FOSTER HOME CARE OF MENTAL PATIENTS

A JOINT PROGRAM OF A SHORT TERM HOSPITAL AND FAMILY AGENCY *

PART I

by LOUISE PINSKY

Hillside Hospital, Glen Oaks, N. Y.

IN the popular mind hospitalization in a mental hospital was, and to an extent still is, invested with a sense of finality and inevitability one feels on reaching a point of no return. The very appearance of a mental hospital, remote and frozen in its immutability, seemed to lend credence to this popular conception of mental illness as tantamount to living death and the physical plant as a monument symbolizing the illnesses it was designed to treat, illnesses leading to complete withdrawal from community living.

Mental hospitals were slow in emerging from their lethargy, slower in catching up with the mental hygiene movement. Nevertheless, the past few decades have witnessed a vigorous reawakening and with it a growing recognition that "the most important value of a mental hospital is its function of transforming a desocialized individual into one who can adapt himself either to a normal society or to some kind of extra-mural care." [1] There is, also, growing realization that, in order to perform this function, it will be necessary to:

(1) Create within the hospital's confines the kind of "therapeutic atmosphere" that approaches, as nearly as possible, community living.

(2) Re-evaluate the whole concept of treatment as a process encompassing more than the clearing-up of symptoms and reaching beyond hospitalization.

(3) Emerge from its self-imposed isolation and establish liaison with the community.

Vast strides have been made in all these areas by mental hospitals in this and other countries. Many revolutionary changes have been introduced in hospital management, an examination of which would furnish illuminating material. For the purposes of this paper, limited as it is in scope, I shall confine my remarks to points two and three above, and to one particular hospital.

Hillside is a 200-bed voluntary hospital for the treatment of mental disorders. The major form of treatment, psychotherapy, is supplemented with somatic therapies. The hospitalization period extends from a minimum of two months to a maximum of twelve months, the average being five to six months. This accepted time limit presupposes, first, that the hospital tries to select from among the applicants those who are most likely to benefit from short-term treatment; second, that the hospital has con-

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[1] *The Community Mental Hospital; Third Report,* Expert Committee on Mental Health, World Health Organization, Geneva, Sept. 1953, p. 17.

fidence in the efficacy of its treatment program; and, most significantly, that the hospital does not consider hospitalization an end in itself, but merely a preparation for the patient's return to the community. Every year about three hundred and sixty patients enter Hillside Hospital. Every year as many patients leave Hillside Hospital. The hospital is thus in constant touch with the community; is, in fact, part of it and, as such, may be rightfully considered a community hospital.

Treatment begins at the time of application and the first relationship the applicant establishes is with the social worker, who sees him through the application process until the day he enters the hospital as a patient. From that time onwards psychiatrist, social worker, and members of other professional disciplines are united in a joint effort to help the patient make optimum use of the available facilities within the hospital and, when the time comes, leave the hospital milieu for normal pursuits. The last person the patient sees upon leaving the hospital is again the social worker. Having facilitated his entering the hospital, the social worker is also the person whose responsibility it is to pilot him back into the turbulent sea, which life outside the hospital enclosure represents to him. It it fitting that this be so, since the social worker represents the link between him and the outside community.

Psychiatrists treating patients in a mental hospital recognize that "leaving the hospital may appear to many patients as an even more frightening experience than entering it, if a severe illness has weakened their self-confidence, since it entails resettlement in home and work." [2] This is, indeed, substantiated from experience, for the same fears that compel a mental patient to seek the sanctuary of a hospital, prevent him from leaving the safety of hospital surroundings and venturing out into a hostile world. Pre- and post-discharge planning for and with the patient is, therefore, an essential part of treatment and should begin long before a definite discharge date is set. Even more, the entire treatment plan should be geared to the program the patient may be expected to pursue after leaving the hospital and every effort should be exerted to prepare the patient to become a productive member of the community within the limits of his capacity.

