FOSTER HOME CARE FOR THE MENTALLY ILL

A Study of the Needs of Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.

by

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The University of British Columbia
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Date May 6, 1960
ABSTRACT

Today much emphasis is placed on the rehabilitation of the mentally ill. This study undertakes a survey of the values of foster home care as a therapeutic resource in the rehabilitation of such patients. The programs presently in operation in Maryland, U.S.A. and Ontario have been examined to determine their effectiveness in meeting needs evinced by recidivist patients at the Provincial Mental Hospital, Essondale, B.C.

A sample group of twenty-one patients was obtained by taking all recidivist patients returning to the hospital from probation between July 1, 1959 and December 31, 1959, who had been active with the social service department during the previous admission. Patients who met these criteria were assessed primarily through the use of rating scales based on information contained in the files. An examination of the needs and resources of these patients indicated that the average patient was unmarried, returning for his fourth admission, without family resources, and limited in social, vocational and educational skills. Previous to this readmission one out of every two had become the client of public welfare agencies, drawing social assistance.

The study suggests that patients' needs may be adequately met through a foster care program which provides emotional support, thus helping to stabilize and aid the patient in his adjustment to the community. The use of this system is also indicated for the care of chronic patients whose symptoms of illness are controlled, yet who are unable to accept full responsibility for their own care. The program could also be adapted to provide care for the geriatric patients who today swell the population of mental hospitals.

Considering the program under three headings: general policy, required facilities and type of patients, methods of implementing foster home care in the community are indicated. Research would be of value in developing methods of selecting patients who would derive optimum benefit from the program, and in assessing the progress made in the new setting. Foster home care, which has as its goal the placing of patients in family settings in the community, is in line with the current emphasis on decentralization of large mental institutions, and, as such, provides a suitable therapeutic resource in the rehabilitation of the mentally ill.
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FOSTER HOME CARE FOR THE MENTALLY ILL
CHAPTER I

FOSTER HOME CARE: A MEANS TO REHABILITATION

Rehabilitation of the mental patient becomes
the concern of the mental hospital the day the patient
enters its doors. Subsequent examination, treatment,
nursing care, psychotherapy and social casework are aimed
at promoting his return and his social adjustment to
community life.¹ More specifically, rehabilitation may
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".²
This sums up the social worker's goals in the rehabili-
tation of the hospital patient and gives appropriate
meaning to the term "rehabilitation" as it is used in
this thesis.

Institutional treatment methods today make it
possible to offer more to the mental patient than mere
custodial care and humane treatment. Through the exten-
sive use of tranquilizing drugs, the outward symptoms of

mental illness may be controlled, enabling many patients to benefit from therapies to which previously they were inaccessible. While this trend results in increased discharge rates from mental hospitals, unfortunately many of the patients being discharged cannot be considered cured; although symptoms of illness are no longer manifest, the residual of illness carried by the patient may remain high. As a result, the patient not fully recovered faces the possibility of a recurrence of his illness; hence many unable to adjust to the normal stresses of community life find themselves back in hospital within a year of their discharge.¹

In addition to this, the patient may be unable to return to his home due to his family being unable or unwilling to take him back; or the hospital authorities may deem it unwise for him to return to the charged emotional relationships of the family which played a part in producing the initial breakdown.

Since many patients have difficulty in their integration into community, it is part of the social worker's role to aid in this adjustment. The process may be conceived of as a means to bridge the gap between hospital and community. It is the social worker's ¹

knowledge of human behavior, social relationships and available community resources that enables him to make a direct contribution to the welfare of the patient.

Foster Home Care

In order to reduce the degree of stress in returning to community life, a more protected environment such as foster home or family home care has been used as a resource in the rehabilitation of the mentally ill in many countries of the world. The terms "foster home care" or "family home care" are used in connection with the placing and supervising in selected homes, of mental patients who according to medical advice no longer require hospital care, but still would benefit from supportive help in their return to community.¹ (These terms, while they may have different meanings in certain texts, are used synonymously in this thesis.)

Probably the most famous example of foster home care, and almost certainly the oldest, is that which was established at the Colony of Gheel in Belgium in the fifteenth century.² At the outset treatment was chiefly a religious ritual; if after nine days in the Church's nine-bed annex the patient showed no improvement in his

¹Crutcher, H.E., Foster Home Care for Mental Patients, The Commonwealth Fund, New York, 1944.
²Jones, op. cit., p. 16.
mental outlook, he was housed with a nearby family where he could thus continue to attend church, seeking a cure. It was in this manner that the family care system of Gheel had its earliest beginning.

In 1852, after the Colony became a state institution, a two hundred-bed infirmary was built for the purpose of housing mentally ill patients. Patients come from all over Europe to this centre. After examination they may be placed with a foster family or may remain in the infirmary for an extended period of observation and study. In 1952, Gheel, with a population of 20,000, had 2700 patients in foster home or family care. Although the payment for care is low, there are always more than enough families who are willing to take patients. It is not uncommon to place very ill patients with these families, although the infirmary is reserved for the more acute cases. There are some risks: recorded are two murders committed by patients in care during the past one hundred years. (Attempted homicide is not uncommon. There are perennial suicides, but these do not cause any great concern to the people of Gheel.) The colony is divided into five sections, each with its own doctor as well as two nurses. Since the war a psychiatric social worker has been added to the general staff. Families are chosen carefully to fit the personality of the patient;
however, both the patient and the family are made aware that a change or transfer may be arranged if the placement is not mutually satisfying.

