THE "HALFWAY HOUSE": A TRANSITIONAL FACILITY
FOR THE REHABILITATION OF THE MENTALLY ILL


by

SHERMAN LEONARD GHAN

Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work

1962

The University of British Columbia
In presenting this thesis in partial fulfilment of
the requirements for an advanced degree at the University of
British Columbia, I agree that the Library shall make it freely
available for reference and study. I further agree that permission
for extensive copying of this thesis for scholarly purposes may be
granted by the Head of my Department or by his representatives.
It is understood that copying or publication of this thesis for
financial gain shall not be allowed without my written permission.
ABSTRACT

There has been a recent and widespread interest in developing new methods of assisting the mental hospital patient in becoming a self-supporting member of society. A new concept, that of "the therapeutic community", has provided insight as to the significance of both physical surroundings and the staff interaction upon the patient's potential for return to the community. Many mental hospital patients become sufficiently free of symptoms to be able to leave hospital, but require further assistance before being able to do so. It is in this context that various kinds of transitional facilities are now being established. The present study examines one such facility, the "halfway house", and attempts by a comparative survey an "operational definition" of its distinguishing features.

The several areas requiring descriptive data were assembled in a questionnaire, which was then sent to all centres which could be located from available references on the subject. Responses were received from twelve examples in the United States, to which are added two from British Columbia. A brief reference only is included for "hostels" which are of comparable character in Britain.

The introductory chapter reviews the perspective of these institutions. This points up rehabilitation as a process that involves many elements, such as the removal of disabilities incurred as a result of being a mental hospital patient, the necessity of providing for gradual reintegration of the patient into the community, the development of new resources to help accomplish this goal, and the changing attitude developed by service personnel in both the large institution and the transitional facility, so that the patient will be able to receive the encouragement and assistance required. The core material, compiled from the questionnaire, is analyzed under the headings of (a) the new features of this social agency, (b) sponsorship and finance, (c) physical facilities, (d) the nature of staff and facilities, (e) eligibility (Chapter II). Dynamically, the "halfway house" is assessed as a therapeutic community, covering (a) staff functions, (b) the residents' progression, (d) special services, (e) discharge criteria (Chapter III).

The conclusions are that the "halfway house" is a new type of social agency that has developed within the last decade. Although it has some similarities with boarding homes, it also retains some of the characteristics of mental hospitals with which it is usually linked. All but one of the examples stress the movement of individuals or clients into the community, and in order to accomplish this, a team of personnel has developed: the houseparent, social worker, and psychiatrist. The makeup of the team is analogous to the mental hospital treatment team of nurse, social worker, psychiatrist. Two elements remain unclear: (a) the policy with regard to eligibility or selection and discharge, and (b) the function of the houseparent. With regard to the former, such matters as high cost of service to the client or policy limiting who is accepted may limit the service. In some cases it is not clear why persons are admitted, except on the basis of unclearly stated need. Some facilities have a clearer view of purpose; i.e., to remove dependency upon the mental hospital or to teach the former patient the social skills required for living in the community. But many houseparents, lacking
professional education, are nevertheless responsible for the physical order of the facility and for setting a therapeutic tone. Some suggested areas for further study are better definitions of the hospital disabilities removed by a stay at the agency, and closer examination of how social interaction amongst clients and staff, as well as the use of community resources, brings this about.
ACKNOWLEDGEMENTS

There are many individuals who have been of invaluable assistance to me in writing this thesis.

Without the constant encouragement and constructive criticism offered by Dr. Leonard Marsh, I would have been hard put to bring the study to completion.

Had the respondents failed to reply to the questionnaire as quickly and frankly as they did, the study could not have been done.

I know now what people mean when, in the acknowledgements, grateful thanks are offered to wives. Thank you, Judy.

Finally, I am indebted to Mrs. Loyd Smith, who devoted a good deal of her time to do the typing.
TABLE OF CONTENTS

Chapter I: Rehabilitation in Transition: The General Considerations

New concepts and new resources. The "Halfway House": a unique transitional facility. Social work and rehabilitation. Method and scope of the study .................................................. 1

Chapter II: The "Halfway House": Its Structure and Facilities

A new type of social agency. Sponsorship and Finance, the private non-profit agencies, public agencies, the private profit-motivated agency. Physical Facilities. Staff as a Facility. Eligibility .............................................................. 27

Chapter III: The "Halfway House": Its Dynamics

The "Halfway House" as a therapeutic community. Staff functions: the houseparent, the social worker, the psychiatrist, other personnel. The residents' progression. Special services. Discharge...... 52

Chapter IV: The "Halfway House" as a Rehabilitation Resource

The "Halfway House" as a social agency. The "Halfway House" as a therapeutic community. Unsolved problems. Contributions of social work in rehabilitation .................................................. 74

Appendices:

A. A Brief Description of the Mental After Care Association of England System .................................................. 88
B. Questionnaire Used for the Study .................................................. 91
C. Illustrative Regulations: Agencies X and Y ................................. 98
D. Illustrative Daily Routine: Agency Y ........................................... 100
E. Bibliography .......................................................... 101

TABLES AND SCHEDULES IN THE TEXT

(a) Tables

Table (1) Symptoms Classified as to Change in Person or Outside ........ 4
Table (2) The Growth of Mental Hospital Populations, Canada, 1936 - 1959 (In thousands of Patients, Selected Provinces) ......... 5
Table (3) Diagnostic Classification of First Admissions by Sex and Province, Canada, 1959, (In thousands of Patients, Selected Provinces) .................................................. 6
Table (4) Diagnostic Classification of First Admissions by Type of Treatment Institution, Canada, 1959, (In thousands of Patients, Selected Institutions) .................................................. 6

(b) Schedules

Schedule "A" Summary Description of "Halfway Houses" Included in the Study .................................................. 25
Schedule "B" Personnel in the "Halfway Houses" .................................................. 36
THE "HALFWAY HOUSE": A TRANSITIONAL FACILITY

FOR THE REHABILITATION OF THE MENTALLY ILL

CHAPTER I

REHABILITATION IN TRANSITION: THE GENERAL CONSIDERATIONS

A review of the literature on the relatively recent upsurge of interest in the rehabilitation of the mentally ill reveals that many forces have been at work. Such forces include the efforts of laymen, legislators, the medical profession, social scientists, social workers, and others.

The term rehabilitation itself has come to have a wider meaning, as is aptly stated by Maxwell Jones; i.e.,

Rehabilitation is a particular aspect of the process of adjustment to, or recovery from, an illness. Treatment may be said to be any interference which aims to bring about or hasten this process. The term rehabilitation has come to imply the sociological aspects of the recovery period, although there is no reason why such aspects should be thus confined. Clearly there are degrees of recovery, and the double amputee or the schizophrenic can hardly be said to make a complete recovery, although rehabilitation methods may with advantage be applied to both. Rehabilitation is at present conceived as something in addition to the more specific treatment methods. It might be defined as the attempt to provide the best possible community role which will enable the patient to achieve the maximum range of activities, compatible with his personality and interests, and of which he is capable. This definition can be applied with equal facility to the schizophrenic or the simple fracture case.

This statement provides not only the background to the present study, but also reflects the converging of research and programming from many directions and disciplines. For example, Hoffer and Osmond, writing of the possible chemical nature of schizophrenia, state that

An equation for schizophrenia could be written: $S = f(Ad+p+c+Sp+d+t)$
where
$Ad = adrenalin$  
$p = personality and factors which have led to it$  
$c = culture$  
$Sp = specific perceptual functions of the brain$  
$d = duration of illness$  
$t = treatment given$

We suggest that while adrenalutin is the main component for developing the disease, the others shape its clinical course. In the later stages of illness, adrenalutin may cease to be made in the body, leaving the patient with the social consequences of decades spent in the "no society" of a large mental hospital, and as Gieger's work indicates, permanent damage to neurones may have occurred.\

The nature of the large mental hospital is coming under close scrutiny. Maxwell Jones describes a successful attempt to redefine the therapeutic role of staff in an effort to demonstrate that all aspects of hospitalization bear on the ultimate recovery of the mental patient. In North America, Ivan Belknap, in an exhaustive study of a large state mental institution, shows that the hospital began with two functions: treating the mentally ill, and

The other was that of serving as a more efficient poor farm, with more centralized organization. The isolation of the hospital, its self-contained industrial and agricultural functions, its general low status, and its constitutional responsibility for the indigent insane are all facts which speak plainly.\

Belknap points out that over the years the treatment function is being increasingly publicized in the form of official policy statements. But, despite such publicity, factors such as the necessity for custodial control and administrative efficiency, along with a poorly educated attendant staff, and lack of properly trained professional staff, have contributed to the maintenance of the hospital as a custodial institution.

Erving Goffman presents the thesis that the large mental hospital is a "total institution", and is comparable to other total institutions such as prisons, monastaries, prisoner of war camps, etc. As a result, one finds two

---

worlds, the "staff" world and the "inmate" world. These worlds, according to Goffman, are often separate and one result of this is that total institutions frequently claim to be concerned with rehabilitation, that is, with resetting the inmates self-regulatory mechanisms so that after he leaves he will maintain the standards of the establishment of his own accord .... In fact, this claim of change is seldom realized, and even when permanent alteration occurs, the changes are often not of the kind intended by the staff.  

Sommer and Osmond, in a review entitled "Autobiographies of Former Mental Patients", state that such books "contain a wealth of material on the mores of the hospital and the effects of a total social system upon its members." They note that prisons and mental hospitals may differ in such matters as the attempt of some prisons to hinder communication amongst inmates, and the attempts of prisoners to organize escapes, while communication is usually permitted and often encouraged amongst mental hospital patients, and well-organized, large-scale escape attempts do not often occur. Sommer and Osmond do point out that persons living in large total institutions, such as a prison or mental hospital, over a period of years may develop symptoms which exist independently of the illness. The symptoms are the result of the physical, psychological, and social effects of being an inmate in a total institution. It is the removal of these symptoms, (summarized in Table 1.) which account for many of the preventative and rehabilitative efforts of personnel engaged in working with the mentally ill.

---


Table 1. Symptoms Classified as to Change in Person or Outside

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Change in Person</th>
<th>Change in Outside</th>
</tr>
</thead>
<tbody>
<tr>
<td>De-individuation</td>
<td>dependence upon institution, loss of capacity to make decisions</td>
<td>-</td>
</tr>
<tr>
<td>Disculturation</td>
<td>acquisition of new values unsuited to previous community</td>
<td>-</td>
</tr>
<tr>
<td>Damage</td>
<td>loss of status, security, etc.</td>
<td>-</td>
</tr>
<tr>
<td>Estrangement</td>
<td></td>
<td>new technology, architecture, etc.</td>
</tr>
<tr>
<td>Isolation</td>
<td>person and outside remain unchanged but contact between them is lost</td>
<td>person and outside remain unchanged but contact between them is lost</td>
</tr>
<tr>
<td>Stimulus Deprivation</td>
<td>acclamation to new sensory patterns</td>
<td>-</td>
</tr>
</tbody>
</table>


The former mental patient may require the essentials of home, employment, and friends in order to be rehabilitated. Nevertheless, the residue of mental illness, plus "symptoms of institutional care", such as de-individuation, disculturation, etc., may act to make this matter extremely complicated. Rehabilitation efforts may be further confused by the lack of family or employment resources, or, if these do exist, by outright rejection of the former patient by his community.

This is not to say that all mental patients suffer from "symptoms of
institutionalization". Sommer suggests that the symptoms may be a result of hospitalization for a period longer than two years. The particular mental illness may also have its effects on the potential re-entry of the former patient into the community. However, the question of whether inability to work is due to the effects of a chronic psychosis or whether it is due to loss or obsolescence of work skills will be answered by varying rehabilitation programs. In the former instance, further medical treatment may be required; in the latter, training or retraining for employment.

The rehabilitation of the former mental patient is becoming a problem of pressing concern. It is important that programing become geared towards this task. In the years 1936 to 1959, (see Table 2.), although in conjunction with a

Table 2. The Growth of Mental Hospital Populations, Canada, 1936 - 1959. (in thousands of patients - selected provinces).

<table>
<thead>
<tr>
<th>Year</th>
<th>Canada</th>
<th>P. E. I.</th>
<th>Ontario</th>
<th>Saskatchewan</th>
<th>B. C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1936</td>
<td>39,833</td>
<td>260</td>
<td>13,574</td>
<td>3,133</td>
<td>3,265</td>
</tr>
<tr>
<td>1939</td>
<td>43,275</td>
<td>270</td>
<td>14,325</td>
<td>3,594</td>
<td>3,722</td>
</tr>
<tr>
<td>1944</td>
<td>47,279</td>
<td>274</td>
<td>15,140</td>
<td>4,169</td>
<td>4,008</td>
</tr>
<tr>
<td>1949</td>
<td>52,663</td>
<td>292</td>
<td>17,260</td>
<td>4,447</td>
<td>4,628</td>
</tr>
<tr>
<td>1954</td>
<td>62,323</td>
<td>297</td>
<td>20,132</td>
<td>4,653</td>
<td>6,288</td>
</tr>
<tr>
<td>1959</td>
<td>66,433</td>
<td>461</td>
<td>22,081</td>
<td>4,403</td>
<td>5,832</td>
</tr>
</tbody>
</table>


1 Sommer, "Symptoms of Institutional Care", Social Problems, p. 255.
general growth in population, and other factors such as increasing ease in admission, the mental hospital population of Canada and its provinces grew steadily. Only Saskatchewan and British Columbia had a small decline. The majority of patients (see Table 3.) were being treated in 1959 for the psychoses, and the vast majority of them were being treated in public institutions (see Table 4.).

**Table 3.** Diagnostic Classification of First Admissions by Sex and Province, Canada, 1959, (In thousands of patients - selected provinces).

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>P.E.I.</th>
<th>Ontario</th>
<th>Sask.</th>
<th>B. C.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.</td>
<td>12,663</td>
<td>93</td>
<td>4,694</td>
<td>810</td>
<td>1,515</td>
</tr>
<tr>
<td>F.</td>
<td>12,030</td>
<td>59</td>
<td>4,940</td>
<td>678</td>
<td>1,471</td>
</tr>
<tr>
<td><strong>Psychoses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.</td>
<td>6,044</td>
<td>29</td>
<td>2,182</td>
<td>416</td>
<td>734</td>
</tr>
<tr>
<td>F.</td>
<td>6,202</td>
<td>23</td>
<td>2,519</td>
<td>382</td>
<td>685</td>
</tr>
<tr>
<td><strong>Psychoneuroses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.</td>
<td>2,197</td>
<td>11</td>
<td>935</td>
<td>139</td>
<td>311</td>
</tr>
<tr>
<td>F.</td>
<td>3,602</td>
<td>15</td>
<td>1,632</td>
<td>202</td>
<td>481</td>
</tr>
<tr>
<td><strong>Disorders of Character, Behavior, and Intelligence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.</td>
<td>3,985</td>
<td>48</td>
<td>1,494</td>
<td>235</td>
<td>325</td>
</tr>
<tr>
<td>F.</td>
<td>1,161</td>
<td>9</td>
<td>760</td>
<td>84</td>
<td>221</td>
</tr>
</tbody>
</table>

Source: *Mental Health Statistics, 1959*, p. 73.

**Table 4.** Diagnostic Classification of First Admissions by Type of Treatment Institution, Canada, 1959, (In thousands of patients - selected institutions).

<table>
<thead>
<tr>
<th></th>
<th>Mental Hospital</th>
<th>Psychiatric Hos.</th>
<th>Hospital for Mentally Defective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Public</td>
<td>Federal</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>24,693</td>
<td>11,570</td>
<td>288</td>
</tr>
<tr>
<td><strong>Psychoses</strong></td>
<td>12,246</td>
<td>7,380</td>
<td>125</td>
</tr>
<tr>
<td><strong>Psychoneuroses</strong></td>
<td>5,799</td>
<td>1,246</td>
<td>69</td>
</tr>
<tr>
<td><strong>Disorders of Character, Behavior and Intelligence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5,946</td>
<td>2,585</td>
<td>73</td>
<td>2</td>
</tr>
</tbody>
</table>

Many of these patients will require something other than medical care in the form of psychiatric therapy, and it is to these patients and their needs that this study is geared. It is to the area of social rehabilitation that many workers are turning, including those people concerned with the large mental hospital. Brooks has stated in a paper dealing with the rehabilitation of chronic schizophrenic patients that his hospital has borrowed from the ideas of the "therapeutic community" as one approach since many patients

... had not only lost effective contact in the community but had also lost much of their vocational and social skills during prolonged hospitalization. It did not seem feasible for them to return to their families or to have individual placements in the community. We began to explore the possibility of providing rehabilitation services for them on a group basis. We gradually developed a comprehensive program of group remotivation and rehabilitation within the hospital. We made plans to extend this work into the community by placing the group in a halfway house facility. This does not, however, indicate that all hospitals have developed the same approach, nor have new methods been even considered in many. The above statement obviously refers only to one attempt to implement the therapeutic community in a state hospital. It does, however, mean that, in addition to recognizing the need for the relief of psychiatric symptoms and the need for homes, jobs, and companions, some writers do recognize the need to avoid the disabling effects of hospitalization and are beginning to turn their programs in that direction.

To restate, one may say that in the rehabilitation of the mentally ill, the main concern is to maintain the principle of the essential dignity of man. It is done by solving the practical issues involved in budgeting for programs, the locating of homes and jobs, and possibly, re-education in a wide range of

---

1 Brooks, George W., "Opening a Rehabilitation House", Rehabilitation of the Mentally Ill, copyright 1959, by the American Association for the Advancement of Science, Washington, D. C., p. 128 - 129.
social skills. Landy states this aptly when he says that

In the broadest sense one may view rehabilitation as a process in acculturation though not in the strict sense of change resulting from culture contact and interaction, as this term has been used in anthropology and sociology. Perhaps a better way to characterize the process from the cultural standpoint is to view it as a series of cultural movements for the patient or enforced cultural conformity from the viewpoint of the social institutions involved in bringing the patient "back to normality".¹

In order to bring the patient "back to normality", two broad considerations must be made. These are, to use Tomalty's terms, the "inner resources" and the "external resources" of the client. The inner resources may involve such things as age, sex, social skills, motivation, etc., of the client. The external resources may include the presence of a family, job, financial resources, etc.² The present study is concerned with one type of external resource, the "halfway house".