Mental hospitals, concerned with the problems of after-care, have sought to implement planning in many different ways. No matter which way seems most suitable, the goal is the same, and this is to prevent, to the extent that it is possible, the recurrence of mental disturbance that is severe enough to require rehospitalization, which is costly and wasteful in terms of individual human values and collective social values. Hillside Hospital is trying to meet this problem and carry out its avowed goal of returning to the community as many patients as will respond to treatment in two different ways: (1) by extending its services into the community through its After-Care Clinic, which offers short-term treatment, both psychotherapy and casework, geared toward helping the discharged patient make a new start, and (2) by using available community resources through collaborative relationships with a network of social agencies.

The foster care program belongs in this latter category. It was started in collaboration with the Jewish Community Services of Long Island as a pilot project in 1950 and was officially launched in 1952. During the five years of its operation as a full-fledged program, 75 patients have been served, which constitute a small segment of the hospital population. From a numerical standpoint, therefore, its significance is not

[2] *The Community Mental Hospital, op. cit.,* p. 17.

great. The intrinsic value of this type of program becomes apparent only if evaluated in terms of patients whose potential rehabilitation hinges on tangible help that could give them a sense of relative security and restore their self-confidence. To some mental patients a hospital is more than a place where they are treated, it is also a place of refuge. Particularly is it true of patients who have no homes to return to, or whose family relationships have deteriorated to an extent that rejoining the family would not be in the best interests of patient or family. With rehabilitation as the ultimate goal, the foster care plan was conceived as a temporary program designed to help patients in their initial adjustment, not as a way of life. The question of how best to execute such a plan gave rise to many considerations. It was recognized that the finding, study and supervision of foster homes required skills that are not an essential part of a psychiatric social worker's equipment and that the acquisition of such skills would require special supervision and more staff. A disproportionate amount of time would have to be expended for a comparatively small number of patients requiring this type of care. All this and more had to be taken into account, but the consideration that outweighed all others was the conviction that "a hospital, by virtue of its equation with illness, should not accompany the patient on his road to recovery, but should assist him in strengthening his ties with the outside community"[3] . . . that the sooner a patient can mobilize himself to leave the hospital environment, the greater the chance of his eventual adjustment. We turned to a social agency in the belief that helping a patient to establish a connection with a community agency would have a reassuring effect in that it would attest the hospital's confidence in the patient's ability to meet the challenge. This was our answer to the baffling question of how to help our patients in their search for homes, albeit temporary. It is, we recognize, but one way of dealing with the problem, not the only way.

A collaborative effort, no matter how well intentioned, poses many problems which must be faced and handled in the course of a developing relationship, if the undertaking is to succeed. One of the first problems that was encountered at the outset and had to be reckoned with was that an autonomous social agency operates differently from a social work department within a hospital where several professional disciplines are involved in planning with a patient. Although the social worker is responsible for carrying out discharge plans, or initiating them, this is done in conjunction with the patients' therapists who are not always familiar with the way social agencies operate and it is difficult sometimes to interpret to them the delay in placement. They do not readily accept the fact that the agency may question their recommendation, may even find the patient unsuitable for placement with a private family. The agency, on the other hand, in its eagerness to protect householders from the vagaries of mental patients may be unduly anxious over a patient's bizarre and unpredictable behavior. An agency's justifiable concern with the possible repercussions of such behavior in the community and a psychiatrist's slowness in appreciating the reasons for the agency's hesitancy are matters that require constant interpretation and re-interpretation. The hospital worker, in her liaison capacity, is at times caught in an impasse and reacts with annoyance at her inability to go

[3] Abraham Lurie, Joseph Miller, Louise Pinsky, William Posner, Hertha Vogelstein, "The Placement of Discharged Mental Patients in Foster Homes: A Cooperative Project Between Mental Hospital and Family Agency." *Journal of the Hillside Hospital,* Vol. V, Nos. 3–4, October, 1956, p. 471.

ahead. Nevertheless, despite the need to adjust to the tempo of the agency, the net result is a growing recognition of each other's concerns and a strengthening of the relationship between hospital and agency. From the standpoint of community organization this kind of collaboration carries with it secondary gains if it makes possible elimination of duplication through the creative use of existing resources.