Based on the lengthy experience and proven value, the system of foster home care inaugurated at Gheel has spread elsewhere. The mental hospitals of Scotland have placed patients in foster care in isolated communities for over one hundred years. In France, Sweden, Switzerland and Germany, foster home care is a common method used to care for some of their mentally ill.¹ In the year 1885, the legislature of Massachusetts passed an act providing for the placement of quiet mental patients in private families other than their own. This was the beginning of foster home care in the United States.² However, this system was used rather sparingly until 1935 when interest in the therapeutic aspect of family care developed. In the states of New York and Maryland, foster home care for patients was developed to a much greater extent than in any of the others. Maryland's program, which will be described in more detail in a later chapter, places much value on the therapeutic and rehabilitative possibilities of foster home care.³

¹Crutcher, op. cit., p. 103.
²Ibid., p. 186.
In Canada, family care has not been developed to the extent that it is used in the United States or Europe. All provinces have used some form of boarding home care for patients at one time or another, but it has never been developed on any significant scale, due to the financial cost and shortage of staff. Ontario and Saskatchewan are the only provinces that have a planned foster home care program in operation.

Parallels in Foster Care

In examination of criteria for the operation of foster care plans for mental patients, an obvious parallel to child foster care principles becomes evident. Both plans recognize the family as the basic unit of society which provides security and a sense of belonging for the individual. Both are designed for the benefit and welfare of the individual. Both operations may come under the guidance of the professional social worker whose training and skills equip him to understand and to handle problems which may arise. Criteria that apply to the placement of mental patients, types of homes used, preparation of the patient for placement, work carried out with relatives to help them accept the therapeutic value of placement, enabling the operators of foster homes to understand and accept the demands the patients may make,
are all closely related to good child foster care practices. One of the basic differences between foster care for mental patients and children is in the area of dependency. Children are generally encouraged to become dependent on the foster parent, whereas the mental patient will be encouraged to show his independence and to do his own planning. British Columbia has developed foster care programs in the area of child welfare, but as yet no similar development has taken place in the area of mental care.

The Situation in British Columbia

In the province of British Columbia, a person deemed mentally ill and in need of hospitalization may receive treatment at the Crease Clinic of Psychological Medicine or the Provincial Mental Hospital, both located at Essondale, B.C. If the illness is not in an acute phase, he may receive treatment at the Burnaby Mental Health Centre, Vancouver General Psychiatric Ward or Out-Patient Clinic, or through private psychiatric treatment. In regard to the acute and chronic treatment centres located at Essondale, the patient's doctor stipulates on the hospital admission forms whether his

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2Mental Hospitals Act, Province of British Columbia, 1940, Section 9.2.

3Clinics of Psychological Medicine Act, Province of British Columbia, 1948, Section 6.2.
patient is in need of treatment at Crease Clinic or at the Provincial Mental Hospital. Crease Clinic is the acute treatment centre where the maximum period of time a patient may receive treatment is four months. In the Provincial Mental Hospital, which accepts both acute and chronic cases, there is no time factor, as the committed patient enters for an indefinite period which is terminated at the discretion of the medical superintendent. There may also be voluntary admissions to both institutions.

Social Service departments are active in both institutions. The Provincial Mental Hospital is made up of three units: Centre Lawn, which is the admitting and semi-acute treatment unit for male and female patients; East Lawn, long term chronic female treatment unit; and West Lawn, the long term chronic male treatment unit. Each of these individual units has its own social service department.

A social worker generally becomes active on a case at the specific request of the patient's doctor, although this is not the only channel through which referrals are received. A case may be opened, with approval of the attending doctor, due to a request for service from any of the following: patient, relatives, nursing staff, or community resources. A number of referrals are direct requests to assist the patient in rehabilitation plans,
although, again, these are not the only services that are requested. Other areas in which help may be offered will be indicated as the focus of this study is described.

Focus of Study

The files of recidivist patients at the Provincial Mental Hospital, Essondale, B.C., will be examined to determine the needs of patients at the point of discharge,\(^1\) to consider why these patients returned from probation, and whether or not a foster home care program would aid in the rehabilitation of patients. Based on information elicited in this study, and the examination of existing foster care programs presently in operation in mental institutions in Maryland, U.S.A., and Ontario, Canada, a criterion that could be operable at the Provincial Mental Hospital, Essondale, will be outlined.

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\(^1\)Mr. Robert M. Sutherland has made an analysis of the needs of 100 male patients discharged from Crease Clinic between April 1, 1952 and March 31, 1953, examining three areas of adjustment: housing, vocational skills and training, and problems of inner stress requiring casework services. Sutherland, R.M., The Rehabilitation of Discharged Mental Patients, Master of Social Work Thesis, University of British Columbia, 1954.
CHAPTER II
NEEDS OF DISCHARGED HOSPITAL PATIENTS

With the use of the new psychopharmacological treatments there has been a decided upswing in discharge rates from mental hospitals. Unfortunately, the value of this trend is somewhat offset by the increase in re-admissions to hospital. At the Provincial Mental Hospital, Essondale, B.C., there has been a 65 per cent increase in re-admissions over the past five years.

TABLE 1
First Admissions Compared with Re-admissions to the Provincial Mental Hospital, Essondale, B.C.

<table>
<thead>
<tr>
<th>Year</th>
<th>First Admission</th>
<th>Re-admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>653</td>
<td>388</td>
</tr>
<tr>
<td>1955</td>
<td>678</td>
<td>461</td>
</tr>
<tr>
<td>1956</td>
<td>617</td>
<td>636</td>
</tr>
<tr>
<td>1957</td>
<td>628</td>
<td>631</td>
</tr>
<tr>
<td>1958</td>
<td>695</td>
<td>671</td>
</tr>
</tbody>
</table>

The rising rate in re-admissions to hospital is partly a result of lack of follow-up facilities. At the present time the community is unable to assume responsibility for ongoing help to a large proportion of discharged patients. There is an obvious need to extend supportive services into the community where the patient needs help; otherwise the benefit gained from treatment and hospitalization is lost. A Foster Home Care Program, one method through which such supportive help may be offered, might be a means of meeting some of the needs of patients which at the present time cannot be met through their own initiative.

