FAMILY CARE HOMES FOR MENTAL PATIENTS

A Comparative Review of Family Care Programs as Rehabilitation Aids, and Some Local Applications.

by

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The goal of treatment is the restoration of the mental patient to the community. This study has sought to show that family care is a useful device for rehabilitation, both for the person for whom return to independent living is expected, and as a means of providing a more satisfactory way of life than the hospital environment for the person who will continue to need supervision.

The method used was to survey the development of family care in Europe, Canada and the United States, and to compare various characteristics of U. S. programs in New Jersey, Wisconsin, Michigan, California, Idaho, Maryland, Kentucky and Minnesota. A report of the Veterans Administration, Washington, D. C. was examined, and a study was also made of special features of foster care programs in the Veterans Administration Hospital at Bedford, Massachusetts, and St. Cloud, Minnesota.

A general assessment was made of existing arrangements for boarding home care of mental patients in British Columbia, with special reference to community resources available, in order to determine the relative merits of boarding home placement versus family care. In this connection the files of all patients placed in boarding home care by one full-time social worker at the Provincial Mental Hospital, Essondale, B. C., between July 1, 1959 and August 31, 1960 (comprising 20 patients in all) were closely examined to establish the main characteristics of the group and their community adjustment.

In the concluding chapter, as a result of the various comparisons made, it was possible to draw up a check list of criteria which could serve as a guide in setting up and developing future family care programs. The check list in summary comprises the following points: (1) orientation of hospital employees and the community to the program; (2) preparation of the patient; (3) sufficient number of social workers to operate the program; (4) sponsors suited to the task of caring for patients; (5) adequate physical standards in the home; (6) provision of medical services for patients; (7) provision of clothing and money for incidental expenses and comforts allowance for patients without means; (8) encouragement of appropriate social activities; (9) homes of varying sizes to meet the needs of different patients; (10) location of the home within access of community facilities for the benefit of patients.

The broad conclusion is that the provision of adequate services will ultimately depend on the assumption by the community of the responsibility for the rehabilitation of the mentally ill.
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FAMILY CARE HOMES FOR MENTAL PATIENTS
In recent years it has become the fashion to talk of mental health rather than mental illness. Although in Canada there are numerous associations concerned with the problems of specific illnesses such as the Canadian Arthritis and Rheumatism Society, and the Canadian Diabetic Association, to name but two, the organization concerned with promoting the prevention of mental illness and interpreting to the community the needs of the mentally ill is named the Canadian Mental Health Association, whose formation grew out of the founding of the Mental Hygiene movement in the United States.

Various criteria have been suggested to define mental health, one of them being normal behaviour. But this in itself presents difficulties. Behaviour that is considered normal in one culture or community may be regarded as quite abnormal in another. In one of the busy streets of a fair-sized city in India the writer has seen a man dressed in flowing black robes, with locks of hair falling well below the shoulders (rather like the popular conception of one of the twelve apostles) wandering amidst
the traffic, oblivious to everything around him, and another individual, who appeared to be in good physical condition, rolling along the sidewalk instead of walking in the accepted fashion. The former was absorbed in meditation, while the latter may have been performing some act of penance; but no one paid the slightest attention to either of them. In a western city, the "apostle" would be regarded as highly eccentric, if not with serious suspicion, while the man who chose to roll instead of walk would be picked up by the police in short order. What therefore is "normal"?

Sol W. Ginsburg, in an article on "The Mental Health Movement and its Theoretical Assumptions" published in 1955 in a volume of essays entitled Community Programs for Mental Health, deplores the lack of an adequate definition of mental health. He remarks that early attempts to define mental health merely identified it with absence of mental illness; yet, except in cases of very severe disorder, there is no clear dividing line between mental health and mental illness.¹

People also began identifying mental health with "happiness", "maturity" and so on, which only added to the

confusion. Thus, in one article mental health is described as "the ability to meet and handle problems, to make choices and decisions, to find satisfaction in accepting tasks, to do jobs without trying to avoid them or pushing them on to others, to carry on without undue dependency on others, to live effectively and satisfactorily with others without crippling complications, to enjoy life and to be able to love and be loved."¹ This prescription for a kind of "gracious living" seems an attempt to define the mature individual, and one wonders how long one could go on adding to the list of suitable attributes.

The author previously quoted prefers to adopt a comparatively simple if somewhat unscientific set of criteria. These are "the ability to hold a job, have a family, keep out of trouble with the law and enjoy the usual opportunities for pleasure." We might then consider that those who are unable to fulfill these basic criteria are suffering from some form of mental disorder.

Diagnostically, a different kind of definition is possible. Thus, mental illness has been described as "a range of psychiatric disorder and manifestation, with biological, physiological and psychological causative:

factors which lead to acute or chronic physical, emotional, and/or behavioural disabilities and conditions unfavourable to mental health."¹

In medico-legal practice the mentally disordered have been divided into two broad groups. The first group is comprised by the mentally defective (those whose minds never fully developed) and the second by the mentally ill (those whose minds developed normally and then became affected by some disorder later in life.) This distinction has practical value. The term "mentally retarded" is now more generally used than "mentally defective." There are varying degrees of retardation from the mildly retarded, sometimes referred to as morons, down to the severely retarded, or idiots, who are chiefly nursing problems.

The causes of mental retardation, though numerous, are on the whole well understood as a result of medical and neurological research. On the other hand, the causes of mental illness as a functional disorder -- that is, where there is no evidence of organic brain impairment -- are still obscure. Certain schools of medical thought see the explanation of mental illness in early traumatic childhood experiences, while others believe that mental illness may be due to bio-chemical factors, as yet not fully identified. Intensive research in the latter field of enquiry is now taking place.

¹Ibid., p. 383.
The Goal of Rehabilitation

Part of the basic philosophy of social work is belief in the worth of every individual, in his potential for growth and change, and in his right to find his most satisfying social adjustment for himself and the community; and, further, that the community has responsibility toward the individual in assisting him in making this optimum adjustment.¹ This philosophy is affirmed in the definition of rehabilitation adopted by the National Council on Rehabilitation (U.S.), in 1943. This postulates "restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which he is capable." The National Association of Social Workers (also U.S.) in its statement on Goals of Public Social Policy published in May, 1958, maintains that it is possible to assist the handicapped individual in achieving a maximum of independent functioning (in terms of self-care, productive work, recreational activity, and social relationships) through a program of co-ordinated rehabilitation services which help the individual in terms of his own needs and life situation, to develop and use his actual capacities to best advantage. "Rehabilitation comprises those medical, psychosocial, educational, and vocational services to, or in behalf of, an individual

¹See e.g., Philosophy, Concepts and Principles of Social Work, The University of British Columbia, School of Social Work. (Mimeographed.)
with a physical or mental impairment that will enable him to realize his physical, mental, social, and vocational potential."¹

These are broadly-based goals. To what extent is the community prepared to accept them for the mentally ill? During the last three decades in Canada, a number of social security measures directed towards the welfare of the aged, the blind and the disabled have been introduced, while great strides forward have been made in the prevention and cure of diseases such as tuberculosis and poliomyelitis. But public recognition of the needs of the mentally ill, and progress in the conquest of mental illness, have moved at a much slower pace.

A British writer has stated that "one out of twelve people in this country will be admitted to a mental hospital during their life-time. Nearly one-half of our hospital beds are being used for the treatment of mental illness."²

Robert S. DeRopp, in an illuminating book on Drugs and the Mind, published in 1957, emphasizes the gravity of this situation in the United States, remarking that mental illness fills more hospital beds than cancer, heart


²Chiesman, W.E., "Return to Work", in Ling, Thomas M., and O'Malley, C.J.S., Rehabilitation, London, Baillere, Tindall & Cox, 1958. (The above is a much quoted figure in U.S., Canada and Britain. It could do with some careful interpretation.)
disease, and tuberculosis combined. But in spite of the fact that schizophrenia is the greatest of all public health problems, the sums spent on research (even in the United States) into the causes and cure of the disease are scarcely equal to the cost of a single jet bomber. No other major ailment is so completely ignored. Dr. DeRopp argues: every victim of poliomyelitis receives the benefit of $28.20 worth of research funds per year, every victim of cancer $27.57, every victim of tuberculosis $26.80. But the schizophrenic, despised and rejected by the public, only has spent on him a mere $4.15 of research money.¹

Not so many years ago, treatment of patients in a large number of mental hospitals was based on the concept that, owing to their removal from reality, there was no necessity to provide them with the comforts enjoyed by people suffering from physical illness. It was also believed that, owing to their mental condition, they could not respond to sympathetic understanding and social contacts. Because of the inaccessibility of many of these hospitals, patients were removed from relatives and friends, and apt to be forgotten. In fact, mental hospitals came to be regarded as a convenient means of removing the mentally ill person from the community rather than as

institutions directed towards their care.

But the old attitudes are slowly changing, and the basic worth and dignity of the individual is coming to be recognized in the mental patient as well as in the patient suffering from physical illness. In recent years, through autobiographical accounts of those who have been patients in mental hospitals, through discussion in magazines and newspapers, on the radio and T.V., the public has become increasingly aware of the problems and extent of mental illness.