The following broad principles have been agreed upon by hospital and agency:

(1) The hospital has primary responsibility for the preparation of patient and family for the foster care program, and for initiating the referral of the patient to the agency.

(2) The agency retains the right to decide whether the patient is suitable for the program.

(3) Upon acceptance of a patient for placement, the agency carries responsibility for working out the financial arrangements, for the choice of home and continued supervision.

(4) Patients remain in placement for a period of about six months, the exact time limit to be determined on a casework basis.

(5) The agency assumes the responsibility for aftercare for a limited period following discharge from the program.

(6) The project is financed through a special grant.

Procedures for the handling of referrals were developed to insure a smooth flow. Although each step in the process was clearly defined and structured, and a time limit between the referral of a patient and his placement established, occasional departures from the procedure cannot be avoided because of unforeseen circumstances, such as illness of the worker assigned to the project, shortage of boarding homes and shortages or changes in hospital staff. Such occurrences call for frequent conferences between agency and hospital representatives for the purpose of ironing out misunderstandings, clarifying problems, redefining objectives.

The first consideration in selecting a patient for the foster care program is his need of a home, either because he has none to return to, or because it is considered essential to facilitate his total adjustment that he be given an opportunity to experience family living outside of his own family. Important though this consideration is, it will be of no avail unless the patient feels the need for a home strongly enough to overcome, at least partially, his paralyzing fear and have sufficient incentive to go ahead with the plan. It is motivation, then, that gives us the first clue to the patient's potential ability to make constructive use of the program. Both therapist and social worker must be discerning in selecting patients, ruling out those whose interest is based only on the "fringe benefits" accruing as a result of placement, such as psychiatric treatment and the security of the financial support he receives until he is able to support himself, considerations that may obscure the purpose of the program. True motivation may be recognized in every move the patient makes—his reaction after the first interview with the agency worker, his readiness for subsequent interviews, the questions he asks, the doubts he shares with the hospital worker. Each step in the process, therefore, acquires special significance and whatever can be done before the patient leaves the hospital relieves his tension and provides a test of his potential adjustment. For instance, through referral to a vocational guidance or job placement agency one may observe the patient's handling of anxiety-provoking situations while he is still under hospital protection. It also gives the patient tangible proof of the hospital's interest and faith in him. At all times a patient's readiness is the barometer signifying timeliness of action.

After spending a year at the hospital, Miss J, a young woman of 27, would not consider the foster care plan which had been proposed. She had done extremely well in the hospital, participating in all activities, serving in various capacities on patient committees, and being liked and respected by patients and hospital staff. She seemed to be a most logical candidate for this program, both in terms of her personality and family situation. She had come to New York from a large midwestern city upon learning that she was pregnant, having broken off relationships with her aunts and uncles. Her only sibling, a brother, 9 years her junior, remained in their native city. Her father, whom she had liked, deserted the family when Miss J was fifteen years old. Her mother died six years later of multiple sclerosis, shortly after Miss J came to New York. Miss J could not rid herself of an overwhelming feeling of guilt for having left her mother, for having acted like her worthless father. Her first act, upon arriving in New York, was to register in a home for unmarried mothers. Her second was to release her newborn baby for adoption. Guilt was piling up; it grew and spread until it completely immobilized her. Although a college graduate, she could not hold a job, she was changing residences, she was sinking deeper and deeper until she plunged into a depression. By the time she entered the hospital, she had eradicated all these happenings from her memory and sought refuge in complete oblivion.

As if awakening from a deep sleep, Miss J yearned to spread her wings, to become independent once more. In this exuberant mood she could not accept the idea of living in a foster home, of depending upon a social agency. Respecting her wishes and sensitive to her feelings, therapist and social worker, while acceding to her wish, also gave her assurance that this type of help would be available if her independent plans did not work out satisfactorily. This young woman, whose ego strivings were strong but whose inner turmoil prevented her from attaining fulfillment, needed to know that she would not again be stranded. As evidence, she was given an opportunity to attend the after-care clinic. It did not take long before Miss J realized that she could not achieve her goal alone; that she needed more substantial help than two sessions a week at the clinic; that the path she had chosen "undermined her feelings of security." Miss J was now ready for placement in a foster home.

