freedom, greater privacy, greater number of activities, and more desirable companions. This preference underscores the finding on the Vineland Social Maturity Scale where the boarding home group was found to be superior in the skills of self-direction and locomotion. This suggests an increased sense of self-worth within the boarding home environment.

Social Contact

Although seven of the patients indicated they had little or no acquaintance with the people in the neighbourhood, they considered their neighbours as follows: three as friendly, one as fairly friendly, two as indifferent, and two as undecided. In terms of whom they would like to have more frequent contact with, over half expressed a desire to see family, friends or volunteers. In contrast, six of the eight patients expressed no desire for increased contact with professional people.

Five of the patients stated that they enjoyed life in this city due to the mild climate, leisure activities, job opportunities, friendships, and long-term residency. One patient reported that he disliked life in the city due to the boarding home neighbourhood, qualifying this by indicating a preference to live in the downtown area. Two patients were un-
familiar with city life. Hence, they were undecided as to whether life was enjoyable for them in this city. On the basis of the information obtained in this questionnaire, six of the eight patients expressed a preference for life in the boarding home and city as opposed to the hospital. Although a majority wished to do more things, over half the patients gave financial reasons as the major obstacle to increase social life. In terms of the patient's capacity to relate to the interviewer, the eight patients were rated fair to very good. Six of the eight patients appeared to approach social situations in either a withdrawn or somewhat reserved manner. The other two patients were felt to approach social situations in an out-going manner.

An effort was made by each interviewer to rate each boarding home patient in terms of the major factors felt to be impediments to social participation.

<table>
<thead>
<tr>
<th>Patient Capacity Factors -</th>
<th>Priority Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Lack of ability to</td>
<td>2</td>
</tr>
<tr>
<td>communicate</td>
<td></td>
</tr>
<tr>
<td>Lack of social skills</td>
<td>2</td>
</tr>
<tr>
<td>Residual symptoms</td>
<td>2</td>
</tr>
<tr>
<td>Other - Alcoholism</td>
<td></td>
</tr>
<tr>
<td>- Retardation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Opportunity Factors -</th>
<th>Priority Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumstances</td>
<td>1</td>
</tr>
<tr>
<td>Finances</td>
<td>2</td>
</tr>
<tr>
<td>Lack of stimulation</td>
<td>2</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
</tbody>
</table>

8 8 8
As the table clearly illustrates, the interviewers assigned a higher proportion of impediments to patient capacity than to patient opportunity. Consequently, we might conclude that although the boarding home patients attribute their inability to increased social participation to limited financial allowances, the interviewers considered capacity factors such as lack of ability to communicate, lack of social skills, residual symptoms, and age, the more important impediments.
CHAPTER VI

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

This study was a preliminary step in an evaluation of the community identification of former mental hospital patients now living in community boarding homes. As the literature revealed, the placement of mental patients in the community appears to be an indication of a changing philosophy in the field of mental health, but to date little effort has been made to evaluate the hypothesized benefits of placement programmes which reflect this philosophy.

The scope of this study was restricted to those patients placed from the Riverview Mental Hospital directly into Vancouver City boarding homes as part of a cooperative programme between the Social Service Department of the Riverview Hospital and the Medical Section of the Vancouver City Social Service Department. The focus of the study was the sense of community identification of the former patients with the Vancouver community. Community identification was defined in terms of three axes: physical presence in a geographic area; quality and quantity of social participation; and, relative opportunities for decision-making and independent functioning. The two latter components were subjected to quantitative analysis by the employment of the Chapin Leisure Participation and Enjoyment Scale (see Appendix F) and the Vineland Social Maturity Scale (see Appendix I) respectively for both the hospital sample and the boarding home sample. Qualitative data was obtained through utilizing questionnaires with the boarding home operators and the boarding home patients.

The proposed design for the study was of a retrospective nature, with comparative data being obtained from patient hospital files and actual
measurement in the community at present. However, as the data from the former source proved inadequate, only a pretest of the research instruments was conducted using a community boarding home sample and a comparative hospital sample of patients deemed to be prospective boarding home candidates, and a longitudinal study was recommended for future investigations. On the basis of the pretest data, limited comparisons were made between the results obtained from the two samples.

Generally, the findings of the study indicated that the amount of social participation decreased following placement into community boarding homes. Similarly, occupational and socialization competency decreased. However, skills of self-direction and locomotion were considerably increased in the community. Feelings of satisfaction with the community placement were predominantly reported by the boarding home patients as were positive feelings towards the community. Impairments to social functioning were felt to be primarily of a financial nature by the boarding home patients, but primarily of a psychological nature by the investigators.

RECOMMENDATIONS FOR THE STUDY DESIGN OF FUTURE RESEARCH

An Alternative Research Design

As already mentioned, the researchers became uneasy about the use of a retrospective study as a means of comparing the community identification of mental patients before and after discharge to city boarding homes. For a variety of reasons, spelled out elsewhere, we sought other possible approaches. The design that was considered to be the most feasible was a longitudinal one. It would involve the administration of instruments to all patients prior to placement from Riverview Hospital directly into Vancouver City boarding homes within a specified time period. This would be followed up after six months and/or one year by administering the same
instruments to the sample in the boarding home. A before and after study of this kind where each subject serves as his own control was felt would provide a better opportunity of measuring the effect of boarding home placement and more reliable "before" data for comparison.

From the point of view of sampling, this design would have an advantage over the present one. After the population was determined and the sample drawn, and as a result of careful perusal of the files and discussions with the Public Health Nurses, we discovered that four of our sample of ten discharged patients had not gone directly from the hospital to the boarding home but had lived with friends, relatives, or on their own first. If this ratio was representative of the total population, the elimination of these people from the sample would have meant reducing its size to an almost unworkably small number. The longitudinal design using only patients placed directly from hospital to boarding home would overcome this difficulty. Otherwise the stipulation of direct placement would have to be eliminated in order to ensure a sample of sufficiently significant size.

