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THE CONVALESCENT CARE OF CHILDREN  
IN MONTREAL

A study based on some phases of the historical background of child care, some present concepts, and programs of foster convalescent care, the immediate past and present situations as regards convalescent care of children in Montreal

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Mary Constance Fraser  
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PREFACE

The writer wishes to express her appreciation to all those who have helped in any way with this study. Her most grateful thanks go to the Montreal Council of Social Agencies for the use of the Minutes of the Council which pertained to this inquiry, and also for their permission to attend the meetings of the Committee on Convalescent Care for Children in Montreal. To the Committee itself, the Children's Memorial Hospital for use of one of their records, and to all those whose knowledge and interest have contributed to the study, the writer acknowledges her debt.

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## CHAPTER I

### INTRODUCTION

The words "to convalesce" mean to grow strong again, and indicate the slow process by which a patient regains strength after an illness. Within the past decades a much greater understanding of what is involved in this process has come about largely due to the great strides made in the fields of medicine and psychiatry. For convalescence has many facets, and is not a mere physical state. It involves the whole person physically, mentally, emotionally and socially, and yet convalescence affects every individual in his own peculiar way. Speaking at a Conference on Convalescent Care in New York, Dr. Perry Pepper<sup>1</sup> put it this way:

"Convalescence is not a constant nor a single state: it presents many phenomena, many truly organic, some psychogenic. We know far too little of the organic results of different acute processes which persist into convalescence; the ideal treatment of convalescence calls for the recognition of these deviations from the normal and their correction in terms of the individual."

Convalescent care is more and more assumed to be a continuing service in which the total needs of the individual are taken into consideration. No medical history is complete without that of the convalescent period, whether that period

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<sup>1</sup>Dr. O. H. Perry Pepper, "The Physiology and Psychology of Convalescence," Convalescent Care, New York, 1940.

is spent in the home, in the country, or in a convalescent institution.

When the patient is a child, the process of convalescence is infinitely more complicated than for an adult patient. A child is growing physically, mentally, and emotionally. Thus a period of illness is bound to affect this growth process. This also means that illness can have profound effects on the development of personality.

In recent years in the field of child care, paediatricians, psychologists, psychiatrists, and social workers have shown that separation from his family can be a traumatic experience for any child. This is even more true of the sick child. Time has a different meaning for a child than it has for an adult, and even a very short separation is a long time in his experience. Thus, in spite of its temporary nature, convalescent care when undertaken outside a child's home, must be considered as a form of child placement. Not only the medical factors must be considered, but also the individual development of the child from a social and emotional point of view. In recent years, a greater understanding of the differing needs of the various age groups has resulted in a better use of both foster and institutional placements.

It is the purpose of this study to review some of the modern concepts of child care as they affect convalescence. In the light of their varying needs, it is proposed to study

the kind of after-care which is thought best for the infant, the pre-school child, the school child, and for the adolescent. It is proposed to study certain selected programs of foster convalescent care in other communities, and to trace the historical background of convalescent foster care in Montreal during the last twenty years. Finally, it is proposed to inquire into the present facilities and resources of the city, and plans for the future. It is also the purpose of this study to consider what kind of over-all program of convalescent care is needed in a large urban centre such as Montreal in order that the city may avoid gaps in its services to children.

The convalescent care of its children has long been a problem in the large and growing city of Montreal and its environs. Events of recent years have served to intensify the problem. One great factor has been the rapid industrialization in the Province of Quebec which has made for a tremendous influx of population to the cities, and particularly to Montreal.<sup>2</sup> As a consequence, the need for hospitals and allied institutions has far outrun the capacity of present facilities for all sections of the population of Montreal and of other cities in the province. Since the

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<sup>2</sup>Population of Montreal in 1901; 325,653: 1921; 618,506: 1931; 818,577: 1941; 903,007: and in metropolitan area of Montreal in 1931; 1,023,158: 1941; 1,139,921. Dominion Bureau of Statistics. The Canada Year Book, 1950. p. 149.

war, crowded hospitals with waiting lists running into the hundreds have made the problem of convalescent care a vital one. An increasing realization of the gaps that exist in the present convalescent services to children in Montreal led interested citizens to form a Committee<sup>3</sup> to study the placement needs of handicapped children. This Committee was set up under the auspices of the Montreal Council of Social Agencies in 1949, and it is representative of the French and English speaking Catholic groups, as well as the Protestant and Jewish groups. The chairman of this Committee is the Director of the Social Service Department of the Children's Memorial Hospital.<sup>4</sup> Also within the last year, the attention of the public in Montreal has been drawn to the needs of convalescent children by the appeal of the Julius Richardson Convalescent Hospital for funds to build a new and larger plant in place of the present inadequate one.