A referral based on an emotional response to the patient, rather than an objective assessment of the patient's readiness for this first and most significant step is likely to miscarry. Similarly, when, in their eagerness to make a plan, social worker and therapist are so caught up in the immediacy of "discharge planning" that they overlook the danger signals, the placement may terminate before the patient has had a chance to experience it to the fullest.

Such was the case of Arlene, who was admitted to the hospital when she was eighteen years old. As the younger of two children, both girls, Arlene had grown up in a home where marital discord, excitement, violence, physical and verbal abuse were the order of the day. The mother, an aggressive, controlling woman, suffered from involutional melancholia when Arlene was eleven years old and was bedridden for two years. The father, was subject to periodic violent outbursts. Until the onset of puberty, Arlene was doing well in school, although she and her sister did not get along. After that, her behavior changed abruptly. She began to cut classes, to associate with a "fast crowd," to frequent dance halls. In 1954, at the age of 17, she became depressed and was referred to the Bureau of Child Guidance. Before she entered the hospital in January 1956, she had worked as a chorus girl in a nightclub.

At the hospital, she established the reputation of an impetuous, impulsive young woman, whose behavior was provocative and seductive. She was petulant, abusive, uncooperative on the ward. Yet, she worked well with the Home Instruction teacher and, despite episodic depressions, was able to pass two Regents examinations and received a High School diploma while in the hospital. Because of this patient's background, she was seen regularly by the social worker in addition to the psychiatric sessions. It was through this special attention that she was sustained during the two setbacks she suffered almost simultaneously: the sudden death of her father and change of therapist. She had reacted with grief and guilt to her father's death, since she had been hostile toward him.

When her anxiety subsided, discharge planning was resumed. This patient had no home to return to, for her mother, too, had a severe reaction to her husband's death and

was not equal to assuming responsibility for Arlene. The selection of this patient for the foster care program was based on need and need alone, for it would have been unrealistic to assume that Arlene, whose concept of family life was so distorted, would want to live with a family. As if to forestall possible questioning, the worker states in the referral letter: "The patient is frightened about leaving the safe hospital environment and feels helpless about the future. She is worried lest she be rejected for anything she reaches out for and protects herself by approaching all new situations cautiously and with a need to test interest."

As the hospital worker feared, the patient reacted with frustration to the first interview with the agency worker, in whose presence she felt inadequate. In her state of anxiety and fear the mere suggestion of a question sounded like a rebuke. This was reflected in her inability to relate to the agency worker. The age differential between the two workers may have accounted for some of the timidity. But, in retrospect, it would seem that, while the hospital worker may have over-estimated the patient's readiness to live in a foster home on the basis of her minimal adjustment in the highly protected hospital environment, the agency worker's approach to this emotionally fragile girl may have been too vigorous.

Cases such as the one described are definitely in the minority. It was presented in order to point up some of the pitfalls inherent in any joint undertaking. There is an awareness on the part of the hospital and agency alike that methods of carrying out this program could be improved and there is equally a readiness to introduce such changes in policy, procedure, and approach as may be indicated. As we have come to the recognition that difficulty in making a decision is one of the symptoms of mental illness, we have introduced a good deal of flexibility in our interpretation of the procedure which, incidentally, undergoes frequent revisions. For instance, we have used the program as an avenue through which a patient may arrive at a decision *not* to use it.

Some differences inherent in the divergent nature of hospital and agency operation are not easily bridged. In a hospital providing short-term care every phase of treatment, including discharge planning, must be geared to the movement of patients. The agency's tempo, on the other hand, is determined to a great extent by availability of homes. This lack of synchronization sometimes leaves a vacuum and the hospital worker finds herself caught in the middle since it is her responsibility to interpret to the doctor why placement cannot be effected on the designated date, as well as apprise the agency worker of the reasons for the pressure. There is an awareness on the part of both hospital and agency that certain aspects of the foster care program need to be re-evaluated in the light of our experience; that the results thus far obtained could be enhanced with improvement and refinement of methods. But the valuable lesson that we in the hospital and agency have learned is that a partnership is as good as each individual partner and that the success or failure of a cooperative relationship depends on the readiness of each participant to subjugate individual differences to make it a truly joint undertaking.