Even with the longitudinal design, there would still be a number of variables that could not be controlled. They include the differences in experiences to which each patient would be exposed after placement because of the variation in boarding home operator characteristics, in the location of the home and because of other less predictable factors. It may be possible for later researchers to take into consideration these variations in their analysis of data. Alternately, if the sample was large enough, a smaller group judged to have been exposed to relatively similar experiences could perhaps be selected for the purpose of a separate analysis.

Additional Considerations for a Longitudinal Study

If a longitudinal study as suggested would be carried out, it would be important that a long enough period be allotted so that a fairly large
sample could accumulate. Some of those placed would no doubt be returned to hospital before the six month period was over and others may have left the original boarding home to live elsewhere. Furthermore, the larger the sample, the greater would be the opportunity for some grouping of subjects with regard to similarities of post-hospital experience.

In addition, if this design were to be used the two questionnaires devised for the study would need revision. They were originally intended for use with discharged patients and boarding home operators but could probably be adapted for use with nursing staff and patients prior to placement.

Further Suggestions

Riverview Hospital has recently opened a pre-discharge unit called Hillside. At the present time only a small proportion of patients go through that unit before discharge. It might be interesting to examine those patients who are placed from Hillside into Vancouver boarding homes as a separate group, administering the instruments just prior to the move to Hillside, again prior to placement in the boarding home and again after six months in the community. The extent to which Hillside is used for patients going to city boarding homes, would determine how important a factor it would be in any future research of this kind. If the use was minimal, patients going through its programme might be excluded from the study sample altogether.

Another possible variation in, or addition to further research would be to identify two samples, one including all those who were maintained by the Department of Social Welfare and another including those who had sufficient private funds to maintain themselves but who still required the supervised setting of a boarding home. (The latter group was excluded in the present study.) A means of comparison of the effect of a very limited amount of spending money on the patient's self-esteem and ability to participate in community activities would thus be afforded.
Since other boarding home programmes are in operation in British Columbia, the opportunity for comparative studies are many. Of particular interest would be a comparison of an evaluation of the Fraser Valley programme, supervised by hospital staff and located mainly in rural communities with an evaluation of the Vancouver programme.

As a point of interest and as a suggestion for an entirely separate piece of research, the present group found, that to its knowledge, no instruments exist to measure feelings of community identification. Scales of community and social participation have been devised as have scales to measure anomie and alienation but none could be found that provided a gauge of the individual's subjective feelings of identification with a neighbourhood or community. The present study had to limit itself to examining specific objectively measurable aspects of community identification and to using some non-standardized open-ended attempts to ascertain subjective feelings. Perhaps a useful piece of research would be the developing of an instrument that would measure feelings of community identification.

SUITABILITY OF INSTRUMENTS

The major task of this particular study was to pretest the instruments devised and chosen by the researchers for use with former Riverview patients in city boarding homes. Late in the process, when it appeared that a longitudinal design would be preferable to a retrospective one, the researchers decided to administer the two standard tests to patients still in Riverview Hospital but awaiting boarding home placement.

Aside from the larger consideration of whether or not the variables chosen were in fact appropriate indicators of feelings of community identification, we can comment on the suitability of the instruments for measuring the qualities we intended them to measure. The following will therefore include comments about the researchers' thoughts on the validity of the instru-
ments as well as recommendations for changes in the instruments and/or their method of administration.

Vineland Social Maturity Scale

Generally it was felt that this scale yielded very interesting and useful data about the hospital and boarding home patients' degree of autonomy and maturity. Because the categories of items could be examined individually, we could obtain information about the patients' highest and lowest levels of achievement. Since the scale was administered directly to the subjects, however, the interviewers found themselves making judgments in the scoring of the items from their knowledge of the patient obtained in earlier interviews. As a result, the crosscheck value of this scale was lost. We would therefore recommend that in future the scale be administered to the boarding home operator or a member of the hospital staff depending on where the patient is at the time.

Chapin Leisure Participation and Enjoyment Scale

As a means of comparing the quantity of leisure activities and enjoyment of them by patients before and after boarding home placement, the revised Chapin Scale was adequate. Because of the lack of normative data and the alterations to the Scale that we felt obliged to make, it was not particularly useful for comparing mental patients to the "normal population". Also after administering 18 of these scales (revised to some extent beforehand), the group felt further revisions were necessary. In addition to recommending that items 1, 4, 7, 20, 28, 38, 39, 41, 42, 45, and 47 be omitted, it was decided that items 2 and 13 were covered elsewhere and should also be omitted. (See Appendix F for the Chapin Scale.) Furthermore, we would suggest that items 15 and 16 be combined since the people in our sample could see no distinction between them. Item 19 should be generalized to "handi-
crafts" including knitting, sewing, crocheting, leatherwork, wood carving etcetera, in order to include both male and female subjects. Item 21 should be divided into two separate items because many listened to the radio but did not watch television and vice versa. Item 26 could be expanded to include both "odd jobs at home and ward chores in the hospital" specifying that no remuneration is involved. "Spectator of sports" referred to in item 35 should not include watching sports events on television. In addition to these changes, we would recommend that the following be added:

- listening to music on records
- going for walks
- playing table games such as checkers, chess, scrabble, monopoly etcetera
- going for drives or bus trips
- going to a restaurant to eat or drink

Furthermore, we questioned the use of a five-point scale with this particular group (mental patients) because of their inability to make fine distinctions between like and dislike very much or dislike very much or between fairly often and frequently and so on. Perhaps with patients with most psychiatric disorders, a three-point scale would be sufficient. In any case in most of the analyses, we collapsed the categories at either end of the scale, grouping scores 1 and 2 together and 4 and 5 together. We recognize, of course, that with all of these revisions we would no longer have a Chapin Scale but rather a leisure participation and enjoyment scale fashioned after the Chapin Scale.

To make comparisons to any "normal" population, the scale would have to be administered to quite a large random sample from the community. Also the validity would have to be redetermined. It would be relatively simple to compute normative data since the information obtained from such
a scale would be quite readily amenable to computer analysis.