There have been a number of developments in the mental health field which have greatly added to the supply of "external resources" from which the client or expatient may draw. These may be grouped into two categories: those resources developed in and existing in the hospital, and those existing in the community, and which are known as transitional facilities. The lines between them may often blur, with the use of a hospital resource being related to the use of a community resource.

One of the most significant changes has occurred within the nature of the mental hospital per se. Many of these changes are characterized by the concept of the therapeutic community, mentioned above. Another change just as


significant and closely linked to the therapeutic community idea is the open door policy. Dr. Duncan McMillan, one of the early advocates of this policy, said in 1958 that at the 1078 bed Mapperly hospital

All wards have been opened for over five years, and we now realize how deleterious the locked door was to the patient. It prevented social adjustment of the patients by short-circuiting their reactions into channels of resentment against the hospital and the staff.¹

The doors were not indiscriminately thrown open, but rather sum up a comprehensive program of community-hospital resource integration, affecting such areas as admission procedure and policy, the development of a therapeutic atmosphere in the hospital, in which "The whole atmosphere of the hospital alters. The patient-staff relationship becomes a pleasant one. The atmosphere of the hospital becomes suitable for preparing the patient for life in the outside community; the doctors, the nurses, the social worker, and the patient, work together with this common objective."² The program is such that "Now our mental health service is based on the domiciliary community work and on the outpatient service with short-term admission to hospitals as required for treatment or rehabilitation."³

This program, which took place in the community of Nottingham, England, required extensive cooperation between national, local, and hospital officials, with the development of extensive community clinics for marriage counselling, juvenile delinquency, epilepsy, etc. Educational rehabilitation services were developed in conjunction with the local unit of the Ministry of Labour.

² Ibid., p. 37.
³ Ibid., p. 34.
In North America, too, planners are concerned with a more extensive therapeutic and rehabilitative care for the mentally ill. McKerracher writes that, in Saskatchewan, an effort is being made

... to meet the problem of planning better psychiatric care. The specific difficulties are huge, isolated, overcrowded, stigma-ridden mental hospitals with a large number of long stay patients. The Saskatchewan plan would replace all mental hospitals with 150 to 300 bed regional psychiatric units attached to general hospitals. It would integrate these with the regional psychiatric, public health, hospital, and general practitioner services. The focus is on rehabilitation and integrated community care.  

The onslaught, as a "total attack", has not neglected those persons who have suffered from the ill effects of hospitalization and long history of disease. Two examples of "total" programs exist in the United States. One is the "Member Employee Program" whereby chronic patients are brought into employment at the Veterans Administration Hospital. A brief description of the program states:

The Member Employee Program is an out-and-out employment program wherein the individual is discharged from the hospital but lives and works in the hospital environment as any other employee living on the station will do. Thus, after a reasonable period, the member-employee will have established a work pattern and a work conditioning process whereby he will be able to function in a job in the community when such a job is obtained for him by the vocational counselling service. The prospective employer will be able to hire an individual who has been considered as an employee rather than as a patient.

The second example of a program for the rehabilitation of the chronic schizophrenic patient is described in The Vermont Story. The emphasis in Vermont is on resocialization, and then employment.

These programs are on a large scale, and in Vermont, involve a close

---

2 Member Employee Program: A New Approach to the Rehabilitation of the Chronic Mental Patient (a collection of papers by the staff of the Veterans Administration Hospital, Brockton, Mass.)
3 Ibid., Appendix A., p. 206.
liaison between state, hospital, and community.

In addition, there are those resources which are located in the community and which may be described generically as transitional facilities, or, as Landy and Wechsler describe them, pathway organizations.¹ One such facility is the psychiatric day hospital.²,³ A psychiatric day hospital may be defined as

... a facility for patients needing intensive treatment within a relatively structured environment. While it offers the same variety of treatment procedures as the mental hospital, it differs in that patients are present for part of the day and do not live at the hospital. It seeks to help a patient to relate to his community rather than be severed from it.⁴

Another is the "halfway house."⁵,⁶,⁷,⁸ A brief description of the "halfway house" defines it as a resource which is "intended to provide the discharged mental patient with a temporary home and with a peer group of other former patients during the initial period of adjustment to non-hospital life."⁹ The

---

⁴ Winick, op. cit., p. 8.

The sheltered workshop is seen...

... not so much as a training site for the acquirement of specific job skills such as stitching, cabinet making, or punch pressing, but as a training site for general work habits and abilities. The assumption is that there is a carryover of work habits to future jobs even if those jobs are different from the ones available with the shop. \footnote{Black, Bertram J. et al, "Altro Health and Rehabilitation: Case Study of a Protected Workshop", \textit{The Journal of Social Issues}, Vol. 16, No. 2, 1960, pp. 40 - 46.}

A fourth resource is known as the \textit{expatient organization}. \footnote{Olshansky, \textit{op. cit.}, pp. 33 - 34.} There is an extensive network of these organizations in Canada. They are sponsored by the Canadian Mental Health Association, and are known as White Cross Centers. \footnote{Goertzal, Victor et al, "Fountain House Foundation: Case Study of an Ex-patient Club", \textit{The Journal of Social Issues}, Vol. 16, No. 2, 1960, pp. 54 - 61.}

The expatient organization is a specialized form of group activity for individuals who share common problems and experiences, and join together to obtain mutual help. \footnote{Rohn, George, \textit{Progress Report on White Cross Centers: Social Clubs for Ex-mental Patients}, a report prepared for the Canadian Mental Health Association, 11\frac{1}{2} Spadina Road, Toronto 4, Ontario, April, 1960.}

The boarding out or foster home, is a widely used transitional resource. Patients in such homes are usually under hospital care, and maintained by hospital funds. The main benefit from these homes derives from the family situation that the patient finds himself in. The boarding out program is, as a rule, administered by the hospital social service department. There is usually not a patient peer group in the boarding out home.

These facilities are not limited to the field of mental patient rehabilitation. Transitional facilities are used in the rehabilitation of alcoholics...
and adult and juvenile delinquents, etc.\textsuperscript{1} Sara Harris, in making a plea for further attention to be paid to the residents of skid row, states that

A Hart Island to bring men back from the grave and a halfway house where they can begin living again cannot seem too expensive under the circumstances .... A combination Hart Island and halfway house would not begin to cost the amount of money every city in this country spends every year to hospitalize and bury and jail its Skid Row habitues.\textsuperscript{2}

The "Halfway House": A Unique Transitional Facility

The "halfway house", as a specialized type of transitional facility is a relatively recent development. There are now a considerable number in the United States, but there are only two in Canada known to the writer. Both of them, The Venture and The Vista, are in British Columbia. C. G. Schwartz, who published a monograph, Rehabilitation of Mental Hospital Patients: A Review of the Literature, in May of 1953, discusses such transitional programs as the foster family-care home, where the expatient, instead of returning to his own home, is found a "foster" home to aid in the rehabilitative process. She also mentions expatient social clubs, the day hospital, night hospital, and open hospital. The "halfway house" is something that is postulated for the future. She states that

Many writers have cited the necessity of setting up a boardinghouse, a residence club, or a "specialized shelter centre", to meet the needs of newly discharged patients who still need a supportive relationship in a warm environment .... It would seem that the development of residence clubs for discharged patients may well be the next new type of service to provide in the attempt to reduce readmission rates and to aid the patient in readjusting to community living.\textsuperscript{3}

\textsuperscript{1} Wechsler, Mental Hygiene, p. 67.
\textsuperscript{2} Harris, Sara, Skid Row, U. S. A., Belmont Books, New York, 1961, p. 171.
\textsuperscript{3} Schwartz, Charlotte Green, Rehabilitation of Mental Hospital Patients: A Review of the Literature, Public Health Service Publication No. 297, May 1953, p. 51.
The earliest reference to a facility named and discussed as a "halfway house" is in an article by Louis E. Reik who wrote, in 1954, that

The mental hospital, with its emphasis on illness and psychopathology, is admirably equipped for the study and care of the sick, but for those with potentialities for healthy living it can, as Eugen Bleuler taught long ago, foster morbid dependency and have an adverse effect. A halfway house, on the other hand, emphasizing health rather than disease, might offer a certain class of patients, not sick enough for the hospital, or well enough to go home, an optimum environment for testing and realizing potentialities for health.¹

He described Spring Lake Ranch at Cuttingsville, Vermont, as a facility fitting this definition.

Since that time, the literature has grown to include articles which deal with surveys of the "halfway house"²,³,⁴,⁵ and articles written as case histories⁶,⁷.

People involved in "halfway house" programs have contributed to the literature discussing the operation of house programs.⁸,⁹,¹⁰,¹¹

³ Huseth, Mental Hospitals, op. cit.
⁴ Huseth, Mental Hygiene, op. cit.
⁵ Wechsler, Mental Hygiene, op. cit.
⁸ Williams, David B., "California Experiments with Halfway Houses", reprint from Mental Hospitals, 1956 Copyright, Mathew D. Ross, Medical Director, American Psychiatric Association.
The term "halfway house" implies, as Reik\(^1\) pointed out, that once half the task of rehabilitation has been accomplished, the remaining obstacles are much more easily overcome. This may be a result of overcoming the psychological and physical barriers involved in leaving the hospital, or it may be that the ex-patient becomes confident in crossing streets, and thus finds that job seeking is less of a hazard. It may be considered an even simpler matter, as was stated in a 1958 description of the two B. C. "halfway houses", The Venture and The Vista.

Dr. Kenning (a participant in a conference) reported good results with a plan worked out in Vancouver, where two homes were set up for former patients to stay in for a short time while relocating in the community. This gives them access to a telephone while job hunting .... Some patients may be sent there simply to develop confidence in themselves outside the hospital setting, if they are long term patients.\(^2\)

The question as to whether the house is half way, or some other fraction of the way out of the hospital depends on a number of variables, as Wechsler\(^3\) has pointed out. These will include the extent to which routines differ from mental hospital life, and the degree to which house living approximates community life. Other significant variables are the extent of remission in the patient, the nature and degree of his hospital treatment, and the extent to which he is accepted in the community. Some facilities may have a preventative purpose and be "halfway in". One example is Woodley House in Washington, D. C., where some residents do not come from a hospital, but may be referred from the community. In many programs, former residents may return to the house for visits. This may have the effect of further stabilizing their community adjustment and, in addition, may

---

\(^1\) Reik, \textit{op. cit.}

\(^2\) Tyhurst, Dr. J. Stewart, "Rehabilitation: Sharing the Job with the Community", \textit{Mental Hospitals}, May 1958, Vol. 9, No. 5, p. 44. (Minutes of a Conference chaired by Dr. Robert B. Prosser).

prevent relapse and hospitalization.

Landy and Wechsler\(^1\) state that in transitional facilities such as the "halfway house", expatient club, etc., three main purposes are served: continuity of rehabilitation, where the patient is led through successive stages in a planned fashion, anticipating and dealing with psychological obstacles and thus providing for a gradual introduction to the community; as decompression chambers, to avoid the ill effects of an abrupt thrust into the community; and as a socialization and/or resocializing agent into society, for example, the unlearning of hospital habits, or readjusting to community values by the resident. Further, they note that four continua are to be found in transitional facilities; the open-closed social system in terms of the amount of "life-space" taken up by the facility, the professional-lay orientation continuum, the dependence-independence continuum, and the movement from patient to non-patient role. Wechsler and Landy feel that transitional facilities need further clarification of matters such as readmission policy, length of stay, positive selection criteria, and an exploration of "need" of the prospective resident.

The functions of the halfway house may be many, the most obvious being that it provides a residence for the ex-mental hospital patient. The number of residents is usually small, in keeping with the concept of "home". Houseparents, people whose role is seldom mentioned explicitly in the literature, are stated to be, as a rule, "warm" persons; i.e., people with whom friendly or accepting relationships may be easily established.

In attempting to establish models for describing "halfway houses", a

---

number of schemes have been used. Huseth speaks of the preventative or halfway "in" house and mentions Resthaven, a house opened in 1912 in Los Angeles, and since closed, which offered a therapeutic experience as well as preventing hospitalization. Another type is the halfway "out" house, for ex-patients. She states that seven have been developed since 1954 in the United States and notes that England has also developed this type of facility (see Appendix "A"). In this category is included the quarterway house, which helps prepare hospital patients who have been highly dependent upon the hospital life for a less protected environment. Such a facility is the Brockton Veterans Administration Hospital foster home cottages. The third type of house is for "mixed" groups, meaning that it includes persons who are never expected to leave the facility, as well as those who are halfway in and halfway out. As has been mentioned above, "halfway houses" exist for alcoholics, ex-prisoners, and mental defectives. The difference here lies in the sponsoring organization; i.e., "halfway houses" are usually organized by groups interested in working with the mentally ill, the alcoholic, the prisoner and so on.

In 1961, Wechsler wrote of the "halfway house model", and stated that six facilities corresponded to this model in the United States. His criteria are that the "halfway house" provides a temporary residence for ex-hospital residents, residents come directly from a hospital, and they are usually segregated by sex. There are few formal regulations. Woodley House is similar, but deviates slightly, in that it is coeducational, and accepts patients from both hospitals

---

1 Huseth, Mental Hygiene, op. cit., pp. 116 - 121.
2 Wechsler, Mental Hygiene, op. cit., pp. 65 - 76.
and private psychiatrists in the community. The work camp model describes rural "halfway houses". An apparent difference is that they do not necessarily provide a bridge to the community. These include Gould Farm, Monterey, Mass., established in 1913, Spring Lake Ranch, Cuttingsville, Vermont, established in 1932, and Meadowlark Homestead, Newton, Kansas, established in 1952.

There is some disagreement as to just how many "halfway houses" do exist. According to Huseth, "halfway houses" for "mixed" groups include Gould Farm, Spring Lake Ranch, and Gateways. Wechsler, however, omits Gateways and speaks of Meadowlark Homestead, Gould Farm, and Spring Lake Ranch. None of the recent articles on the subject mention the halfway houses in British Columbia, The Venture and The Vista. (It might be pointed out that "halfway houses" usually go by "code" names; The Venture, The Vista, Gateways, etc., and will be referred to by their code name or as "the facility", "the agency", "the house", etc.)

A recent publication, Action for Mental Health: The Final Report of the Joint Commission on Mental Illness and Health, identifies three "types" of "halfway houses".

1. The cooperative urban house - with residents limited to a small number of ex-patients of the same sex, with good enough remission to get along with minimum supervision, and potentially or immediately employable.

2. The rural work-oriented halfway house - often referred to as a farm, ranch, or homestead - and larger than the urban type. It accepts ex-patients of both sexes as well as persons never hospitalized for mental illness.

3. The treatment-oriented halfway facility - a residential treatment centre standing halfway between the patient's home and the mental hospital. Residents are still patients and are not required to assume any large degree of personal or domestic responsibility or to participate in community life.

---

It will be a major task of the study to attempt to agree, add to or subtract from the above mentioned efforts to construct a model of the "halfway house". "Halfway houses" have been regarded as ranging in purpose from providing a telephone, to a new development as a psychiatric facility in the form of a combination hospital-"halfway house". It is also meant to be a force in "deinstitutionalizing" its clientele, or for the prevention of hospitalization. Some consider it to be a rest home, better than the hospital, for those who can only move halfway out of the hospital.

**Social Work and Rehabilitation**

Belknap has pointed out that social workers in one large mental hospital consider that they are treated in terms of rank and housing privileges less well than higher business employees on the business side of the hospital and the craft employees such as the electrician. Many of them state that their relations to the ward physicians are thoroughly unsatisfactory, in that their possible role in the treatment of patients is neither understood nor appreciated. Because of our familiarity with the views of physicians on the functions of social workers ... we knew that there was some justice in the complaints about lack of understanding and appreciation.  

He considers that this attitude may be a cause of the high rate of turnover in staff, and tends to lead to an increase in the number of untrained workers in hospital social service departments. Even more detrimental, with the upsurge in interest in the "team" approach as an integral part of the therapeutic community, such status differences "have blocked communication between team members, because the authority organization of the total hospital is not consistent with equalitarian team procedures."  

If social work has a valuable contribution to make to

---

1 Belknap, *Human Problems of a State Mental Hospital*, op. cit., pp. 118 - 119.

the treatment and rehabilitation of the mentally ill, such attitudes can only lead to loss, on the part of the patient, of service to which he should be entitled.

Schwartz recognizes that

The problem of clearly defining the functions of the various personnel involved in a treatment-rehabilitation program is of central concern to those attempting to develop a team approach to rehabilitation, for a team implies both a set of clearly defined and coordinated roles oriented towards achieving a commonly held goal and esprit de corps or satisfaction with the assigned roles and working relationships.1

She points out that the problems lie around the issues of power, authority, responsibility, recognition, and "importance". In addition to solving these issues, provision must be made for adequate numbers of staff. A properly balanced treatment team is essential in a rehabilitation program carried out in a multidisciplinary setting.2 In 1957, a serious shortage of social work personnel existed.

A recent survey (unpublished) conducted by the Mental Health Division of the Department of National Health and Welfare indicated approximately one social worker for every six hundred patients in Canadian mental hospitals. The apparent shortage is severe enough but the actual shortage is more acute since many positions are filled by untrained, or partly trained, workers and there is a serious lack of administrative and supervisory personnel.3

This study noted that there was a high degree of interest in psychiatric social work in the United States. However, a recent study4 found that in the United States, according to minimum American Psychiatric Association standards, mental hospitals are only forty percent adequate in the number of social workers employed.

It is the contention of the writer that there is little likelihood of

1 Schwartz, Rehabilitation of Mental Hospital Patients, op. cit., p. 39.
2 The Social Worker: Rehabilitation and the Psychiatric Patient, Report Series Memorandum No. 4, Mental Health Division, Department of National Health and Welfare, Ottawa, November 1957, p. 9.
3 Ibid., p. 16.
large scale effective rehabilitation occurring until the place of the social worker has been won, in sufficient numbers, on the treatment team. Social workers claim an interest and special knowledge in the social functioning of individuals. This, if it is true, is an invaluable addition to the range of services available in the treatment of the mentally ill person. Furthermore, it may be noted that historically, the social worker has been involved in a team oriented largely toward hospital treatment. Social work thus need not be confined to rehabilitation efforts. For individuals suffering from the effects of long term hospitalization or for people who do not need complete hospitalization, varying use of social workers might be profitably considered.

Alternate types of cases requiring support and treatment in the evening because of lack of family ties may be cared for in a halfway house or, as some hospitals have developed it, by a night hospital which functions in essentially the same way. The principal difference is that the halfway house is usually not under the management of medical personnel but under someone with social service skills or perhaps merely a warm, motherly person.¹

Perhaps, the first requisite in the use of personnel is imagination.