In her field work at the Children's Memorial Hospital, the writer has had the opportunity to study at first hand some of the difficulties of finding convalescent placement for children whose homes were unsuitable for economic, social or emotional reasons to provide the necessary care within the home itself. While some of these children could

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<sup>3</sup>The Committee on Convalescent Care for Children in Montreal, hereafter referred to in this study as "The Committee."

<sup>4</sup>Mrs. Christina James.

be taken care of at the Julius Richardson Convalescent Hospital, there were many who by reason of age or medical condition needed either foster care, or certain treatments that were not available in that institution. For these reasons, then, a study seemed relevant of the convalescent care of children in Montreal within recent years. A study of the present resources, and the plans for the future in the light of current thought also seemed pertinent.

The scope of this study has been confined to the consideration of convalescent care for children who are recovering from acute illness, and who need only short term or temporary placement. The historical background has been limited to the past twenty years as it was in the early 'thirties that the first study of the foster care of infants was undertaken in Montreal and a plan for their care evolved. The evolution of present day concepts in child care is discussed with particular reference to convalescent foster and institutional care. From the point of view of organization and philosophy, two specific programs of foster convalescent care have been considered, namely, the Speedwell Plan of New York, and that of the Children's Mission to Children in Boston. The establishment of these two programs as integral parts of the total services to convalescent children in these centres is considered. Finally, the findings and conclusions reached by the Committee on Convalescent Care for Children in Montreal with regard to the present facilities and gaps

in the resources are considered, and also the Committee's recommendations for future planning.

The writer has gathered most of her material for this study from the writings of various professionals in the field of child care such as Dr. Laurette Bender, Dr. Benjamin Spock, Anna Freud, Dorothy Burlingham, and many others.<sup>5</sup> Information has also been gained from the minutes of the Montreal Council of Social Agencies, the minutes of the Committee on Convalescent Care for Children, and by interviews with social workers, nurses and doctors, who have been active in the field of child care in Montreal within the last twenty years. The writer was fortunate also in being permitted to attend the meetings of the Committee and the sub-committees which have been studying the facilities and needs of convalescent children in Montreal. She has been fortunate in that she has been able to make use of the findings and recommendations of these groups.

Since convalescent care is one part of the total services to children, the first part of this study is devoted to a short review of present day concepts of child care in general. This leads into the discussion of the specific programs of foster convalescent care as initiated in New York and Boston. The next chapter summarizes the history of convalescent care for children in Montreal within recent years, and it leads to a chapter in which the

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<sup>5</sup>See Bibliography.

present resources are discussed in the light of present standards of child care. Finally, the findings and recommendations of the present Committee are discussed.

## CHAPTER II

### SOME PRESENT CONCEPTS IN CHILD CARE

In the first chapter of this study, it was stated that convalescent care for children is a form of child placement, although of a temporary nature. Since it is a form of placement, it is proposed in this chapter to consider some of the basic concepts which are presently held in the wider field of care for the dependent child. It is a basic assumption of this study that those elements which enter into good practice in the placement of children generally, also hold good in convalescent placement, in spite of its temporary nature. In fact, their importance is intensified by the added physical and emotional factors which the illness has brought about. Therefore, a knowledge of what is currently considered to be good practice in the services to dependent children in general, is important to any study of services to convalescent children.

The first half of this century has seen much progress in the development of services to dependent children. In fact, the past fifty years have shown that a revolution in thinking and practice has taken place. This progress in the development of services to children throughout the country, nevertheless, has been very uneven, and shows many ups and downs.