Boarder and Boarding Home Operator Questionnaires

As mentioned earlier, a longitudinal design would mean that both of these scales would have to be adapted for use with patients and nurses in the hospital in addition to discharged patients and boarding home operators in the community. In the present study, the questionnaires were adequate as a means of providing material to crosscheck with other data obtained. However, on the questionnaire for boarders, items 2a and 2b might profitably be changed from open-ended questions to ones specifying a number of categories including one category for "other". The pretest revealed that most of the individuals in our sample of hospital and boarding home patients were not capable of producing spontaneous, creative answers and required encouragement and suggestions of possibilities before answering. Item 3 on the questionnaire for operators might be subdivided into two questions, one being concerned with contact with friends, relatives, etcetera, that occurs within the boarding home and the other concerned with contacts that occur elsewhere such as the home of friends, downtown or at church.

CONCLUSIONS

Due to the nature of this study and to the small size of the sample, any conclusions that are made at this point are purely tenuous. Perhaps they might be better classified as implications for further investigation.

Ideas Concerning the Hypothesis

The hypothesis in this study is that "placement of mental patients in community boarding homes increases their identification with the community." This identification, we felt, was subjectively perceived by individuals but could be objectively measured. Generally, we found that the subjective aspect of our hypothesis was verified. The patients' subjective feelings about
being a part of the community were positive and they did, in fact, claim to enjoy life in the community more than in the hospital. This new feeling of "happiness" they attributed to such factors as more freedom, more opportunity to do things on their own, and more desirable companions.

The Concept of Community Identification

As was mentioned previously, there is no well delineated theoretical definition of this concept in the literature. There may well be a good reason for this as the definition may vary between cultures, socio-economic classes, age groups, individuals and so on. An absolute definition, therefore, may be impossible. However, for purposes of this study, we made a somewhat arbitrary definition of this concept in terms of physical presence in a geographical area, social participation in leisure time activities, and social maturity for decision-making and independent functioning. As the findings showed a decrease in the amount of social participation by the patients in the community and an increase in autonomy, specifically in the areas of locomotion and self-direction, we might consider some of the implications of this for future study.

Social participation as a measure of community identification may not be, in actual fact, a good index. Perhaps a sense of well-being can be achieved without active participation in community activities. Some of the people undertaking this research suggested that the whole idea of community identification may not be relevant if the individual is content within himself and does not interfere with the rights of others. Another consideration may be that social participation may deserve less weight as a variable. If social participation is a major part of this concept, then we might conclude that we have not used reliable instruments for this particular sample or that the amount of social participation per se is not important for this group of patients. Perhaps the quality of relationships is more important.
than the actual number of social contacts or the activities in which the patient engages.

With respect to autonomy and independent decision-making the boarding home patients seemed to have a greater feeling of self-worth and identity than they did in the hospital. A considerable degree of the patients' contentment with life in the boarding home was a reflection of the increased freedom and opportunity for self-directed activity which the environment afforded them. Again, perhaps the relative weight given to this variable might be increased. This aspect of the concept of community identification may be more important than others, for if people have a feeling of worth they may feel better regardless of where they are. By the same token, if the patients had more freedom in the hospital they might identify with it in a more positive way.

Thus, it is important to question our definition of the community identification and to consider the differential weight to be given to each of the variables determining community identification. Better results might occur if more refined instruments were designed to measure the objective and subjective aspects of this concept.

Assessment of Programme Functions

The findings, though limited by the small sample, suggest that the boarding home programme has enhanced the subjective aspects of community identification as defined for purposes of this study. The patients expressed the notion of enhanced self-worth. To the extent to which this may be true of the boarding home programme population in general, the programme will have achieved a considerable measure of success. Participation and social competence, except in the areas of locomotion and self-direction, decreased. This would be viewed as regrettable. An attempt might well be made to overcome this deterioration by reshaping and broadening the programme to include:
psychiatrically trained staff to encourage, teach and help the patients; new regulations regarding financial questions, as for example, allowing larger earnings from sheltered workshops, part-time jobs and occupational therapy for social and recreational purposes; and the provision of more appropriate meeting places and activities.
BIBLIOGRAPHY


37. *Life Line: Aftercare.* Montreal, Medical Film Center, Smith, Kline and French. (no date).


APPENDIX A

December 6, 1966

Miss S. McDiarmid
Director of Medical Services
The City Social Service Department

Dear Miss McDiarmid:

As you may know, the Research faculty at the School of Social Work has introduced some changes into the student thesis programme this year. Briefly, they are as follows:

1. An attempt to focus all student research projects around a central integrating theme. The theme selected for this year is "The Nature and Effects of Social Work Intervention."

2. Student theses need not, as in past years, encompass one specific problem. They may include several facets of a research problem or they may deal with one phase of a total research cycle which might take several years to complete in its entirety.

It is within this total framework that all research projects this year will be conducted.

I am writing as a representative of five M.S.W. students who are conducting a research study of the following topic:

Community Identification and Participation Amongst Mental Hospital Patients Placed in Boarding Homes.

You may be familiar with our topic through Mr. Sopp, but I will include our preliminary statement in the event that you do not already have it.

"Apart from the well-documented saving in public expenditures, placement of mental hospital patients in boarding homes is assumed to enhance the patients' sense of being 'part of the community'. Is this assumption valid in the context of present boarding home placements?"

We are specifically concerned with a random sample of Riverview Hospital patients who are presently residing in Vancouver city boarding homes. As you and your staff are responsible for the supervision of these homes, we would like to meet with as many of you as possible to discuss the following aspects of this program:

1. The number of boarding homes in the City that accommodate Riverview Hospital patients.
2. The number of patients currently in boarding homes and some general information with respect to their age, sex, illness and length of hospitalization.