Schwartz has pointed out that rehabilitation may mean many things. "Rehabilitation has been conceived of as what is done to bring about the patient's recovery, as the process by which the patient recovers, as the goal of services rendered - the recovery of the patient, and as one phase of the treatment given."²

It is argued that if a social worker or other professional is involved in providing service, the mentally ill person will go through the process of being rehabilitated. This is desired by both the treatment team and, hopefully, the patient. The means and end will be determined by the nature of the program in

² Schwartz, op. cit., p. 2.
conjunction with the wishes of the patient and/or his family. It is becoming recognized that rehabilitation is not one specific phase or type of treatment.

Horwitz, in a recent study of rehabilitation as it related to social work education, states that

In this project "rehabilitation" was defined as a process whereby a handicapped individual achieves an enlargement of physical capacities, social competence and personal satisfactions. Concerted services, designed to comprehend a complexity of needs, are commonly required if such a person is to achieve the full life. Social workers in the widest range of service settings contribute to the rehabilitation of the handicapped, cooperating with others on the rehabilitation team, addressing themselves in particular to those needs of clients which have to do with difficulties in the area of social functioning.

Within this definition Horwitz states that the functions of the social worker should include provision of direct services. This would include assessment, planning, providing services, procuring team services or team operations, and evaluation or follow up. Indirect services, i.e., efforts to improve agency functioning and work with the community, are also part of the social worker's function.

Horwitz points out that the student of rehabilitation must appreciate the importance of "the impact of prolonged institutionalization upon the social development of individuals, and the differential impact of such isolation from the mainstream of life when it occurs at crucial stages of social development." In order to be of effective value, the social worker must combine his activities with those of team members in his agency, and utilize the resources of other agencies. In short, rehabilitation is not accomplished by one person or one agency.

It is part of the task of the study to determine the extent of social

---

2 Ibid., pp. 18 - 33.
3 Ibid., p. 36.
work involvement in the operation of the "halfway house". This will serve to explain more clearly how social workers are involved on the treatment team, and, in part, to indicate the specific tasks to which social workers must address themselves in fostering the rehabilitation process. It is intended further to indicate the extent to which social work has adapted to and fostered the growth of new concepts in rehabilitation, bearing in mind the problems of lack of trained staff, misuse of staff, lack of status, etc. It is the conviction of the writer that further "operational definition" of the role of the social worker is desirable and necessary, within the areas of assessment, planning, provision of services, team services, and so on.

Method and Scope of the Study

In designing the present study, consideration had to be given to four important areas:

(a) the theoretical framework of the study;

(b) the formulation of criteria in order to define the "halfway house" for purposes of this study, besides discovering where the "halfway houses" are;

(c) the drafting of a questionnaire as the major research tool in order to secure the most relevant information;

(d) the best method of presenting a description and analysis of the data.

The theoretical framework has been developed in the preceding discussion. Rehabilitation is seen as a changing concept and in the broadest sense, it may mean the total experience a person undergoes in receiving the service. In practical terms it may mean overcoming disabling factors such as the loss of a leg or loss of contact with the community. Rehabilitation may be the finding of
a home, or a specific "treatment" such as occupational or industrial therapy. Rehabilitation is all of these things, plus the recognition that it is a process undergone by an individual when he undertakes, or is expected to reach, a particular goal. The success of rehabilitation is usually measured by the degree to which the individual, and the professionals concerned, consider that the formal and informal goals of the program have been reached. This may be the simple act of the client moving physically from hospital to community, or his ability to live within the community and enjoy satisfactory social relationships.

Defining the criteria by which a "halfway house" could be selected for study was a difficult task, since this is, in large part, the subject of the thesis. This writer was guided by certain general considerations. First of all, the facility had to describe itself as a "halfway house". It had to have as its client the former mental patient. The number of residents accommodated had to be small, although no definite limit was set. It was decided to limit the scope of the study to North America, since the number of "halfway houses" on the continent are small. In Schedule "A" a brief description is given of the houses examined in this study.

The two houses in British Columbia, The Venture and The Vista, are compared with the rest. No separate evaluation of standards is attempted. It appears that the "halfway house" or hostels, as they are called, is a well known resource in England. The system of hostels operated by the Mental After Care Association in England is discussed separately in Appendix "A". The information on Rutland Corner House is derived from a case study on the house. A reply to the questionnaire was received from all houses listed in Schedule "A", with the exception of Rutland Corner House.

In designing the questionnaire, (see Appendix "B"), several revisions
**SCHEDULE "A"**

**SUMMARY DESCRIPTION OF "HALFWAY HOUSES" INCLUDED IN THE STUDY**  
(Total of 14)

<table>
<thead>
<tr>
<th>Name*</th>
<th>Location</th>
<th>Maximum Capacity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Brockton Foster Home Cottage</td>
<td>Mass., Brockton V. A. Hospital</td>
<td>10</td>
<td>Male, on hospital grounds</td>
</tr>
<tr>
<td>(B) Gateways</td>
<td>California, Los Angeles</td>
<td>60</td>
<td>Both sexes, urban</td>
</tr>
<tr>
<td>(C) Meadowlark Homestead</td>
<td>Kansas, Newton</td>
<td>10</td>
<td>Both sexes, rural</td>
</tr>
<tr>
<td>(D) Portals</td>
<td>California, Los Angeles</td>
<td>11</td>
<td>Male, urban</td>
</tr>
<tr>
<td>(E) Quarters for Men</td>
<td>California, Santa Clara</td>
<td>7</td>
<td>Male, urban</td>
</tr>
<tr>
<td>(F) Quarters for Women</td>
<td>California, San Jose</td>
<td>7</td>
<td>Female, urban</td>
</tr>
<tr>
<td>(G) Rehabilitation House</td>
<td>Vermont, Burlington</td>
<td>12</td>
<td>Male, urban</td>
</tr>
<tr>
<td>(H) Rehabilitation House</td>
<td>Vermont, Montpelier</td>
<td>12</td>
<td>Female, urban</td>
</tr>
<tr>
<td>(I) Rutland Corner House</td>
<td>Massachusetts, Boston</td>
<td>9</td>
<td>Female, urban</td>
</tr>
<tr>
<td>(J) Spring Lake Ranch</td>
<td>Vermont, Cuttingville</td>
<td>30</td>
<td>Both sexes, rural</td>
</tr>
<tr>
<td>(K) Texas Program</td>
<td>Texas, Austin</td>
<td>Not known</td>
<td>Both sexes, a system of nursing homes for aging mental patients</td>
</tr>
<tr>
<td>(L) The Venture</td>
<td>British Columbia, Vancouver</td>
<td>9</td>
<td>Male, urban</td>
</tr>
<tr>
<td>(M) The Vista</td>
<td>British Columbia, Vancouver</td>
<td>10</td>
<td>Female, urban</td>
</tr>
<tr>
<td>(N) Woodley House</td>
<td>D.C., Washington</td>
<td>10</td>
<td>Both sexes, urban</td>
</tr>
<tr>
<td>(O) M.A.C.A. Hostel</td>
<td>England</td>
<td>40</td>
<td>Both sexes, urban**</td>
</tr>
</tbody>
</table>

* in some cases abbreviated  
** discussed in Appendix "A"
were made after study and consultation. The questions were grouped under the
following headings: Sponsorship and Finance, Eligibility, Physical Facilities,
Staff, Services (a) general (b) special, and Discharge.

In Chapter II, the discussion is focussed upon the broad areas of spon­
sorship and finance, eligibility, physical facilities and staff facilities. Chap­
ter III is devoted to the consideration of staff functions, the daily routine,
special services, and discharge. The analysis is largely descriptive and com­
parative. It is not intended to evaluate specific "halfway houses" in terms of
success in reaching the goals set for that "halfway house", but rather to draw
such distinctions as what the functions of team members are, what residents do,
and how and for what reasons discharge occurs. The evaluation of the success of
a house would require a more controlled study than is possible within the scope
of this thesis. In Chapter IV, significant aspects of the house as a social
agency are brought together. In addition, the claim that the house is a type
of therapeutic community is re-examined.
CHAPTER II

THE "HALFWAY HOUSE": ITS STRUCTURE AND FACILITIES

The "halfway house" may be viewed as a new and unique welfare institution. It has arisen as the need for means of assisting certain disabled individuals to enjoy the privileges and responsibilities of citizens in the community became apparent. It is one of the lesser known examples of the process which Wilensky and Lebeaux have described in their recent study: "Social welfare (as the means) becomes accepted as a proper, legitimate function of modern industrial society in helping individuals achieve self-fulfillment. The complexity of modern life is recognized. The inability of the individual to provide fully for himself or to meet all his needs in family and work settings, is considered a 'normal' condition; and the helping agencies achieve 'regular' institutional status."  

As a welfare institution, the house embodies in varying degrees the distinguishing characteristics of social welfare institutions. These are: "(1) formal organization, (2) social sponsorship and accountability, (3) absence of profit motive as dominant program purpose, (4) functional generalization - an integrative, rather than segmental view of human needs, (5) direct focus on human consumption needs."  

An analysis of the framework or dimensions of the "halfway house" can be clarified by these means: how far is it a welfare agency, established to deal with a social problem, the rehabilitation of the mentally ill? So far as it has

---

2 Ibid., p. 146.
a therapeutic purpose, this is explored in the next chapter. However, before this can be done, the tangible elements that form the house must be understood. How is it financed? Who works in it? What is provided? And finally, who is the client? How is he selected and why? In answering these questions, it is hoped that some light will be thrown onto the nature of the house as (1) a new social agency, (2) a new type of institution per se, and (3), in psychological terms, a new and unique therapeutic community.

Sponsorship and Finance

In general, the house may be seen in terms of sponsorship in one of three ways: as a public (federal or state) agency, as a private non-profit agency, or as a private, profit motivated institution. Of the fourteen houses dealt with in this study, eight are private non-profit agencies, four are public state or provincial agencies, one is a federal public agency. The Texas program is the sole profit oriented program. Many of the private agencies receive or have received funds from public sources.

(a) The Private Non-Profit Agencies:

Meadowlark Homestead, a rural house, obtains funds from residents' fees and loans from individuals and banks. It is governed by a board of directors who are elected by constituent members, and is also responsible to the Kansas State Department of Public Health. Spring Lake Ranch, also a rural house, follows much the same organizational pattern. Spring Lake is unique in that it was founded in 1932 by a family who literally carved the House out of the wilderness. They have remained to this day the directors of the ranch, but are now responsible to a board of trustees. Rutland Corner House was established in 1877 as a temporary residence, employment agency, and rehabilitative centre for homeless and/or
handicapped women. In 1954 its charter was amended so that the house could operate as a transitional residence for former mental patients. It is organized as a private, non-profit agency with a board of directors. Funds are derived from residents' fees as well as from an endowment fund and dividends from investments. The house does not belong to community welfare organizations or fund drives.

The Quarters for Men and Quarters for Women are organized as corporate, tax exempt "halfway houses", under the Rehabilitation Planning Committee for Agnews State Hospital Inc., a group of private citizens. The director administers both houses, which are financed two-thirds by federal state funds and one-third by contributions from the community, fund raising on the part of the Rehabilitation Planning Committee, and residents' fees.

Gateways in Los Angeles, is part of a larger private social agency, the Jewish Committee for Personal Service, which is, in turn, a member of the Los Angeles Federation of Jewish Welfare Organizations and the Los Angeles Community Chest. The Gateways Mental Treatment and Rehabilitation Centre with ten beds was established in 1954, operational funds coming from gifts or contributions, and residents' fees. The recent construction of a sixty bed unit was financed by a federal-state grant and private funds. Although Gateways in 1958 "qualified ... for full accreditation by the American Psychiatric Association out of thirteen local hospitals applying to the A. P. A. for such recognition," it is considered that "for the recovering state hospital or ex-hospital patient, Gateways provides a valuable transition back into the community."
Portals, established in 1954, is also a privately financed, non-profit agency. Resources for the fiscal year ending March 31, 1961 came mainly from room and board charges ($5,620.50) and contributions from the Portals House Associates, other organizations and individuals ($25,975.90). The house is interested in seeking membership in the Los Angeles Community Chest. Woodley House follows the same pattern as Portals in terms of organization. Operating funds come mainly from the residents' fees. There is no organized fund drive, and contributions from individuals are not solicited.

(b) The Public Agencies:

The one federally financed house is the Foster Home Cottage at the Brockton Massachusetts Veterans Administration Hospital. It is located on hospital grounds and is under the administration of the social service department of the hospital.

The two Canadian houses, The Venture and The Vista, are financed and sponsored by the provincial government, with operational responsibility resting with the provincial mental health services. Presently, the authority and responsibility for their daily operations is delegated to a psychiatrist who works closely with a social worker. The Vista was established in 1948 and The Venture in 1952. The rehabilitation houses at Burlington and Montpelier in Vermont are financed by matching federal and state funds. Operational responsibility lies in the hands of the Vermont State Vocational Rehabilitation Department. There is close cooperation with state mental hospital personnel.

---

1 Annual Report, April 1, 1960 to March 31, 1961, Portals House, Los Angeles, California.

(c) **The Private Profit Motivated Agency:**

The "Texas Program" is somewhat unique. It consists of a number of privately owned nursing homes, licensed by the Texas State Health Department. Nursing home operators must, in addition, maintain standards set by, and honour a contract with, the state mental hospital. The nursing home operators are paid for patient care by public assistance funds. The overall program is under the administration of the state hospital social service department, although operators have a certain degree of control over their own establishments. It appears on the face of it that this program is, in reality, a boarding out or foster home type of arrangement, but it is included in the present study because it was described as a "halfway house". In 1959 it was reported that 806 patients had been placed in such homes. Out of this number, "... twelve patients recovered sufficiently to earn a full discharge. Thus the nursing home program has become also a halfway house program for rehabilitating the aged patient."¹

**Physical Facilities**

The majority of houses accommodate between nine and twelve residents, although the two Quarters have as few as seven beds each, and Gateways now has sixty beds. Spring Lake Ranch has room for thirty residents. The Vermont Rehabilitation Houses each provide two beds expressly for visitors to the house, usually prospective residents from the mental hospital. So far as can be ascertained, the Vermont Houses are the only ones which have a guest room. The Vista has a double bed usually occupied by one person which is kept for emergencies; for instance, a former resident may decide within two weeks of leaving that she

---

¹ Middleton, John, "A Nursing Home and Followup Program, Austin State Hospital", *Mental Hospitals*, January 1959.
would like to return to the house.

The physical facilities of any home or institution can and do provide social and psychological boundaries for the persons living in them. As noted above, the number of occupants is usually low, and thus the atmosphere is less that of an "institution" and more that of a "home". This fact, plus the added qualities of the building being in general an old house originally built for a large family, located in a residential area, will tend to decrease the resemblance of the house to a hospital. There are certain subtle elements, however, which tie the house to a parent institution, and which in fact make the house take on the colouring of the institution.

Perhaps the very fact of the total numbers of residents accommodated in 1961 will demonstrate the point. Spring Lake Ranch had a total of sixty residents, Portals thirty-two, the Brockton Foster Home Cottage twenty-five, and Quarters for Men, thirty-one. Five hundred and forty-six patients from the state hospital were placed in Texas nursing homes in 1961. Woodley House has had thirty-six residents since 1959. From October 28, 1961 to January 31, 1962, The Vista has had a total of twenty-nine residents. The rapid turnover of population may indicate that some success is being made in the rehabilitation of residents. Nevertheless, it does mean that in terms of continuity of its residents, the house is not a home. Then too, in a home, one does not expect to find that the inhabitants are exclusively adult, or that they are mentally ill persons. The significance lies in the fact that the small numbers sharing rooms is a distinct departure from the mental hospital. Instead of sixty to one hundred patients on the same ward, there are no more than three persons to a room in any of the houses. The median is two persons to a room, and occasionally one person has his own room. In this respect, the house does take on the colouring of a home. There are some exceptions in that the Brockton Foster Home Cottage has only single rooms,
and the Spring Lake Ranch has ten separate housing units providing a total of twenty-two single rooms and four doubles.

As a rule, there is a bedroom or a suite for the "houseparent", but in some cases it is only a sleeping arrangement for the person who happens to be on duty.

In terms of living arrangements then, the houses seem to follow a pattern of "home" living space. The furnishings of the houses, if they approximate those of The Venture and The Vista, are, for the most part, new, appear comfortable, and are of a pleasant colour and appearance. What strikes one is the general utilitarian, spartan appearance of The Venture, a male house, as contrasted with the cheerful, doily and flower decked, cosmetic strewn, look of The Vista, the house for females. There is not, as a general rule, a great number of extra rooms. One finds, as in any large family home, a kitchen, living room, dining room, and occasionally a lounge, games room, t.v. room and den, or a small library. Gateways is an exception with occupational therapy units and an auditorium as well as a library. Spring Lake Ranch has arts and crafts, woodwork, automobile and photography shops, as well as a sauna bath. All houses provide bedding. Clothing is not provided, but at those houses closely connected to a hospital, some clothing is available "as needed". Gateways, part of a larger system of social services, gives clothing only "in case of destitution".

The question of what one does in the house in terms of social or recreational activities may in some senses be redundant if one accepts the thesis, as some do, that in North American homes, families no longer have common interests or activities or, if they do, tend to find them outside of the home. Whether or not this is true, and if so, what effect this tendency has on the nature of family life, is not of concern here. The nature and extent of social and recreational facilities is one aspect of total institutions. If all social life is provided
for, there may be little incentive to leave the house. The "halfway house" be-
comes a small scale total institution. On the other hand, many institutions have
a program such as industrial, occupational, or recreational therapy which is con-
sidered to be an integral part of the therapy. Do these programs have a thera-
peutic effect in themselves, or is the social interaction that comes of people
participating in the activity therapeutic? The same questions could be applied
to the "halfway house". No answer is attempted here, only a description of what
exists.

The majority of houses have arrangements for dances or parties, card
games, informal discussions and some form of self government so that house affairs
may be discussed by residents. At seven houses, one can play ping pong, or engage
in arts and crafts. Spring Lake Ranch and Gateways, the largest agencies, have
the greatest variety. At Gateways one can attend the art gallery and theatre,
go bowling, or practise golf. Spring Lake Ranch has skiing, play reading, visi-
ting lecturers and movies. Portals, on the other end of the scale, with only
seven residents, has one social activity per month. It appears that card games
are the one activity which is engaged in at all houses. Perhaps this activity
provides for an excellent medium of communication.