The latter part of the nineteenth century was undoubtedly the heyday of what has been called the institution-

al era<sup>1</sup>. Society has always had to find ways and means of taking care of its homeless and helpless children, and on this continent the era of institutions more or less superseded many of the earlier methods of care. The almshouse, where children were crowded in with the aged or insane, was gradually done away with, as was the system of apprenticeship or indenture. Institutions sprang up not only for the orphans and for children who had suffered cruelty, and for child offenders, but also for the education of the blind, the deaf, the mentally retarded, and many others. All this indeed represented a great advance over the methods of colonial days which had changed little since the time when the Elizabethan Poor Laws were passed. It was, nevertheless, this so-called institutional era that saw the beginning of organized care for children in foster homes.

At the turn of the century, the Charity Organization Movement, which had begun in England and quickly spread to this continent, had a profound effect on the methods of child care. This was chiefly because of its stress on the need to individualize the person. This idea soon permeated the Children's Aid Societies which were springing up throughout the country. The value of the institution began to be questioned as workers saw that it was impossible to give a

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<sup>1</sup>Emma O. Lundberg, Unto the Least of These, Appleton, New York, 1947, pp.74-75.

child individual care and attention in the crowded, impersonal, rigid institutions of the day. It was also at this time that the importance of the family in the life of a child was realized as never before. It was felt that no institution could be an effective substitute for the child's own parents and siblings. It could never provide him with the love, the sense of belonging, and even the conflict that is found in ordinary family life. The ideal answer to this seemed to be in the provision of parent-substitutes in a foster home setting when the child was deprived of his own family for any reason.

For a time, the pendulum was swinging away from the concept of institutional care to foster care for any child. The tremendous expansion of foster home programs which followed, threatened to eliminate all institutional placements in time. It was felt that any foster home which met certain standards, mainly physical and economic, was automatically better for any given child than an institution.

Within the last decade, there has been still another swing of the pendulum, and considerable modification of the idea that foster homes are preferable to institutions in all cases. The exigencies of the war years were partly responsible for this change in attitude with the increasing break-up of family life, and the great pressure exerted on the child-placing agencies. Since the number of foster homes required were not available, the institution was the

only solution, and proved quite satisfactory.

Another factor in this swing of the pendulum, was the rapid advance that had been made in the field of child psychiatry. This has made for a better understanding of the development of personality, and it has emphasized the need to consider the whole child. It had been found that some children seemed unable to adjust in a foster home setting, and were often sent from one home to another. When an institutional placement was tried, often as a last resort, a good adjustment was made. Certain children who had been deprived of affection and security in their own homes were less threatened by the impersonality and routine of the institutional setting than they were in foster homes. The problems of such children were much more easily treated in the group setting. And so in the last few years, both the limitations of the institution, and its positive contributions in the realm of child care have become better understood.

However, the thinking which led to the development of foster home programs has been justified on the whole. This is especially true in cases of very young children. Every child needs love, attention, and the feeling that he belongs to someone. Babies, particularly, need the individual care and affection of their mothers or mother-substitutes. Many studies have shown that infants and very young children who have been under institutional care for

any length of time show regression or arrested personality development.<sup>2</sup> Such children have been shown to be backward in many ways in comparison to those brought up in their own homes or in foster homes.<sup>3</sup>

It was for these reasons that legislation was advocated by professional workers in the United States forbidding institutions in various States to give care to children under two, three or four years of age. Many writers<sup>4</sup> on the subject of child care claim that six years is the minimum age at which a child should be accepted for long term care in an institution. These same writers are generally agreed that in the case of short term care, a child up to the age of four should be placed in a foster home. Even this should be done only if the mother is quite unable to look after the child herself. Other writers, while agreeing with these tenets in the main, are not so specific with regard to the exact ages at which young children are placed in foster homes or institutions. They stress the fact that decisions should depend on the needs of the individual child,

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<sup>2</sup>Lester Peddy, The Background to Current Thinking and Problems in Convalescent Care, New York, 1948, pp.30-31.

<sup>3</sup>Anna Freud, and D. T. Burlingham, Infants without Families, International University Press, New York, 1944, pp.11-26.

<sup>4</sup>Cecilia McGovern, Services to Children in Institutions, National Conference Catholic Charities, Washington, 1948.

his circumstances, and the resources available.