Great advances have been made in the treatment of mental illness, including the development of psychiatric out-patient clinics, mental health centres, child guidance clinics, the use of psychotherapy, physiotherapy, and insulin and shock treatment. The tranquilizing drugs, reserpine and chlorpromazine, originally introduced in 1952, and in wide use by 1956, have had remarkable results in the treatment of mental illness, and a whole battery of new and improved medications has developed since that time. Referring to their effect on hospital discharge rates Dr. DeRopp states: "Following the widespread use of these new drugs, in 1956 for the first time in approximately 200 years of the history of public mental hospitals in the United States, instead of the expected increase of 10,000 patients, there was a reduction of over 7,000 patients. In New York there was a 23% increase in discharges from state mental hospitals between April 1955
and April 1956. It would be a mistake to attribute this to the drugs alone. Coincident with the use of drugs, there has been an increased appropriation for personnel. Also, the drugs, by suppressing many of the symptoms of psychiatric illness and by modifying behaviour, permit the healthy forces in the patient and the socializing forces in the hospital to function. Patients become more communicative and rehabilitative procedures are more possible.\textsuperscript{1}

The new conception of the mental hospital is an institution primarily concerned with the rehabilitation of the patient on a team-work basis, rather than a place for the custody of the mentally ill. Thus in the Physician's Manual of the B. C. Psychiatric Service it is stated that a mental hospital is not a place of custodial care, but a specially created environment in which mentally ill patients can adjust, and a place where they can receive treatment according to their needs. Patients will continue to need total push therapies involving the cooperation of the physiotherapist, the occupational therapist, the recreation therapist and the social worker, and all other forms of psychotherapy. The problems of mental disease will never be solved by any one group of professional workers, and cooperation and coordination of all groups, both professional and otherwise, are essential in the psychiatric

\textsuperscript{1}\textit{Ibid.}, p. 467.
Increasing emphasis is being placed on the relation of individual attitudes to the structure and operation of institutions. Thus Saul H. Fisher in an article entitled "The Recovered Patient Returns to the Community" recently published in *Mental Hygiene* remarks that it has been shown that hospital organization, the roles of the individuals in the hospital, and the functioning of the various sub-parts of the social structure have a bearing on the therapeutic course of the patient and can explain many of the symptoms patients show in hospital.\(^2\)

Dr. Maxwell Jones has carried out an experiment along these lines for some years at the Industrial Neurosis Unit at the Belmont Hospital in England. Dr. Jones explains in his highly significant book on this work\(^3\) that an attempt is made to absorb the patient into the "unit community", where social and vocational roles are provided him. These roles approximate as far as possible to what is found in the relatively healthy community outside. The therapeutic community views treatment as located not in the application by specialists of certain shocks, drugs or interpretations, but in the normal interactions of healthy

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\(^1\)B. C. Provincial Health Services Physician's Manual, 1951.


community life. Tensions associated with various roles can be worked out while still in hospital and in this sense the unit is a transitional community. Jones believes that it is possible to change social attitudes in relatively de-socialized patients with severe character disorders, provided that they are treated together in a therapeutic community. The implications of this for developed community resources, such as appropriate boarding units, is referred to at further points in this thesis.

**Post-discharge Needs of Mental Hospital Patients.**

New community attitudes and advances in scientific knowledge of the treatment of mental illness have changed the focus of mental hospitals from primarily custodial institutions to centres where the available resources are brought together and concentrated upon the rehabilitation and, where possible, discharge of the patient. Following upon the use of new therapies, especially the tranquilizing drugs, hospital discharge rates are increasing rapidly. But the task of reintegrating patients into the community remains to be solved. What are some of the problems faced by the mental patient on his return to community life? It will be helpful to list these under three headings.

**Social Factors.** Mental illness still carries with it a stigma. The public is apt to regard the mental
patient as being either dangerous or "queer", or both. As a result, the patient himself is afraid to admit that he has received treatment in a mental hospital; this in itself forms a barrier to communication, since the patient believes his illness will not be "accepted" by those with whom he comes into contact.

If the patient has spent a long period in hospital, his social efficiency will be impaired by removal from community contact. If he returns to his family, he will need to re-learn how to live with them again and how to live in a changed world, while his own family too will be obliged to adjust to a different way of life. During his years of hospitalization, members of his family may have died, or lost contact with him, or formed new patterns of living so that they are unwilling to have him return. Or the family situation may have been such a contributing factor in his illness that other living arrangements are necessary for him.

As a residual effect of his illness, the patient, more especially the recovered schizophrenic, may have great difficulty in forming relationships with other people. He may easily become suspicious, frustrated, and unwilling to participate in social activities.

**Economic Factors.** When the patient leaves the hospital he may again be faced with the problem of supporting himself, and perhaps his family. He may have
lost his special work skills through lack of use while in hospital, and he will not have had the opportunity to learn new techniques. Perhaps a period of retraining will be necessary. Through his hospitalization he has lost his place in industry or other employment, and, especially in view of lack of recent employment experience, will find reinstatement difficult. This will be doubly so if he has reached the middle-aged bracket when even a so-called normal worker finds it a hard task to be accepted for employment in competition with younger men, or where employment policies discourage the recruitment of older applicants.

Added to these difficulties the stigma of mental illness still confronts him. Should he tell his prospective employer that he has been a mental patient and risk unfavourable reaction to this news, or should he say nothing about it, and try to account as best he can for his period of absence from the labour market. These are very real questions which discharged mental patients are asking every day.

**Medical Factors.** The discharged mental patient may still suffer some residual effects of his illness and be in need of regular medical consultation and treatment. Yet such care may not be available in the community in which he lives, or alternatively such facilities may
be available but the patient unable to pay their cost. It has been estimated that the cost to the patient of tranquilizing drugs alone may run as high as thirty to fifty dollars a month. Few patients are able to continue on medication without outside assistance. A further factor is the tendency on the part of some patients to deny their illness by refusing to seek medical advice or to take medication prescribed. For these patients some kind of community supervision is necessary if their health is to be maintained.

Louis Leveen and David Priver have described, in a recent article in *Social Casework*, the operation of the Gateways Health Centre established in Los Angeles, California, in 1954 by the Jewish Committee for Personal Service.¹ This is a combined hospital and mental health centre, offering psychiatric treatment and rehabilitation facilities, both to people living in the community and to discharged mental patients. Mr. Priver is Assistant Executive Director, and Mr. Leveen a caseworker at the centre. Outlining some of the difficulties that the mental patient has to face in his return to the community, they point out that long-term hospitalization in any setting reactivates a person's dormant dependency needs. When he is mentally ill this problem can be particularly severe. Frequently the mental hospital patient who

returns to the community suffers from intensified feeling of insecurity and extreme lack of confidence from which his mental illness afforded an escape.

The rehabilitation of the person who has been discharged from a mental hospital is further complicated because, in most cases, there is still a residue of the mental illness. Unlike others who experience emotional problems and whose defences are still intact, the person who returns to the community from the state mental hospital is likely to be disabled in most areas of social functioning. Often his disintegration is so complete that he needs help in all the vital areas of living -- job placement, living arrangements, and so on.

The "Family Care" Approach.

To assist those patients ready for discharge from hospital who have no homes to which they can return or where emotional factors in the family situation would be detrimental to the patient's mental health, family care has proved a useful means of reintegration into community life. It has been described as "a specialized plan for the extramural care and treatment of mentally ill and mentally deficient patients who have received the maximum benefits of hospitalization but are not ready to return to their own homes or to their individual places in the community." 1 Thus, patients referred for

1 Family Care Program, State of California, Department of Mental Hygiene. (Mimeographed.)
family care are believed to have made sufficient pro-
gress in hospital to live outside the institution, but
are considered not yet capable of managing on their own
without some help and supervision. Family care has a
two-fold purpose; to provide a more happy, stimulating
and socializing experience than is obtainable in hospital
for long-term patients who will continue to need care
for an indefinite period, and to provide a stepping
stone for the convalescent patient for whom it is hoped
there will be an eventual return to full self-responsibility
and independent living. There is also the added advan-
tage to the hospital that the discharge of patients no
longer in need of the hospital environment will make more
hospital beds and staff services available for the treat-
ment of acute cases.

There is nothing new about the principle of family
care. As far back as 1792 in England, a group of Quakers
discussed the advantages of an institution for the care
of mental patients in which a family atmosphere predomi-
nated. As a result of the adoption of ideas presented
by William Tuke, an institution known as "The Retreat"
was established near York in 1796. Among the principal
objects of the founders was the provision of a family
environment for patients as shown in the non-institutional
character of the building and its surroundings, emphasis
on employment and exercise as therapeutic measures, and the treatment of patients as guests rather than inmates.

Almost a hundred years later, Dr. S. Weir Mitchell, an American neurologist, in an attack on institutional medical officers delivered at the fiftieth annual meeting of the American Medico-Psychological Association, was saying: "There is another function you totally fail to fulfill and this is by papers in lay journals, to preach down the idea that insanity is always dangerous, to show what may be done in homes, or by boarding out the quiet insane, and to teach the needs of hospitals until you educate a public which never reads your reports, and is absurdly ignorant of what your patients need." It is interesting to speculate how far he would still feel compelled to say this today.

Family care of the mentally ill and the mentally defective is said to have its origins in Gheel, Belgium, as early as the end of the sixth century, and is usually attributed to the shrine of an Irish princess named Dymphna. The shrine was celebrated for its miraculous cures of mental illness, pilgrims journeying to it from

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long distances in the hope of being restored to sanity.¹

The Church assumed the responsibility for the housing of these patients, and, as the numbers increased, many were placed with sympathetic private families. As the work grew, it became subject to local governmental regulations; but, after this situation had prevailed for fifty or sixty years, it became apparent that family care in Gheel was meeting a nation-wide need. The national government took over responsibility for the program, and the present hospital facilities were established. Thus the hospital assumed the scientific care of patients living with families in direct response to a community need for help in a situation which had been developing for several hundred years. Today there are thousands of patients living in homes in Gheel and nearby villages.

This form of family care has come to be known as the colony system. Although the shrine at Gheel and the traditions of care for mental patients in families could not be duplicated elsewhere, the general pattern was adopted at the colony established at Dun-sur-Auron in France as early as 1893.