Meals are served family style; the one notable exception is The Venture,
where there is no cook, and the men eat at a local restaurant. As will be pointed
out below, the style of eating can become an important element in the selection
of residents for house living. Special diets are served at some agencies; i.e.,
Meadowlark, Spring Lake Ranch, Brockton Foster Home Cottage, the Texas nursing
homes, and the two Vermont Rehabilitation Houses. As an indicator of the degree
of formality with regard to eating, respondents were asked if "raiding the icebox"
was allowed. Suprisingly, seven replied that it was not. Others added qualifica-
tions such as the following: the Vermont houses, Texas, both Quarters, and
Gateways provide an evening snack; Meadowlark Homestead replied that "treats are provided at times".

Twelve of the agencies are in an urban setting, and two are rural. Of those that are closely oriented to a mental hospital, eight are in a community different from that of the hospital. Only one, the Brockton Foster Home Cottage, is on the same grounds as the hospital. Gateways, and Woodley House are not linked to hospitals. The nursing homes in the Texas Program are located in many communities. Most agencies are large, older family homes that were remodelled. Gateways recently became a 60-bed institution, while the rural agencies were built specifically for their present purpose.

**Staff as a Facility**

Just as the physical facilities determine the nature of the house, so will the personnel play an important part. It is intended in the present discussion to state who is involved directly in the house. A discussion of their functions will be dealt with in Chapter III. One would not expect to find a complement of staff in an ordinary home, and although the house concept calls for a substitute mother and father, perhaps the very complexity of contemporary society has required that other service personnel be added.

The usual complement of staff (see Schedule "B") includes a houseparent, the services of a full or part-time social worker and a cook. Medical personnel are involved in an indirect way. Gateways has the most variety, including nurses, recreational therapists and a dietician, but there is no-one filling the role of "houseparent". Houseparents may do "shift" work. For instance, The Venture has two housefathers who alternate on four-day shifts. The housemother at The Vista works a five-day week. In addition, there are two aides and a general handyman.

It has been noted that there is usually a person who acts as a
### SCHEDULE "B"

**PERSONNEL IN THE "HALFWAY HOUSES"

(Total of 14)**

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Represented in the Unit**</th>
<th>Total Number**</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housefather</td>
<td>9</td>
<td>9</td>
<td>Some agencies have only a housemother or housefather. Spring Lake Ranch has a number of employees living on the Ranch who are regarded as houseparents.</td>
</tr>
<tr>
<td>Housemother</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Cook</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Janitor</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>5</td>
<td>11</td>
<td>Gateways has six full-time social workers on staff. The Vermont Rehabilitation Houses have a Vocational Rehabilitation Counsellor who is untrained.</td>
</tr>
<tr>
<td>Part time</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>2</td>
<td>4</td>
<td>There are two full-time doctors at Gateways. There are five doctors on staff part-time at Gateways.</td>
</tr>
<tr>
<td>Part time</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>1</td>
<td>The Director of Quarters is a psychologist.</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>1</td>
<td>The Director of Woodley House has a degree in Occupational Therapy.</td>
</tr>
<tr>
<td>Dietician</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* number of units (Houses) in which there was at least one.

** in all 14 cases replying to the questionnaire.
housemother or housefather. These persons have, at the most, a high school education, along with experience as psychiatric aides. In some instances, the director, who might be a social group worker, as is the case at Rutland Corner House, or a former occupational therapist such as at Woodley House, may have the duties of director and houseparent.

There is a social worker directly employed or on staff at seven houses. Social workers are employed as directors at three houses; i.e., Portals, the Brockton Foster Home Cottage, and Rutland Corner House. The two Vocational Rehabilitation Counsellors connected with the Vermont Rehabilitation Houses are untrained persons, who are on the staff of the Department of Rehabilitation. The respondent stated that the "vocational rehabilitation counsellor has a small office or counselling room in each house, but he is not considered part of house staff." Vermont draws on trained social workers from the state hospital for consultation. With the exception of the Vocational Rehabilitation Counsellors at Vermont, all social work personnel have the M. S. W. degree. Quarters has a psychologist with an M. A. degree as its director. Gateways, at one extreme, employs six qualified social workers and seven psychiatrists, two full-time and five part-time. At the other end of the scale, Spring Lake has no professional staff. They reply that "we have found that professional people are not happy in this setting. Our most effective staff have had such backgrounds as marble cutter, art teacher, general, minister, chemical buyer, fund raiser, actress, etc. It is this human quality for which staff are chosen, not their qualifications."

Medical personnel are usually involved in an advisory, or occasionally, as at Gateways, The Venture and The Vista, in an administrative capacity. In some instances, final discharge of legally committed patients is in the hands of the doctor. This will be discussed further in Chapter III.
Cooks are employed at some houses, dieticians and janitors less frequently, since residents in most houses share in maintenance duties.

Rutland Corner House is unique in that it provides a field placement for a social work student.

The direct staffing is not elaborate in this small facility. However, one can see that in some programs, the hospital team of nurse, social worker, psychiatrist, has been transmitted with some small variations to the "house" team of houseparent, social worker, doctor.

**Eligibility**

Eligibility requirements, explicitly and implicitly stated, are in themselves a dimension, as real as the number of rooms, and the kinds of staff. The question "Who is the "halfway house' for?" will logically lead to the question, "What does the 'halfway house' do?"

Wechsler and Landy, in their recent review of transitional facilities such as "halfway houses", expatiant social clubs, sheltered workshops, etc., have suggested the need to develop positive policies with regard to such matters as length of stay, readmissions, selection (or eligibility), and determination of need of clients. With regard to problems associated with eligibility or selection, they state that

Most facilities tend to operate on the basis of negative selection criteria (i.e. rehabilitation potential, work tolerance, etc.). Consequently they have not developed systematic admission policies and depend primarily upon current or recent experiences to inform them. Three effects are possible: (1) the success of the agency cannot evaluated if only "good risks" are admitted, while "poor risks" are omitted; (2) certain types of needy ex-patients may be ineligible for all existing facilities; (3) facilities may not be aware of the extent of homogeneity of the patient population they serve and therefore may not set up appropriate procedures for staff selec­tion, activity programming, physical plant, and relationships with referring
and cooperating agencies.  

It is impossible to analyze in detail the eligibility and selection requirements of every house. The emphasis here will be to discuss significant aspects on a comparative basis that might be an influence when a person is being considered as a candidate for house residence. Such matters as age limits, work and skill requirements, method of orientation to the house, what the purpose of residence in the house is meant to be, etc., will be considered in an attempt to provide a finer description of those elements that are significant in choosing clients. There is a further benefit from such a discussion. Since the house may be viewed as a newly developed social welfare institution, it will provide new insights into what a welfare client is required to be before receiving service.

It will be of interest to note whether or not social workers play a part in selection, since if their area of competence is in "social functioning" it is logical to assume that some weight will be given to the "experts" in this matter.

Five houses admit males and four are limited to females. Out of these, six houses are part of a program that provides a facility for both men and women, i.e., the Quarters for Men and the Quarters for Women, The Venture for men and The Vista for women in Vancouver, and the two rehabilitation houses in Vermont. The Brockton Foster Home Cottage serves what appears to be a veterans' hospital with a predominantly male population. Five houses accept both men and women.

Eight respondents replied that there are no minimum or maximum age

---

limits. Woodley House replied, "Adults only, whatever that means. High stairs automatically limit the aged and infirm." Some houses have a minimum age of fifteen to eighteen years because of the difficulty these people might have in obtaining employment, and a maximum age limit for the same reason. The Texas Program is a notable exception, as it accepts only the aged as clients. Although the question was not asked, it would be important to know if an attempt is made to provide some form of group balance on the basis of age. As can be seen, in some programs, one cannot be too young or too old or he will not be chosen.

Residents come from a variety of sources. The majority are referred from public or private mental hospitals. Occasionally residents come directly from the community. The question of whether the house is halfway "in" or "out" will be answered by the source and direction of flow of residents. Rutland Corner House, the Texas Program, The Venture and The Vista, both Quarters, Brockton Foster Home Cottage accept patients only from public hospitals, federal or state. At the Vermont "halfway houses", 90% of the residents come from state hospital, 8% from private mental hospitals, and 2% from the community. In 1961 Portals had twenty-five residents, twelve from federal mental hospitals, twelve from state hospitals, and one from the community. Spring Lake Ranch receives referrals from an "advisory council" of thirty-three private psychiatrists and neurologists who may refer their patients from private mental hospitals, public mental hospitals, or directly from the community. Gateways received patients from all sources mentioned above. Only Gateways, Meadowlark Homestead, Spring Lake, and Woodley House had patients referred from families, public welfare agencies, or private hospitals. The clients at Woodley House come directly from the community. They are all under treatment by a private psychiatrist. It is the only agency that emphasizes the prevention of hospitalization.
Most of the agencies exclude certain types of people. Eleven replied that there were exclusions for conditions such as alcoholism, drug addiction, anti-social behaviour, acting out behaviour, psychopathic behaviour, etc. Three stated that there were no exclusions because of a specific disorder. Woodley House replied, "Currently there are ten residents in the house. While I'm not positive about this, I'd guess that nine are schizophrenics and one a non-psychotic delinquent. I don't ask for or make diagnoses." Meadowlark replied that there are no exclusions "but some we cannot handle because of their condition, such as 'dangerous' to employees, violent, etc., depending upon recommendations of doctors, psychiatrists, etc." Brockton Foster Home Cottage replied that only the "mentally ill" are accepted, but they state in an article that the cottage is exclusively for people suffering from schizophrenia. The Venture and The Vista exclude homosexuals and alcoholics but qualify this by accepting them if the condition is "under control". Rutland Corner House excludes overt homosexuals, psychopaths, and alcoholics, and what they describe as "severe actors out" or "excessively manipulative persons", but will accept these people if they can control the behaviour. In addition, they ask (1) is there room, (2) which person seems neediest, (3) will she fit into the house in terms of age, sex, temperament, and special behaviour patterns, (4) does she appear to have a reasonable potential for congenial interpersonal relations and for using the house as a spring board into the community, for which it is intended. Schizophrenics are the main residents at Rutland Corner House.

Most respondents were unclear as to what mental illnesses are acceptable.

---

to the agency. Some, such as the Vermont Rehabilitation Houses and Brockton Foster Home Cottage are limited to chronic schizophrenic patients. Others may have epileptics, mentally retarded, schizophrenics, and "mentally ill", but the respondents were not clear what they were dealing with. In one sense, if the "halfway house" is seen as a model family, then whoever comes along is accepted, but this is not the case. On another level, it may be postulated that specific illness produces specific social disabilities, and the "halfway house" could deal with them. In any event, respondents knew what they didn't want, but were not too clear on what type of mental illness was acceptable.

It might be argued that people with specific illnesses should not be regarded as being desirable as candidates for the house since the hospital would "cure" them. As another alternative, the house may provide a residence for people who are being treated elsewhere, as at Woodley House. Then too, it has been assumed that schizophrenia brings its particular problems of social functioning, and the house might be used as a partial remedy for this. Finally, the agency may see as its purpose the curing of "institutional ills", as the Brockton Foster Home Cottage and the Vermont Rehabilitation Houses seem to do. The questions noted above are not answered here, but should be explored further.

When an application has been accepted, some form of orientation or introduction to the "halfway house" will occur. Residents coming from a hospital will talk with a psychiatrist and/or a social worker about the proposed resource. In some instances, hospital patients visit the house as a regular part of the program, such as at Vermont, Brockton and Portals. At some agencies, discussions

---

between present and prospective clients take place. Agencies where this occurs are Spring Lake Ranch, the Vermont Rehabilitation Houses, and the Brockton Foster Home Cottage. The main form of orientation appears to be a talk with psychiatrist or social worker with occasional visits by the prospective resident to the house. Prospective residents for the Vermont Rehabilitation Houses are formed into a special group in hospital. This is a part of a rehabilitation program, which is organized into specific steps or areas, including (1) drug therapy, (2) ward care, (3) group therapy, (4) graded privileges, (5) activity therapy, (6) industrial therapy, (7) vocational counselling, (8) blurring the boundaries between hospital and community. The final step may be a period of house residence. Primary orientation comes from the vocational rehabilitation counsellor, along with weekend and day visits to the houses. At the Brockton Foster Home Cottage, "intensive casework" by the social worker on the patient's team is provided before the resident moves to the house.

Selection of residents for most agencies is determined by doctors and social workers. Houseparents play a small part in resident selection. The exceptions are Woodley House, where the director carries all roles, and Spring Lake Ranch, Quarters, and Vermont. Only at Vermont, among those hospitals where residents come from hospitals, are nurses involved in selection. Vermont replied that at one point, nurses were asked which patients they could least afford to lose because of their usefulness on wards, or what patients they felt were not receiving treatment but could profit from a stay in the house. On the basis of replies to such questions as these, selections were made. Applications to The Venture and The Vista come from doctors and/or social workers in the hospital who

---

1 Chittick, op. cit., pp. 31 - 34.
refer prospective residents to a social worker who processes applications. If, after consultation with the psychiatrist, who is responsible for the total after-care program of the hospital, the referral is accepted, the social worker completes all arrangements.

The cost to residents for staying in the house may be seen in one of three ways: (1) as a necessity in order to keep the house operating, (2) as a therapeutic factor, and (3) as a community responsibility. Cost to the resident has been included as an aspect of eligibility and selection because it is a real element. If the prospective resident is eligible on all other counts, he might be excluded because of inability to pay. Exclusion on these grounds might be a negative approach.

Three houses, The Venture, The Vista, and the Brockton Foster Home Cottage expect no payment for service. Residents of The Venture and The Vista are provided with twenty dollars for their expenses, provided that they have no funds of their own. Gateways expects all or part payment, depending on "ability to pay". The respondent from Spring Lake Ranch stated that "our rate is $500 per month. Perhaps I should add that this is flexible. We accept some low or non-paying guests; in fact, as many as we can within the limits of our budget. Also, few guests continue to pay the full rate for more than a month or two. At this time our average rate is $340 per month." The rate apparently decreases as the resident contributes more and more to work done on the Ranch.

Woodley House is unique enough to deserve extended comment regarding its monthly rate. They say that

"Rates are scaled to encourage residents to seek outside employment and interests. Those who are entirely dependent on the facilities of the house pay more than those who work or go to school part-time, and those who are fully employed pay least. Residents who can cooperate and share with a roommate may
also pay reduced fees. Each resident's rate of payment may vary with changes in his status.

<table>
<thead>
<tr>
<th></th>
<th>Double Room</th>
<th>Fees</th>
<th>Single Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Fully employed or occupied</td>
<td>$155.00</td>
<td></td>
<td>$190.00</td>
</tr>
<tr>
<td>(2) Partly employed or occupied</td>
<td>$195.00</td>
<td></td>
<td>$235.00</td>
</tr>
<tr>
<td>(3) No work plans</td>
<td>$250.00</td>
<td></td>
<td>$300.00</td>
</tr>
</tbody>
</table>

(These residents are expected to work in the house)

The fee is determined by the house after consultation with the therapist in charge, and takes into consideration not only time spent in outside activities, but also type of work in relation to resident's future goals, general independence, age, experience, and so on.

Residents are paid for work done in the house that would otherwise be provided by other paid help; i.e. typing.

Volunteer work or school may be paid on the same level as regular paid employment."

The Vermont Rehabilitation Houses charge on a basis that when the resident's earnings at a job are more than enough to cover medication (up to $8.00 per month) and a minimum allowance of $3.00, then two-thirds of the balance will be used to pay board and room up to $21.00 per week, and one-third for clothing and incidentals, up to $7.00 per week. The resident assumes more responsibility as his earnings increase.

A third type of financing is the flat rate. For example, residents at Portals pay $16.00 per week, which is one-quarter of the agency's operating budget; Rutland Corner House charges $15.00 per week, about half of the total cost of maintaining the house.

It should be noted that those "halfway houses" which charge fees are, for the most part, "private", non-profit "halfway houses". The Vermont Rehabilitation Houses are an exception. In the Texas Program, the nursing home operators are paid from state public assistance funds. Agencies derive varying amounts of their operating budgets from residents' fees. For example, in 1958, Gateways had a total budget of $99,964.00: $62,000.00 from fees, and $37,000.00 from
contributions. Portals and Rutland Corner House also derive a substantial part of their budget from residents' fees. The respondent from Meadowlark Homestead was unclear. "Someone is responsible for it (payment), but rates are often low."

Respondents were asked if, when residents come from hospitals, the length of hospitalization was a determining factor; i.e., are short-term or long-term patients preferred. An arbitrary division of two years was used to indicate a dividing line between short- and long-term patients. Two programs, the Texas Program and Vermont, indicated that they were dealing exclusively with long-term patients. Five respondents replied that length of hospitalization was not important, but that they preferred short-term patients. Five replied to only one part of the question, stating that no consideration of length of hospitalization was made. The respondent for The Venture and The Vista stated that long-term, "hard to rehabilitate" patients are not sent to the "halfway house", but placed in boarding homes. Woodley House, through its high fees, may preclude the long-term patient who has no private capital, or who lacks a family who would provide the funds.

Length of hospitalization has been considered to be an impediment to rehabilitation. For this reason, some "halfway houses" may not accept such clients because of anticipated difficulties. Up-to-date information is not available on Rutland Corner House, but in 1960, Landy wrote that

To a significant degree, residents who had been hospitalized longer than the group median of 9.5 months had more frequently an adequate house adjustment than those with shorter hospitalizations. While contrary to what might be expected, it is probable that patients with longer institutional residence are more experienced in adapting to what may be called group or "dormitory" culture. However, length of hospitalization is not related to community outcome. Thus chronicity is not in itself a determinant of rehabilitative fate. Furthermore, it may be inferred that house residence tends to counteract the more noxious effects of chronicity. Incidentally, those with longer hospitalization records also spent more time in the house.1

One of the elements that might be considered as essential in measuring success of rehabilitation is obtaining and holding a job. Respondents were asked if acceptance of prospective residents depended on their ability to obtain or be trained for a job. Portals, Quarters for Men and Women, and the Vermont Houses select those who can obtain or be trained for jobs. The Texas Program, the Brockton Foster Home Cottage and Meadowlark Homestead do not use these criteria in making selections. Spring Lake Ranch tends to choose individuals who are capable of finding work when they leave. It seems logical to assume that those who can obtain or be trained for jobs might be better "rehabilitative risks". On the other hand, one might question why the "halfway house", ostensibly dealing with problems of social functioning, would utilize such criteria. One might also argue that if the "halfway house" is located close to the employment market, it will be easier for more retiring persons to look for and obtain work.