A child in the six to twelve year old group who goes to school, should be less dependent on the mother than the younger child, and more able to stand some separation from his family. As a general rule, it is felt that if it becomes necessary to place a child in this group, an institutional placement is preferable. This is especially true with regard to short term placement. When it is a question of a relatively short separation, the institution is often more acceptable to both parents and child. To the parents, the thought of the institution may be less threatening than that of a foster family who may supplant them in the child's affections. This, however, may not always be the case. Some parents may prefer a foster family rather than the "stigma" of an institutional placement. Again, the child's particular needs and wishes must be an important factor in the decision as to his placement. As a general rule, however, the child within the six to twelve age group is better off in an institution for a short term separation unless there are relatives or friends to whom he may go.

When it is a question of a long-term placement for a child within this age group, foster home placement should be considered as well as institutional placement. A child of this age, while able to stand some separation from his family, does need the experience of normal family living. No institution, however good, is an adequate substitute for life

with parents, siblings, and relatives, with all the attendant joys, sorrows, and conflicts. Thus, when it is known that a child must be away from his own family for some considerable time at this impressionable age, a foster family is likely to be a better substitute. Here, he gradually becomes a part of the family, sharing its ups and downs, and meeting the world as he never could in an institution.

Whether a child of this age is placed in an institution or with a foster family, his home ties are very important to him. Every effort should be made to keep the child in touch with his family if it is at all possible. Parents' visits, news of them, presents, photographs, all help to keep memories of home vivid. A child of this age does not like to be different from other children. He needs to feel that he, too, has parents who love him and take an active interest in him in spite of an enforced separation from them. When there are sisters and brothers, these, too, should be placed in the same institution or foster home, if possible, and separated no more than is necessary. Even though there may be a good deal of sibling rivalry, sisters and brothers represent strong links with home, and lessen the child's feeling of "difference" or "aloneness".

An institution, which has good standards, should have a staff sufficiently large and competent to look after the children in small groups. Each group should have its own "group mother". Thus each child is enabled to have at

least something of the individual care and attention that he craves. This is important for any child, but it is essential for the child whose parents cannot visit, or who take little or no interest in him. By taking a special interest in such a child, the group mother can give him a sense of belonging to someone, as well as helping him to feel an integral part of the group. Thus, she can offset to a degree the child's sense of being different by having parents who, in his mind, may fail to measure up to other parents. Essentially, the group mother in an institution, and the foster mother in a home have similar roles. They give the love and security the child needs for normal development at a time when his parents are unable to do so, and at the same time they pave the way for his return home by strengthening the ties between parents and child.

What of the child from about twelve to sixteen years, in the adolescent period? The normal young adolescent is beginning to assert his independence, and to move away from his family in greater or lesser degree. This is as it should be. This is the "gang" stage where the most important thing is to be one of the crowd. In our society, adolescence is often marked by a period of tension between parents and child. The adolescent is developing his own personality and struggling to gain an independence that his parents are generally unwilling to grant him. For these reasons, the adolescent is more likely to fit into a group

setting in an institution than into a foster home placement. The institution provides a relatively impersonal setting, and the adolescent is merely one of the group. In a foster home with its highly personal setting, he is likely to have the same conflicts and tensions which he had at home, but in an intensified form.

There is the exception to every rule, and a child or adolescent who is emotionally disturbed may adjust better in a foster home. In the ordinary institutional setting without specialized help, he may be completely unable to make an adjustment, and be a disrupting factor in the group. An understanding foster mother and membership in the small family group are more likely to be of benefit to an adolescent who is emotionally disturbed than any institution that is without highly trained personnel, and specialized groups. While most children are able to get along in either a foster home or an institution, it has been found in evaluating the adjustments made by older children in institutions, that the children who presented the most difficult problems were those who had been deprived of warm, affectionate relationships with their mothers in infancy<sup>5</sup>. If these children can be enabled to establish a warm relationship with an adult during placement, they will be greatly benefited. This is often easier to provide in a foster home than in an institution unless that institution has specially trained

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<sup>5</sup>Ibid., pp. 16-17.

personnel and facilities for psychiatric consultation. An emotionally disturbed adolescent in a foster home may also need psychiatric help as well.

In the foregoing pages, institutional placement and foster care for the dependent child in general have been discussed. As already mentioned, convalescent care for infants and children is but a small part of that total field, but, nevertheless, a very specialized one. Convalescent care, which involves the care of children who have been acutely ill, presents all the problems common to the care of any dependent child, and also a number of additional ones, both medical and psychological in nature.