It should not need to be reaffirmed that mental patients are human beings and as such have basic needs for food, clothing and shelter. However, because of illness, they have been removed from the natural community and placed in an institutional setting (which in itself is a community within a community, but one in which the daily needs of the individual are met in a highly structured and ordered manner). What, then, are the needs of patients at the point of discharge? Why is it that many of these patients return from their probationary period requiring further treatment and hospitalization? Would a foster home care program meet some of the needs of recidivist patients who are unable to remain in the community for any extended time period? With questions such as these in mind, a group of recidivist patients of the Provincial Mental Hospital, Essondale, B.C. was examined.
Selecting the Sample Group: Recidivist Patients

A six month time period, July 1, 1959 to December 31, 1959, was used in obtaining a sample of recidivist patients. This particular time sequence was chosen as it meant that all patients returning from probation during this period would have been discharged from hospital at some date in the year 1959. The following criteria were used to obtain the sample of recidivists for this particular study:

(1) Patient was active with the Social Service Department during this last admission.

(2) Patient was discharged on probation from Centre Lawn and returned prior to termination of his probation during the stated time sequence.

By including in this study all patients who met these criteria, a total of twenty-one recidivist patients was obtained. In order to carry out an analytical study of the files of these patients it is essential that certain information be available. The clinical files, social service notes, letter file and visitors sheet, on each patient, were examined. Where possible, brief discussions were held with the patient's doctor regarding the patient's progress in hospital and the reasons for return. (This was of necessity limited, as several doctors were no longer in the Essondale service.) The point at which the social service
department became active varied from case to case, and the period of activity depended on the type of service requested.

Generally the social service activity could be grouped into three categories:

(1) Situations in which social casework services were extended over a period of time and where, with medical consultation, rehabilitation plans were worked out with the patient. Ten patients of the sample group examined came under this category.

(2) Situations in which the Social Service Department was active in obtaining additional background information on the patient or where, at the point of discharge, help was requested in completing discharge plans. Eight patients fell within this group.

(3) Situations where social service contact was limited to one interview concerning a referral to a community resource for financial or employment assistance. There were only three patients who came under this category.

Adequate information on the patient's progress and response to treatment was contained in the files; however, information on the factors precipitating the return of the patient from probation was limited. In this area it was necessary to infer the reasons from material disclosed in recorded interviews with patients. Fortunately, there was enough material of sufficiently high calibre in
the files from which a study of the needs of mental patients in relation to the foster home care program could be carried out.

Patients in the Study Group

Of the twenty-one recidivist patients comprising the group, eleven were women and ten, men. This group was predominantly Canadian, fourteen having been born in Canada. Another three (of Russian, Finnish and English origin) had lived in Canada for many years. Only four were recent immigrants: two from Hungary and one each from Germany and Poland. Examination of the marital status of the group revealed that fifteen of the twenty-one had never married, four were separated (of whom two had entered into common-law relationships), one was divorced and one was married. Similar information about the total population of the institution is not readily available.

Diagnosis

"Schizophrenia is one of the most frequent forms of the major psychoses, constituting from fifteen to twenty per cent of the first admissions to public hospitals for mental diseases. Because the disorder tends to chronicity and in many instances does not shorten life it will usually be found that sixty per cent of the population of state
hospitals is made up of schizophrenic patients."¹

Of first admissions to the Provincial Mental Hospital, Essondale, B.C. between April 1, 1957 to March 31, 1958, 30.2 per cent bore a diagnosis of some form of schizophrenic disorder. Of the readmissions during the same time period, 70.2 per cent carried a diagnosis of some schizophrenic disorder. In this study it is seen that seventeen or 80.19 per cent of the recidi­vist patients reviewed here had a diagnosis of a schizo­phrenic disorder. Schizophrenia may occur at any time from late childhood to late middle age.² Twelve of the patients in this study were in the twenty to forty year age group, which follows the general age pattern of schizophrenia.

²Ibid., p. 390.
## TABLE 2

The Diagnosis of a Group of 21 Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.

<table>
<thead>
<tr>
<th>Illness</th>
<th>No.</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Schizophrenic Reaction</td>
<td>16</td>
<td>36.1</td>
</tr>
<tr>
<td>2. Passive Aggressive Personality</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>3. Catatonic Schizophrenia</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>4. Sociopathic Personality Disturbance</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Anti-Social Reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Chronic Brain Syndrome Gross Trauma</td>
<td>1</td>
<td>48</td>
</tr>
</tbody>
</table>
Doctors state it is difficult to forecast the future adjustment of patients who have had a schizophrenic reaction.¹ In some cases the course is continuously progressive; in others it is intermittent. More frequently it is a question of remissions and relapses. In this group of patients the relapse rate or readmission rate for both patients bearing a schizophrenic diagnosis or some other diagnosis is notably high. These twenty-one patients account for 89 admissions to hospital -- an average of 4.2 admissions per patient.

Needs of Patients

There are many needs which must be considered when a patient is being discharged from an institutional setting such as a mental hospital and is returning to the community. Hospital, community and the patient himself all have a responsibility in meeting these needs. Not only must the physical needs of food, clothing, shelter, be met, but there should also be "an opportunity to grow up free to make choices which will make it possible for him to secure a living, establish a home, raise children, enjoy leisure, and feel at home in the universe."² It is

¹Ibid., p. 417.
essential that some degree of harmony be maintained in the way he meets these needs; otherwise he finds himself in conflict with his environment.

Vocational Need

Recognition is given the fact that a satisfying work experience is essential to good mental health. North American culture places much emphasis on work and the ability to obtain and hold a job, consequently there is a tendency to look down on those who are unable to maintain themselves in gainful employment. Work, which provides not only an outlet for aggressive and competitive drives, but also a means for making social contacts, enhances the patient's feelings of personal worth.