Respondents were asked if it is desired that residents have specific work skills, such as secretarial training or a trade. Eight replied "no" without reservation. Five replied "yes", but qualified their answers, saying it would be preferred, not required. The reasons varied. Gateways has a sixty day time limit; thus the question is redundant. The Quarters for both men and women require that "residents must be physically and mentally able to go to work regardless if he has a trade". Vermont comments that "naturally these people are easier to place. However, the number of trained chronic patients is not high, so we do not require work skills."

The majority of articles on "halfway houses" state that they arose when, as a result of drug therapy, patients had no place to go or families who didn't want them. Speaking of Rutland Corner House, Landy states that

Patients who have been referred fall into two main groupings: those with no families; those with pathological family relationships to which the patient is unable to adapt. In either case, the patient is not
psychologically prepared for independent residence and living .... For
many (patients) the halfway house seemed to provide a needed transitional
period in an environment where independence and maturity were valued and
couraged.¹

Peffer and Glynn write that

Two groups of mental patients still challenge the best efforts of the hospi­
tal team to return them to the community — and keep them there. These are
the patients hospitalized for many years, who are well enough to return to
the community, yet who have no homes or relatives to return to, or have
relatives who are unwilling to accept them.²

Upon setting up a foster home cottage to approximate the community home, ("Since
the home is the basic unit of society, it is within this framework that man is
happiest."), the authors found that

Soon after the foster home program was inaugurated here, our social workers
found that their techniques in motivating patients to try a foster home
were severely handicapped by the hospital setting. The patients were con­
vinced they were sick; in spite of their day by day performance, they were
certain they required hospital care. Other patients would advise them, "You
don't want to leave here; this is a wonderful place; you've got it made!"
Relatives too, emphasized that the patient should not leave the hospital
where there was so much for him; after all, he had been hospitalized for
ten, fifteen, twenty years. What could he do on the outside? Who would
want him? Who had room for him?³

Respondents were asked if "dependency" in prospective residents was a
requirement for selection. Dependency was not defined per se, nor was it defined
in terms of dependency on something. It was anticipated that the response would
be "yes". Eight "halfway houses" replied that dependency, as they understood it,
was not a criterion. The Brockton Foster Home Cottage, Rutland Corner House, and
the Texas Program state that it is a factor in selection. The Vermont Rehabilita­
tion House respondents were in conflict. One replied, "Yes, as it expresses the

¹ Landy, op. cit., p. 31.
² Peffer and Glynn, Mental Hospitals, p. 14.
³ Loc. cit.
need for service," while the other said, "I don't understand what you mean - we have no formal position on this phenomenon. Most long-term patients of course have some kind of dependency needs." The Venture and The Vista accept only short-term patients who are employable. Clients of The Venture and The Vista are not considered to have spent enough time in hospital to become dependent on it. Some hospitals, like the British Columbia Provincial Mental Hospital, may utilize other resources; for example, boarding out homes, for "dependent" patients.

Opinion is split as to whether residents who have family resources will be accepted as clients. Gateways, Spring Lake Ranch, Woodley House, Brockton Foster Home Cottage, and Meadowlark all state definitely that selection is not based upon a lack of family resources. Other respondents consider that this matter depends on the individual case. This is a definite criterion at both The Venture and The Vista. It appears that lack of family resources, or undesirability of return to the family is a determining factor in selection of residents, but further study of selected residents would provide a more conclusive answer.

All respondents expect residents that will have only partial remission from symptoms of mental illness. There are certain qualifications. Gateways state that there must be remission "sufficient to allow the resident to utilize the open setting." In the case of The Venture, where residents go for meals to a nearby restaurant, residents should be free enough from illness to eat in open society in an acceptable manner. This is significant in that clarification of the question of the "well enough to leave hospital, but no place to go" formula needs exploration. How well is well?

Having considered some of the elements that are operative in selecting clients for this new type of welfare institution, one might do well to ask, Why are they there? What is to be done? Does the agency deal with problems peculiar
to the long-term mental hospital patient in social and psychological terms? The Brockton Foster Home Cottage states that house use is indicated for patients who "are so dependent upon the hospital that they refuse to leave or their relatives refuse to participate in their return to the community." Does only the long-term patient face this problem? This question is beyond the scope of the study, and is a problem for further research. However, it is possible to say that dependency upon hospital then, is one rationale for house use.

Others see the house as a facility for socialization so that lost social skills, or skills that have never been acquired may be mastered. This might include such seemingly simple matters as learning to use telephones and recognizing traffic signals, or becoming "familiar" with the community and finding work, as well as learning to use money. Many agencies see as one primary purpose the learning of "appropriate" social behaviour through peer group and resident-staff, resident-community relationships. At least one use for the house, according to the respondent from Meadowlark Homestead, is for those people who "find this or a similar home the only place where they can operate without undue frustration or confusion." This is, in one sense, certainly a retreat from the world.

The "halfway house" has been examined in terms of its structure - how and why its residents are selected, the organization and operation, and the facilities provided. One can say that the "halfway house", in terms of structure, is a formal organization, although less formal than a larger institution. It attempts to accomplish a number of tasks, some complex such as the program at the Vermont Rehabilitation Houses; or more simple ones, such as providing an easier way of getting in contact with the job market as at The Venture and The Vista.

However simple the stated goals are, it must be remembered that all houses cater to individuals who, to some degree, suffer from mental illness. The
discussion which follows in Chapter III will be focused upon the meshing of the elements described and discussed above. What happens and how? - i.e., the dynamics of the "halfway house".
CHAPTER III
THE "HALFWAY HOUSE - ITS DYNAMICS

Having considered the structural elements that contribute to the shaping of the "halfway house" as a new and unique welfare institution, it is possible to examine at length some of the elements that contribute to its therapeutic purpose. Into a physical structure, organized on a formal and accountable financial basis, have been placed a group of persons suffering or recovering from mental illness. They are there to meet the community "halfway", and, to assist them, personnel of both professional and non-professional status have been provided. What happens when this mixture of substances meets? What is the catalyst that will set off the reaction, that will facilitate a successful rehabilitative outcome? Perhaps the answer is to be found in the concept of the therapeutic "atmosphere" or "community".

Landy has stated that

In the therapeutically oriented modern psychiatric hospital, the cultural objective of rehabilitation is to build bridges of support across stages in the "long road home", in which potential discontinuities may hinder the patients' efforts at psychological reconstitution and social acceptance. These stages and possible dislocations occur when the patient (1) leaves his community of orientation for the hospital; (2) moves from the acute or disturbed admission ward to the convalescent ward; (3) moves, in an increasing number of institutions, into an agency which serves as a transitional buffer for the often traumatic change from hospital to community culture (day hospital, "halfway house", foster home, etc.); (4) moves from the hospital or transitional residence into his former or a different community and residence.1

The "halfway house" may differ in many respects from the therapeutic

---

community described by Jones. But the main difference is that it is not meant to "treat" psychiatric disorders. However, there have been claims made that the house may function as a type of therapeutic community which is meant to "treat" or remove the social and psychological barriers that prevent the individual from participating fully in community life.

It is possible to become involved in a semantic argument over the meaning of the term "therapeutic". In order to avoid such an involvement, it will be assumed that each agency has some implicit or explicit therapeutic purpose. These purposes may be articulated by the use of expressions such as "bridging the gap between hospital and community" or, on the other hand, by definitive statements that present the intention of the house program as being one of providing a place for the expatient to live until he has found another home and/or a job. Another, more intangible, therapeutic purpose is the use of the house as an aid in removing psychological dependence on the hospital, or as a vehicle whereby the patient can relearn the ways of living as "normal" community members do; that is, as a sort of "decompression chamber" for overcoming the effects of having been submerged in institutional living.

In discussing what "goes on", the approach will be primarily descriptive, with four main elements being considered: (1) the functions of staff, in particular those of (a) psychiatrists, (b) social workers, (c) houseparents, (d) others; (2) the resident's progression - what is life like in the house? (3) the special services provided to the resident; (4) discharge.

Staff Functions

(a) The "Houseparent": In his survey, Wechsler states that

Each halfway house has at least one staff member in attendance. This person may be the "house director", "housemother", or "housekeeper". As the titles may imply, the person is not always a professional in the field of mental health. In addition to this staff member, halfway houses usually have at their disposal the services of personnel from hospitals or agencies with which they are associated. Social workers, psychologists, and psychiatrists may serve as house consultants. However, halfway houses are not treatment centered, and such professionals usually perform their service outside the house setting.

As has been pointed out above, the complement of personnel may vary from few to many. The educational background of "houseparents" is, as a rule, no more than high school, with mental hospital work experience. These persons are hired because they have a warm personality and are "able to get along with others".

Landy, in describing Rutland Corner House, notes that the director is also the "housemother" as well as acting as executive director to the board, etc. In her role as director, Landy states that

The director's role is a crucial variable in the functioning of the house. She is perceived by the women in many different ways, principally in the following roles: (1) family surrogate figure, (2) counselor, (3) confidante, (4) caretaker, (5) supervisor, (6) cultural teacher of expected ways of doing things.2

In many respects, the role of houseparent is limited, and in some cases it is vague and undefinable. The houseparent is, in terms of formal responsibilities and duties, the low man on the status totem pole. Also, it would seem that, in contrast to the implication of a peripheral role of other professionals in Wechsler's statement above, to the effect that "in addition to this staff


member, (the houseparent), halfway houses usually have at their disposal the services of personnel from hospitals or agencies ..., the houseparent is at the disposal of the professional. Only where the houseparent carries executive functions will he play central and significant roles. Although the houseparent may perform the functions assumed by Landy, he will do so only in an ad hoc manner, based on common sense and intuition and the fact that the houseparent spends a good deal of time with residents. This is not to belittle their contribution. While the evidence is not conclusive, it would seem that only at agencies where there is not a professional person on staff does the untrained houseparent carry major executive and clinical responsibilities.

Except for Gateways, which for purposes of this section is aptly described by Leveen and Priver as a "... combined hospital and mental health centre and is the halfway house to which come selected patients in the Los Angeles area,"¹ all houses provide for some form of living in arrangements for the houseparents. On closer examination, it is discovered that even the houseparents in the great majority of houses do not live in "permanently". A shift work arrangement is usually in operation, as at The Venture, The Vista, Woodley House, etc. Brockton Foster Home Cottage provides rooms for two housefathers who live in, but they are former hospital patients themselves who are members of the hospital member-employee program (see page 10, Chapter I), and are on the verge of leaving the hospital. At the Vermont Rehabilitation Houses, there is a suite for a married couple who live in and make the "halfway house" their home. Portals has a "housefather" who lives in, but he is more properly described by the respondent

as "a caretaker, an elderly untrained maintenance man hired for his pleasant personality and ability to get along with the residents." In the rural houses, all staff live in. At Rutland Corner House, a social work student "lives in" but is not the houseparent.

By virtue of the fact that the "houseparent" is the individual having most contact with residents, it will be not unexpected to find that important and significant interactions and relationships will be built up, as evidenced by the following:

During the first two weeks the house was supervised by Jackson, an attendant with many years of hospital experience. During this time things ran more smoothly than afterwards, but the lodgers felt that by using an attendant - whom they all had known as patients - the hospital was laying a heavy hand upon the house. This is illustrated in the following comment:

"He threw a scare into me because plainly the situation wasn't solidified yet and I thought that if Jackson set the pattern of reporting each incident that came up to various doctors and to the male supervisor and focusing attention of the hospital staff ... it would defeat the idea of the patients who were interested in seeing it formed. We were resentful about the supervisory, directive idea he had about the job - not to condemn him, because that's probably how these jobs should be carried out." ¹

Landy goes on to state that

There were other reasons why the men resented Jackson's presence. They felt his approach was too mothering on the one hand, too impersonal on the other. In independent later observations of the attendant on the ward, it seemed to the writer that his approach in fact consisted in doing many things for the patients, but very little with them. He seemed to put up an invisible curtain whenever interest in intimate problems of the patients seemed to be in order. As caretaker, Jackson performed his duties efficiently, and would be considered a "good" psychiatric aide.²

In general, the pattern of doing "for" rather than "with" may be seen as the main functions of most houseparents - cooking, cleaning, to a lesser degree parcelling out of duties, and, in some rare cases such as at Spring Lake and the

² Loc. cit.
Vermont Rehabilitation Houses, involvement in recreation. Only at Spring Lake and at Vermont are houseparents involved in control of finances from a planning point of view. Instead, houseparents are usually allotted a budget, which is determined by the state department responsible for the agency. If there is a split of executive and houseparent functions in private agencies, the former plans and controls the budget in conjunction with the board.

Most respondents were vague in their responses as to what the specific duties of houseparents were. They made statements such as "overall supervision of everyday living" or "frankly, it's like being parents in a regular home except that much of the housecleaning is given to clients, and sometimes some of the cooking." The respondent from Brockton Foster Home Cottage was more specific when he replied that houseparent duties include "helping patients socialize, helping with table manners, and helping them to obtain the outside look." Perhaps the very informality and diffuseness of houseparent duties and functions are the essence of their worth. For instance, only at The Vermont Rehabilitation Houses and The Vista do houseparents hold "formal" discussions with residents. The essential form of interaction is informal and interaction arises out of daily situations. In one sense, lack of authority and participation in selection adds to this element of informality. The houseparent in most settings accepts whoever comes along. (This is not the case where executive and houseparent functions are combined such as at Woodley House or at Rutland Corner House).

The houseparent does have a certain degree of responsibility for keeping order but he may report infractions of rules to a social worker or psychiatrist. Nevertheless, keeping order, setting limits within house rules and informal discussions with residents will be a major contribution towards the socialization and rehabilitation of the client.
(b) The Social Worker: Where a social worker is involved in house activity, his role is usually explicitly stated, as can be anticipated in a professional activity that is considered to be "purposeful". These activities are considered by the social worker at the Brockton Foster Home Cottage to be carried out on the basis of...

sound casework principles. The patients have the feeling throughout that movement takes place only as they are prepared to accept it. They feel that they have the major say in what happens to them. Each is free to accept or reject the prospective foster homes he visits ....

As has been pointed out above, in Chapter II, not all agencies have social workers involved, but the majority do. Where there are social workers, their functions include informal consultation about the residents with houseparents. They may also help residents find homes and jobs. Other tasks may be group discussion and/or individual interviews, the writing of reports, referral of residents to community agencies, and conferences with doctors. If residents have families, social workers may provide casework services on a family basis. Finally, social workers may organize and/or participate in social activities. Where the social worker and "houseparent" are one and the same person, as at Rutland Corner House, the interaction may be less formal and structured and the social worker will perhaps assume, to a greater degree, the roles mentioned above, of family surrogate figure, counsellor, etc. The director, a social group worker and the social work student in residence at Rutland Corner House all follow this pattern. A discussion of the subtle psychological interactions of each social worker at various houses is beyond the scope of this study.

---

It appears that at the rural houses, Spring Lake and Meadowlark, the respondents see no differentiation between the functions of social worker and houseparent. At Meadowlark Homestead, the "social worker-houseparent"'s main job is the planning of social and recreational activities and participation in such events. Spring Lake Ranch has no professionals, but the staff do "everything" as it were. Some of the "ranchers", as houseparents are called, have university education in such fields as drama and education, others have varied backgrounds, as noted in Chapter II. The emphasis at both Spring Lake and Meadowlark is on activity, into which all residents and staff enter, in a spirit of togetherness, and the interaction arises out of daily and intimate contact. Except for brief trips to the nearby community, all activity occurs within the boundaries of these agencies. At Woodley House, in an urban setting, one person is the director and housemother, but she often calls on interested persons in the community such as an accountant and a social worker for consultation. The role of the director, by her own preference, is diffuse and informal. She replied that "Sure enough, without administration problems emerge with undreamed of clarity. It is so much easier to deal with these problems in Woodley House than in an institution. It's me alone, with no staff meetings to befog the issue. I don't have to check with other people. I do what the maid does, I do what the nurse does, I do what the administrator does, and I only have to confer with myself. It may be hard work, but I don't have to cooperate. It is a very efficient and therefore thrifty system."

In such instances as these, contact with residents is constant and flexible. One does not find the formal institutional arrangements that structure interaction, rather it takes place on a much less formal level.

There is a group of houses, including Gateways, Portals, the Brockton
Foster Home Cottage, The Venture and The Vista, where the activity of social workers is carried out on a regularized structured basis. The social worker carries out professional responsibilities such as facilitating intra- and inter-agency communication about the resident, and on the other hand, interviewing the resident either once or twice a week, or as needed (i.e., when there is a problem to be solved). The Quarters male and female houses are directed by a clinical psychologist, who considers that he does all the professional duties of the social worker; i.e., counselling, referral, writing reports, etc.

The Texas Program is supervised by the social service department in a state hospital, and there is no provision for interviews with residents of boarding homes. This is the responsibility of the housemother or nursing home operator. They (social workers) function as communicants between the hospital doctors, housemothers, or nursing home operators and community. They do not help residents find other homes, except on rare occasions.

Another type of social worker involvement is where the professional responsibility is divided. This happens at "halfway houses" that are closely connected with state mental institutions. Here, probably because of the complexity of the institutional framework, there may be "two sets" of social workers.

For instance, for The Venture and The Vista, there is a social worker who is in charge of coordination of programming. Her duties are to discuss patients with houseparents (informal), referral to community agencies, formal one hour per week interviews with residents, consultation with the administrative director of the houses, and the writing and reviewing of reports pertaining to acceptance into the house and discharge. A second social worker is involved with a group work focus. Her emphasis is on recreation and group discussion. A third social work involvement stems from the resident's "personal" social worker - the
worker assigned when the resident first entered hospital. This worker may initiate referral to the house, carry on the casework relationship, and in addition follow the resident into the community. There may be and often is an overlap in the function of social workers based in the hospital and the social worker based in the houses, although an attempt is made to separate the two.