France, Germany, Switzerland and Scotland introduced family care in the latter part of the nineteenth

¹Crutcher, Hester B., Foster Care for Mental Patients, The Commonwealth Fund, New York, 1944, pp. 96-103.
century, Denmark has had this system in use for approximately thirty-five years, while Sweden and Czechoslovakia have made use of family care for about twenty-five years. With the exception of the colony at Dun-sur-Auron, patients have been placed directly from the hospital to which they were committed, and no importance has been attached to the development of a colony system.

Family care, or foster home care, was first introduced into the United States in 1885 in the Commonwealth of Massachusetts, and was later developed in other states. The utilization of family care declined for a time because state administrations made improper use of this device in order to reduce hospital costs. Thus patients were sometimes placed in foster care who could not possibly benefit from such a program since they were actually too ill to leave hospital. Modern-day experience with family care in the United States dates from the nineteen-thirties.¹

In Canada, family care has not been developed as far as in Europe and the United States, although Ontario and Saskatchewan now have planned foster-care programs. All provinces have used some type of boarding home care

¹Pugh, Edward N., A Study of the Family Care Program, Veterans Administration Hospital, Waco, Texas. (Mimeographed.)
from time to time, but it has never been developed on a large scale due to financial cost and lack of staff to operate the program.¹

Focus of study.

The purpose of this thesis is to examine family care as a useful device for the rehabilitation of discharged mental patients, who have no homes to which they can go, but who need some supervision on their return to community life. After surveying current literature on the subject, a three-fold method of enquiry has been followed. (1) The development of family care in Europe, Canada and the United States has been reviewed, and some features of U. S. programs compared; (2) A general assessment of current arrangements for boarding home care in British Columbia has been made, with special reference to the community resources available to discharged mental patients; (3) A small sample of cases discharged to boarding-home care from the Provincial Mental Hospital, Essondale, B. C., over a period of fourteen months, has been closely examined. Through these lines of enquiry it has been sought to establish basic criteria for a sound family-care program.

Family care is designed to meet the needs of two principal groups of patients. The first group consists of long-term patients whose illness is of a chronic nature. They have shown progress in hospital to the point where it is considered that their behaviour is sufficiently stabilized for them to derive benefit from living in home surroundings under some supervision, but marked improvement is not anticipated. The second and smaller group comprises patients recovering from the acute stages of illness for whom family care is seen as a stepping-stone to full self-responsibility, though a high level of adjustment is not necessarily expected.¹

In New Jersey, family care was first conceived of as an extension of hospital care to relieve overcrowding but gradually the custodial aspect gave way to therapeutic considerations and the family care program was regarded as one of several channels by which certain patients might be assisted in a more complete integration into community living.²

¹Crutcher, Hester B., Foster Home Care for Mental Patients, The Commonwealth Fund, New York, 1944.

²State of New Jersey, Family Care Manual, Division of Mental Health and Hospitals, New Jersey Department of Institutions and Agencies, July 1, 1959.
In its family care manual the State of Wisconsin, Division of Mental Hygiene, states that placement is an extension of the therapeutic or rehabilitative plan for the patient and under no circumstances is family care to be used as a substitute form of custodial care.\(^1\)

In contrast the Michigan Department of Mental Health notes that the focus of the family care program has varied in accordance with the needs of the department. The program was initiated in 1942. In the beginning, emphasis was placed on patient rehabilitation, (i.e. a transition period in which the patient is helped to readjust to community living in a carefully selected home under hospital supervision before moving on to convalescent status or discharge) but over the years the focus has changed from time to time in accordance with the amount of personnel available to select appropriate patients, find suitable homes, supervise patients placed therein, interpret the program to the community, and assist the family care therapists in developing skill in working with patients.\(^2\) It is pointed out that when it is necessary to place large numbers of patients with little or no increase in staff, patients of the "custodial" type should be placed in special facilities.

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\(^1\) *Family Care Manual*, State Department of Public Welfare, Division of Mental Hygiene, Wisconsin. September, 1960. (Mimeographed.)

\(^2\) *Michigan Department of Mental Health, Family Care Program*, December 19, 1960. (Mimeographed.)
type are selected and homes that can accommodate large numbers of patients are sought in order to make at least minimal supervision possible, such supervision, of necessity, amounting to little more than making sure that the patients receive adequate physical care. This means that there is little movement in such a program except between the hospital and the family care home, and back again. But most hospitals are making an effort to place all patients with therapeutic intent regardless of diagnosis or length of hospitalization. The degree to which each is successful is commensurate with the degree to which total staff understands, accepts, and participates in the program.

Selection of the Patient.

Patients are usually referred for family care planning by the psychiatrist to the social service department after a careful review of the case to determine whether or not there are mental or physical symptoms which indicate a need to keep the patient longer in hospital. The patient's physical condition should be well stabilized. His adjustment on the ward, whether he mixes well with the other patients or remains seclusive, whether he is quiet or combative, whether he cooperates with the staff or resists authority, are all
factors to be considered. The extent to which the patient is able to look after his own needs in bathing, dressing, looking after his clothes, and his measure of success in carrying out daily tasks in the hospital will all be indications of his ability to adjust to home life. Patients who are suicidal, violent or destructive are excluded from family care placement as is the case with the alcoholic and the drug addict, most family care manuals having something in their regulations to this effect. However, it is interesting to note that the Veterans Administration Hospital, Bedford, Massachusetts, shows flexibility in this matter. In a letter to another Veterans Administration hospital explaining their family care program, their Chief Social Worker remarks that although they do not consider patients who have been recently assaultive, patients who are alcoholics, or patients with an addiction problem, as good family care prospects, yet they have in fact placed patients who have had these problems to varying degrees when everything about their situation seemed to warrant family care consideration.  

This hospital makes a point of involving staff people in family care planning primarily through the use

1Copy of letter from Rebecca Glasmann, Chief, Social Work Service, Veterans Administration Hospital, Bedford, Massachusetts, dated January 15, 1959, to Chief Social Worker, Veterans Administration Hospital, Downey, Illinois.
of a family care board which is an approving body for potential family care homes, for patients being placed, and for other administrative problems pertinent to the program. This board consists of the family care workers, staff supervisors, chief social worker, ward physician of the patient concerned, the chief of professional services, the clinical psychologists and other staff personnel who have played a particular role in the patient's hospitalization.

The social worker to whom the patient is referred usually has a number of interviews with the patient to determine his feelings about going to a family care home, and to assess his readiness to leave the hospital. She may also interview his relatives to explain the need for family care. During this period she will have discussions with the nursing and other ward staff about the patient's general behaviour. Patients who have become used to hospital life are often frightened at the thought of leaving the security of the institution. Some need time -- often several months -- to adjust to this new idea, and in fact a few can never bring themselves to the point when they can leave the hospital. No patient who does not wish to be discharged should be obliged to go to a foster home against his will. In its Family Care Manual, New Jersey specifically states: "The
individual shall be given the right to approve or disapprove of the home. No one shall be placed in a family care program against his wishes."

In addition to the individual casework with the patient, various devices have been used to motivate the patient towards wanting to go to a foster home. California reports the use of patient group meetings to help orient potential family care patients to the program. The approach is one of informing and interesting the patient and also of dispelling his fears about placement. Successfully placed patients returned to their hospitals for some of these meetings to help correct misconceptions about family care. At one state hospital patients from nearby family care homes appeared on closed-circuit television before both patients and employees to discuss the program.¹

The Veterans Administration, Washington, D. C., in its report entitled Foster Home Program for Improved Psychotic Patients describes a number of measures which have been successfully tried. One hospital maintains a continuing group program with foster home care candidates. This is an open-ended group so that patients may come

¹ State of California, Department of Mental Hygiene, Family Care: Technique and Achievement, September 1960. (Prepared for the Monthly Report to the Governor.)
and go as they please. Other hospitals test the patient's ability to adjust on the outside by giving him day passes, then week-end passes or longer, to stay in the foster home before final placement is made. In one hospital the patient is stimulated to accept foster home care by having him first visit foster homes with the foster home worker. The social worker tries frequently to take the patient to homes where there are other patients who have been in the ward with him. Hospitals have invited back for a visit some of the patients who have been successfully placed in foster homes. In the course of conversation with their old "buddies" the homes in which they are now living will inevitably be discussed. Sometimes a foster mother is brought to the hospital to meet staff members or patient groups in order to describe her home and the patient who may be living there, with the object of spreading greater knowledge about the program to the hospital staff and patients.

Several hospitals have separate cottages housing about twenty or twenty-five patients, where candidates for foster-home living reside. Here home conditions are stimulated, and the occupants are exposed in varying degrees, to the responsibilities which go with more independent living in the community. Volunteers have
been used as companion therapists to promote patient interest in foster home care. It is reported that they have been singularly helpful in stimulating patients to accept this type of living.¹

Finding the Homes.

The work of finding the foster home and evaluating the sponsor usually devolves upon the hospital social worker. Sometimes the family care supervisor at the hospital assesses the sponsor in an initial interview, and subsequently the social worker visits the sponsor in the home to gain her own impressions of the family situation. The supervisor and the social worker are then able to combine their views in making an assessment.

Where this is a new program to be introduced, the support of many community groups and volunteers may be needed. It is also necessary to bring the objectives of the program to the attention of the public through the medium of articles in the press, through radio and T.V. announcements and so on.