FOSTER HOME CARE OF MENTAL PATIENTS

A JOINT PROGRAM OF A SHORT TERM HOSPITAL AND FAMILY AGENCY*

PART II

by HERTHA VOGELSTEIN

Jewish Community Services of Long Island, Jamaica, N. Y.

WHEN in 1952 Jewish Community Services of Long Island started to place patients discharged from Hillside Hospital in private families, a program had to be developed different from the then existing placement programs of State Mental Hospitals. While in State Hospital programs the doors of the hospital remain open for the patient in placement and he can return for longer or shorter periods, the former patient of a short term hospital cannot count on going back. Furthermore, in State Hospital programs the hospital remains in active contact with the placed patient who is on parole. Jewish Community Services, however, had to experiment with the purpose in mind of having the former patient separate himself completely from Hillside Hospital during his stay in foster homes, and to have him face the community as the place where his future lies.

This difference had been among the motivations for the Hillside Hospital social work staff approaching a family agency for placement of their discharged patients. The family agency answered this challenge by creating a set of supports and expectations that seemed apt to hold this kind of client in the community during the difficult period after his discharge from the hospital and to prepare him step by step for a life no longer dependent on hospital care.

The following are the outlines of the program worked out over the years as a special service for Hillside patients: for a period of six months the Hillside patient is offered (1) a home with a private residence family, (2) psychotherapy for the time of placement, (3) financial support, (4) casework service, coordinating agency services with other services needed for the client's integration into the community, as employment services, schools and training institutes, public as well as private.

In most situations, these six months afford time to evaluate with the client how much he can do and cannot do. The first two months serve the client to get adjusted in the foster home and to begin his training or to start on a job; during the second two months, he establishes himself more firmly in home and work, gaining some self confidence he so urgently needs; in the last two months client and worker focus more and more on plans for a future in the community. If at the end of the six months the client still needs the support of the agency, an extension of services is provided.

The six months period has never been adhered to rigidly. Preliminary statistics of 1956 show that of 51 persons placed, 29 stayed under care between three months to one year, and 4 persons stayed more than one year.

The patient referred by Hillside Hospital for placement continues to live at the hospital for about six weeks. During these weeks, he travels to the office of the family agency for frequent interviews. These pre-placement interviews have a fourfold purpose: (1) to help the patient face separation from the hospital, (2) to inform him of the services the agency offers him and the demands connected with them, (3) to find out whether the patient has the qualities needed to hold out under community pressures, and (4) to establish a relationship with the agency worker who will be the person with whom the client has to deal as long as he is under the agency's care.

The two most crucial questions discussed during these interviews are: does the client want to live in and with a family and can he take on the responsibility of starting a meaningful occupation, either job or school or training, within the first two months after placement? In short, life with a family and work, two important factors of community living, are posited, without which this plan would not have the stabilizing effect it so often has proved to have.

The financial arrangement is another important part of the discussions during pre-placement. This amounts to preparation for dealing with one of the most exacting and puzzling factors of community life, *money*. Money in its double role as symbol and as means of purchase calls forth countless anxieties. Help in handling money and in budgeting are a vital part of rehabilitation. The degree to which the emotionally disturbed client learns how to manage his financial affairs is often indicative of his ability to live with his problems.

During the pre-placement process, the person referred by Hillside Hospital makes the change from being a patient to becoming a client. If the process has been successful, the client will be familiar with all the details of the program and will recognize the agency worker as the person who will help him to make full use of the different parts of the program. He knows that the agency will pay the foster family for his room and board ($35. a week in 1957), pays for his psychotherapy, and will provide him with spending money until he begins to work and to earn a salary. He knows that he will be permitted to keep the salary for his first two weeks on a job entirely to himself for his free use. From then on, his budget and his contribution towards his upkeep will be reevaluated almost weekly and will be scrutinized in accordance with his changing needs.