At the Vermont Rehabilitation Houses, responsibilities and duties are divided between two governmental departments; i.e., the state mental hospital and the Department of Education, through its division of Vocational Rehabilitation. In this instance, hospital workers are involved in a rehabilitation program, and use the houses as a resource. Their duties are referral to and consultation with the Vocational Rehabilitation Division personnel. The Vocational Rehabilitation counsellor accepts referrals and acts as a professional in that he is problem- and purpose-oriented towards helping the resident further the rehabilitation process, although he is untrained by social work standards. Although the Vocational Rehabilitation counsellor has an office in the house, he is not considered a part of the house staff. Rather, he acts as consultant to houseparents and as a liaison between the agency and hospital doctors and social workers who are interested in the progress of the former patient.

Another function of social workers, discussed at length in Chapter II, could be described as that of executive, pointing up the administrative, as well as clinical orientations that social work has in house operations.

It was of some interest to discover that, although many authors have considered house use as indicated where lack of family resources or pathological relationships between resident and family exist, making return to family unfeasible, the workers or their equals at Gateways, Spring Lake, the Brockton Foster Home Cottage, the Texas Program, and the Vermont Rehabilitation Houses, devote at least part of their time to work with families. But whether this is to
facilitate family reunion or further separation is not known.

(c) The Psychiatrist: The main functions of the psychiatrist are as consultant to the agency on clinical matters, and as a source of referral or prospective residents. Gateways, Spring Lake Ranch, and Woodley House draw heavily on private medical or psychiatric practitioners for their clientele. Further, psychiatrists are occasionally involved in direct therapy at some houses. In addition, the final authorization of discharge in many instances rests in the hands of the psychiatrist. This aspect will be elaborated upon below in the discussion of discharge. Executive function as such is rarely in the hands of a psychiatrist although they often serve on the board of directors in the private agency type of "halfway house". In some cases, medical personnel in state hospitals may have final authority. However, only at The Venture and The Vista, where executive responsibility was recently assigned to a psychiatrist who is the administrator for hospital after-care services, is a psychiatrist directly responsible. At the Brockton Foster Home Cottage and the Texas Program the social worker has executive responsibility, and for the Vermont Rehabilitation Houses, the Vocational Rehabilitation Division, under laymen, is the final authority in house operations.

(d) Other Personnel: There are other semi-professional and non-professional persons involved in house operations. These include staff such as janitors, cleaning women, cooks, etc. Since their function is clear and they are a minor part of house staff, a separate discussion of their functions is redundant. Others such as nurses, occupational and recreational therapists, etc. are found only at Gateways, and will be considered under the discussion of special services. Volunteers are involved too, and they will be discussed under the heading of special services.
The Residents' "Progression"

Before considering what is provided to the resident in the way of services, it seems best to outline some of the elements that provide boundaries to daily life in the "halfway house".

The first concrete boundary is the length of stay permitted each resident. Most respondents indicate a flexible maximum time limit, somewhere between two to six months. Gateways, on the other hand, has a definite time limit of sixty days. In most agencies, there have been some residents who have remained for two years. Some agencies, for example, Spring Lake, Woodley House, and the Vermont Rehabilitation Houses do not have a maximum limit set down in policy. The Vermont respondent replied that "There is no fixed maximum; a few days to eighteen months. Beyond eight months, we closely examine why the resident is still at the house." In keeping with this tradition, the great majority of respondents indicated that policies were liberal and flexible in cases where the resident exceeds time limits. They were asked what happens to the resident who exceeds the time limit; i.e., if he returns to the hospital, stays on, or is otherwise removed. Many replied that the resident was unconditionally allowed to remain. Others, including Gateways, The Vista, and The Venture, felt that such a question could only be answered on an individual basis. At Gateways this is decided on "the recommendation of social service and/or the medical staff."

The Vermont Rehabilitation House is the only agency which indicated that a resident could be and occasionally was returned to hospital. They point out that this is presented as a positive therapeutic move to the resident rather than as indicative of a punishing, rejecting, negative attitude. It is possible that, at other houses, residents may occasionally return to a hospital, but the extent to which this occurs is not known.
The two rural houses, Meadowlark and Spring Lake Ranch, considered by Wechsler to be end of the road points, both indicate that there is a time limit, and that the resident is expected to move on, although they have no policy if this limit is overstepped.

As can be anticipated, all houses have some form of rules (see Appendix "C") for living. The respondent from Woodley house indicated that an attempt is made to avoid the use of rules. However, occasions arise when "prospective residents often ask about rules. I tell them that we don't have any written rules, because there isn't enough paper in the world to write them on. Ours are all the rules of society. When in doubt, check with me, because I think I know what they are ...."

In general, there are rules or regulations governing the use of alcohol, which is forbidden, although at Portals, Woodley House and Spring Lake, residents may drink when in the local community. There are also regulations governing hours; most houses expect residents to be home between ten and eleven-thirty in the evening. The Vermont Rehabilitation Houses do not have a curfew, but state that residents are "counselled" if odd hours are kept.

The third general rule has to do with meals. They are usually planned according to a schedule (see Appendix "D") except at Venture, where no cooking is done.

There are various regulations unique to individual houses. For example, Spring Lake Ranch, a coeducational house, has a standing rule that states, "one boy or man not alone with one girl or woman in an empty building." At the Brockton Foster Home Cottage, residents are to obtain a pass from the

---

social worker before leaving hospital grounds.

Except for the rural houses, where trips are arranged regularly to the local communities, Quarters male and female, and the Texas Program, the remaining houses allow residents freedom to come and go as they please during the day and evening.

Residents may bring friends into the house during the day or evening but only at Woodley House, Spring Lake Ranch, and Meadowlark are overnight guests allowed. The Vermont Rehabilitation Houses have guest beds but they are not for friends of residents, but rather "former residents are encouraged to use the rehabilitation house as a home base for a visit, a Sunday or evening meal, or as a temporary residence in an emergency. The rooms are also used by potential residents from the hospital."

All houses expect residents to participate in housekeeping duties; i.e., keeping rooms tidy, dish washing, gardening, etc. At Spring Lake Ranch, the "guests" or residents are expected to engage in a "work program of forestry, farming, and building maintenance."

Medications if necessary are obtained and taken in a variety of ways. Some residents are responsible for this themselves; other agencies, such as Spring Lake Ranch, Meadowlark, the Texas Program, and Gateways have this activity supervised by the houseparent, or, at Gateways, by a nurse.

The resident, it will be seen from the above discussion, is bound by rules. In the urban houses, he is expected to get up for breakfast, partake in housekeeping activities, be at other meals, and to be "at home" at a specified time. He may look for a job or a home, go visiting, read books, or chat with friends during the day. At the rural houses, Spring Lake Ranch and Meadowlark, much of his daily activity is spent in the round of chores, activities, and duties
that fill the day.

**Special Services**

In addition to this, the resident has a variety of special services provided to him which may impinge upon his life at regular intervals. Aside from any other consideration, such as formal methods of financing, administration, staffing, etc., the very fact that "special services" are provided, or that personnel engage in activities for and with the resident that resemble those of larger institutions, leads one to conclude that the "halfway house" is not simply "half of a house".

This is perhaps typified by the fact that "formal" records of one sort or another are kept at all houses with the exception of the Vista. These records may be complex compilations from many disciplines, such as at Gateways, or the records made by social work personnel only. They may also be notes kept by houseparents, for example, a simple record of who came, when they came, and when they left, as at The Venture. Alternatively, notes might be taken on interaction, personality factors, etc., as at Gateways. While it is not known whether the practice is widespread among houses, part of the record at The Vista consists of a condensation of the medical and social history forwarded from the hospital on each resident, telling the houseparent in simple language the peculiar psychiatric and social problems the resident possesses. Information is usually placed on file, as the resident leaves the house. A social worker may record and forward information based on data gathered at the house, when referring the resident to an agency.

Another form of "special service" is the provision of "therapies". It is not likely, in this age of tranquillizers, that a transitional facility will lack clients who take medications either as a "chemotherapy" or for
sustaining purposes. Many agencies, in fact, the majority, provide what they term "psychotherapy" and "group therapy". Gateways, going one step further, has, in addition to psychotherapy, group therapy, and medications, "casework, E. C. T., and a sheltered workshop." The Vista, Gateways, Spring Lake Ranch, Woodley House, the Brockton Foster Home Cottage, and the Quarters male and female houses, all have clients receiving psychotherapy. The therapist may come to the house, but more often, as in the case of Woodley House and others, the residents go to the therapist. The Meadowlark Homestead respondent replied that, "If the doctor thinks it is necessary, they may have psychotherapy at Prairie View Hospital, about two miles from here." Group therapy is also used widely, although it may be informal discussion, such as at Portals, where it is not considered to be group therapy but a "weekly discussion on the living situation." On the other hand, it may be formal group therapy or social group work carried out by a trained group worker, as at The Venture and The Vista. In any event, group therapy, whatever the form and nature of it, takes place at The Venture, The Vista, Gateways, Spring Lake Ranch, the Brockton Foster Home Cottage, the Quarters male and female, and at the Vermont Rehabilitation Houses. It is of interest, although perhaps only to social workers, to note that the respondent from the Brockton Foster Home Cottage indicated that both psychotherapy and group therapy were available, and provided by a "caseworker".

Another type of special service that is available to residents, although it seems less actively used, is educational facilities. Six houses indicate that residents have in the past or are presently engaged in course work. The numbers of persons taking courses is usually very small. At Spring Lake Ranch, there is private tutoring or college correspondence courses available, for which the residents pay extra fees. Woodley House residents may attend
university, paid for by the resident. The Brockton Foster Home Cottage is closely linked with a mental hospital, and there are courses "as offered by the educational therapist, but none have taken advantage of this." Occasionally residents at the Vermont Rehabilitation Houses and at the Quarters male and female houses may take courses financed and offered by the respective state Vocational Rehabilitation Division. The Vermont houses, which are a part of the state Vocational Rehabilitation Division, have residents taking such varied courses as "Business, university, brace making, and nurses aide". At all agencies, residents, if they are able, finance their own tuition. Perhaps a limiting factor to the extension of educational facilities is the fact that residents are not expected to stay for long periods of time, and the main emphasis is on gaining employment, using whatever skills the client already possesses.

The use of volunteers is another special service within the framework of planned rational "activities". Volunteers are also involved in terms of providing members on boards, and as financial supporters. This has been mentioned at length in Chapter II. With the exception of The Venture, The Vista, and Woodley House, all agencies utilize volunteers. Rutland Corner House has a board of directors composed of volunteers, but their involvement with residents is not known. Volunteers are used in the main to provide an opportunity for residents to meet, and interact with, interested community individuals. As a rule, the interaction with residents occurs around visits to the house, which may be "limited to regular attendance of the volunteer at monthly parties", in the case of Portals. Usually volunteers meet with residents daily or weekly. Other activities may be trips such as car rides in the country, trips to museums, picnics, etc. Volunteers at Spring Lake Ranch, the Quarters male and female houses, and at the Vermont Rehabilitation Houses on occasion take the residents into
their own homes to live, or for visits, and they occasionally provide permanent jobs. At the Vermont Rehabilitation Houses, the staff takes pride in the fact that "three legislators' wives gave instruction in crafts for several months, and church groups have been active at times."

Finally, as a group of individuals who are resident in an institution designed to meet a particular problem; i.e., that of rehabilitation, residents have available to them another set of special services. These are the welfare agencies of the community at large, who, in providing service, help bridge the remaining gap; that is, from the "halfway house" to full community living. The agencies utilized most frequently are employment and public assistance agencies. Others, such as the Y. M. C. A., ex-patients' social clubs (another transitional facility), sports facilities, are used less frequently by residents. Residents at the Brockton Foster Home Cottage do not receive service from community agencies because they move from the cottage to boarding or foster homes in the community, and then utilize community agencies, if necessary. The Woodley House respondent replied that "I hope all agencies are interested", but doesn't indicate if any are actively so.

Only The Venture, The Vista, and the Vermont Rehabilitation Houses utilize resources of the ex-patient social clubs, while the Texas Program calls on the assistance and programs of groups for the aging. Residents at Gateways are able to utilize the total network of social services of which Gateways is but a part.

Residents reach these facilities in one of two ways, through their own actions, or through the efforts of the director or social worker. The social worker at The Venture, The Vista, Gateways, Rutland Corner House, Meadowlark, Portals and the Texas Program, the psychologist at the two Quarters houses, and
the rehabilitation counsellors at Vermont have, as part of their formal functions, the referral of residents. At Spring Lake and Woodley House, the "houseparents" do the referring.

The preferred procedure with regard to making the referral is the telephone. Occasionally social histories, brief written notes, and case conferences might be utilized. The more formal methods are followed at The Venture, The Vista, Gateways, Spring Lake Ranch, Meadowlark, Rutland Corner House, the Quarters male and female houses, and by social workers involved in the Texas Program.

Discharge

Discharge from the house should logically indicate that the individual is exactly one-half rehabilitated, and perhaps could now be further served by a three-quarter house. This, however, is not what discharge from the house is meant to imply. Rather, it means that the resident has either received benefit from the facility, and is now able to live on his own, or alternatively, he has not received benefit, and is released in order to find further help. A discussion of discharge criteria would lead one into a close evaluation of the particular agency's success in meeting its stated goals. Do they meet their own standards in providing service? How do they know? etc. Such an evaluation is beyond the scope of the present study.

One can ask how the resident leaves, and look at some of the reasons why he leaves. In the majority of houses, many of the residents are patients on extended leave from public mental hospitals who have entered hospital on a voluntary or committal basis. Only Gateways, Spring Lake Ranch, and Woodley House have residents who are "private citizens", under no legal obligation to remain at the house. All residents who are of certified patient status on extended leave must have the permission of a legally qualified person before they can go. This
person is usually the hospital director or a psychiatrist acting on his behalf.

In more practical terms, the decision of the resident to leave the house is, as a rule, a composite decision of the staff persons involved in the house as well as the resident. It would seem that the staff personnel, such as the social worker, consulting psychiatrist, and houseparent, in that order of importance, must concur in the decision before the resident actually takes his life in his own hands. The respondent from Portals stated that, in all cases, the "discussion of discharge is not pertinent since residents are free to leave at any time." Every attempt is made to ensure that the client has the freedom to determine his own destiny.

No matter how the resident leaves, where he goes, or what he does to support himself, the emphasis at all agencies, except for the nursing homes in the Texas Program, is on leaving. The resident understands that the "halfway house" is a transitional facility and although he may remain for as long as two years, he must eventually go. Towards this end, there are discussions amongst residents, with the "houseparents", and with a professional such as a social worker or psychiatrist, if there is one available.

Similarly, part of the daily activity of the resident, houseparent, and/or professional is devoted towards discussing or finding prospective homes and jobs. In the main, the resident is usually responsible for, and motivated towards, carrying out these activities with support, guidance and encouragement from houseparents and/or professionals. Volunteers are rarely involved in home or job finding, as has been pointed out above, and since no house except the Brockton Foster Home Cottage has a regularized system of boarding or foster homes for the resident to go to, he must rely on newspapers, word of mouth, or community agencies for his future home and livelihood.
Attempts have been made to evaluate the success achieved by the ex-patient in rehabilitation, such as the Barrabee-Finesinger Social Adjustment Scale, which measures occupational, economic, family, and community adjustment. Landy, in his study of Rutland Corner House, designed a rehabilitative "profile" to assess the rehabilitative status of residents. The profile consisted of five dimensions, including occupational status, occupational stability, family and interpersonal relations, behaviour integration, and subjective happiness.

From a distance, it is difficult to assess the effect of interpersonal relations and peer group life that residents undergo. In other words, when does one know when a resident has received maximum benefit, and is ready to leave the agency? When he wants to, or when he has found a job and a place to live, as at The Venture, or when he has overcome the symptoms of institutional care and has socially and psychologically caught up with the rest of the world, as the program at the Vermont Rehabilitation Houses calls for?

All respondents were asked a series of subjective questions in order to ascertain what they thought determined readiness for discharge from the house. No house requires that residents have saved a minimum amount of money, although Quarters encourages the saving of fifty dollars before leaving. All houses, however, are interested that residents have some means of support, whether it comes from public funds, earnings from a job, or from the resident's family.

Many respondents preferred that residents be familiar with the physical nature of the community, i.e., streets, stores, etc. Exceptions are the two

---


rural agencies, Meadowlark and Spring Lake Ranch, The Venture and Gateways. Most respondents felt that residents should be capable of taking their medications. It is interesting to note that Gateways doesn't require residents to be able to take medications since an attempt is made to see that residents are "symptom free" before leaving. In regard to the last point, all respondents, with the exceptions of The Venture and Gateways feel, in general, that residents do not have to be "symptom free" in order to leave and establish themselves in the community.

On the other hand, many respondents would like the resident to have both self-confidence in his future, and be subjectively happy with the idea of moving into the community. The majority of respondents tend to look for signs of socially appropriate behaviour in terms of table manners, and dress habits, but none, with the exceptions of Spring Lake Ranch, Quarters and Meadowlark, felt that this included the ability to carry on social conversation. The one notable exception to all of this, and perhaps the most honest of the respondents, was the director of Woodley House who replied, "Who knows when a resident should leave?"

Most respondents qualified their replies, indicating that many of the points mentioned above are "preferred but not required". Others mentioned qualifying conditions such as ability to take responsibility for personal care or that the resident not be a danger to himself or others. It can be inferred that houses tend to think not in general terms, when considering the discharge of a resident, but of the particular individual. General considerations such as those mentioned above are taken into account, but are not applied as rigid criteria.
There are now at least fourteen agencies in North America which describe themselves as "halfway houses".¹ There are many differences among them, as well as important and significant similarities. Perhaps in time, as the nature of their clientele changes, and as the network of social services serving the mentally ill expands and becomes more specialized, the "halfway house" will undergo further transition. Thus, staff functions may be more specific and objectives in service may be clearer. Whatever the future, there is a growing recognition that facilities and agencies serving the mentally ill must begin to approximate community life. The "halfway house" has probably come to stay, and by studying its structure and dynamics, valuable insights can be gained into the way in which new services develop in contemporary society. The "halfway house" also serves as an example of how concepts such as the "therapeutic community" or social rehabilitation are translated into action.

The "Halfway House" as a Social Agency

It has been argued that the "halfway house" is a new type of social agency concerned with a social end; that is, the reintegration of a person who has been mentally ill into the mainstream of normal community life.