Veterans Administration Hospital, Bedford, Massachusetts, have not felt that homefinding has been a particular problem over the years. They have used such devices as stimulating referrals through agencies such as the Red Cross, the Family Service Agency and the

¹Foster Home Program for Improved Psychotic Patients Veterans Administration, Washington, D.C., January 1960.
State Division of Child Guardianship, which have been helpful. Newspaper publicity has also been used. They have found that a surprisingly successful method of obtaining suitable homes has been through answering advertisements for room and board situations. Here they encountered much less resistance than was expected when it became known that a home and care was needed for a mental patient. Many of their referrals have come from people already engaged in family care activities as caretakers.¹

A report received from the State of California Bureau of Social Work confirms that the best recruiters are the caretakers themselves, who refer their friends. The patients also interest others in the question of family care. In California, field workers are responsible for investigating and certifying homes. However, although certain physical standards are required of the home, of much more importance is the evaluation of the caretaker's own qualifications. Homes are of all types with a wide range of capabilities among the caretakers. Many caretakers make good use of the services of social workers, and are creative, imaginative and understanding in assisting patients to move back into the community. Some are

¹Copy of letter from Rebecca Glasmann. (See reference p. 24.)
especially helpful to patients seeking employment or undertaking training, while other equally good caretakers are more successful with patients who may require care over a period of years. ¹

In order to make the task of supervision by the social worker more manageable and to avoid excessive time spent in travel, it is advisable that the homes should be within a reasonable distance of the hospital. These may be quite close to the hospital but not usually outside a fifty mile radius. This also gives the patient and the sponsor a greater feeling of security should an emergency call for the social worker be necessary.

Qualities expected of the sponsor are warmth, friendliness, understanding, acceptance of mental illness, and an ability to cooperate with the social worker in planning for the welfare of the patient. It is important that the sponsor should have some financial security other than reimbursement for the care of patients. Otherwise financial need may unconsciously influence the sponsor in taking an over-optimistic view of a patient whose symptoms indicate that he needs to be returned to hospital. New Jersey's Family Care Manual stipulates that the sponsor should have the financial resources to

¹Personal Letter from Miss Lexie Cotton, Supervising Psychiatric Social Worker II, Department of Mental Hygiene, State of California, December 21, 1960.
meet the cost of necessary improvements to the home, if any, and that the sponsor should be able to meet the initial expense of maintaining individuals through the period of early operation.

Standards of the Homes.

Requirements of the home vary from one program to another. The following are the basic requirements for family care homes as stated in the family care brochure for prospective caretakers of State Hospital North, Orofino, Idaho:

1. "The sponsors will be of suitable character, temperament, and physical health to be able and willing to provide adequate care, comfort, and understanding of trainees on leave of absence, and to work cooperatively with the social worker and the hospital for the best interests of the trainee. Other members of the family must be agreeable to the program.

2. The sponsor must have a net income from an already existing source which is regular, dependable, and sufficient to maintain a comfortable standard of living.

3. The homes must meet minimum housing standards, and local, city or county health, fire and zoning ordinances.

4. Each trainee shall be provided an opportunity to share in family life, shall be provided with three meals per day, and individual beds."  

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1Family Care Brochure, Superintendent, State Hospital North, Box 672, Orofino, Idaho.
The regulation stating that trainees' bedrooms may not be above the first floor is probably designed to meet the needs of placement primarily in rural districts where wooden buildings are more common and fire hazards greater. Such a rule would scarcely be practicable in a city area.

Scope of Accommodation.

In the earlier phases of family care, especial emphasis was directed to the position of the patient in the family constellation. In Maryland, foster care for mental patients was first introduced at the Springfield State Hospital in 1935. Writing about the Maryland plan in 1954, Henrietta B. DeWitt explains that not more than two patients are placed in one home because it is felt that a family cannot absorb more than two people into its pattern of living without effecting drastic changes in the design of family relationships. It is believed that the patient should not be placed in a position of unfavourable competition with other members of the family. Thus, the placement of an elderly woman in a home where there is already a grandmother might jeopardize the therapeutic advantage to be gained from the situation because the patient would have a rival with whom she would not be able to contend. It is even considered that the placement of two patients of the
same age and sex might not be advisable as this would tend to set them apart as "the patients" rather than aiding their acceptance as individuals.\(^1\)

However, this concept is now by no means accepted as valid by many other states. In New Jersey homes of all sizes are used because it is believed that although some patients do better if they are the only person in the home, others improve if they are with a larger group. Some homes have twenty-five or thirty boarders, but in many cases the homes are usually shared with welfare clients. Many larger homes are used because the communal type of living seems to further the resocialization process and to be an excellent intermediate step to encourage independence, getting along with others, and final discharge from the institution. Most hospitals today are "open-door". The fact that the public has come into the hospital means that the patients themselves are different. Very few need the earlier protection and close relationship which was very much a part of earlier family care programs.\(^2\)

In Kentucky, the Department of Health is authorized to place two or three patient together; in Wisconsin

\(^1\)DeWitt, Henrietta, The Foster Care Placement of State Mental Hospital Patients: Maryland Plan, 1954.

numbers are limited to four. In California not more than six patients may be placed in one home, as is the case in Massachusetts (although Commonwealth legislation permits up to ten retarded persons.)

**Financing of Programs and Rates of Assistance.**

There is considerable variation among the different states in the methods of financing family care programs; also in the rates paid for the support of patients in homes. The cost of support is often shared between the hospital institutions concerned and categorical public assistance programs. In New Jersey, as in Kansas and the State of Minnesota, in particular, much emphasis is placed on the coordination of relief planning with categorical assistance.\(^1\) The maximum total monthly payment for an individual from a mental hospital in family care in New Jersey is $85.00 a month for room and board, plus $7.00 for medical and dental services, $4.50 for personal incidentals, $2.00 for personal laundry, and $1.50 for dry cleaning and clothing maintenance. Clothing is furnished on an "as needed" basis by the institution. The maximum total per diem figure chargeable to the county is $3.29 for an individual in family care, $2.79 being for room and board, and the remainder itemized to be allocated to the various additional expenses as listed above.\(^2\)

\(^1\) Personal Letter from Mrs. Eleanor Engelbrecht.

\(^2\) State of New Jersey, Family Care Manual.
In Wisconsin the cost to the state of the supervision and maintenance of any patient boarded out must not exceed the average per capita cost of his maintenance in the state hospital or colony. The county of his legal settlement is charged with certain of these expenses in accordance with statute.¹

In Idaho the Division of Mental Health pays a maximum rate of $72.00 per month per patient in family care. These patients do not qualify for assistance from the State Department of Public Assistance, which administers the categorical programs of old age assistance, aid to the blind, aid to dependent children, and aid to the totally and permanently disabled. Neither is assistance obtainable from the county commissioners who only grant assistance in cases of desperate need.²

In Massachusetts payment for a state-supported patient in a boarding home must not exceed $4.00 per day, though remuneration for a privately supported patient is not subject to limitation.³

The Michigan Department of Mental Health divides family care homes into classes, rates paid being in


²Idaho Department of Health, Thermofax copy of National Institute of Mental Health Project, received from T.R. Mager, Chief, Social Service Department, March 20, 1961.

³Family Care Manual prepared by Family Care Committee of the Massachusetts Mental Health, Social Workers Association, 1951.
accordance with the number of patients in the home. A Class I home is approved for one to two patients, a Class II home for two to four patients, and a Class III home for five or more patients. Present rates for each class of home per patient are $2.45 per day for Class I, $2.30 for Class II, and $2.05 for Class III. In its 1961-1962 budget the Department has requested a substantial increase in boarding home rates since these rates have not kept pace with rising costs. The new rates requested are $3.20 per day for a Class I home, $2.75 for Class II, and $2.35 for Class III.¹

The Veterans Administration is not able to pay the expense incurred by veteran-patients in homes other than their own. This restricts family care almost entirely to those patients who are in receipt of compensation or pension, and who are able to pay in whole or in part the expenses incurred.²

According to a report describing the family care program administered by the Veterans Administration Hospital, Bedford, Massachusetts, the range of payment to family caretakers is $25.00 to $35.00 per week. Until recently $25.00 was the expected fee, but this is rapidly coming up to $30.00 as an average. As needed,

¹Michigan Department of Mental Health, Family Care Program, December 19, 1960.

²Pugh, Edward N., A Study of the Family Care Program, Veterans Administration Hospital, Waco, Texas. (Mimeographed.)
payment of $40.00 to $45.00 is not considered exorbitant if the patient requires special care such as nursing service, rigid diet, or specialised supervision.  

In California caretakers are paid $100.00 per month for each patient, which may be from the funds of the Department of Mental Hygiene, patient's own funds, or a combination of funds from different sources. In this state difficulty is being experienced in securing accommodation, particularly in the urban areas, because of the higher foster home rates paid by some other programs such as those for children and for the veterans administration. Social workers in the Department of Hygiene report that their competitors are paying as much as fifty per cent more in some communities for similar placements.  

In British Columbia, rates paid for boarding home care are in the middle range. As noted in a later chapter, the Department of Welfare pays up to $85.00 per month with an additional $10.00 per month for comforts allowance for those patients without resources. The Department of Veterans Affairs also places some patients in boarding homes under supervision, payment being made from

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1 Copy of letter from Rebecca Glasmann.

2 Letter from Miss Lexie Cotton.
the veteran's own resources. Needy veteran patients on War Veterans Allowance, whose maximum income is $90.00 a month find difficulty in obtaining adequate accommodation in competition with the $85.00 Department of Welfare rate, and also in competition with other veteran patients on higher disability pensions.

**Group and Community Activities.**

Individuals, groups and community agencies are playing an increasing part in helping the mental patient in the resocialization process, while the patients themselves organize their own groups to discuss mutual problems, and also assist in promoting a wider understanding of mental illness.