One problem which is common to any program for children, but important to guard against in a convalescent institution for children, is the ever-present danger of cross-infections. Babies and children of pre-school age have not had the chance to develop the resistance to infection which older persons have acquired. An epidemic, once started, spreads like wild-fire. This is one reason that many children's convalescent homes keep their minimum admission age to about six years. Consequently, if there is no foster care plan available for the child under six years of age, and the home is not suitable for social, emotional, or economic reasons, the child is often kept in the hospital to convalesce. Not only is this expensive, but it keeps the bed from being used by a more acutely ill child. How-

ever, if such a child is not kept in hospital, but sent home to convalesce, there is every likelihood of his returning to hospital time and again. In the long run, it is better and less expensive to keep him in hospital in the first place.

While infants and pre-school children are thought to benefit more in a foster home than in an institution, the total needs of the individual child must be considered. In a convalescent placement, the child's medical needs must be evaluated also. There are certain medical conditions which even in the convalescent stage would be difficult for the average mother or foster mother to handle. Young as they are, it may be necessary for some pre-school children, who would normally be better at home or in a foster home, to convalesce either in hospital or convalescent institution. Another consideration is the fact that some pre-school children feel less abandoned by their parents in a group setting than in a foster home. Likewise, some parents are less threatened by the continuing care of an institution than by a foster home plan, although they may be helped to accept it. Caseworkers today feel that it is most necessary to evaluate all these factors when one is planning for the convalescent care of this particular age group.

The school age child is away from his home at least part of the day. Thus, when in hospital or other institution, separation from his parents is not likely to be as traumatic an experience for him as it may be for the pre-school child.

The school child, therefore, is more able, as a rule, to accept convalescent care in an institution than in a foster home, providing it is for a relatively short period. It is important that he should feel that he is participating in any plans that are made for him. The child of this age cannot decide what is best, but he does need to know what is going to happen to him, and something of the reasons for it. If he does not understand and participate in the planning, the convalescent period may not serve the purpose for which it was intended at all. However, when he does participate in and accept a plan for convalescent care in an institution, rather than in his own home or a foster home, the placement can be of great value to him.

Illness is always accompanied by a certain amount of regression and dependency regardless of the age of the patient. Because these tendencies often persist into the convalescent stage, this is a period in which the patient needs understanding as much as he did in the acute stage of his illness. So often it has been thought that rest, sunshine, and good food are the only requirements of the convalescent period, and that the patient will automatically recover from his dependency on others, his irritability, and his other regressive traits when his physical health improves. Much depends on the meaning the illness has had for the patient, and what satisfactions, if any, he has derived from it. To assume that all is well when the patient's physical needs

are met, is a fallacy that can be very damaging. This is especially true in the case of a child's developing personality. Convalescence can be a negative thing in which the regressive tendencies become a fixed part of his personality, or it may be a constructive period in which these traits disappear and many valuable lessons are learned. In a convalescent institution with a staff who have an understanding of the disease process, and of a child's emotional needs, the convalescent period can be truly one of growth physically, mentally, emotionally, and socially. Moreover, the convalescent child is with other children who also have been ill, and with them he can work and play within the limitations of his physical condition.

In a convalescent institution, the child who has become withdrawn and anxious can often be helped merely by seeing others like himself and what they are able to do, and by being drawn gradually into the group, and their play. Again, the child who has become aggressive and demanding may find an outlet and satisfaction in group play that he would not find if he were to convalesce alone. For him, group games, and especially those at which he is adept, may act as a ventilator for his aggression, and in time modify his behaviour. Group play helps to make convalescence more fun for any child, but with children who show serious regressive tendencies, it can be used with great therapeutic effect. It is important, therefore, that there be at least

one member of the staff of the institution, preferably a trained worker, who understands group play and its therapeutic uses.

A school child who is ill for a considerable time misses a great deal of work, and catching up after returning to school often puts a severe strain on him. When such a child convalesces at home or in a foster home, it is a task in itself to keep him happy and amused, much less to help with school work that has been missed. A good convalescent institution for children, however, will have at least one specially trained teacher on its staff who is able to give individual coaching to each child in accordance with his need, and in keeping with his physical strength. This does much to enable the child to return to school without undue fear and strain.