At times, twenty-five per cent of the program's board payments have been paid by our clients out of their earnings. This does not include payments of the client's own family to the agency where the family was able to make contributions.

In the last pre-placement interview, the client meets the prospective foster mother in the agency's office. The items discussed between client, foster mother, and agency worker during this interview demonstrate the combination of supports and demands with which the agency tries to work in this program: the client will be free to come and go as he pleases in the home, he will get the key of the house or the apartment and he may return at any time, having the key means freedom but also the responsibility of keeping the apartment properly locked. His freedom to come and to

* Presented at the Annual Meeting of the National Conference of Jewish Communal Service, Atlantic City, N. J., May 26, 1957.

go does not mean that he has the right to change the family's way of life, rather *he* is expected to adjust to their established way of life. It is important that he keep the meal hours agreed upon during this interview. If that should not be possible now and then, he must notify the foster mother in advance. He may come home late at night, but then he has to be careful not to disturb the family; and if he brings friends along, they are not permitted to stay over night. There is a balance of give and take in these details which often has helped to establish balance for the client, especially during the first days after his discharge from the hospital. A visit to the foster home is arranged during that same interview. If it proves satisfactory to foster family and client, he will move into placement within the next few days.

The agency cannot and will not give to the client an environment as clearly structured as that of the patient in the hospital. But aware of his needs and fears, the agency creates a kind of sanctuary for the client where his progress once more, as it had been during his hospitalization, becomes important not only for him but for the persons who establish this sanctuary. On the day of placement, the client finds himself in the center of a triangle whose corners, foster family, psychiatrist, agency worker, are held together and coordinated by the family agency.

There is an almost inexhaustible variety of approaches open to the client in relation to the three corners of this triangle. The only thing he cannot do is to avoid these meaningful contacts. Time and again, when he has tried himself out with one or the other of the three, or when he has made an attempt to penetrate into the vastness of the world outside of the sanctuary, he will return to the center of the triangle where he feels safe and secure in the knowledge that foster family, psychiatrist, and agency worker are concerned with his well being, are concerned with his progress.

Life with the foster family draws the client into the outside world in an unobtrusive way. If he permits it, he becomes part of the family. He takes his meals with them, is present when they have visitors, is taken along for a ride, and watches television with them in the evenings. He has a room of his own, and the privacy of this room is protected, so that he can withdraw to it whenever he wishes. But daily and almost hourly contacts with the family make communication necessary. It is often in his relationship with his foster family that the emotionally disturbed client experiences the first break-through out of his self centered isolation into relaxed communication with others. This experience remains memorable for a long time to come.

Many clients have stayed on in their private residences long after their discharge from agency care. Almost all of them have remained in contact with the former foster family for years after they had left them. They return in times of stress for an evening where they can feel "at home," and they come for help and advice when they are in difficulties.

The role of the psychiatrist in this setting is twofold. He deals with the emotional problems of the client and is the consultant of the worker. The overwhelming mass of problems with which the client is beset makes their elimination necessary. Only then will he become able to focus on problems of adjustment and rehabilitation. In his contact with his psychiatrist the client is permitted to be a patient again. Here he finds the understanding he is craving for, the assistance he needs in order to

get his twisted feelings untwisted. There is less of a challenge here than in the foster home and in his contact with the agency worker. Close coordination has to be established between psychiatrist and social worker all along, especially concerning the pace at which the client-patient can move towards independence. The different roles, defined and understood in the beginning, emerge clearly time and again in the conferences.

With the agency worker rests the responsibility of coordinating the various elements, while keeping in focus the client's whole situation and his actual and possible movement. She keeps up a dynamic contact with psychiatrist and foster family, she helps the client to use the services inside and outside the agency and with her he learns to understand his own part in his activities. The vitality of the client-worker relationship is enhanced by the fact that she has to play two different roles in relation to the client. Probing, testing, finding out whether the prospective client is a person who can be placed with a family without danger to ordinary community life, whether he is a person who can truly benefit from this program, are the agency worker's responsibility during the pre-placement interviews. Supporting, bridging gaps, weaving and reweaving the often torn texture of life, and giving a helping hand in times of crisis are her responsibilities during the span of time while the client is in placement. In these two different roles the identity of the worker's personality has to remain intact throughout. If she succeeds, the client will lean on her, will use the services offered to him with ever deeper understanding and will move towards the point from where he steps out into an independent life.