A number of activities involving patients, family caretakers, volunteers and community organizations are reported from the State of California. For instance, it is learned that in San Francisco a patient helped to "educate" a group of San Francisco employers to the vocational planning needs of the mentally ill. She herself became sufficiently interested to enroll in a night-school course to brush up her office training, carrying her enthusiasm for this undertaking home to her fellow-patients. In another San Francisco home a group of six male patients used the "therapeutic community"

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1 State of California, Department of Mental Hygiene report, 1960.
approach in assuming a responsible role in relation to their own social conduct by forming a house committee of patients, later including the social worker and the caretaker in the discussions. Two patients visited one of the state hospitals to help in an inservice training program for administrative nursing personnel on the subject of family care. In Oakland two family care patients worked as volunteers for a local community welfare council, doing receptionist and general office work.

A caretaker-and-patient-picnic in one city in California helped to bring out family care fathers whose jobs often make them difficult to meet in the course of the regular day's work. The caretakers had discussions in their own groups on the subject of mental health and their role in the family care program. They were also able to "compare notes" about common problems of household and patient management and to consider ways of dealing with them. The caretakers prepared and edited a departmental publication named the Family Caretakers' Clarion which became a state-wide source of news and information on family care for everyone connected with the program.

At one hospital volunteers interested themselves in the recruitment of new homes, provision of specific
needs for certain patients such as clothing and eyeglasses, and the provision of transportation for patients. Plans for a much-needed family care home for adolescent patients were developed by a volunteer group in the Los Angeles area.

With the cooperation of several community agencies including the mental health association, the county hospitals and the sheriff, a family care program was developed in the San Diego area at some distance from the parent hospital. The mental health association placed free classified advertising in the neighbourhood newspapers with the result that the first three homes were located by the association.

Miss J. Lucille Poor, Community Service Consultant, Department of Public Welfare, St. Paul, Minnesota, and Mr. Thomas Wals, Director of Circle F, have written an account of the Circle F club in Minneapolis which has as its purpose the social rehabilitation of the returning patient. In many ways this is conducted along similar lines to the Canadian Mental Health Association social centre described elsewhere in this thesis. One important difference is that the club admits as members, in addition to discharged patients, those patients who are still in hospital awaiting discharge plans, or patients whom it
is considered could derive especial benefit from an outside social experience. The volunteers are club members along with the patients, the chief requirement being that when they attend the program, they do so primarily to enjoy themselves, and to be concerned that those around them have a pleasant social experience. The authors of this account remark that when refreshments are offered "it is interesting to see patients serving patients, volunteers serving patients and patients serving volunteers. A visitor could not differentiate between unpaid workers, staff members and patients.... The patients begin having different self images and as a result develop a new role. More lasting relationships begin to emerge on a behaviour rather than a verbal level."

The club was established with the help of many volunteer and professional groups, and the support of the State Department of Public Welfare, the State Department of Vocational Rehabilitation and the Minneapolis Council of Churchwomen. The State Department of Public Welfare was interested because discharged patients suffered from an apparent lack of welcome on the part of the community. The Department of Vocational Rehabilitation, who offered a money grant, showed
interest because they considered it was a poor investment to retrain a patient whose social isolation might adversely affect his efficiency during training or his later work performance on the job, and might lead through recurrence of symptoms to a return to hospital. The Council of Churchwomen, who provided office and recreation space in one of the downtown churches, was interested because of their ideals of service to mental patients. This was a real community effort. The welding together of these various community resources made the formation of the club possible.

Growth of Family Care.

In order to give some indication of present status and recent development of family care in the United States, a few statistics may usefully be quoted. In New Jersey, at the present time, there are approximately 500 patients in care, utilizing 200 homes. The patient clientele is drawn from five institutions for the mentally ill and five for the retarded.\(^1\) In Kentucky 320 patients have been placed in homes other than their own since June, 1958.\(^2\) In California there are at present approximately 1,700 patients in 498 family care homes. Patients include all ages from two years (mentally retarded) and up.

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\(^1\) Letter from Mrs. Eleanor Engelbrecht.

\(^2\) Is Yours an Understanding Community?, Kentucky Department of Mental Health, H. L. McPheeters, Commissioner, August, 1960.
All patients are ambulatory except for some mentally retarded crib patients.  

It is interesting to note the gradual increase in placements in California. The totals for three earlier year-end placement of patients in family care are: -

1950 - 1951 ... 367
1951 - 1952 ... 536
1952 - 1953 ... 665

In Michigan in December 1960, 1,205 mentally ill and mentally retarded patients were in care. In the 1961-1962 budget a request has been made to raise total placements from the current level of 1,205 to 1,580, an increase of 375.

In the Veterans Administration there has been a steady increase in the number of patients residing in foster homes as shown below: -

1955    797
1956    1,011
1957    1,249
1958    1,554
1959    1,946

1Letter from Miss Lexie Cotton.

2Family Care Program, State of California, Department of Mental Hygiene (mimeographed and undated.)

3Michigan Department of Mental Health, Family Care Program.
These figures are obtained from a Veterans Administration report on Foster Home Care published in January, 1959. According to advice received from Mr. Roger Cumming, Director, Social Work Service, Veterans Administration, Department of Medicine and Surgery, Washington, D. C., the figure for those in care as at January, 1960 is 2,375.

From various reports received, both from state departments of hygiene and from the Veterans Administration, it is apparent that foster home care could be substantially increased if additional funds and staff were available to handle placements. This brief review of the growth of some family care programs in the U. S. indicates that although the programs are not on a large scale, there has been a steady increase in patient placements during the last ten years.
Chapter III

Current Arrangements in British Columbia

British Columbia, in common with the majority of Canadian provinces, has no established program for family care of mental patients, but this province does have a very active program of supervised boarding home placement. In order to bring more clearly into focus the situation of the patient who may be referred for boarding home care, it is advisable to review briefly the treatment services available for the mentally ill, the provincial institutions established for the care of mental patients, and admission and discharge procedures.

Facilities for Treatment.

Vancouver General Hospital accepts patients who are not acutely ill in its psychiatric ward, as also does the Royal Jubilee Hospital in Victoria, while selected patients living in Vancouver and surrounding municipalities can obtain treatment at the Burnaby Mental Health Centre, which operates a Children's Clinic, Adult Clinic and Day Hospital. Patients in need of longer term treatment in the more acute stages of illness can be admitted to the Crease Clinic of Psychological Medicine or the Provincial Mental Hospital,
both situated at Essondale. In addition the Provincial Government has established a number of Homes for the Aged (for the care of mentally ill persons age sixty-five and over) at Port Coquitlam (adjacent to the Provincial Mental Hospital) and other homes at Vernon and Terrace (the latter home being for male patients only). Patients may also, of course, receive treatment from private medical practitioners and private psychiatrists.

The Provincial Mental Hospital and the Crease Clinic of Psychological Medicine are administered under separate acts of the legislature \(^1\), but the work of the two institutions is closely integrated. Crease Clinic is the acute treatment centre where the maximum period a patient may receive treatment is four months, although the average stay is about eight weeks. Patients are discharged from the clinic and immediately admitted to the hospital if it becomes evident that they will need a longer time for treatment than the statutory four month period. The hospital accepts both acute and chronic cases for an indefinite time, terminated at the discretion of the medical superintendent.

Patients can enter both institutions on a committal or voluntary basis. For ordinary committal to the

\(^1\)Mental Hospitals Act, Province of British Columbia, 1940, and Clinics of Psychological Medicine Act, Province of British Columbia, 1948.
hospital the signature of two doctors who are not partners and a judge or magistrate is required, as well as that of a relative, or someone else knowing the circumstances of the case if no relative is available, but for committal to the clinic the signature of the judge or magistrate is not necessary. For admission on a voluntary basis, only the signature of the patient and a physician is required. A patient who enters either the hospital or the clinic voluntarily may obtain his discharge after five days of the receipt in writing of a request for this made by the patient to the medical superintendent.

Patients are discharged from the Crease Clinic in full, as is the case with voluntary patient from the hospital, but committed patients from the hospital are usually discharged on six months probation which can be renewed, if necessary. During the probationary period the patient can be returned to the hospital at the discretion of the medical superintendent should his mental health deteriorate, without the necessity for new committal papers. Patients frequently go on leave from hospital to relatives or friends with the permission of the medical superintendent, this being sometimes on a trial basis preparatory to discharge.¹

¹Information regarding admitting and discharge procedures is based on Section 3 of the British Columbia Mental Health Services Physician's Manual, 1951.
The Hospital and the Clinic.

The Provincial Mental Hospital and the Crease Clinic are situated in beautiful and extensive park-like grounds on a hillside overlooking the Fraser River about twenty miles from the City of Vancouver. East Lawn is the women's long-term treatment unit of the hospital, the other units comprising Centre Lawn, which is the admitting building and semi-acute treatment centre for male and female patients, and West Lawn, the long-term treatment unit for male patients. The Crease Clinic has its own social service department, as do each of the hospital units referred to above.

Social service staff have contacts with patients on a continuing basis to help resolve emotional conflicts, deal with many day to day problems which may be causing patients anxiety, work with relatives in the community to interpret the patient's illness and what is best for his rehabilitation, in consultation with the psychiatrist and other professional staff, formulate discharge plans based on the individual needs of the patient, help the patient to accept separation from the hospital, and maintain a program of after-care
during the six months probationary period, sometimes longer if necessary. It should be pointed out that hospital social workers from Essondale are only able to give after-care service to those patients within daily reach of the hospital; those living in more distant areas of the province are referred to the local provincial social welfare branches for follow-up care.

The hospital has no special funds allocated to it for a family care program, but through the cooperation of municipal and provincial (district) social welfare offices, selected patients are placed in care under the normal program for supervised boarding homes. Private placements may be arranged for patients with money of their own, or relatives prepared to maintain them in care, but for those without resources, a request is made to a municipal or district social welfare office for boarding home placement on public (social) assistance.