3. The number of patients who receive Social Assistance and the number who are on private funds or income.

4. The role of the Public Health Nurse with respect to supervision of the patients, the problems encountered in keeping patients in the boarding home, and/or returning them to the hospital, and the problems that the patients have in adjusting to this setting and to the larger community.

5. The types of activities and resources available in the community for these patients, especially around the area of social activities.

6. The types of boarding home operators and their involvement with the patients.

We realize that there are many demands on your staff and would not take up too much of their time. We would appreciate your consideration of our request and welcome any comments or suggestions that you might have to offer. I will contact you next week by telephone to arrange an appointment regarding our specific questions and, hopefully, a visit with your staff to the various boarding homes early in the New Year.

Yours truly,

(Mrs.) J. L. Hanson
for Mr. Peter Adrian
Miss Karen Greer
Mr. Joseph Kirkman
Mrs. Mary Russell

JLH:me

cc: R. E. Sopp

* A similar letter was sent to Miss D. Begg, Supervisor of Social Services at Riverview Hospital requesting their assistance with the study.
APPENDIX B

EXPERIENCE SURVEY QUESTIONNAIRE

PUBLIC HEALTH NURSES - MEDICAL SECTION, CITY SOCIAL SERVICE DEPARTMENT

Characteristics of Patient Population

1. How many Vancouver boarding homes are used for Riverview patients?

2. What is the total patient population?

3. What are the general characteristics of the patients:
   a. average age or age-range
   b. sex
   c. diagnosis
   d. marital status
   e. financial status - how many receive social assistance?
     how many work at remunerative occupations?

Nurses Role

1. How often do they visit each home?

2. What is the nature of their contact with individual patients?

3. How frequently do they involve themselves with individual patients?

4. What difficulties do they encounter in dealing with sick patients?

5. What difficulties do they encounter in keeping patients in the community?

6. What difficulties do they encounter in re-referral to hospital?

Nurses Perception of Patients

1. What community resources or facilities do patients use?
   a. White Cross Centre
   b. YMCA, YWCA
   c. Other

2. Do they encourage patient participation in such activities?

3. Do they make referrals to social or other agencies?

4. What are the main problems of patients in the community?

5. What are the main problems of patients within the homes?
Nurses' Perception of Boarding Homes

1. Characteristics of population of homes. How many are:
   a. welfare patients?
   b. private patients?
   c. social assistance non-patients?
   d. private citizens - if not, why not?

2. Are boarding home operators dependent on patient's board for income?

3. Does this affect their attitude towards patients?

4. Are there significant variations among the homes with respect to:
   a. operator's interest in patients
   b. degree of activity in homes
   c. fostering of independence or dependence in patients
APPENDIX C

EXPERIENCE SURVEY QUESTIONNAIRE

BOARDING HOME OPERATORS

1. Can you tell me what the average daily routine would be like for the boarders in your home?

2. Do the boarders look after their own clothing? rooms?

3. Do the boarders (all or some) contribute to the general management of the boarding home? If so, how much, approximately? Do they have particular regular jobs to do or is it on a volunteer basis?

4. What sorts of special interest, if any, do all or some of the boarders have inside the home? (e.g. hobbies, reading)

5. Same question for outside the home. (e.g. movie-going, window shopping)

6. Do they all handle their own comforts allowance or do you help them manage it?

7. Do the boarders have much contact with members of their family or friends from pre-hospital days that you know of?

8. Do many of the boarders have friends in the community or do they mainly socialize with the other boarders?

9. Do you do all the cooking, cleaning and managing of the home yourself?

10. What are the particular problems you encounter in running a boarding home for former Riverview patients?

11. Do you feel the boarders have difficulty in adjusting to life in the boarding home and in the community? If so, what, in your opinion, are the major problems faced by them in their adjustment?
APPENDIX D

EXPERIENCE SURVEY QUESTIONNAIRE

RIVERVIEW STAFF - SOCIAL SERVICE DEPARTMENT

1. Why was the boarding home programme originally set up?
2. What are the objectives of the boarding home programme?
3. How would you evaluate the present boarding home programme?
4. What particular problems do you see existing in the present programme?
5. How do you see the boarding home programme developing in the future?
6. What preparations are made with the patients prior to placement?
7. What information are the patients given before they are moved?
8. What selection considerations are used in choosing to place patients in the Vancouver programme?
9. What is the discharge policy of boarding home placed patients in respect to leave and aftercare service?
10. Do Riverview social workers ever visit patients in Vancouver boarding homes after placement? If so, how often and under what circumstances?
APPENDIX E

PATIENT STATISTICAL DATA

Cumulative Results

1. Name: ____________________________

2. Age in years: (a) 15 to 25 (b) 26 to 35, 1 (c) 36 to 45, 2 (d) 46 to 55, 5 (e) 56 to 65, 1 (f) 66 and over, 1

3. Sex: (a) Male 7 (b) Female 3

4. Marital Status: (a) Married (b) Single 6 (c) Divorced (d) Widowed (e) Separated 4

5. Last school grade completed: (a) 1 to 6 (b) 7 to 10, 5 (c) 11 to 12, 2 (d) over 12, 2 (e) not known, 1

6. Diagnosis: (a) Schizophrenic 8 (b) Manic Depressive Psychosis (c) Behaviour Disorder (d) Psychoneurosis (e) Other 2

7. Length of time since onset of illness: (a) less than 2 years 1 (b) 2 to 5 years 3 (c) 5 to 10 years 1 (d) over 10 years 5

8. Number of hospitalizations: (a) 1, 4 (b) 2, 2 (c) 3, 2 (d) 4 (e) 5 or more, 2

9. Living situation between hospitalizations: (Circle any applicable) (a) boarding home, 2 (b) independent, 1 (c) with family, 6 (d) other, 1

10. Length of time in present boarding home in years: (a) less than 1, 2 (b) 1 to 2, 3 (c) 2 to 3, 2 (d) 3 to 4, 1 (e) 4 to 5, 1 (f) over 5, 1