For the mental dischargee, work is of primary importance in his rehabilitation. Yet, for many, it proves to be a stumbling block, creating stress and anxiety which may lead to a relapse. The residual of illness carried by the patient at the time of discharge may account for one reason why stress builds up so rapidly in the work situation. It also plays its part in the patient's ability to find and hold a satisfying employment situation. Again, the degree of education and training will be a significant

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factor here. The group of patients examined in this study with little to offer to the prospective employer, would have little chance of becoming gainfully employed. The qualifications of three out of four recidivist patients studied here fall into a category of fair to poor when rated on their potential employability.
### TABLE 3

**Employability of 21 Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.**

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Patient has high school or equivalent training; a trade currently in demand on labour market; is return-to his former job; or owns own business; or has money to invest in a business and ability to make a good choice. Presents himself well in interview, would present favourable personality profile to prospective employer.</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>Obtained high school or equivalent training; possesses some skills but not specific trade. Has steady work history though occasional seasonal layoffs. Could take trade training. Can present adequate picture of himself and his capabilities.</td>
<td>3</td>
</tr>
<tr>
<td>Fair</td>
<td>Patient left school after finishing Grade 8; no specific skills, has worked at a variety of jobs. Cannot express himself well, appears to disadvantage in interview.</td>
<td>3</td>
</tr>
<tr>
<td>Poor</td>
<td>Patient has less than Grade 8 or equivalent; limited to manual work or has experience only in unskilled work. Poor personality profile, unstable history. Language barrier. Residual of illness patient is carrying prevents him from making use of previous training or skill.</td>
<td>12</td>
</tr>
</tbody>
</table>

One female patient returned to husband and will not be competing in labour market.
Financial and Material Resources

When discharge plans are being made, careful consideration should be given to the actual financial and material resources of the patient. It is of primary importance that some financial means be available to cover the time interval between the discharge date and the date when the patient becomes financially self-supporting again, or is eligible for financial assistance through a welfare agency. This entire area may produce considerable stress if the patient's financial position is somewhat precarious. Certain material goods will be required, either as equipment for a particular job or as simply protection from the elements. Only one person in this study could be described as falling into the category of being completely self-sustaining: a woman returning to her husband who would be attending to her financial and material needs. The others were equally divided between the partly self-sustaining and the dependent categories.
### TABLE 4

Financial and Material Resources of 21 Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.

<table>
<thead>
<tr>
<th>Degree</th>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely self-sustaining</td>
<td>Patient has private income; owns property; capable of buying or renting a home. Has material goods or can purchase same. No apparent stress in this area. Good family resources.</td>
<td>1</td>
</tr>
<tr>
<td>Partly self-sustaining</td>
<td>Has limited income or personal savings. Will need employment to maintain financial solvency and acquire necessary material goods. Supportive help indicated until working and established again.</td>
<td>10</td>
</tr>
<tr>
<td>Dependent</td>
<td>Has no income, savings or real estate. Material possessions very limited or non-existent. Will require financial assistance until self-supporting. Definite limitations in type of work patient can undertake.</td>
<td>10</td>
</tr>
</tbody>
</table>
The Importance of Family and Friends

It is important to belong and to feel needed and wanted. The need to love and be loved is part of the basic human psychological structure. Today, due to increasing urbanization and industrialization, family ties have become weaker and these are further affected by the demands industry makes that mobility be an essential requirement for a job, expecting its workers to move from place to place. The effects of loneliness upon people can be seen today as a deterrent to good mental health. It has been theorized that a close linkage exists between the patient's response to treatment and the degree of interest shown in him by his family and friends. Unfortunately for the mental patient, as his readmissions occur closer together, necessitating longer periods in hospital, the family and friends lose faith in the possibility of recovery and gradually cease to visit the patient. This may have a very damaging effect on the patient and his desire for recovery. Still, there are family situations which are so damaging to a patient's mental health that the doctor advises the patient against returning home. This can create problems for the patient as to where he can go. For others, the family has already

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severed contact. Yet all these patients desire and need personal contacts and people to take an interest in them while they are trying to make an adjustment to community. It is in this area that foster care has its greatest potential: lacking the highly charged emotional relationships that may develop within the family, it can offer the patient many of the benefits of a family setting.
### TABLE 5

Interest Shown by Relatives and Friends in a Group of 21 Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.

<table>
<thead>
<tr>
<th>Degree of Interest</th>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Patient has regular visits or correspondence from family or friends. Contact is maintained with hospital in order to follow progress and plans for discharge. Patient goes on regular leaves to visit relatives or friends when feasible. Clear indication expressed on part of relative or friend of willingness to offer direct assistance in the establishment of patient in the community. Patient is also desirous of this.</td>
<td>3</td>
</tr>
<tr>
<td>Moderate</td>
<td>Patient has occasional visits and correspondence from relatives or friends. There is little effort on their part to contact hospital authorities for progress reports on patients. They will take patient home for visits, provided they have received adequate notice and reassurance as to patient's health. Willing to help patient upon discharge, as they feel morally obligated.</td>
<td>13</td>
</tr>
<tr>
<td>None</td>
<td>No visits or correspondence to patient by relatives or friends. Relatives have contacted hospital to advise they will not accept patient's return to their home upon discharge. No friends willing to help patient nor relatives living in this country.</td>
<td>5</td>
</tr>
</tbody>
</table>
TABLE 6

Reasons for Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959, Not Returning To Live With Relatives.