If the district or municipal welfare office "accepts" the patient, a suitable vacancy is sought among its licensed boarding homes. As soon as one is available the hospital social service department is so informed. Before the request is made for boarding care the patient's preferences as to the district where he
would like to be rehabilitated are ascertained, and when the boarding home vacancy becomes available, the patient is usually taken to see the home so that he can form an opinion as to whether or not he would like to live there. If the patient feels this particular home is not a place where he could be happy, another vacancy is sought elsewhere.

The rate paid for patients on social assistance in boarding home care is up to $85.00 a month, with an additional amount up to $10.00 a month for comforts allowance. A recipient of social assistance in boarding home care is permitted to retain limited resources for his own use but in this case he is not provided with comforts allowance until he has used up his own funds.

Supervision of mental patients who are living on social assistance in licensed boarding homes may be given by the hospital social worker, or be taken over by the provincial or municipal social welfare office concerned, or in some cases there may be joint supervision. Arrangements are also made for each patient to receive medical care, either through a local physician or hospital out-patient clinic. Every effort is

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1Department of Social Welfare, B.C. Admission Form (Licensed Boarding Home or Private Hospital). "The Department of Social Welfare does not participate in hospital clearance plans for private cases: i.e. where cash assets in the case of a single person are more than $250. or for a married person more than $500. or where full payment will be made by others."
made to place the patient in a home where a family atmosphere predominates, and where the patient will find the other patients and the sponsor congenial to him. Community Resources.

As has been pointed out earlier in this thesis, the mental patient who is discharged from hospital usually needs help in most areas of living. The patient who is placed in a supervised living situation has his needs for food, shelter and some companionship met, but without assistance he may still remain isolated in the little world of his boarding home. The stigma of mental illness is apt to undermine his confidence in meeting new people and in participating in the many social activities provided by community agencies. Further, as a part of his illness, he tends to withdraw from social contacts.

To help with the social rehabilitation of the mental patient, the volunteers of the Canadian Mental Health Association operate a social centre in the City of Vancouver. This provides both social activities and professional counselling. All those admitted to the centre must at some time have been mentally ill, but the teenager, the aged, the alcoholic, the drug addict and the psychopath are excluded. Patients may apply
directly or be referred by health organizations such as the Crease Clinic, the Provincial Mental Hospital, and the Burnaby Mental Health Centre. Some are referred through community agencies such as the Family Service Agency, and others through private psychiatrists.¹

The director of the centre is a professional social worker. With the permission of the patient, he contacts the hospital where the patient received treatment. In the case of patients who have been directly discharged from Crease Clinic or the Provincial Mental Hospital, the social worker at the hospital is asked to carry the case while the patient is attending the centre. The director also gives counselling to patients, though not of an ongoing nature, regarding day-to-day difficulties which may arise over housing, employment, marital conflicts and so on, referring the patient, where necessary, to the appropriate community resource.

The centre has attractive premises conveniently situated on a main bus route in the western part of the city. From nine o'clock until five there is a drop-in program which is not organized. A library,

magazines, games, a record-player and T.V. are provided, while tea, coffee and cookies are available when needed. There are organized activities three evenings a week. To arrange these programs the patients form their own executive, and, with the help of staff, plan such activities as games, dancing, bingo, expeditions, and other entertainment. An art class is conducted on an informal basis on one evening during the week.

No attempt is made to have every evening occupied. It is hoped that patients will use the centre as a bridge to other community activities so that, after a time, they will no longer need the facilities and support which the centre provides. In fact, the objectives of the centre have been realized. Patients do move on to become absorbed in other community interests so that membership is always changing. A number of younger patients placed in boarding homes use the centre in the earlier stages of discharge.

A similar centre has been opened by the Canadian Mental Health Association volunteers in North Vancouver, and later it is hoped that it may be possible to open other centres elsewhere.

Burnaby Mental Health Centre operates a social club one evening a week in connection with the Adult or
Sustaining Clinic, where patients may receive counseling and take part in social activities. However, the number of patients accepted for this service is quite limited, the Centre being reserved for those patients with a good chance for full rehabilitation.

Patients who are seeking employment may be referred to the Special Placements Division of the National Employment Service, which gives special assistance in job finding to persons suffering from some physical or mental handicap. The National Employment Service, in this case, requests a medical and social assessment from the hospital, and also an employment history, which is only given with the patient's written permission. Some patients refuse to make use of this service which involves admitting they have received treatment in a mental hospital, preferring to contact private employment agencies or prospective employers directly.

Two half-way houses, the Vista for women and the Venture for men are maintained by the hospital. Each can accommodate seven patients at any one time. These are boarding homes where patients may stay for a period up to three or four weeks while they are making arrangements for employment and accommodation. In some
instances the homes are used to test out the patient's potentiality to adjust to community life. Those who are unable to find employment may be referred for social assistance, while for others who have demonstrated that a protected living arrangement is still needed, a boarding home placement is sought. While staying at the Vista or the Venture, patients are still "on leave" from the hospital and the clinic.

Limiting the stay of patients in these homes to three or four weeks is occasioned by the necessity to have accommodation available for new patients about to be discharged, but this short period of stay is scarcely adequate for the patient to make the necessary adjustment to living outside the hospital. Additional facilities are desirable so that the halfway house can provide accommodation for patients for several months. The patient could then stay in the home for a further period of adjustment after employment was obtained.

Discharge to Boarding Home Care -- A Representative Group from East Lawn Unit.

The patient population of the unit is approximately 1200, although this necessarily varies from day to day in accordance with admissions and discharges. An "open door" policy is followed, except for a small number of
closed wards for the severely disturbed or deteriorated. All patients who are well enough, and physically able, have some job to do in the hospital such as work in the laundry, nurses' homes, kitchens, cafeterias, the educational centre, library, printing shop, beauty shop and audio-visual centre. A rehabilitation officer in the unit is responsible for placing patients in the various positions to be filled, on a therapeutic basis in so far as is possible. Patients do not receive pay for work done in hospital.

Most patients have "grounds privileges" which give them the right to come and go as they please during certain hours of the day within the confines of the hospital property, to wander about the gardens, visit the tuck shop or the recreation centre. Patients may attend occupational therapy, industrial therapy, music therapy and so on, in accordance with the treatment plan.

The women spend much of their spare time in the day rooms reading, chatting, sewing, knitting, playing cards and games. There are also many organized recreational activities such as dances, films, sports and picnics in summer.

The Canadian Mental Health Association has its
own office in the hospital grounds. Volunteers visit the patients on the wards, operate the restaurant at the recreation centre, run the apparel shop where clothing they have collected is distributed to patients in need, especially to those who are ready for discharge, and organize various forms of entertainment.

There is provision for a social work staff at East Lawn of five social workers and a supervisor, but on account of staff shortages and absence of workers on educational leave, it is not always possible to maintain the full complement. The work involved in the selection, placement and supervision of patients in boarding home care is distributed among all the social workers in the unit, no one worker being exclusively assigned to this area of activity.

Selection and Analysis of the Group.

For the purposes of this study, the files of all patients who were placed in boarding home care by one full-time social worker between July 1, 1959, and August 31, 1960 were examined in order to determine the main characteristics of the group. Six months after the last patient in the group was discharged on probation, a check was made to ascertain how many had returned to hospital, and how many were still outside.
Of the twenty patients placed, sixteen had a diagnosis of schizophrenic reaction of some kind, eleven of these being schizophrenics of the paranoid type. Of the remaining four, one was a manic depressive, one had a diagnosis of personality pattern disturbance, schizoid personality, one (age seventy-five) had a diagnosis of chronic brain syndrome associated with cerebral arteriosclerosis, and the remaining patient was an epileptic and high grade moron. Her diagnosis was brain syndrome with convulsive disorder with psychotic reaction.

Marital status of the patients was as follows: single seven, married three, separated four, divorced one, widowed five.

The following table shows distribution of patients according to age group with average number of years spent in hospital (not necessarily continuously).
TABLE I
Distribution of Patients according to Age and Average Length of Hospitalization.

<table>
<thead>
<tr>
<th>Age group in years</th>
<th>No. of persons</th>
<th>Average length of hospitalization in years</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 - 45</td>
<td>6</td>
<td>6.5</td>
</tr>
<tr>
<td>45 - 55</td>
<td>8</td>
<td>7.4</td>
</tr>
<tr>
<td>55 - 65</td>
<td>4</td>
<td>11.7</td>
</tr>
<tr>
<td>65 - 75</td>
<td>2</td>
<td>11.5</td>
</tr>
</tbody>
</table>

It will be noted from the above table that the majority of the group of twenty patients were in the middle-aged bracket with long periods of hospitalization.

The average age of the group was 55.8 years and the median age 50.5 years. The average number of years of hospitalization was 8.3 years and the median nine years. The shortest continuous period spent in the unit for patients with one hospitalization was eight months and the longest eighteen years.

The educational level of the patients was as
follows: nine had attained Grade 12 and one Grade 11, three had attained Grade 8, and seven Grade 6 or less. In the Grade 12 and 11 group, comprising ten patients, seven had taken up to one year's additional business or professional training, but only five had shown a continuous record of employment prior to the onset of mental illness. Two of these were schoolteachers, one with twenty years teaching experience and the other with ten. These were the only professional members of the group. In the lower educational categories, comprising half the number of patients, one patient, a widow, regularly was employed in a factory for some years prior to her marriage, but after the death of her husband, had lived on social assistance continuously for several years until her admission to hospital in 1959 following an acute psychotic episode. The remaining patients could show no history of steady employment, appearing to have drifted from one unskilled job to another.
TABLE II

Financial Status of Patients.