11. Length of most recent hospitalization in years: (a) less than 1, 8 (b) 1 to 2, 1 (c) 2 to 3 (d) 3 to 4 (e) 4 to 5 (f) over 5, 1

12. Status on leaving hospital: (a) Capable, 4 (b) Incapable, 5 (c) not known, 1

13. Prognosis on leaving hospital: (a) Improved, 8 (b) Unimproved, 2

14. Hospital work activities --- List: all performed ward chores such as laundry, kitchen, truck or gardening work.

15. Hospital social activities --- List: all participated in ward activities such as ping pong, cards, pool or T.V.
APPENDIX F

LEISURE PARTICIPATION AND ENJOYMENT SCALE

F. STUART CHAPIN

<table>
<thead>
<tr>
<th>How Often Do You Do These Things</th>
<th>How Well Do You Like These Things</th>
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</thead>
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<tr>
<td>1. Never</td>
<td>1. Dislike very much</td>
</tr>
<tr>
<td>2. Rarely</td>
<td>2. Dislike</td>
</tr>
<tr>
<td>3. Occasionally</td>
<td>3. Indifferent</td>
</tr>
<tr>
<td>4. Fairly often</td>
<td>4. Like</td>
</tr>
<tr>
<td>5. Frequently</td>
<td>5. Like very much</td>
</tr>
</tbody>
</table>

*1 2 3 4 5  1. Amateur dramatics             1 2 3 4 5
1 2 3 4 5  2. Amusement parks and halls     1 2 3 4 5
1 2 3 4 5  3. Art work (individual)         1 2 3 4 5
*1 2 3 4 5  4. Attending large social functions (balls, benefit bridge, etc.) 1 2 3 4 5
1 2 3 4 5  5. Attending small social entertainments (dinner parties, etc.) 1 2 3 4 5
1 2 3 4 5  6. Book reading for pleasure     1 2 3 4 5
*1 2 3 4 5  7. Conventions                  1 2 3 4 5
1 2 3 4 5  8. Conversation with family     1 2 3 4 5
1 2 3 4 5  9. Card playing                  1 2 3 4 5
1 2 3 4 5  10. Church and related organizations 1 2 3 4 5
1 2 3 4 5  11. Dancing                      1 2 3 4 5
1 2 3 4 5  12. Dates                        1 2 3 4 5
1 2 3 4 5  13. Entertaining at home        1 2 3 4 5
1 2 3 4 5  14. Fairs, exhibitions, etc.     1 2 3 4 5
1 2 3 4 5  15. Informal contacts with friends 1 2 3 4 5
1 2 3 4 5  16. Informal discussions, e.g., "bull sessions" 1 2 3 4 5
1 2 3 4 5  17. Indoor team recreation or sports--basketball, volleyball 1 2 3 4 5
1 2 3 4 5  18. Indoor individual recreation or sports--bowling, gym, pool, billiards, handball 1 2 3 4 5
1 2 3 4 5  19. Knitting, sewing, crocheting, etc. 1 2 3 4 5
*1 2 3 4 5  20. Lectures (not class)        1 2 3 4 5

*Denotes items deleted.
<table>
<thead>
<tr>
<th>How Often Do You Do These Things</th>
<th>How Well Do You Like These Things</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Never</td>
<td>1. Dislike very much</td>
</tr>
<tr>
<td>2. Rarely</td>
<td>2. Dislike</td>
</tr>
<tr>
<td>3. Occasionally</td>
<td>3. Indifferent</td>
</tr>
<tr>
<td>4. Fairly often</td>
<td>4. Like</td>
</tr>
<tr>
<td>5. Frequently</td>
<td>5. Like very much</td>
</tr>
</tbody>
</table>

1 2 3 4 5 21. Listening to radio or TV
1 2 3 4 5 22. Literary writing--poetry, essays, stories, etc.
1 2 3 4 5 23. Magazine reading (for pleasure)
1 2 3 4 5 24. Movies
1 2 3 4 5 25. Newspaper reading
1 2 3 4 5 26. Odd jobs at home
1 2 3 4 5 27. Organizations or club meetings as a member
*1 2 3 4 5 28. Organizations or club meetings as a leader (as for younger groups)
1 2 3 4 5 29. Outdoor individual sports--golf, riding, skating, hiking, tennis
1 2 3 4 5 30. Outdoor team sports--hockey, baseball, etc.
1 2 3 4 5 31. Picnics
1 2 3 4 5 32. Playing musical instrument or singing
1 2 3 4 5 33. Shopping
1 2 3 4 5 34. Sitting and thinking
1 2 3 4 5 35. Spectator of sports
1 2 3 4 5 36. Symphony or concerts
1 2 3 4 5 37. Telephone visiting
*1 2 3 4 5 38. Theatre attendance
*1 2 3 4 5 39. Traveling or touring
1 2 3 4 5 40. Using public library
*1 2 3 4 5 41. Visiting museums, art galleries, etc.
*1 2 3 4 5 42. Volunteer work--social service, etc.
1 2 3 4 5 43. Writing personal letters
1 2 3 4 5 44. Special hobbies-stamps, photography, shop work, gardening, and others not included above
*1 2 3 4 5 45. Fishing or hunting
1 2 3 4 5 46. Camping
*1 2 3 4 5 47. Developing and printing pictures
APPENDIX G

QUESTIONNAIRE FOR BOARDING HOME OPERATORS

(PC) 1. How does this person get along with the other boarders?
   Very well (2) Well (5) Fair Poor Very Poor (1) Not known

(PC) 2. How would you rate this person's ability to mix socially with others?
   Very good (1) Good (4) Fair (1) Poor (1) Very Poor (1) Not known

(F) 3. How often does this person see:
   a. relatives  b. friends  c. acquaintances
      a. Over once a week Once a week (2) Once a month (1) Sporadically (2)
         Not at all (3) Not known
      b. Over once a week Once a week (1) Once a month (1) Sporadically (2)
         Not at all (3) Not known (1)
      c. Over once a week Once a week Once a month Sporadically (2)
         Not at all (4) Not known (2)