<table>
<thead>
<tr>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotionally damaging relationship between relatives and patient. Patient's doctor advises against continuing this living arrangement. Patient himself states he will not return to past living arrangements.</td>
<td>4</td>
</tr>
<tr>
<td>2. Relatives are unable or unwilling, and have contacted hospital or patient advising they cannot or will not assume any responsibility for patient upon discharge. Prior to this hospitalization patient had severed family ties and was living independently.</td>
<td>2</td>
</tr>
<tr>
<td>3. No relatives available or capable, either as result of death, or of patient being an immigrant in this country. Patient prefers to establish himself and live independently.</td>
<td>9</td>
</tr>
</tbody>
</table>
Community Resources

In the Greater Vancouver area there are three hundred and twenty-nine formally constituted agencies, organizations and departments of government which exist as health, welfare and recreation resources for Vancouver.\(^1\) The discharged hospital patient supposedly should have little problem in finding a suitable outlet for his interest or needs. This, however, is not the case. Often the patient, feeling the stigma of having been mentally ill, does not wish to become involved with clubs or groups, since he feels he is different and that others are aware of these differences. Many others still have difficulty forming social relationships and are inclined to withdraw from situations where they are expected to contribute of themselves.

For reasons such as these, special resources are needed to meet the needs of patients. There is a Mental Health Centre in Burnaby, B.C., to which a limited number of patients discharged from hospital who are remaining in this area may be referred. This centre is an active treatment centre for prevention of illness, and as such, treatment and policy are geared to working with people who have not had prior admissions to a mental

hospital. There is, however, an evening clinic one evening a week when discharged patients from the Provincial Mental Hospital are seen and supportive help or renewal of medication may be obtained.

There are also two "half-way houses" operated in Vancouver: the "Venture" for male patients, the "Vista" for female patients.\(^1\) These originated to meet the needs of patients ready to leave hospital whom it is felt either should not return to their own family due to an emotionally damaging relationship or who lack finances and require supportive living arrangement while seeking employment. They also serve as a resource for hospital in testing out a patient's ability to return to community and in observing whether his symptoms of illness will remain controlled. Both of these resources provide a needed resource, however they are limited to a small number of patients. Generally not more than seven can be accommodated in either home at any one time. The length of stay in these half-way houses is limited to one month, although for certain special cases the period of time may be extended. The patient is expected to complete plans to move to private accommodation prior to the termination of the month's stay, in order to release beds for other patients.

\(^1\)British Columbia, Annual Report of Mental Health Services, Queen's Printer, 1958, p.L 46.
A social centre for discharged mental patients, designed to provide a program of activities and counselling which will aid in the social reintegration of persons who have been mentally ill, has recently been established in Vancouver by the Canadian Mental Health Association.

The following table is designed to show the various resources in the community to which the patients in this study group were referred. Five patients were not referred to any resource, while, in some instances, patients were referred to two or more resources. As a further indication of financial dependency, eleven or 52.3 per cent of the patients studied were referred to a public welfare agency with a request that they be granted financial assistance.
TABLE 7

Referrals Made to Community Resources on Behalf of Recidivist Patients at the Provincial Mental Hospital, Essondale, B.C., 1959.

<table>
<thead>
<tr>
<th>Name of Agency</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public Welfare Agency</td>
<td>11</td>
</tr>
<tr>
<td>2. National Employment Service (Special Placement Division)</td>
<td>3</td>
</tr>
<tr>
<td>3. Mental Health Centre</td>
<td>1</td>
</tr>
<tr>
<td>4. Vista</td>
<td>2</td>
</tr>
<tr>
<td>5. Private Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>6. Private Employer</td>
<td>1</td>
</tr>
<tr>
<td>7. Immigration Department</td>
<td>1</td>
</tr>
<tr>
<td>8. Unemployment Insurance Commission</td>
<td>1</td>
</tr>
</tbody>
</table>

Some patients were referred to more than one source.
Five patients were not referred to any agency at the point of discharge.
In analyzing the files of this group of recidivist patients it has not been easy to obtain clear-cut reasons for the patient's return. Symptoms prevalent at the time of readmission are well-documented, but the problem of what happened to the patient in the interval between his last admission and this one, leaves many questions unanswered.

One point noted about return from probation is that in few cases is the patient accompanied by a relative. Normally, on any admission or readmission, if relatives are accompanying the patient they are interviewed by the Social Service Department for appropriate information. At Crease Clinic this system works very well, as a high percentage of admissions are accompanied to hospital by close relatives. Many Provincial Mental Hospital admissions, however, occur after 4:30 p.m., the end of the normal working day when social service staff is not on duty. Again, when patients are brought to hospital under the escort of the police, R.C.M.P., or private ambulance service, the background information regarding reasons for return is usually not available. Recognized by the medical staff as a definite lack, it is hoped that something may be done to bring about improvement in this area. Also, with the present shortage of social workers in the Provincial
Social Welfare Department, it takes many weeks to get a report from them on the factors precipitating the patient's relapse. While causes for return from probation were not explicitly stated, it was possible to deduce certain reasons from information contained in the files.
TABLE 8

Reasons for the Return of 21 Recidivist Patients from Probation to the Provincial Mental Hospital, Essondale, B.C.

<table>
<thead>
<tr>
<th>Description</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients returned to have probationary status revised by hospital authorities.</td>
<td>2</td>
</tr>
<tr>
<td>2. Patient was returned by the police. No report was submitted as to conditions precipitating this return to hospital.</td>
<td>4</td>
</tr>
<tr>
<td>3. Patient found the stress of his social situation (community, family, job) more than he could endure with resultant recurrence of illness.</td>
<td>10</td>
</tr>
<tr>
<td>4. Patient returned as he looked to hospital as resource, having spent most of his formative years there.</td>
<td>2</td>
</tr>
<tr>
<td>5. Patient returned due to an acute recurrence of illness symptoms.</td>
<td>3</td>
</tr>
</tbody>
</table>
Foster home care as a rehabilitation resource may provide through the family setting the significant additional aids which will enable the patient to resolve his inner and outer conflicts. It provides an environment where emotional needs can be met, and friendships develop in a normal fashion. From this secure and interested family setting, the patient can move out into the competitive vocational field knowing he has a haven to which he may return at the end of the working day.