<table>
<thead>
<tr>
<th>Description</th>
<th>No. of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>No financial resources of any kind or very limited resources which still left the patient eligible for social assistance.</td>
<td>12</td>
</tr>
<tr>
<td>Sufficient means for maintenance in the community for a few months only and for cost of re-training.</td>
<td>2</td>
</tr>
<tr>
<td>Capital of from $4,000 to $6,000, enough for maintenance for limited period.</td>
<td>2</td>
</tr>
<tr>
<td>Regular pensions from Old Age Assistance or Workman's Compensation, teacher's pension, other pension plus some capital.</td>
<td>4</td>
</tr>
</tbody>
</table>

It will be seen that only 20 per cent of the group had a permanent income, 60 per cent had no resources whatever, while the remaining 20 per cent had sufficient means for their support for limited periods only.
From the foregoing review of the twenty patients in the group, some predominant characteristics emerge. Sixteen patients or 80 per cent of the group had a diagnosis of schizophrenia, the majority being paranoid schizophrenics. This type of patient has his own special difficulties in the area of social relationships, since he projects his feelings of hostility on to others, tending to blame them for his own shortcomings. This generates an attitude of suspicion on his part which complicates his relationships with others, especially in the area of employment. Thus, he is quite likely to leave his job because of imaginary grievances, or be fired because of hostile behaviour to his superiors or fellow workers.

The five patients (twenty-five percent of the group) who had shown a steady employment record, prior to the onset of illness, had all attained an educational level of Grade 11 or 12, plus additional training. The employment record of the remainder was poor.

Thirteen of the patients had married. Excluding the five widows, on whose marital adjustment there is not adequate information, none of the remaining eight had successful marriages. One was divorced, four were
separated, and of the remaining three, one decided against going back to her husband, while the husbands of the other two were unwilling to have their wives home again. Since difficulty in the area of social relationships is one of the characteristics of the mental patient, a history of marital maladjustment is to be expected in this group. The possible connection between low educational status and mental illness suggests a useful area for further research, although some studies have already been made in this field.¹

The Homes.

The twenty patients were placed in ten different homes. The two homes furthest from the hospital were at White Rock, about twenty-five miles distant, three were in the City of Vancouver, two were in New Westminster, two in Burnaby and one in Port Coquitlam. Thus all the homes were less than an hour’s drive of the hospital, and could be readily reached in an emergency.

Numbers of boarders in the homes ranged between one and thirteen. But average numbers were between five and six. Some homes catered exclusively for mental patients while others received both mental

¹Hollingshead, August B., and Redlich, Frederick C., Social Class and Mental Illness, New York, John Weley and Sons Inc.
and welfare clients.

Most patients shared rooms with one or two other boarders. Standards of taste and comfort varied. The home with the highest standards was chosen by a private patient, whose means enabled her to pay a rate of $125.00 a month. This home also had male boarders placed by the Department of Veterans Affairs. In all homes where patients from East Lawn were living on social assistance, women boarders only were received.

The homes all had television. In some homes boarders had their own lounge; in others it was shared with the family. The interest taken by the sponsors in their boarders varied a good deal. Some sponsors did little beyond providing adequate food, shelter and supervision, so that in these homes patients were largely dependent on each other, or on a few visits with relatives and friends, for companionship and recreation. Other sponsors took considerable trouble in promoting social activities and community contacts for patients, and in encouraging patients who felt ready to seek work.

The social worker usually visited the patient on a weekly basis during the first month until she
became assured that the patient had "settled down". After this visits gradually became extended to a monthly schedule. However, extremely dependent patients sometimes needed to be visited several times during the course of the first week or two until they became more reassured. Emergency visits were sometimes required if the sponsor reported unusual behaviour indicating a return of former symptoms. These visits might lead to urgent consultation with the psychiatrist after the situation had been "sized up" by the social worker, and perhaps a decision that the patient should be returned to hospital.

After the six months check was made, it was found that of the twenty patients, seven had returned to hospital owing to a recurrence of symptoms, while thirteen had remained outside. Of these, four were maintaining themselves in full-time employment. Two of the employed patients were single women, age thirty-five and forty-six respectively, who had returned to office work, one was a widow age thirty-five who had obtained domestic employment, and one was a married woman whose husband refused to have her return home or to contribute towards her support. She made herself so useful to the sponsor in the home where she was placed, that she was given a full-time job there after
her probationary period expired. Some patients made a good adjustment from the start, while others tended to be restless, seclusive, quarrelsome or complaining. One paranoid patient who had shown good progress in hospital, rapidly deteriorated in the boarding home, wrote accusing letters to the sponsor, refused to dress or bathe herself, or to eat the food provided, and was soon returned to hospital. Other patients in the home settled down happily. Another patient "panicked" as soon as she was out of hospital, demanding to be returned the next day. With help from the social worker, she was gradually able to overcome her fear of living outside the hospital, and is one of those patients who are now self-supporting.

It was not possible to determine what led to the breakdown of those patients who needed to come back to hospital, but the social worker considered that in most cases failure to take the medication prescribed was an important contributing factor. Although tranquilizing drugs cannot in themselves cure mental illness, they are of great value in controlling psychotic symptoms. It is therefore of especial importance that patients living in boarding homes should be regularly supervised in the taking of these medications.
CHAPTER IV

Family Care as a Means to Rehabilitation

Human life is lived within the medium of society or "communities". The man or woman who comes to a mental hospital for treatment, does so because of a breakdown in his ability to function normally in society. As Morton Teicher has reiterated in a recent article on "The Role of the Psychiatric Social Worker" published in Canadian Welfare, the acid test of psychiatric treatment is the social rehabilitation of the patient. The only justification for any treatment program is the degree to which it successfully restores ill people to a state of well being. This is true enough, but as Teicher points out, the process is doubly difficult for the psychiatric patient because of the negative attitudes in the community towards mental illness. "Family care", or its variations such as supervised boarding homes or half-way houses, is one of the intermediate or middle ways to cope with this problem.

Within the last few decades, great advances have been made in the treatment of the mentally sick through the use of many new techniques and therapies, but, when the patient's illness is sufficiently in remission for him to leave hospital, rejecting community attitudes may undo much of the progress he made there. Social isolation of the patient can contribute to a recurrence of symptoms and to an early re-admission to hospital. The foster home provides a setting where the patient can feel secure and welcome, and where, with the help of the social worker and the sponsor, and fellow-members of the household, he can find satisfaction in everyday living.

Some of the philosophical and practical assumptions of social work include recognition and acceptance of each individual as a self-respecting person no matter what his state of health; recognition of the right of every person to a "health and decency" standard of living and to opportunities to experience satisfying human relationships; recognition that the right of the individual and of society are inter-related; recognition that progress in social welfare arises from broad community understanding, as well as creative contributions by individuals and professional groups. ¹

The social worker's approach towards helping the patient effect a more satisfactory social adjustment is of a two-fold nature. He may apply certain psychological methods to decrease the patient's emotional stress and conflicts; or he may, with the consent of the patient, intervene to change the environment. Dr. R. F. Tredgold, in a book on mental illness published in 1958, entitled *Bridging the Gap*, emphasizes the fact that the psychiatric social worker is trained to help people involved in domestic, occupational and personal problems associated with potential psychiatric breakdown, and to help those who have been in hospital to adjust themselves to community life on discharge.¹ This assistance can be given in countless ways, not only by practical measures such as helping patients to obtain suitable jobs and to make use of available social services, but also in less tangible ways — e.g. by restoring broken social contacts, encouraging self-confidence, or by merely lending a sympathetic ear to the patient's troubles until confidence is established.

**Family Care as a Therapeutic Device.**

This thesis has pointed out some of the special needs of mental patients, particularly in the provision of employment and training, economical living accommodation, adequate social assistance, medical services,

and opportunities for social life. Attention has been particularly focused on the needs of mental patients ready for discharge from hospital, who have no homes to which they can go, but are still unable to manage without some supervision. This has led to a consideration of the family care home as a therapeutic living situation to meet the needs of this special group of patients. The relative merits of family care and boarding homes can also be better assessed by reference to this experience.

The review of foster care for mental patients makes it clear that it has been in use in Europe for several centuries, and also has a longer history in the United States than might be at first supposed. Although introduced there in 1885, it is only within the last ten years or so that it has been widely taken up in North America.

From this experience several gains and "leads" are already evident. Many techniques have been used in the motivation of the patient towards leaving hospital, and in furthering the resocialization process through the use of group activities. Emphasis has been placed on integrating hospital and community services in the interest of the patient. Family care is seen not only
as a means of providing a more satisfactory way of life for the patient who will probably never be able to manage on his own, but also to assist the patient who has a good prospect of a return to independent living.

In Canada, family care has not been widely developed, though supervised boarding home placement has been used in most provinces. As the Provincial Mental Hospital at Essondale, British Columbia, has one of the most active programs of boarding home placement, this was chosen for the study of a representative group of patients (from the East Lawn unit) recently discharged to boarding home care. The greatest proportion of these patients suffered from some form of schizophrenic illness, paranoid schizophrenia being the predominant diagnosis. The majority of the married patients had unsatisfactory marital relationships which precluded return to their marital partners. Most of the patients had no families to whom they could go, while 60 per cent of the group had a low level of education, while their employment record with a few exceptions was consistently poor. Although 65 per cent of the patients were still living outside the hospital after the six months probationary period had expired, only 20 per cent of the
total group had succeeded in establishing themselves in full employment. It proved difficult to determine why some patients had succeeded while others failed.

Examination of these cases, and of comparative experience, both suggest that further techniques need to be perfected for assessing patients who are suitable for boarding home or family care; and these must be applied in the hospital before the patient leaves.\(^1\)

Although many factors are taken into consideration in referring a patient for care, such as remission of symptoms, ability to get along with fellow patients, ability to look after personal needs, and so on, certain psychological factors which may bring about failure in the patient's adjustment to the home may be overlooked.