(OC) 4. Compared to the other boarders, how do you encourage this person to participate in community activities?
   Over once a week Once a week Once a month Sporadically (5)
   Not at all (3) Not known

(F) 5. How often do other persons (such as volunteers & P.H.N.) encourage this person to participate in community activities?
   Once a week Two to three times a month (2) Once a month
   Sporadically (2) Not at all (1) Not known (3)

(PO) 6. How convenient is it for this person to get to community facilities such as community centres, movies, etc.
   Very convenient (5) Convenient (2) Reasonably convenient (1)
   Inconvenient Very inconvenient

(PO) 7. How adequate are the financial resources of this person to take advantage of community facilities?
   Very good Good (2) Fair (3) Poor Very Poor (3) Not known

(F) 8. How often does this person participate in various community activities?
   Over once a week Once a week (3) Once a month Several times a year
   Not at all (5) Not known

(PC) 9. How does this person get along with the people in the neighbourhood?
   Very well Well (3) Fair (2) Poor (1) Very poor Not known (2)
(F) 10. How frequently does this person go to the After-Care Clinic?

- Over once a month (1)
- Once a month (1)
- Three to six months (4)
- Six to twelve months
- Not at all (2)
- Not known

(PO) 11. a. Does this boarder handle their own comfort allowance?
- Yes (6)
- No (2)

b. How much does he receive?
- $10.00 (3)
- $16.00 (5)

(OC) 12. How would you rate the operator's interest in this patient?

- Very good
- Good (6)
- Fair (1)
- Poor (1)
- Very poor
- Not known
QUESTIONNAIRE FOR BOARDING HOME PATIENTS

You have already told us about some of your social activities. Now we would like to ask you about your own feelings regarding your social life and your life in this community.

1. Generally would you like to be more active _____ less active _____ the same _____ undecided ______.*

2. What activities would you like to do more of _____________________________

__________________________________________

less of _____________________________

__________________________________________

3. Why are you unable to do more of the things that you would like to do?

financial reasons ________________

lack of companions ________________

transportation problems ________________

feel uncomfortable about participating ________________

others (specify) ________________

4. Where did you have more to do?

in the hospital ________________

in the boarding home ________________

5. Where did you enjoy life more?

in the hospital ________________

in the boarding home ________________

Why? ________________

6. Do you think the people in your neighbourhood are generally:

Friendly ______, Fairly Friendly ________, Indifferent ________

Unfriendly ________, Undecided ________.

7. How many people in this neighbourhood are you acquainted with?

Quite a few ________, some ________, very few ________, none ________.
8. Would you like to have more frequent contact with:

- Family
- Friends
- Neighbours
- Professional People
- Volunteers

9. Do you enjoy life in this city?

- Yes
- No
- Undecided

If yes, why

If no, why not

10. Are you satisfied with your life in the boarding home?

- Yes
- No
- Undecided

* * * * * * * * * * * * * * *

For Interview’s Use Only:

1. How would you rate the capacity of this person to relate to you during this interview?

<table>
<thead>
<tr>
<th>At Start</th>
<th>At Finish</th>
<th>How do you feel about making this decision? Certain</th>
<th>Doubtful</th>
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<tbody>
<tr>
<td>Very good</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Poor</td>
<td></td>
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</tr>
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</table>

2. How would you rate this person's approach to social situations?

- Outgoing
- Somewhat Reserved
- Withdrawn

Certain | Doubtful
What do you consider to be the major factors impeding this person's social participation?

(Mark any that are applicable in order of importance as you see it)

Age
Lack of ability to communicate
Lack of social skills
Appearance
Finances
Transportation
Lack of stimulation
Residual symptoms
Other (specify)

Appendix H1

Questionnaire for Boarding Home Patients

You have already told us about some of your social activities. Now we would like to ask you about your own feelings regarding your social life and your life in this community.

1.* Generally, would you like to be more active (5) less active (3) the same (3) undecided

2. What activities would you like to do more of? Movies (4) Odd jobs (3) Visiting friends (2) Reading (1) Walks (1) Outdoor sports (1) Concerts (1) Live theatre (1)

What activities would you like to do less of? Sitting around (2)

3. Why are you unable to do more of the things that you would like to do?

<table>
<thead>
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<th>Ranked by Priority</th>
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<th>Two</th>
<th>Three</th>
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<tr>
<td>Financial reasons</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lack of companions</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Transportation problems</td>
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<td>3</td>
<td></td>
</tr>
<tr>
<td>Feel uncomfortable about participating</td>
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<td>2</td>
<td></td>
</tr>
<tr>
<td>Health</td>
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<td>1</td>
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<td>Communication problem</td>
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<td>Priority 3 not made</td>
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</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>8</td>
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</tr>
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</table>

4. Where did you have more to do?
   In the hospital (3)
   In the boarding home (3)
   The Same (2)

5. Where did you enjoy life more? In the hospital (2) In the boarding home (6)

   Why? 2 patients preferred the hospital because of more companionship, and more leisure activities
   6 patients preferred the boarding home because of increased freedom, more leisure activities, greater privacy, and desirable companionships.

6. Do you think the people in your neighbourhood are generally:
   Friendly (3) Fairly friendly (1) Indifferent (2) Unfriendly Undecided (2)
7. How many people in this neighbourhood are you acquainted with?
   Quite a few (1) Some (3) Very few (4) None (4)

8. Would you like to have more frequent contact with:

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<th></th>
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<td>Professional people</td>
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<td>1</td>
</tr>
<tr>
<td>Volunteers</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

9. Do you enjoy life in this city? Yes (5) No (1) Undecided (2)
   If yes, why? mild climate, leisure activities, job opportunities, long-term resident, and friends here
   If no, why? dislikes neighbourhood and prefers living downtown
   If undecided, why? city is strange

10. Are you satisfied with your life in the boarding home? Yes (6) No (2) Undecided

APPENDIX I

VINELAND SOCIAL MATURITY SCALE

by

Edgar A. Doll, Ph.D.