Within this program a good many discharged patients have become able to stabilize themselves in the community and to remain active in jobs or other social roles. A follow up has been planned with the purpose of studying the factors that have contributed most to the stabilization of the client. Among 74 persons placed up to early 1957, 62 have remained in the community, 9 needed shorter or longer hospitalization, and 3 are at present in mental hospitals.

Two case illustrations follow:

Miss J, twenty-six years old, was referred after a year's stay at Hillside Hospital. When she was discharged from the agency's care after fifteen months, she had already moved into a place of her own and was holding a good job. She remained in psychotherapy paying for it out of her income. Short contacts with her over the years showed that she was moving on to better jobs, had made contact with several cultural, educational, and political organizations and had found new friends. Hardly could this have been expected of the withdrawn and rather confused young woman she first appeared to be. Her adjustment may remain tenuous because of her deep seated problems. Nevertheless, she is moving towards establishing herself firmly in the community and seems to become more and more able to deal with failure and disappointment.

Miss A, 29 years old, and referred after one year at Hillside Hospital. She was placed with a widow, an unusually strong and at the same time understanding woman. In her house Miss A was permitted to do what her mother had never been able to let her do —namely, to grow up. Miss A, the youngest of many children had been babied to such a degree that she still used to dream she was in a crib. In the house of the foster mother she was given opportunity to be active as a young woman should. She learned how to cook and to keep house, what she had wanted to do for a long time, and to be hostess when friends of hers came for a visit.

At the same time, Miss A went through a retraining process with the Division for Vocational Rehabilitation. After nine months of training, she found a job as laboratory technician. She performed well and progress was noticeable in many areas. When she was discharged, one year after placement, Miss A remained at first with her foster mother on an arrangement of her own. After another year, she was ready to move into an apartment she had found and was about to furnish. She is now planning to attend courses in

order to establish herself on a higher level of her profession.

The foster home has played a most constructive part in the rehabilitation of this young woman. So did other foster families in many other situations. It will be of interest to know who these foster families are and how they are to be found.

At the start of the Hillside Placement Program, several families who had worked in the agency's placement program for older persons were willing to try themselves out with young adults. It is characteristic for this program that by far the greater number of patients referred to us is between twenty and thirty-five, and only few are over fifty. New families, who joined in this work, were mostly friends or relatives of the first group. There has been a core of about twelve families who have stayed with the program throughout. It has become their choice and they find satisfaction in the challenge it offers. None of these families is professional.

In New York City, most of the foster families are refugees who have escaped from the great upheaval in Europe during the thirties. They are Russian-, Polish-, Austrian-, German-, Hungarian-, and Danish-Jewish families, while the Hillside patients, placed with them, are American born, with very few exceptions. I have found these families to be particularly tolerant of persons who are different and extremely sensitive to their needs. It seems that this tolerance, which makes itself felt in many daily situations, makes it possible for severely disturbed clients to adjust in these homes and to use them as a stabilizing factor in their general adjustment.

All placement programs are indebted to the field of child placement. Different as this program is, it is no exception. Child placement has initiated the process of getting persons out of institutions, of uniting them again to the general stream of life by placing them in foster homes. The integration of persons on the border of society is part of the great change which our society is undergoing at present. The underlying idea of this process is that man is meant to live together with his fellowman, that he should be separated from his fellowman neither by work, nor by sickness, nor by age, be it old age or childhood, unless he separates himself from his fellowman by crime.

This integration of the outsider into the community is an area where social work and social action come close together. By building and creating services that contribute to this process of integration, the social agency may play an ever growing role in this field. It may easily be that this is the field where the great battles of the future will be fought.