In Minnesota, one of the Veterans Administration Hospitals (at St. Cloud) is carrying out a unique experiment in setting up a centralized motivation clinic within its existing hospital facilities.\(^2\) The clinic has a two-fold purpose: (1) to motivate suitable

\(^1\)Mr. Eugene Elmore, in an analysis of a group of geriatric patients, hospitalized for mental illness in the Home for the Aged, Port Coquitlam, B. C., has devised a number of rating scales for assessing the readiness of patients for discharge. He considers that family care is a useful resource for quiet, chronic patients; and could also be developed for senile patients who no longer need institutional care. E. Elmore, Discharge Planning in the Homes for the Aged, Master of Social Work Thesis, University of British Columbia, 1959.

\(^2\)Family Care of Patients, Plan for Motivation Clinic, Veterans Administration Hospital, St. Cloud, Minnesota.
patients, who are reluctant to leave the security of the hospital, to desire a new environment; (2) to provide a testing period for others who are seemingly ready to leave and not superficially psychotic. By this means it is hoped to eliminate those patients who might fail.

Patients referred for placement are screened by a clinical team, which makes the final selection. Accepted patients are housed in a special ward where each individual receives treatment according to a detailed plan formulated by the team -- e.g. group or individual psychotherapy, special service programs, community experiences and vocational counselling. The therapeutic plan is directed toward testing the patient's ability to adjust to new situations, new work assignments, situations requiring social contact, ability to get along with others, and extent of supportive supervision required; in general it seeks to determine the patient's strength in relation to the placement opportunities available.

Those patients who show sustained progress are moved to another ward for a more intensified program of motivation and preparation towards release from hospital. The whole general atmosphere of this ward is organized
to simulate as nearly as possible life outside the hospital. Patients selected are expected to show increasing ability to assume responsibility for their own affairs. The patients are given latitude in the use of passes, funds, visits into the community, visiting prospective family care homes, alone or with team members, and in the general handling of their own affairs. Patients are encouraged to use the principle of self-government on both wards as a means of stimulating them to accept responsibility for their own behaviour, and in making decisions for themselves.

The clinic has not been in operation long enough for the merits of its program to be fully assessed, but results reported so far have been encouraging. This "motivation clinic" suggests a useful approach in other hospitals for determining the patient's ability to gain advantage from a family care placement. Both in liaison with the patient and in utilizing community resources, there are obvious roles here for social workers.

Boarding Homes versus Family Care.

Boarding home placement has generally been used as an alternative to a family care home, and, in fact, in some instances it may even approximate to a family
care situation. Experience in British Columbia has demonstrated that supervised boarding home placement can be a move along the road to self-responsibility and independence in the community. The first step in this direction is usually a part-time job, which not only gives the man or woman the absorption of work in itself, but enables the patient to contribute towards his support in the home. However, present social assistance regulations in British Columbia place obstacles in the way of this mode of rehabilitation for the boarding home patient. As already mentioned, the rate paid for social assistance recipients in need of boarding home care is up to $85.00 per month, but the general social assistance rate for one person responsible for his own living arrangements in the community is only $66.00 per month. Thus, as soon as a patient’s earnings reach this figure, he is no longer entitled to social assistance, which means he is usually obliged to find a room for himself elsewhere.

To cite an example, one member of the group of twenty patients from East Lawn, with a long history of mental illness, was discharged to a boarding home where five other patients resided. She made an excellent adjustment in the home, soon showing initiative in
seeking part-time work in a cafe washing dishes. She was successful in this, each month extending her working time. In this way she increasingly contributed towards her own support. But the time came when her monthly earnings jumped from $60.00 to $75.00, so that she was no longer eligible for social assistance. She was obliged to establish herself in a housekeeping room, which might be a "promotion" for a normal person; but for her it could be dangerous, since she still needed the support and protection which the home provided. This is an anomaly in the regulations which needs to be rectified, so that patients who have become self-supporting, but unable to afford the boarding home rate, may continue to reside in the home if they so desire.

Although the present arrangements for supervised boarding home care for discharged mental patients have met with a considerable measure of success, this method of placement necessarily has its limitations. It is doubtful if they should be a substitute for a family care program. Under the present system, the hospital is circumscribed by Department of Welfare regulations, in its choice of home, control of supervision, and in
making financial arrangements for the patient.

The hospital social worker, through his specialized training and experience and his close contact with the patient in hospital, best understands the needs of the patient. The hospital social worker, in consultation with his department, is the person best qualified to select the home, to supervise both the patient and the sponsor of the home, and to introduce or encourage appropriate social and group activities. It is the hospital social worker who can most easily detect a recurrence of the patient's former symptoms so that these may be brought to the attention of the psychiatrist at the earliest opportunity. Perhaps a return to hospital, a change of medication, or a change to another home, may be indicated. Under present conditions of boarding home placement in British Columbia, supervision may take several forms. It may be carried out by the hospital social worker, it may be taken over by the municipal or provincial worker, or it may be a joint undertaking. However cooperative the other municipal or provincial department may be, this method of working is not as satisfactory as where the hospital worker has full responsibility for supervision.

When the hospital is dependent upon the available
boarding home vacancies offered by another department, the placement, though adequate, may in itself be a compromise. The hospital worker may have preferred a different setting for his patient, but his choice is limited by the vacancies presented. Further, when the hospital is in a position to choose the home and evaluate the sponsor, a closer working relationship is likely to develop between the hospital social worker and the sponsor than in the present situation; under this, the hospital social worker supervises a patient in a home which has been licensed by the Department of Welfare for social assistance recipients in general in need of care. The sponsor naturally feels that her chief responsibility is to the department which has licensed her home. In spite of these difficulties, the success achieved certainly reflects the close degree of cooperation which exists between the hospital social service staff and the Social Welfare Branch.

Criteria for Family Care.

The Veterans Administration, Washington, D. C., in its report on its foster home program, to which reference has already been made in Chapter II, suggests a number of ways in which a foster care program may be initiated. It is pointed out that special attention
should be paid towards orienting the entire hospital staff towards the program so that they understand its function and the role they may play in it. Not only can members of the staff help identify patients who might benefit from family care, but they can promote community interest in it by discussing it with relatives and friends. The community also needs to be oriented to the program, which can be done through publication of articles in the newspapers, talks on the radio and T. V., lectures to community groups, and so on.

In conclusion, the joint evidence of the comparative studies examined in this survey, and a review of the existing arrangements for boarding home care in British Columbia, make possible a check list of basic criteria for a sound family care program. The writer would suggest the following:

(1) Orientation of hospital employees and the community to the program.

(2) Preparation of the patient: if possible through motivation techniques and scientifically planned testing periods: if not, at least by general counselling and social work interviews.

(3) Sufficient number of social workers to participate in the evaluation and preparation of patients for home
care, finding the homes, and supervising the patient and the sponsor in the home.

(4) Sponsors who are personally suited to the task of caring for mental patients, and who have the ability to cooperate with the social worker. Some degree of financial stability of the sponsor is also necessary.

(5) Adequate physical standards in the home; and provision of sufficient and suitable food.

(6) Provision of medical services for patients.

(7) Provision of clothing, money for incidental expenses and comforts allowances, for patients without means.

(8) Encouragement of appropriate social activities for patients, both within the home and in the outside community.

(9) Homes of varying sizes to meet the needs of different patients.

(10) Location of the home within easy access of public transportation and community facilities for the benefit of patients.

It goes without saying that no program will be adequate without sufficient funds. There is danger that such a program could be seized upon as a measure of administrative economy to make more beds available for
new cases, without due regard to the capacity of the patient to benefit from home placement, and without due regard to the provision of a therapeutic milieu for the patient. The program cannot be served by money alone, and the check list brought together above may serve as an aid in the planning or developing of further programs of this kind.

Conclusion.

The broad conclusion is that "family care" is a useful device in the rehabilitation of the mentally ill -- for the patient for whom return to independent living is the goal; and also as a means of providing a more satisfactory way of life than the hospital environment for the patient who will need a continued supervised living situation. Anyone who has visited a boarding home where the "inmates" sit in their rooms, staring into space, waiting the diversion of the next meal, will realize how a home placement can become a total failure in providing a satisfying and useful life for the individual concerned. It is not merely enough to place a patient in a home where physical standards are adequate. The patient needs to be encouraged in many activities to aid in his resocialization. In this process the warmth,
understanding and ingenuity of the sponsor are factors of the greatest importance.

The provision of adequate services for the re-integration of the patient into community living will ultimately depend on the acceptance by the community of the responsibility for such services, and on their ability to welcome the patient back again into their midst. There has been much discussion of the rehabilitation of the mental patient; but the community itself, which, for so long, has consigned the mentally ill to the seclusion of mental hospitals, must also play its part in rehabilitation. There is a social work job to be done in helping set up adequate family care, and in interpreting it to the "community" in its many guises.
APPENDIX A

Form of letter addressed to Chiefs of Social Service in U. S. State Departments of Hygiene, or Veterans Administration Hospitals, requesting information on family care programs.

Address
Date

Mr.   
Chief of Social Service,
State Department of Hygiene, or Veterans Administration Hospital,
Address.

Dear Mr.   

I am a student at the University of British Columbia completing my social work degree, and have chosen as the subject of my MSW thesis "Family Care Homes for Mental Patients." In this connection I am anxious to obtain particulars regarding family care programs for mental patients in the United States, and I wonder whether you would be kind enough to give me some information as to what arrangements you have in for patients discharged from mental hospitals who are not considered capable of managing on their own without some supervision, and who have no relatives to whom they can return.

If any surveys have been completed as to the type of patient referred for care or the type of home, this would be very helpful, or any published or mimeographed material relating to general policies. Any information you could let me have in this connection would be very much appreciated.

Thanking you,

Yours very truly,
APPENDIX B

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