<table>
<thead>
<tr>
<th>NAME</th>
<th>Sex</th>
<th>Grade</th>
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<th>When</th>
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<th>Recorder</th>
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| Informant's est | | Basal Score* |
|-----------------|-------------------|
|                 |                   |

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<tr>
<th>Handicaps</th>
<th>Additional pts</th>
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<th>Category+</th>
<th>Score*</th>
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<tr>
<td></td>
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<td>LA Mean</td>
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| C         | 1. "Crows"; laughs |  | .25 |
| SHG       | 2. Balances head    |  | .25 |
| SHG       | 3. Grasps objects within reach |  | .30 |
| S         | 4. Reaches for familiar persons |  | .30 |
| SHG       | 5. Rolls over       |  | .30 |
| SHG       | 6. Reaches for nearby objects |  | .35 |
| O         | 7. Occupies self unattended |  | .43 |
| SHG       | 8. Sits unsupported |  | .45 |
| SHG       | 9. Pulls self upright |  | .55 |
| C         | 10. "Talks"; imitates sounds |  | .55 |
| SHE       | 11. Drinks from cup or glass assisted |  | .55 |
| L         | 12. Moves about on floor |  | .63 |
| SHG       | 13. Grasps with thumb and finger |  | .65 |
| S         | 14. Demands personal attention |  | .70 |
| SHG       | 15. Stands alone |  | .85 |
| SHE       | 16. Does not drool |  | .90 |
| C         | 17. Follows simple instructions |  | .93 |

+Key to categorical arrangement of items:
SHG - Self-help general  C - Communication  L - Locomotion  O - Occupation
SHD - Self-help dressing  SD - Self-direction  S - Socialization
SHE - Self-help eating

*For method of scoring see "The Measurement of Social Competence".
<table>
<thead>
<tr>
<th></th>
<th>I-II</th>
<th></th>
<th>II-III</th>
<th></th>
<th>III-IV</th>
<th></th>
<th>IV-V</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>18. Walks about room unattended</td>
<td>1.03</td>
<td>35. Asks to go to toilet</td>
<td>1.98</td>
<td>45. Walks downstairs one step per tread</td>
<td>3.23</td>
<td>51. Cares for self at toilet</td>
</tr>
<tr>
<td>O</td>
<td>19. Marks with pencil or crayon</td>
<td>1.10</td>
<td>36. Initiates own play activities</td>
<td>2.03</td>
<td>46. Plays cooperatively at kindergarten level</td>
<td>3.28</td>
<td>52. Washes face unassisted</td>
</tr>
<tr>
<td>SHE</td>
<td>20. Masticates food</td>
<td>1.10</td>
<td>37. Removes coat or dress</td>
<td>2.05</td>
<td>47. Buttons coat or dress</td>
<td>3.35</td>
<td>53. Washes face unassisted</td>
</tr>
<tr>
<td>O</td>
<td>22. Transfers objects</td>
<td>1.20</td>
<td>39. Gets drink unassisted</td>
<td>2.43</td>
<td>49. &quot;Performs&quot; for others</td>
<td>3.75</td>
<td>55. Uses pencil or crayon for drawing</td>
</tr>
<tr>
<td>SHE</td>
<td>23. Overcomes simple obstacles</td>
<td>1.30</td>
<td>40. Dries own hands</td>
<td>2.60</td>
<td>50. Washes hands unaided</td>
<td>3.83</td>
<td>56. Plays competitive exercise games</td>
</tr>
<tr>
<td>O</td>
<td>24. Fetches or carries familiar objects</td>
<td>1.38</td>
<td></td>
<td>2.85</td>
<td></td>
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<td></td>
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<tr>
<td>SHE</td>
<td>25. Drinks from cup or glass unassisted</td>
<td>1.40</td>
<td></td>
<td>2.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHG</td>
<td>26. Gives up baby carriage</td>
<td>1.43</td>
<td></td>
<td>2.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>27. Plays with other children</td>
<td>1.50</td>
<td></td>
<td>2.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHE</td>
<td>28. Eats with spoon</td>
<td>1.53</td>
<td></td>
<td>2.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>29. Goes about house or yard</td>
<td>1.63</td>
<td></td>
<td>3.15</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SHE</td>
<td>30. Discriminates edible substances</td>
<td>1.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C</td>
<td>31. Uses names of familiar objects</td>
<td>1.70</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>L</td>
<td>32. Walks upstairs unassisted</td>
<td>1.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHE</td>
<td>33. Unwraps candy</td>
<td>1.85</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>34. Talks in short sentences</td>
<td>1.95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHG</td>
<td>35. Asks to go to toilet</td>
<td>1.98</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>36. Initiates own play activities</td>
<td>2.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHD</td>
<td>37. Removes coat or dress</td>
<td>2.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHE</td>
<td>38. Eats with fork</td>
<td>2.35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHE</td>
<td>39. Gets drink unassisted</td>
<td>2.43</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>SHD</td>
<td>40. Dries own hands</td>
<td>2.60</td>
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<tr>
<td>SHG</td>
<td>41. Avoids simple hazards</td>
<td>2.85</td>
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<tr>
<td>SHD</td>
<td>42. Puts on coat or dress unassisted</td>
<td>2.85</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>43. Cuts with scissors</td>
<td>2.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C</td>
<td>44. Relates experiences</td>
<td>3.15</td>
<td></td>
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<tr>
<td>SHG</td>
<td>45. Cares for self at toilet</td>
<td>3.83</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SHD</td>
<td>46. Washes face unassisted</td>
<td>4.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>47. Buttons coat or dress</td>
<td>4.70</td>
<td></td>
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<tr>
<td>SHD</td>
<td>48. Helps at little household tasks</td>
<td>4.80</td>
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<tr>
<td>O</td>
<td>49. &quot;Performs&quot; for others</td>
<td>5.13</td>
<td></td>
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<tr>
<td>S</td>
<td>50. Washes hands unaided</td>
<td>5.13</td>
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<td>SHG</td>
<td>51. Cares for self at toilet</td>
<td>3.83</td>
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<tr>
<td>SHD</td>
<td>52. Washes face unassisted</td>
<td>4.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>L</td>
<td>53. Goes about neighbourhood unattended</td>
<td>4.70</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>SHD</td>
<td>54. Dresses self except tying</td>
<td>4.80</td>
<td></td>
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<tr>
<td>O</td>
<td>55. Uses pencil or crayon for drawing</td>
<td>5.13</td>
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<td></td>
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<tr>
<td>S</td>
<td>56. Plays competitive exercise games</td>
<td>5.13</td>
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</table>
V-VI