A formal method of organization has been called for in order to establish and maintain the agency. This formal organization and the elements of

¹ There may well be others which this survey did not discover.
accountability and responsibility permeate all aspects of the agency. In the places established as private agencies, one finds a board of directors, or its equivalent, has usually been appointed and some form of executive staff has been engaged. Centres which are the responsibility of public authority come under the direction of a particular department, and staff are civil servants. Funds must be obtained and spending is integrated with the needs and aims of the larger organization. It would seem then, that the unit is more than just a boarding home with its landlady collecting room and board and directing her establishment. The initiative of the private citizen has not been sufficient to establish and maintain the house as a private philanthropic activity. The complexity of the area of service and of daily operations has called for specialization of functions. The involvement of many lay and professional people becomes necessary.

Usually "halfway" units have originated from the mental hospital itself, and this is reflected in two broad areas, the makeup and the functions of the staff and the activities that occur in and around the house.

Because of the usually small number of clients, the facility does not boast a large complement of personnel. But, just as the mental hospital has a tradition of the "team", composed of psychiatrist, social worker, and nurse, so does the house have its "team", the psychiatrist, who plays a rather minimal but important role, the social worker, or his equivalent, bearing the major administrative or clinical responsibilities, and the houseparent, who is often analogous to the psychiatric nurse or attendant.

The role of houseparent (which has already been elaborated upon in Chapter III), is often, in the formal sense, simple: keeping order, cooking, doing or directing housekeeping. It may, on the other hand, involve the formal elements of executive responsibility, meeting house operating problems and
working with the board, as well as carrying out professional or clinical duties such as casework or counselling, referral to other agencies, screening of referrals, etc. This division of the houseparent role seems to be due to two factors; i.e., (a) the educational qualifications and (b) whether or not the houseparent is indeed master of the house. If the houseparent is a paid professional, or is the non-professional who spearheaded interest in developing the agency, his function is more technical and responsible.

While it can only be implied, it does not seem unreasonable to assume that the social and psychological interaction among the resident peer group, and between resident and houseparent, vitally affects the tenor of the house life, and is important in the outcome of the rehabilitative process. It seems that many "houseparents" are elderly persons and lack education above the high school level, in those units where there is a division between executive/clinician and houseparent roles. On the other hand, in facilities where the roles are combined into one, the "houseparent" has had some sort of professional training, whether it be in social work, psychology, or occupational therapy. In any case, through interaction with residents, the houseparent will often have a positive or negative therapeutic function.

It is possible to ask the questions, "Are all the units considered in this study 'halfway houses'?" and "If not, why?" All of them are social agencies, but beyond this, qualification must be made. The "halfway house" in historic terms was not conceived as a practical embodiment of the "social welfare" concept, but rather to bring to reality the concept of a facility which would act as a bridge between community and hospital. Seen in this framework, the development of those aspects making up a social agency seem accidental and the by-product of birth and growth. Probably they are inevitable. If a "halfway house" is understood to be a relatively small residential dwelling, located at some distance from
a large mental hospital, from which the majority of residents come, staffed by an elderly couple who are ideal and prototype mothers and fathers, then they are not all "halfway houses". Further, if the understanding is that residents come and spend only a brief time, while they get their bearings, and then move out into the community at large, receiving little or no assistance from anyone, but motivated by their own desire to get established, and able to do that, then even fewer are "halfway houses".

The facilities examined in this study were selected on the basis that they described themselves as "halfway houses". Certain ways of classifying them have been mentioned in Chapter I. It is possible to include as "halfway houses" only those that have an urban setting, are staffed by houseparents who carry out the main functions, and where little medical or other special services are provided. It is also possible to distinguish between urban and rural units where the major difference lies at first sight in the "end of the road" aspect, and the total involvement of the resident in the life at the rural house. However, since both rural and urban houses stress the transitional character of the client's stay, this distinction breaks down. As for the total involvement, this may be seen as an unfortunate carry-over from the mental hospital structure or as a less structured, and hence therapeutically beneficial decompression chamber, much as the urban house, the difference being that one is in the country and the other in the city. Another distinction made is that of the treatment type of unit, but, as has been shown in Chapter III, all houses claim to have some form of treatment, whether it is simply the giving of maintenance doses of tranquillizers or the beneficial and healing effects of living in the country, or group and psychotherapy.

The criteria that define the agency must, of necessity, be flexible.
The community and the mental hospital are often defined in reference to each other; the mental hospital is not the community, and visa versa, although upon closer examination, common elements may be observed in the structure and function of each. So with the "halfway house", existing somewhere along the continuum between hospital and community. The facility will take on the flavour of both hospital and community. One unit is now a sixty bed institution, with a medical staff and a program ranging from electric shock therapy to recreational therapy and organized trips to the museum by residents. Yet it is described by staff members as a "halfway house" and rapid treatment centre. The functions are two-fold: to actively treat mental illness and to assist in the rehabilitation of former mental hospital patients. This facility is perhaps a combination community mental hospital and "halfway house", the former growing out of the latter.

Another facility is a "halfway house" only by accident. What was, and mainly is, a system of boarding out or foster homes for the aged mental patient has turned, in some cases, into a stepping stone to the community. There is a further variation on the theme, what might be termed a "one-quarterway house". This is a facility located on hospital grounds from where residents move into a second facility, the boarding out or foster home, and thence into the community. But the essential feature of this resource, like all the others, remains the same, to provide a place of residence for the former mental hospital patient where he can acquire the confidence to make a further step into the community.

Perhaps certain significant criteria emerge which allow one to state more definitively what a "halfway house" is. A "halfway house" is a concept in the eye and heart of the resident and the "helping" personnel. Further, it is a residential setting with a relatively small number of clients who are expected to move out within a short period of time. The "halfway house" has a formal
structure and a complement of staff who provide a range of services, which may resemble those of the hospital, or may consist in the bringing of the resident to the community and its services. It must be recognized that the agency varies according to local needs as participants see them, and this probably accounts for the subtle variations between them.

The House as a Therapeutic Community

There is considerable variation among agencies as to what kinds of persons are eligible to become clients: the aged, veterans, long-term patients, persons with or without work skills, and, in some cases, men or women only. Despite the apparent differences, it is not unreasonable to conclude that the client has come to the agency because it meets a unique need. It is there to provide some form of therapeutic service. There are some questions that arise out of this statement. Does the house have a therapeutic purpose? Is the house a therapeutic community? What is the therapeutic community meant to treat or accomplish? It is not possible to provide exhaustive and explicit answers to all of these questions, but the beginnings of an answer do emerge.

Therapy traditionally means the treatment of a disease, or alternatively, that some object or activity has a therapeutic quality which is meant to enhance or facilitate treatment. It would be misleading to claim that the places considered above are designed to facilitate the carrying out of therapy in the sense of persons coming to receive a concrete treatment. Rather, they are more properly seen as having a therapeutic quality that will be in essence part of a larger therapeutic effort, that of the total process of moving from illness to wellness. Within this framework, one can identify a number of such therapies or therapeutic qualities: the provision of medications, casework, group work, psychotherapy, the
healing qualities of work on a farm, and the interaction of the resident peer
group, as well as interaction of resident with houseparents.

The concept of the therapeutic community means basically that all activ-
ity, all social interaction, and the physical surroundings, are treatment.
Special attempts are made to democratize staff relationships. Thus, all staff
and clients become involved in the therapeutic program, individual expression is
encouraged in both staff and clients. Artificial rules, punishments, and restric-
tions are avoided, as respect for individuality and improved communications
become dominant. Institutional life begins to approximate community life in a
positive sense. Most units include these elements to some degree. Residents and
staff participate in work and recreation. There are procedures for communicating
information among all levels of staff, and between residents and staff. It has
not been within the scope of this study to define the concept of the therapeutic
community or to ascertain accurately the degree to which the house is such an
agency. However, it can be said that they have specific qualities that appear to
be those of a therapeutic community, as outlined above.

Therapeutic Elements of the House

Aside from the provision of counselling or casework, psychotherapy, or
"recreational therapy", etc., that many hostels offer, it is possible to isolate
specific elements that support the claim that the "halfway house" is a type of
therapeutic community.

First of all, the very fact that the agency is transitional in nature
sets the tone which informs residents that they are on their way to full commu-
nity life. It is not like a hospital which bears evidence to the patient that he
could possibly spend a lifetime there. Should the resident return to hospital,
the house usually accepts him back, facilitating the progressive, forward looking attitude of the resident. In the British system of hostels (see Appendix "A"), there are residences where clients may spend a lifetime.

Secondly, a major difference between house and hospital lies in the fact that at many places, a resident is free to leave at any time. This is of major significance when one considers that the mental hospital is not an easy place to leave, since many patients are legally committed, or, if voluntary patients, may have their status changed if the psychiatrist sees fit. The statement of some respondents that there are no criteria for discharge since the residents may leave any time, points up the attempt to return self-determination to the resident.

A third way in which the agency may be considered to be a therapeutic community is due to the fact that it provides a framework for learning what is required in community living. There are many aspects. The small group of peers will provide an opportunity for working out mutual problems such as; Where are the jobs to be found? How does one approach the employer? etc. Residents may discuss various ways of spending leisure time, since they will shortly be free of a life where much of leisure time was organized for them. Even though there is a program of social activity at all houses, this is usually organized by residents and staff in a cooperative spirit and will be in keeping with group wishes. The resident is not expected to spend his evenings "at home".

In addition to the above, a further element of the therapeutic community enters in the form of resident-staff interaction. Houseparents, social workers, etc., are available to discuss with the resident his fears and hopes with regard to the future. Of no less importance, many residents may find the pressure of living in a more relaxed and natural community stressful, particularly as they take on responsibility for coming to meals, tidying rooms, getting along with
other residents, etc. The staff will play a significant part in assisting the resident to become accustomed to a pattern of life approximating that of the community. This is a vital element in this particular therapeutic community.

Finally, the very nature of the unit as part of the community brings the community to the resident. The client is no longer isolated in a hospital. Participation in social and recreational life, contact with other welfare agencies, the activity of volunteers, all stemming from or focused upon the house and its residents, provide the further bridge that is required if the resident is to finish his journey from hospital to community. This tends to make daily activity purposeful; the resident can see the end to which he is working.

Unsolved Problems

There remains to be considered those aspects of the agency that raise questions and pose problems. Within the general area of selection, eligibility, orientation, etc., it is difficult to generalize beyond the fact that residents at most houses are chosen primarily on the basis of their not being psychopaths, actors out, alcoholics, etc., and will not disturb the smooth running of the house. But many places seem geared to accepting a particular kind of client. For instance, one deals with what they consider to be patients who are "dependent" on the hospital and the purpose of the house is to help patients overcome this. Another accepts patients from hospital who are homeless, jobless, and who are able to function in a socially acceptable manner. Such clients require only a sort of "hostel" while they establish themselves. Another is geared to the problems of the chronic schizophrenic who has spent years in hospital and has all of life to relearn. At least one program deals only with the aged mental patient and they deal with a set of problems unique to the aging. Since all houses deal with persons who may have had symptoms of mental illness when they came, and even
upon leaving, it cannot be said that "mentally ill" persons do not come to the house, rather that they should not disturb it.

It was thought that houses would deal with symptoms of institutionalization (discussed in Chapter I). Since these are thought to develop only after prolonged hospitalization, it would appear that, because most places accept or prefer short-term patients, such an approach is not the case. Only the Vermont Rehabilitation Houses and the Brockton Foster Home Cottage seem to be geared to such problems or symptoms. Certainly further research could be carried out to determine (a) if such problems or symptoms do develop, and (b) if a "halfway house" can or does eliminate them. With regard to the latter point, in fairness one cannot ignore the fact that, for many hospitals, the "halfway house" is not the only transitional facility available. For example, residents at The Venture and The Vista are short-term patients who are, as has been pointed out, functioning at an acceptable level when they leave hospital. Other patients, who may have spent a longer time in hospital, and who require a long-term program of rehabilitation may go to a foster or boarding out home. For those ex-patients who require only a social contact, there is the ex-patient social club, sponsored by the Canadian Mental Health Association.¹

In summary, it would be difficult, except in the most general terms, to state what particular psychological problems residents have to overcome. This would require further careful study.

Many agencies find it financially necessary to charge fees. Others

charge fees, on a room and board basis, not because of agency financial need, but so the client will learn an added element of community living. (It can be argued that if the welfare service is essential, fees should not be charged). If a potential client might be prevented from a beneficial stay at the house because of inability to pay fees, ethical questions are raised. However, one can argue that room and board charges will face the resident upon leaving the hostel and he will have to develop saving habits, etc. Perhaps the most reasonable answer is the one worked out at the Vermont Rehabilitation Houses where residents pay for room and board after work has been obtained and as earnings and savings increase. Finally, the relatively high rates charged at Spring Lake Ranch and Woodley House may indeed motivate the client to move into the community quickly.

It would seem that, since many "houseparents" are chosen mainly because of "warm, human" personalities and often have no more than a background of psychiatric nursing, close cooperation with a professional such as a social worker would be essential. This would help ensure that in those cases where houseparents were former psychiatric nurses, any tendency towards routine for the sake of routine could be avoided. Further, since houseparents often have little formal education on human behaviour, etc., anxiety on the part of the houseparent could be alleviated. In any event, communication among all house personnel is essential if a therapeutic atmosphere is desired.

Just as there is some need for a rational approach to selection of residents, so is there a need to know when the resident has received benefit from a stay at the unit. The decision regarding discharge will be based upon a subtle blending of the state of psychological readiness of resident, as well as proper living arrangements in the community. For some hostels, the answer to when a person is ready is simple - a home and a job. Others require the loss or
transfer of dependency upon the mental hospital. At least one example desires freedom from symptoms of mental illness. Some would like to see the resident relearn all skills that the well person has which enable him to function in society at large. One can conclude by saying that the questions, who should be accepted and when they should be discharged, are not clearly thought out at many agencies.

To date, the "halfway house" is an established idea in the United States. Will more of these agencies be developed? It is not possible to answer without considering the nature of changing mental health services. The Canadian Mental Health Association (referred to in Chapter I) has an extensive network of social clubs across Canada. Many provinces are beginning to decentralize their mental health services (for instance, Saskatchewan) through community mental hospitals and travelling mental health clinics. Thus there will be less isolation of the mental patient. With new therapies, treatment will be speedy. The emphasis will be on keeping the patient in the community. As time goes on, there may be less need for a rehabilitation facility per se, as services become more coordinated and effective. At least one "house", Gateways, has grown from a small urban residence to a sixty bed institution. The boarding out program is also coming into extensive use, as well as psychiatric treatment in the home. Thus there may be a merging of "special" facilities as mental health resources become more extensive.

The Venture and The Vista provide a resource for the examination of pertinent questions that arise out of a comparative and descriptive enquiry. What is the type of client that is best suited to the "halfway house" when other transitional facilities are provided in the resource network? Can the house serve the psychopath, the alcoholic, or the drug addict? By eliminating these potential
clients, one may be denying them a valuable resource; and, even more significant, one may be adopting a defeatist attitude toward these social and physical illnesses. What is the quality of the relationship between staff and residents that leads to the best possible therapeutic community? What are the best rational criteria upon which to base judgments as to the readiness of residents for discharge? A follow-up study of clients discharged from the house would serve to clarify areas where the program might be strengthened and how the use of community resources might be better integrated. It would be particularly important to carry out a more detailed study of staff functions. This would serve not only as an aid to the house, but might be a guide to fostering the establishment of the therapeutic community in the mental hospital itself.

Contributions of Social Work In Rehabilitation

In this study, an attempt has been made to demonstrate that a word such as "rehabilitation" cannot be understood unless the concrete structure of the resource where rehabilitation occurs is described and understood. Further, the concepts and principles to which the services and goals of the agency are geared must be understood in the light of the varying functions of staff who give service to the client. In other words, an attempt has been made to give an operational definition to the word "rehabilitation".

The use of social work skills in rehabilitation is not a new phenomenon. Social workers are involved in both practice and research. But it has been stated before that the rehabilitation of the mentally ill is a recent endeavour and, as such, the nature of social work involvement is changing. The "halfway house" is a new resource to which social workers may refer clients, and it is an agency where a specialized social work function may be carried out.
There is strong evidence that social work ought to be involved in the "halfway house". This is significant if only because this agency is a unique resource which will enable the worker to practise in his area of competence, the social functioning of the client. It is of interest to note, however, that other professionals and laymen who are not social workers consider that they carry out social work functions; i.e., counselling, referral, administration, programming, etc. It was not within the scope of the study to evaluate effectiveness of these persons so that it is not possible to state who does the better job - the social worker, the psychologist, the occupational therapist, or interested layman. Nevertheless, the "halfway house" is a legitimate area of research and practice for social workers. Furthermore, as has already been demonstrated at one "halfway house", this agency can serve as a training centre for social work students. Perhaps The Venture and The Vista could be used in a like manner. In the same spirit, workers, with a special competence in social relationships, might be utilized as teachers or educators for houseparents in those agencies where the houseparent is not a professional.

In conclusion, the "halfway house" as a new social agency is, in itself, in a stage of transition. There are many questions still to be answered. Since this kind of resource is now an established entity, the questions are not related to how to get started, but rather, to determining how to do a better job.
APPENDIX "A"

Halfway Houses in Britain - A Brief Description of the Mental After Care Association of England System

The Mental After Care Association (hereafter referred to as the Association) was founded in 1879. At that time Reverend Hawkins, chaplain to what is now Friern Hospital in London, became convinced that the reason for the high rate of return of patients discharged as recovered was due to their having to face the shocks of returning to an unsympathetic community. In addition, many were without financial resources, friends, or families. When the Association was one year old, the Earl of Shaftesbury became its president. The Association was the first organized psychiatric social service in Great Britain.

Today the Association is a private, non-profit agency depending entirely upon private contributions for funds. The agency is not bound in any way to keep rules or regulations that might be imposed from outside regarding admission of clients. The one minor exception is local authority regulations regarding the number of clients and the amount of housing space they require.

The Hostels, as the homes are referred to, are of two main types. Those of the first group are known as the Long Term (permanent) Homes for the Chronic and Aged. Those of the second are referred to as Short Term Rehabilitation Homes. The Hostels are located throughout England, and are not attached to a particular mental hospital. There is no policy requiring that persons living in a particular area must go to the hostel in the area. However, it is understood apparently without question that an unsuitable client is taken back to the hospital or clinic from which he came.

The main criterion for admission is a psychiatric recommendation to the effect that (a) a hospital patient is "safe to live" under mild supervision,
APPENDIX "A" (cont'd)

(b) that he is likely to benefit from a stay in one of the hostels. In addition, the Association must decide that a suitable vacancy is available. Epileptics, drug addicts, and acute alcoholics are not admitted under any circumstances.