Some consideration will now be given to the existing plans in operation in Maryland and Ontario to determine whether programs of the type in operation there would be suitable in this province. Possible criteria for use in setting up a similar plan in this province will be suggested in the following chapter.
CHAPTER III
A FOSTER HOME CARE PLAN

As shown from the analysis of files of recidivist patients at the Provincial Mental Hospital, Essondale, certain factors common to the group were observed. A high percentage (70.2) of these patients bore a diagnosis of a schizophrenic disorder,¹ which has a poor prognosis, since it tends to be progressive and chronic in nature. Needs of these patients, while great in the areas of food, clothing and shelter, were also very noticeable in the areas of vocation, financial and material resources, family and friends; and needs of this nature could only be met through special resources. There are facilities in the community to aid the patient in his adjustment, but no pretext is made of being able to meet all his needs. For those with suitable educational qualifications there is the possibility of training or retraining through vocational courses; financial need can be met to some degree through social assistance, although this in itself is only a subsistence living rate. At the present time, there is no resource offering a family setting where a patient in a protected and understanding environment can

¹Table 2, p. 16.
make another attempt at life. It was noted that of the group of recidivist patients examined in this study a significant number were not returning to live with relatives, but planned to make their way independently. Frequently, as time passes and attempts by the patient to meet his basic needs are frustrated, he begins once more to withdraw from the social world that inflicts this uneasiness and insecurity upon him. It is not too long before the anxiety and tension have built up to a degree sufficient to bring on a recurrence of symptoms, necessitating a further period in hospital.

From examination of the foster care plans presently in operation at the state hospitals in Maryland, U.S.A. and the provincial mental hospitals in Ontario, Canada, it is evident that these hospitals have found the foster home care plan a definite asset in the meeting of patients' needs; needs which, if not exactly the same as those of patients here, are similar enough that plans of theirs might conceivably be adapted for use in British Columbia.

1Table 6, p. 26
2Table 8, p. 33
3Padula, H., "The Mental Hospital: A Specialized Treatment Service or Way of Life?" Presented at the Institute of the University of Pennsylvania, School of Social Work, June 24, 1954. (Mimeographed.)
4Ontario Department of Health, "A Handbook on Approved Homes in Ontario Hospitals", 1957. (Mimeographed.)
"The Maryland Plan", in operation since 1935, has a highly successful record of placement. At the outset it was designed mainly for the placement of long-term chronic patients whom it was felt could live out their days in a foster home setting. This released beds for more acute cases, simultaneously helping to relieve the overcrowded conditions of the hospitals. To the amazement of hospital authorities, some patients began improving in this social setting until they were able to appear before their parole board to request discharge. It was at this time that foster care was recognized as a valuable tool in the rehabilitation of the patient as well as in the provision of care for the chronically ill.

While Ontario provincial mental hospitals have not used foster home care as extensively, a careful study has also been made of their system. One decided difference in the operation of a foster care program between Ontario and Maryland is that the plan in Maryland hospitals is set up and supervised by the hospital social service departments, whereas in Ontario both social workers and nurses are used to supervise their foster care program.

The latter plan could lead to administrative problems as to the authority and areas of competence assigned to the respective professions. The professional social worker's skill and knowledge acquired through his training particularly equips him for supervising such programs, as he has knowledge not only in the handling of problems arising in areas of relationship and human behavior, but also in developing extensively the use of community resources for the benefit of the patient in his adjustment. Consideration should also be given to the fact that patients and foster home operators might find it confusing to have two individuals overseeing the operation of their home.

The Ontario plan does not stress the importance of limiting the number of patients placed in a home, nor does it attempt to structure patients' personalities and ages to create a family setting, as for example, selecting an older patient who might be the grandmother or grandfather figure, or a younger patient who might be in the age range of a son or daughter. The Maryland foster care plan uses this idea extensively and has had considerable success with it.\footnote{Ibid., p. 7.} There it is believed that a family cannot absorb more than two people into its pattern of living without creating drastic changes in the design of family relationships. The role of the patient in the
foster home is carefully considered in order that he will not be placed in a position of unfavourable competition with other members of the foster family or perhaps excluded from the family group. The placement of two patients of the same sex and age could set them apart, with the consequence of their being looked upon or thought of as "the patients", which might well mean they would not be recognized and accepted as individuals.

The literature written about the use of foster care in Maryland state hospitals goes into considerable detail regarding the value of preparing the client for this program, and the importance of having relatives, if any, realize the value and thinking behind the placement of the patient in this type of setting. Use of "planned intervention" in certain situations where long-term chronic patients have no wish to leave the hospital also requires skill in diagnosis of the personality of the patient as well as the ability to recognize when to use it.

What a Foster Home Care Plan Involves

From examination of existing foster care programs and recognition of the degree to which the hospital social worker is presently involved in rehabilitation, the hospital must have additional social workers available whom it can free from other duties in order to establish

1Ibid., p. 13.
a foster care program. Since a program of this type must begin in a small way, gradually growing in size, significant results should not be expected within a few months of its inception. Based on programs presently in operation and available literature on this subject, the following criteria, grouped under three general headings: General Policy, Facilities, and Patients, is offered, to indicate areas which must be considered in foster care.

**General Policy.** All patients placed in foster care would be under the regulations, management and discipline of the hospital as the program would be operated by the hospital's social service staff. This, too, would simplify the return of a patient to institutional care if the need should arise, since it would eliminate the usual admission procedure. It would be the responsibility of the social worker to keep recording up to date on the progress of patients in foster care. He should also be expected to advise the business administrator on a monthly basis of the number of patients in foster care, and the number of days each patient remains in an approved home. Any change in the patient population in a home would be similar to that followed in child welfare administration.