The problem of the adolescent who needs convalescent care is sometimes a difficult one. In discussing the dependent child, it was seen that the child between twelve to sixteen years of age is usually considered an adolescent. It was also seen that at this stage of development, the adolescent is generally able to make a better adjustment in an institution than in a foster home. This is also true in the case of convalescent care, but the problem is largely in the finding of facilities. Many children's convalescent homes admit children up to the age of twelve years only, or at the most, up to fourteen years. The adolescent over this

age, must go to an adult institution. The average adolescent, however, is neither a child nor a mature adult, but something of both. Whether or not he will be happy in an adult or in a children's institution depends largely on the individual himself, what his particular needs are, and what his illness has been. There are also certain medical conditions which might be hard for the adolescent to handle in a group setting because of embarrassment to the individual himself, or the adverse effect it would have on the others. For example, an adolescent girl of fourteen years of age who has just had a baby, will hardly fit into a children's home. Neither is she likely to fit happily into an adult institution. However, the best arrangement is a ward in the children's institution for the younger adolescent, and a ward in the adult institution for the older adolescent. A comprehensive plan for foster convalescent care may be used to take care of those special cases for whom care in either a children's or adult institution is contra-indicated.

In discussing present day concepts of child care, it has been emphasized that the total needs of each child must be considered, and this in relation to existing facilities in the community. If the child is upset by his feelings about his convalescent placement, his recovery will be affected. Frances Upham<sup>6</sup> states that emotionally disturbed

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<sup>6</sup>Frances Upham, A Dynamic Approach to Illness, Family Welfare Association of America, New York, 1949, Ch. 5.

children furnish fertile soil for the development and progress of organic illness in adult life. Therapeutic measures must take into account the child's feelings as well as the disease. Otherwise, the child may spend the rest of his life using illness as a means of handling his inner turmoil. Therefore, in planning convalescent care, the worker should try to help the family give the care that the child really needs.

In planning for convalescent care, the worker frequently has to call upon other agencies in the community for help. A family agency may give casework services to the parents or supplement the income in order to provide the extras that are often needed. Extra nourishment, fruit, toys, carfare for visits, and other numerous things that help to make illness and convalescence more comfortable, may be beyond the parents' means. This is often true even though the larger expenses such as the doctor and hospital bills may be taken care of by other means. The visiting nurse service may be used to teach the parents the essentials of the child's care, or in carrying out any special nursing care in the home. A mother who is quite capable of caring for a well child, is often quite incapable of caring for a sick one without such support and guidance as she would get from a visiting nurse.

Whatever type of convalescent care is planned, there should be time for the medical social worker to get to know

the child and his parents. No plan can be successful without the understanding and co-operation of all who are vitally concerned. It is important for the child to understand that any plan that is made, whether it be to go to a foster home or an institution, is merely a temporary measure designed to restore him to his family as soon as he is well enough. It is also important that the family is drawn into all the planning for the child. No decisions should be made without their understanding and co-operation. Careful planning involves teamwork with the child as well as the discussion and sharing of his total needs on the part of the medical staff, social worker, the parents, and the other agencies concerned. The strengths and weaknesses of the family situation should be considered, and the limitations of the various facilities should be discussed frankly with the parents before any decision is made.

Whether convalescent placement is in a foster home or in an institution, every means should be used by the social worker to strengthen the ties between home and family. If visits from the parents are few and far between, because of distance or unavoidable reasons, letters and pictures help to keep the child from feeling rejected. The worker's visits should also serve this purpose by bringing him news of his family, and by letting him talk about them if he wishes to do so. In a foster convalescent placement the foster mother can do much by keeping the parents informed of the child's

condition by letter or telephone, by encouraging visits, and by talking to the child about his family. Due to the popular belief in the beneficial effects of country air, many children's institutions are located so far out in the country that it is difficult for the parents to visit often. Nevertheless, it is important that every effort should be made to encourage visiting at regular intervals, and that every other means be used to keep the child in touch with his family. In the past, many institutions tended to discourage this because of the so-called "unworthiness" of some parents who were not able to give adequate care at home for economic or social reasons. Visiting was also discouraged because the children became excited or upset, and it involved extra work for the staff. It is now realized that an enforced separation can be used constructively. The child should go home to a family that is better able to care for him, and that understands his needs better than it did before the illness. The child, too, may be able to cope with the difficulties of family life better than he did.