The hostels accept both men and women between the ages of twenty and fifty. The number of residents accommodated varies between twenty and forty, depending upon the size of the hostel.

Clients are usually accepted on a four week basis, which may be extended if the need arises. No active psychiatric treatment is given and if a prospective resident shows indications of needing such treatment, he is not admitted. There are few "rules". The clients spend their days helping in the house, working at jobs in the community, enjoying community social activities, shopping, visiting friends, etc. At the hostel, games, television, and radio are provided. At those places where there is a garden, residents are encouraged to be interested in it, and games such as croquet and clock golf are provided.

The hostels are in charge of a warden and his assistant. Both are trained nurses, qualified and experienced in work with the mentally ill. In addition, there is a housemother, cook, and the part time services of the Association social worker.

The residents are visited frequently and regularly by the social worker from the head office of the Association. Progress notes are made monthly or quarterly on each resident. These are sent to the authority through whom the resident was admitted. In addition, the social worker consults with the warden and other staff on problems regarding the daily operations of the hostel. The Association, through the social worker, maintains close contact with all other social service organizations, voluntary or state supported. In particular, it
cooperates fully with local authorities, labour exchanges, and the appropriate
government departments and officials in obtaining suitable employment for
discharged clients.

With regard to discharge, the resident can never be prevented from
leaving, and therefore the wish to go determines readiness. Apparently residents
are encouraged to leave when social improvement seems adequate for independent
life, even though the resident himself may not feel confident about his "readi­
ness" for independence. Such a step is discouraged in cases when it is considered
to be premature. Residents need never leave the care of the Association since
the Long Term Hostels are always available.
APPENDIX "B"

Questionnaire Used For The Study

The "Halfway House": (Transitional Facilities for the Rehabilitation of the Mentally Ill)

I am doing a study of "Halfway Houses" (as defined above) in Canada and the United States, attempting to analyze their nature and contributions in rehabilitation. For convenience, this large subject has been divided under the headings of: Sponsorship, Eligibility, Facilities, Staff, Services, Discharge. Can you give me the relevant information for your program or agency? If I have missed any pertinent points, or you would like to make more extended comments, please feel free to write on the back of the questionnaire.

We hope you will agree this is an important subject which demands a definitive survey. If you would like to have a summary of the results when it is completed, please let us know. Thank you for your cooperation in making this survey possible.

Leonard Ghan (Master of Social Work student)
University of British Columbia, Vancouver, B. C., Canada.

I. Sponsorship and Finance:

1. Who financed your particular "Halfway House"? State _____ Federal _____
   Local agency _____ Private _____ If there is mixed financing, please explain: ____________________________

2. Who has operational responsibility? Private agency _____ State agency _____
   Private enterprise _____ Private hospital _____ State hospital _____
   Other (please elaborate) ____________________________

II. Eligibility:

1. What kinds of people are admitted? Male _____ Female _____ Both _____

2. Are there any age limits in eligibility? Yes _____ No _____
   Maximum age _____ Minimum age _____

3. What are the sources from which residents come?

<table>
<thead>
<tr>
<th>Public Mental Hospitals _____</th>
<th>Public Welfare Agencies _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Mental Hospitals _____</td>
<td>Private Welfare Agencies _____</td>
</tr>
<tr>
<td>Medical Practitioners _____</td>
<td>Private Hospitals _____</td>
</tr>
<tr>
<td>Families _____</td>
<td>Other (please specify) _____</td>
</tr>
</tbody>
</table>
APPENDIX "B" (cont'd)

II. Eligibility cont'd:

4. Is there any exclusion because of specific disorders (e.g. alcoholism, homosexuality, etc.)? Yes ____ No ____ If the answer is 'Yes', for which disorders? ____________________________

5. Is the "Halfway House" only for persons with a specific disease?
   Schizophrenia ____ Alcoholism ____ Drug Addiction ____ Other (please specify) ____________________________

6. Is any form of orientation to the "Halfway House" provided?
   a. Talks with present residents of the house to prospective residents ____
      Talks with houseparents to prospective residents ____
      Talks with a social worker to prospective residents ____
      Talks with a psychiatrist to prospective residents ____
      If discussions are used, what form do they take? ____________________________

   b. Are prospective residents formed into a 'special' group on the hospital ward? ____

   c. Do prospective residents visit the house beforehand? ____

   d. Other orientation arrangements (please specify) ____________________________

7. Who makes the selection? Doctor ____ Social Worker ____ Ward Nurses ____ Houseparents ____ Panel ____ If a panel chooses, what is its composition? ____________________________

8. Do prospective residents undergo a re-socialization program in the hospital? Yes ____ No ____ Is a social worker involved in this? Yes ____ No ____ Other ____________________________

9. Is the resident expected to pay all ____ part ____ or none ____ of his maintenance costs?

10. Does length of hospitalization bear on selection? Yes ____ No ____
    Are short-term patients (up to two years) or long-term patients (over two years) preferred? Short-term ____ Long-term ____

11. Does selection depend on the potential ability to obtain a job? Yes ____ No ____ Or to be trained for a job? Yes ____ No ____
APPENDIX "B" (cont'd)

II. Eligibility cont'd:

12. Is it preferred or required that prospective residents possess work skills, such as secretarial training, a trade, etc? Yes ___ No ___
   If the answer is 'Yes', please elaborate __________________________

13. Is the manifestation of 'dependency' a criterion for selection?
   Yes ____ No ___

14. Does selection depend upon lack of family resources? Yes ____ No ___

15. Is the prospective resident expected to be in complete ____ or partial ____ remission from psychiatric symptoms?

16. Is it felt that persons admitted to the "Halfway House" require only a "way station" to stop at, before eventually obtaining their own accommodation? Yes ____ No ___

17. Are there elements due to hospital residence for which "Halfway House" living is considered to be a remedy, such as:
   Unfamiliarity with the community ____
   Unfamiliarity with traffic lights ____
   Unfamiliarity with telephones ____
   Unfamiliarity with the job market ____
   Inability to behave in a socially appropriate manner ____
   Other (please specify) __________________________

III. Physical Facilities:

1. How many residents are accommodated at one time (maximum)? _____

2. How many separate residents were accommodated during the year (1961)? _____

3. Does each resident have his/her own room? Yes ____ No ____ How many singles? ____ Doubles? ____ Other __________________________

4. In addition to bedrooms, what other living facilities are provided?
   Kitchen ____ Living room ____ Dining room ____ Lounge ____ Games room ____ Other __________________________

5. Is clothing provided? All ____ Some ____ None ___

6. Is bedding provided? All ____ Some ____ None ___

7. What recreational activities are provided for by the Halfway House?
   a. Passive: Reading material ____ Radio ____ T.V. ____
      Other (please specify) __________________________
   b. Active: Ping-pong ____ Pool tables ____ Arts and crafts ____
      Other (please specify) __________________________
   c. Social: Dances ____ Self government ____ Lectures ____ Card games ____ Discussions ____ Movies ____ Other (please specify)
APPENDIX "B" (cont'd)

III. Physical Facilities cont'd:

8. Are meals served "family" style ____ or cafeteria style? ____ Are special diets provided? ____ No ____

9. Is the resident allowed to "raid the icebox"? Yes ____ No ____

10. Is the Halfway House: On hospital grounds? In the same community as the hospital? ____ In another community? ____ In a rural setting? _______

11. Is the building: remodelled as a Halfway House? ____ designed and built as a Halfway House? ______

IV. Staff:

1. Does the "House" staff include?
   a. Cook ____ f. Social worker: full time ____ part time ____
   b. Housemother ____ g. Doctor: full time ____ part time ____
   c. Housefather ____ h. Other (please specify) ________________________
   d. Dietician ____
   e. Janitor ____

2. Do any of the staff live in? No ____ Yes ____ If so, who? __________

3. Do any of the staff wear uniforms? No ____ Yes ____ If so, who? __________

4. What qualifications are required of:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Academic</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director, Matron, or Supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Houseparents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. What are the duties of:

<table>
<thead>
<tr>
<th>Houseparents</th>
<th>Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cooking</td>
<td>a. Discussing patients with house-parents</td>
</tr>
<tr>
<td>b. Cleaning</td>
<td>b. Helping residents with homefinding</td>
</tr>
<tr>
<td>c. Handling of finances</td>
<td>c. Group discussion with residents</td>
</tr>
<tr>
<td>d. Screening of companions</td>
<td>d. Referral of residents to agencies</td>
</tr>
<tr>
<td>e. Distributing duties</td>
<td>e. Regular interviews with residents How often?</td>
</tr>
<tr>
<td>f. Organizing recreation</td>
<td>f. Discussions with doctors</td>
</tr>
<tr>
<td>g. Other</td>
<td>g. Helping families of residents</td>
</tr>
</tbody>
</table>

i. Writing of reports  
j. Other
APPENDIX "B" (cont'd)

IV. Staff cont'd:

6. Do houseparents hold discussions with residents: (a) Formal: Yes ____ No ____ (b) Informal: Yes ____ No ____

7. Are there case conferences? ____ Staff conferences? ____

V. Services:

A. General Services:

1. What is the maximum length of stay for each resident? _______________

2. If the resident exceeds the time limit, is he (a) allowed to remain? ____ (b) returned to hospital? ____ (c) Other (please specify) ____

3. Among "house" rules, are house residents:
   a. Expected to keep specified hours? Yes ____ No ____
   b. Expected not to consume alcohol? Yes ____ No ____
   c. Other (please specify) __________________________

   (If there is a standard list of rules, would you please send a copy)

4. Are residents expected to stay home during the evening? Yes ____ No ____

5. Are residents permitted to bring guests into the "house" in daytime ____ evening ____ overnight ____ ?

6. What duties are residents expected or encouraged to participate in?
   Tidying bedrooms ____ Dishwashing ____ Gardening ____ Other (please specify) __________________________

7. Are medications given to the resident to administer to himself? Yes ____ No ____ Are they given by the houseparents? Yes ____ No ____ Other (please specify) __________________________

B. Special Services:

1. Are formal records kept of the residents' progress? Yes ____ No ____

2. If the resident has a job, is his laundry done for him? Yes ____ No ____ Is he expected to share in laundry duties? Yes ____ No ____ If he is not working, is he expected to do his own laundry? Yes ____ No ____

3. Do residents receive psychotherapy, or some other form of psychiatric treatment, in the "Halfway House"? Psychotherapy ____ Group therapy ____ Medications ____ Other (please specify) __________________________
APPENDIX "B" (cont'd)

V. Services cont'd:

B. Cont'd.

4. Do residents have access to educational facilities?

<table>
<thead>
<tr>
<th>Type of Course</th>
<th>How Financed</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Are volunteer groups from outside involved with the "Halfway House"?
   Yes ____ No ____ Do they: make friendly visits ____ , take residents on trips ____ , supply furnishings ____ , take residents into their homes ____ , provide jobs ____ , Other (please specify) _________________________

6. a. What community agencies are interested in the Halfway House? Employ­ment agency ____ Social Assistance agency ____ Social clubs (e.g. YMCA) ____ Ex-patients' clubs ____ Community sports facilities ____ Other (please specify) _________________________
b. How are referrals made to these agencies? By residents' own enquiries ____ By referral from social worker ____ By houseparent ____ Other (please specify) _________________________

7. Does communication between the "Halfway House" and community agencies include: telephone referral ____ case conference ____ social histories ____ written referral without social history ____ Other (please specify) _________________________

VI. Discharge:

1. What is the legal status of residents? Voluntary patient ____ Certified patient ____ Patient on extended leave ____ Discharged patient ____ Private citizen ____

2. Who determines readiness for discharge? Supervisor or director ____ Resident ____ Social worker ____ Houseparent ____ A doctor ____
   A team ____ If a team, what is its composition? _________________________

3. Who has legal responsibility for discharge of resident? _________________________

4. How are preparations made for leaving the "Halfway House"? Group dis­ussions ____ Discussions with houseparents ____ Discussions with social worker ____ Other (please specify) _________________________
APPENDIX "B" (cont'd)

VI. Discharge cont'd:

5. How are future homes located? Through the newspapers ____ Activity of resident ____ Activity of houseparent ____ Activity of social worker ____ Auxiliary or volunteer ____ Other (please specify) ____________

6. What factors determine readiness for discharge?
   a. Demonstrated familiarity with the city? Yes ____ No _____
   b. Ability to take medications as prescribed? Yes ____ No _____
   c. Is the resident required to have saved a certain amount of money? Yes ____ No _____ Minimum ____________
   d. Is evidence of "self-confidence" in the resident required? Yes ____ No _____
   e. Is evidence of socially appropriate behavior required? Yes ____ No ____. Does this include "appropriate" standards of table manners ____ Dress habits ____ Conversational ability ____ Other (please elaborate) ____________
   f. Is freedom from symptoms of mental illness required? Yes ____ No ____
   g. Is evidence of "happiness with idea of moving into the community" required? Yes ____ No ____
   h. Other (please elaborate) ____________
APPENDIX "C"

Illustrative Regulations: Agencies X and Y

Agency X

1. Each client may attend the church of choice.

2. The house parent is to be kept informed as to all absences from the house.

3. Each client should return to the house by 11:00 o'clock on week-day evenings except when groups are out for special activities or on Friday or Saturday when all clients should return by 1:00 A.M. Adjustments to be made with house parents.

4. All illnesses or accidents should be reported immediately to the house parent. In case a physician is needed, the house parent will be responsible for calling him.

5. Weekly payments toward room and board are to be made promptly to the house parent who will give the client a receipt each time a payment is made.

6. Any loss of work or change in working hours is to be reported immediately to the house parent and to the Counselor. Any change in work assignment or plans to change jobs must be made known to the Counselor at once and may not be done without counselor's approval.

7. The house should be quiet after 10:00 P.M. for the benefit of those who wish to sleep. Any radio or television set should be tuned down to a very low volume.

8. Only cash purchases may be made. Credit or lay-away plans are not permitted. Buying, spending, (including travel expenses for weekend visits), and saving should be planned with the Counselor on a regular budgeting basis.

9. Clients should not plan to be away from the house more than two weekends each month.

10. It is planned that a Psychiatrist and a member of the Project Staff from the State Hospital will visit the house at least one evening each week for discussions with the entire group and/or such individual attention as may be needed. These visits will be scheduled in advance and all clients should plan to be present.

11. Smoking shall be confined to first floor and basement. No alcoholic beverages are permitted on the premises and use prohibited during stay in house.
SMOKING IS ALLOWED IN BEDROOMS BUT NEVER IN BED

Beds to be properly made, rooms aired, mopped and dusted, mats shaken, ash trays emptied, etc. daily by 10:00 A.M.

ALL ROOMS WILL BE INSPECTED BY SUPERVISOR AT LEAST ONCE A WEEK

Baths, shampoos, washing, ironing, etc. not to be done before 9:00 A.M. nor after 9:30 P.M.

Any dyeing of hair to be done in basement.

Bath and basin to be left clean after use and bathroom tidy.

All laundry other than panties, stockings and gloves to be washed and dried in laundry room or outdoors.

Under no circumstances is washing of any kind to be dried in bedrooms.

Patients must not go into other bedrooms when occupant is not present.

No visiting in rooms after 10:00 P.M.

Staff on duty to be notified of any absence for meals, if possible well in advance and permission must be obtained for overnight or weekend leave.

Visitors allowed in the office only and visits are restricted to one hour, other than social workers.

Please see that lights are turned off when not required and that taps are not left running or dripping.

THANK YOU
APPENDIX "D"

Illustrative Daily Routine: Agency Y

WEEK DAYS:

RISING TIME: (Nurse's aide will call you) 8:00 A.M.

BREAKFAST: 8:00 - 9:00 "
Kitchen to be cleared and left tidy by 9:15 "

LUNCH:

DINNER:

SUNDAYS AND HOLIDAYS:

RISING TIME: 9:00 A.M.

BREAKFAST: 9:00 - 10:00 "
Kitchen to be cleared and left tidy by 10:15 "

DINNER:

SUPPER: Help yourselves. 5:30 - 6:30 "
Kitchen to be left clean and tidy.

ALL ABOVE SUBJECT TO CHANGE WHEN NECESSARY

Coffee, tea, milk or fruit juice and cookies 3:00 - 4:00 P.M.
Help yourself evening break 9:00 - 10:00 "
Kitchen to be left clean and tidy.

RETIRING TIME: Sunday through Thursday 11:00 P.M.
Lights out 11:30 "

Fridays and Saturdays 11:30 "
Lights out 11:45 "
APPENDIX "E"

BIBLIOGRAPHY

General


BIBLIOGRAPHY (cont'd.)

General (cont'd.)

Member Employee Program: A New Approach to the Rehabilitation of the Chronic Mental Patient (a collection of papers by the staff of the Veterans Administration Hospital, Brockton, Massachusetts.


Rohn, George, Progress Report on White Cross Centres: Social Clubs for Ex-Mental Patients, a report prepared for the Canadian Mental Health Association, 11 ½ Spadina Road, Toronto 4, Ontario, April, 1960.


The Social Worker: Rehabilitation and the Psychiatric Patient, Report Series Memorandum No. 4, Mental Health Division, Department of National Health and Welfare, Ottawa, November, 1957.


BIBLIOGRAPHY (cont'd.)

General (cont'd.)


Specific


Annual Report to the Jewish Welfare Federation for Gateways, Los Angeles, 1958. Available by writing to the Executive Director of Gateways Hospital, 1891 Effie Street, Los Angeles 26, California.

Brooks, George W. N., M. D., "Opening a Rehabilitation House", Rehabilitation of the Mentally Ill, copyright 1959, by the American Association for the Advancement of Science, Washington, D. C.


BIBLIOGRAPHY (cont'd.)

Specific (cont'd.)


Peffer, Peter A., M. D., and Glynn, Frederick, M. S. S. W., "The Foster Home Cottage - A New Approach to Discharge", Mental Hospitals, 1956 Copyright, Mathew D. Ross.

Portals House Annual Report, April 1, 1960 to March 31, 1961. Available by writing to the Executive Director of Portals House, 1188 South Bronson Avenue, Los Angeles 19, California.


Tyhurst, Dr. J. Stewart, "Rehabilitation: Sharing the Job with the Community", Minutes of a Conference chaired by Dr. Robert B. Prosser, reprinted in Mental Hospitals, May, 1958, Vol. 9, No. 5.


Williams, David B., "California Experiments with Halfway Houses," reprint from Mental Hospitals, 1956 Copyright, Mathew D. Ross.