Medical and dental services would have to be provided by the hospital as this program would be an
extension of hospital care into the community. Other matters which would have to be considered are allowances for patients who have no financial resources. As indicated by Table 4, page 22, this area would be one affecting a large percentage of patients. Similarly, the need for suitable clothing would have to be met by the hospital as the recidivist patients generally are lacking in material resources. In some instances relatives might be willing to supply this need, but as Table 5, page 25, indicates, there was a limited degree of interest shown by relatives of the twenty-one recidivist patients studied.

Careful timing as to the placing of patients in foster care is essential for the success of the plan. The patient should understand the reasons for his being placed in a foster home and any possible disadvantages should be discussed with him. Visits to the proposed home are a useful and helpful method of introducing a patient to the plan.

Since foster home care can readily be adopted not only for rehabilitation, but equally well for long-term chronic care of patients, it would be useful to classify the homes according to the purpose they serve. Homes for chronic patients would be set up on the basis that the patient would be living out his days there,
unless for medical reasons he had to be removed. On the other hand, if a home were being used for rehabilitation purposes, it would be expected that the patient would eventually be moving out on his own. In these homes one might expect to place patients prior to probationary discharge or those currently on probation from hospital. The length of time the patient could remain in this setting would depend on the discretion of the patient's doctor and the supervising social worker. Once the patient became employed he would be expected to pay a portion or the full cost of the foster care rate, but the factor of employment could not be the only criterion upon which a patient's readiness for discharge to community would be evaluated.

**Facilities.** In selecting the homes to be used in a foster care program, certain physical factors must be given careful consideration. The actual location of the home is important, both in its relation to other homes in the area and in regard to its distance from the hospital and other foster care homes. Good travel connections would be essential in picking homes for rehabilitation purposes in order that patients could commute for work. There are certain physical standards upon which an assessment could be made. The home should show evidence
of cleanliness, have provision for adequate physical care, and some facilities for recreation. A living-room which may be used by both patients and family would play an important part in the socialization of the patient. It is generally considered advisable to have a male member in a family where male patients are to be placed, and while children are no contraindication to the use of a home for foster care, careful screening is indicated.\(^1\)

While certain physical standards must be required in a home, of primary importance is the personality of the operator who will manage the home. Any other persons who occupy the home should also be considered as they, too, will be in continuous contact with the patients. Such considerations are necessary as it is in the area of relationship that a high percentage of mental patients have difficulty. The operator of the home should be a woman, and because of the various roles she may be expected to play she will need to be an understanding person, kindly and sympathetic, yet knowing when and how to be firm. It would be necessary that she be respected and liked in the community, and that her motive for taking patients in foster care be mainly humanitarian. In this regard there should be a source of income apart from that derived through foster care. It

\(^1\)Ontario Department of Health, "A Handbook on Approved Homes in Ontario Hospitals", 1957, p. 6. (Mimeographed.)
would be helpful if the home operator were to possess ingenuity and be able to help patients find occupations and interests suited to them. Her training could come through a series of lectures which would familiarize her with hospital policy and treatment programs. She would be required to assume responsibility for the welfare of the patient on a twenty-four hour basis and during minor physical illness, although having assurance from the hospital that the patient could be returned to hospital on decision of the social worker or other hospital authority, should he require a more controlled setting either because of physical or mental symptoms. Another important area would concern her ability to work with authority figures, such as the social worker, who would have the responsibility of supervising both the home and the degree of care afforded the patient.¹

Patients. Patients for placement in foster home care will be chosen by the social worker in consultation with the medical superintendent of the hospital or his representative and the charge nurse from the patient's ward. Patients with needs similar to those outlined in the study of the sample group of recidivist patients, including both certified and voluntary patients, would be eligible for

¹Ibid., p. 7.
rehabilitation in approved foster homes. Certain categories of patients who generally would not be placed, except under special circumstances, are alcoholics, drug addicts, syphilitics under treatment, invalids or semi-invalids, or uncontrolled epileptics, as it is essential to place patients who will be readily accepted by the community. Such patients can be very demanding of the operator's time, to the detriment of other patients in the home, as well as creating problems in the community. Neither should the operator of a home be expected to care for incontinent patients or those with unclean habits.

Patients suitable for chronic care in foster homes would be older, responsible chronic patients who do not require nursing home care and who do not have financial means of their own, nor family or relatives willing to take them. Suitable also for this type of program are patients who do not require hospital care, but need supervision. This would include patients who, though they have a fixed delusional system, are not a problem in management. Here, too, would fit patients who need to remain on medication of an oral nature that could be supervised by the home operator.

From the foregoing requirements, it is obvious that a foster care plan requires considerable planning, sufficient professionally trained social work staff
capable of supervising its operation, and a community willing to participate in its development. Foster home care can be the means of opening another door to the community, hopefully providing the impetus for patients who have in the past been unable to rehabilitate themselves. Examining such a program from the economic standpoint it can readily be shown that it is less costly to maintain a patient in foster home care\(^1\) than in the institution.\(^2\) However, its greatest value is as a therapeutic tool to aid in the rehabilitation of the mentally ill.

\(^1\)Daily per capita cost of boarding home care for Social Assistance clients is $2.85. This rate has been established by the British Columbia Department of Welfare.

CHAPTER IV

REHABILITATION IN THE COMMUNITY

Social workers began working in psychiatric hospitals some fifty-five years ago. Over these years there has been considerable advancement in treatment methods until today the role of the social worker as a member of the treatment team is a valued one. Actively collaborating in all phases of the patient's treatment, from the period preceding admission, through hospitalization and after care, their knowledge of social adjustment, psychological aspects of mental illness and of community resources, has enabled them to spearhead movements to bring community and hospital closer together.¹

Goals in Treatment

The primary goal in psychiatric treatment of the hospital patient is to bring his illness into remission, enabling the patient to return to his family and community, to function in that environment in a reasonably adequate and satisfying way. The professional training of the social worker especially equips him to work with the patient for the resolution of conflicts arising in the area of social functioning.