In many communities, adequate planning for the convalescent care of children breaks down because of a lack of facilities. A scheme for foster care is often non-existent, and the existing institutions fail to meet the need. If there is no co-ordinated plan in the community, many children are bound to suffer from makeshift placements that do not begin to serve their purpose. An integrated and co-

ordinated program involves a plan for home care which should make it unnecessary for many children to convalesce outside their own homes. It would also have adequately supervised foster convalescent homes with foster parents who not only understand children, but who understand the special needs of convalescence. In addition, the convalescent institution is a vital part of any program. Since it is being realized more and more that convalescent care is a part of the total medical program, the convalescent institution is often attached to the hospital itself, thus ensuring continuity of care. If it is not attached to the hospital, it should be located near enough to the medical centre to ensure continuity of treatment, and make visiting easy for parents and social workers. In any large community, only a co-ordinated plan which makes use of home care services, foster homes, and a convalescent institution, can meet the needs of infants, and children of all ages.

It is true that the last fifty years, and especially the last ten years, have seen tremendous changes in the concepts of child care. In this chapter, it has been seen that the pre-school child needs the care of his own mother or mother substitute in a foster home, rather than the impersonal care of an institution. The school child in the six to twelve year age group, and the adolescent up to about sixteen years, make better adjustments as a rule in an institution. Whether a placement is a long-term one, as it

may be with a dependent child, or a short-term, convalescent placement, a decision regarding the type of care should be made only after considering the total needs of the child. It must take into account the child's physical, mental, and emotional needs, as well as the social and economic factors. This involves teamwork on the part of all concerned with the child and his family, and adequate facilities to carry out the plan.

Since the care of the infant and pre-school child is the primary interest in this study, consideration will be given in the following chapter to two outstanding programs of foster convalescent care. It is not proposed to consider any specific institutional program since it is not pertinent to these particular age groups, and since an institutional program is, in any case, common to almost any large community today.

CHAPTER III  
TWO SPECIFIC PLANS FOR THE FOSTER CARE  
OF CONVALESCENT CHILDREN

In the second chapter, it was seen that the almshouse and the indenture system gave way to the institution. This in turn was almost superseded by the foster home movement with the coming of changing philosophies of child care. The programs, which are about to be considered, were products of this movement which was concerned with bringing foster care to all children deprived of their own homes. This chapter, therefore, will be devoted to a description of the Speedwell Plan of New York, and the Children's Mission to Children in Boston.

If the latter part of the nineteenth century could be called the institutional era, the beginning of the twentieth century was certainly the era of foster care programs. Since the underlying philosophy was that babies and children need that individual care and attention which is found only in a home, foster home care was early extended to include convalescent care. Dr. H.D. Chapin who was the founder of one of the most famous programs for the foster care of convalescent children, stated it thus:<sup>1</sup>

"Babies need individual care and affection -  
in other words - a mother, which is

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<sup>1</sup>Quoted in the Speedwell Plan and its Realization,  
The Speedwell Society, New York, 1947, p. 3.

" another reason why they do not thrive so well when handled in mass. This explains why, as a rule, babies do better even in a poor home than in a good institution."

"Children need home and family life. The family is the oldest human unit of association-- and the best physical, mental, and moral development of child life takes place in the individual home. For a child deprived of this benefit, it is better to procure another individual home instead of handing it over to a large institution."

It was as early as 1902 that the Speedwell Society of New York was organized by Dr. Chapin to furnish foster home care for convalescent children. It was then incorporated in the State of New York "to place convalescent and frail children in foster homes for temporary care under medical and nursing supervision--". Dr. Chapin when speaking about the organization of the plan in later years said that this idea that babies and children were better off in homes than in institutions soon led to boarding out. He felt that while this represented a distinct improvement, there were also dangers if it were done in a careless or haphazard way. The dangers of boarding out consisted in a careless selection of homes, followed by insufficient oversight of the children. The Speedwell Society was started with a view to conserving the benefits of boarding out, and to avoid its dangers.