O  57. Uses skates, sled, wagon  5.13
C  58. Prints simple words  5.23
S  59. Plays simple table games  5.63
SD 60. Is trusted with money  5.83
L  61. Goes to school unattended  5.83

VI-VII

SHE 62. Uses table knife for spreading  6.03
C  63. Uses pencil for writing  6.15
SHD 64. Bathes self assisted  6.23
SHD 65. Goes to bed unassisted  6.75

VII-VIII

SHG 66. Tells time to quarter hour  7.28
SHE 67. Uses table knife for cutting  8.05
S  68. Disavows literal Santa Claus  8.28
S  69. Participates in pre-adolescent play  8.28
SHD 70. Combs or brushes hair  8.45

VIII-IX

O  71. Uses tools or utensils  8.50
O  72. Does routine household tasks  8.53
C  73. Reads on own initiative  8.55
SHD 74. Bathes self unaided  8.85

IX-X

SHE 75. Cares for self at table  9.03
SD  76. Makes minor purchases  9.38
L  77. Goes about home town freely  9.43

X-XI

C  78. Writes occasional short letters  9.63
C  79. Makes telephone calls  10.30
O  80. Does small remunerative work  10.90
C  81. Answers ads; purchases by mail  11.20

XI-XII

O  82. Does simple creative work  11.25
SD  83. Is left to care for self or others  11.45
C  84. Enjoys books, newspapers, magazines  11.58

XII-XV

S  85. Plays difficult games  12.30
SHD 86. Exercises complete care of dress  12.38
SD  87. Buys own clothing accessories  13.00
S  88. Engages in adolescent group activities  14.10
O  89. Performs responsible routine chores  14.65
XV-XVIII

C 90. Communicates by letter .......................... 14.95
C 91. Follows current events .......................... 15.35
L 92. Goes to nearby places alone ...................... 15.85
SD 93. Goes out unsupervised daytime .................. 16.13
SD 94. Has own spending money ......................... 16.53
SD 95. Buys all own clothing .......................... 17.37

XVIII-XX

L 96. Goes to distant points alone ...................... 18.05
SD 97. Looks after own health .......................... 18.48
O 98. Has a job or continues schooling .................. 18.53
SD 99. Goes out nights unrestricted ..................... 18.70
SD 100. Controls own major expenditures ................. 19.68
SD 101. Assumes personal responsibility ................. 20.53

XX-XXV

SD 102. Uses money providently ......................... 21.5+
S 103. Assumes responsibility beyond own needs ........ 21.5+
S 104. Contributes to social welfare .................. 25+
SD 105. Provides for future .......................... 25+

XXV+

O 106. Performs skilled work .......................... 25+
O 107. Engages in beneficial recreation ................. 25+
O 108. Systematizes own work .......................... 25+
S 109. Inspires confidence ............................ 25+
S 110. Promotes civic progress ........................ 25+
O 111. Supervises occupational pursuits ............... 25+
SD 112. Purchases for others .......................... 25+
O 113. Directs or manages affairs of others ............ 25+
O 114. Performs expert or professional work ............ 25+
S 115. Shares community responsibility ................. 25+
O 116. Creates own opportunities ....................... 25+
S 117. Advances general welfare ........................ 25+
GRAPH SHOWING SOCIAL AGES OF PATIENTS IN HOSPITAL AND BOARDERS IN COMMUNITY AS MEASURED BY THE VINELAND SOCIAL MATURITY SCALE.

NUMBER

BOARDING HOME SAMPLE. OF 8.

HOSPITAL SAMPLE. OF 10.

AGE GROUP
(YEARS)

MEAN SOCIAL AGE OF PATIENTS IN HOSPITAL - 15.3 YRS.
MEAN SOCIAL AGE OF BOARDERS IN COMMUNITY - 14.5 YRS.
GRAPH SHOWING RELATIVE COMPETENCE OF BOARDERS IN
COMMUNITY AND PATIENTS IN HOSPITAL IN SPECIFIC
CATEGORIES OF THE VINELAND SOCIAL MATURITY SCALE.

BOARDING HOME SAMPLE.

HOSPITAL SAMPLE.

SELF-DIRECTION

LOCOMOTION

COMMUNICATION

OCCUPATION

SELF-HELP: DRESSING

SOCIALIZATION

PERCENT
### APPENDIX L

**AVERAGE PERCENTAGES OF ACTIVITIES PERFORMED**
**BY EACH SAMPLE OUT OF TOTAL NUMBER POSSIBLE**
**IN EACH CATEGORY OF ACTIVITY.**

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<th>Individual Activities</th>
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<td>INSIDE</td>
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<tr>
<td>BOARDING HOME</td>
<td>HOSPITAL</td>
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![Bar chart showing average percentages of activities performed by each sample.](chart.png)
APPENDIX M:

AVERAGE TOTAL SCORES ON CHAPIN LEISURE PARTICIPATION & ENJOYMENT SCALE OF BOARDING HOME AND HOSPITAL SAMPLES.

- BOARDING HOME SAMPLE.
- HOSPITAL SAMPLE.

---

TOTAL SCORE

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<th>ENJOYMENT RATING</th>
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<td>140</td>
</tr>
<tr>
<td>60</td>
<td>120</td>
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