Various resources such as "half-way houses," out-patient clinics, day hospitals, foster care programs and social clubs for patients have been provided to extend supportive services into the community. British Columbia has used all these, with the exception of a foster home care program, but no research has been carried out here to determine the value of foster home care for mental patients. This study examined foster care programs used elsewhere in order to relate the merits of these plans in meeting the needs of patients. It was also a requisite that needs of patients at the point of discharge be determined, as well as factors which appear to precipitate a relapse.

As previously described, twenty-one patients who returned to hospital prior to termination of their probationary period were assessed. Chosen by a routine sampling method, all had some degree of activity with the social service department prior to discharge.

The Average Patient

The typical patient examined by this study was found to be thirty-six years of age, diagnosed as having some form of schizophrenic disorder, and in his (or her) fourth admission to hospital. Unmarried, with few friends, no family environment to which he could return, no financial
resources, an inadequate education, and a lack of work skills, his prospects for successful rehabilitation are discouraging.

Limited to certain fields of work as a result of his inadequacies and lacking financial resources, one out of every two in the sample group became the client of public welfare agencies, drawing social assistance. This subsistence level of financial assistance does little to help in the rehabilitation of the mentally ill. Forced under such circumstances to obtain a small, dingy room where he does his own cooking and laundry, he begins in this atmosphere once again to withdraw from the harsh reality of life. Contributing to his withdrawal is the lack of interest shown in him by relatives, and his very limited circle of friends. Many patients, since they feel deficient in the social graces, avoid joining clubs or social groups for fear of being considered odd. This, too, contributes to the general pattern of withdrawal from life, so common to the mental patient. For some patients, who return to live with their natural family, the intense emotional relationships within the family appear to precipitate a relapse. Examination of the sample group disclosed the chief reason for the patient's return was stress of the social situation.

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1 The present social assistance rate in British Columbia is $66.00 per month for a single person.

2 Table 8, p. 33.
From examination of the foster care plans in Maryland and Ontario, it can be inferred that their patients have had needs similar to Essondale patients, and that these have been met satisfactorily by foster home care. The progress of even quite deteriorated patients, who were able to gain a sense of security and a feeling of belonging from the personal interest taken in them by the operator of the home, indicates the value and potential of this resource.

Having a wide range of application, foster home care, in addition to its use for rehabilitation, is quite adaptable to the care of quiet chronic patients for whom little progress is expected. There is every reason to believe it could be readily adapted to aid in the after-care of senile patients who no longer require institutional care, but for whom the community or relatives are unable to provide a resource.\(^1\)

Originally foster home care was developed for the placement of quiet chronic patients, however many patients improved even to the point where a complete discharge was possible; hence the program's use as a rehabilitation resource came into being.\(^2\)

\(^1\)An analytical survey of a group of patients hospitalized for mental illness in the Home for the Aged, Port Coquitlam, B.C., indicates the feasibility of discharge for a number of elderly patients, provided there is some resource available for their care. E. Elmore, Discharge Planning in the Homes for the Aged, Master of Social Work Thesis, University of British Columbia, 1959.

\(^2\)Crutcher, Hester B., Foster Home Care For Mental Patients, The Commonwealth Fund, New York, 1944.
In this study the examination of the program developed under three general areas: general policy, needed facilities, and types of patients, in each area giving indications of factors worthy of careful attention. From an economic standpoint this program could be expected to reduce the daily per capita cost (\$4.59)\textsuperscript{1} of keeping such patients in the mental institutions. This, however, is not the chief merit of such a program, although it could well be a factor in presenting the value of the program for this province.

Presenting Foster Home Care to the Community

An important organization job would be the presentation of the plan to the community. Support by the local branch of Canadian Mental Health Association would be valuable. Among their group of volunteers who come weekly to the hospital might be found a good source of potential foster home operators, as well as strong advocates for the program in the community. It would be necessary for social workers and medical personnel from the hospital to address various groups in the area, such as women's organizations, men's service clubs, religious groups and

\textsuperscript{1}Daily per capita cost. The Provincial Mental Hospital, Essondale, B.C. Annual Report Mental Health Services, Province of British Columbia, 1958, p. L 25.
others known to be interested and influential in supporting worthy community projects. Through an effective presentation of the plan, it would be hoped to arouse acceptance and support.

An important consideration in initiating the program is timing. If the community has not been prepared to accept the idea of a foster care program, then premature attempts may be disastrous. Many people may approve of the program, yet object very strongly if patients are to be placed in the house next door. Here an essential factor in community organization processes must be recognized, that of perceiving, eliciting and handling the fears, concerns and objections of the community. If the community is judged to be ready, then a campaign might be launched in conjunction with the annual "Open House" held by the hospital.

Research Considerations

The sample group studied here indicated the needs of patients and showed that these needs could be met, in part, through a foster care program; however, at the present time there is no accurate estimate of the number of patients in the Provincial Mental Hospital, Essondale, B.C., who could benefit from a foster care program. Possibly the answer to this will be obtained through a questionnaire for use in rating patients on the ward.
A vital question, "Why do patients improve and recover in the foster home setting?" requires scientific research. It is recognized that some progress may be due to the interest and concern patients receive from their foster families, but hypotheses are not enough. Isolating the variables that bring about recovery or improvement will require careful study. It will also be helpful to obtain or devise some technique by which the degree of movement or change in a patient through foster home placement can be measured. Such a rating scale would be a valuable tool in social work research.

The emphasis today in decentralization of large mental institutions, with a community orientation toward mental health services, is on keeping the patient in his natural environment rather than in isolating him from the community. Since foster home care is a program which aims at a similar goal, the placing of the patient in a natural family setting in the community, the time may be here for its development in this province.
APPENDIX A

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