The plan is centred around a unit system<sup>2</sup>, with

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<sup>2</sup> Lester Peddy, The Background to Current Thinking and Problems in Convalescent Care, United Hospital Fund of New York, 1948, pp. 31-33.

each unit having a group of foster homes within a given geographical area. There are now five units altogether which care for as many as one hundred children per day. Four of the five units are for general convalescent care, and take children of two weeks of age. Ever since 1938, the fifth unit has taken children with rheumatic fever only, including those with cardiac damage. In this special unit ambulatory children from three to twelve years of age are accepted.

The various units are joined through a central office. This office handles all the applications, the admissions, and discharges. There is a central medical advisory board which formulate the medical policies, and clears medical questions referred to it from the units. Children are referred to the central office from the hospitals and other community agencies.

There is a committee of sixteen or more women to each unit. The chairman of each unit is a member of the Board of Directors of the Society. Part of the work of each unit is done by volunteer committees. There is a welfare committee whose duty it is to approve every foster home, and to visit the children every week. Another committee is responsible for transportation of the children, and still another to see that they have proper clothing.

Each unit has its own doctor who receives a part time salary. He examines all the children on admission and

at discharge, and is always on call. The children are also seen once a week in either the foster home or the doctor's office. Each unit has its own registered nurse who is on a full time basis. She makes a daily visit to each child in the homes, gives any treatment that is necessary, and any instructions needed to the foster mother.

Foster families must have a large enough income to meet immediate needs in order to meet the requirements of the Society. Most important, however, is a woman with a deep motherly instinct. Each foster home must have a separate room for the Speedwell children, and a reasonable standard of cleanliness is expected. Young children belonging to the foster parents are allowed in homes where general convalescent care is given. In the unit which cares for children who have had rheumatic fever, the foster homes must not have own children under fifteen years of age. All the homes are licensed. Before any home is accepted under the plan, every member of the family must have a complete physical examination by the unit physician which includes an x-ray and a schick test. Two children are placed in a home as a rule, but this varies somewhat.

The Speedwell Society furnishes clothing, medication, formula ingredients, toys, and a quart of milk daily for each child. The Society also pays the prevailing rate for foster home care.

There are many advantages to a plan such as that

of the Speedwell Society. It does give individual care to each child. It also guards against the dangers of cross-infections that are so prevalent in children's institutions. It takes care of the child who because of certain physical or emotional problems, would not be suited to a group setting. A plan like this is elastic, and it is a great deal cheaper than institutional care. When more beds are needed, it is merely a question of finding more foster homes, not the provision of new or larger buildings. However, it is here that such a plan may break down. One of the greatest difficulties for most communities is in the finding of suitable foster homes. Even in New York, where there are skilled home finders, it has always been an acute problem. Most centres find it difficult to get enough foster homes for ordinary purposes, let alone suitable ones for convalescent foster care. One feature of the Speedwell plan that one might question is the use of so many volunteer workers. These certainly have a place in looking after transportation and clothing, but the actual supervision of the foster homes would seem to need the services of skilled social workers.

The Children's Mission to Children in Boston<sup>3</sup> is another interesting plan for the foster care of convalescent children. This is a century old, privately-

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<sup>3</sup>Elizabeth E. Bissell, "Foster Homes in Medical Care Programs for Children," The Child, Children's Bureau Publication, February 1950.

supported agency originally started with the aim of "helping any child in need of a friend". This agency has been placing children in foster homes for about fifty years, and for convalescent care for nearly thirty years. It serves the hospitals, clinics, private doctors, and other social agencies in Boston. In 1949, it was affiliated with the Children's Medical Center, and it is the only agency placing children for convalescent foster care in the locality. This was brought about by a joint decision made by the children's agencies of Boston.

The Children's Mission to Children offers convalescent foster care to boys and girls in two types of homes. The first type of home is called by the agency a "medical home" or a "group bed home". This type of home is for children who still need bed care. This takes in those with bronchiectasis, arthritis, nephritis, hemophilia, spinal fusion, asthma, cerebral palsy, or rheumatic fever. From four to fourteen children are cared for in one of these medical or group bed homes although the agency itself would like the maximum to be six to a home. The foster mothers who care for larger numbers are all unusually competent women who are able to maintain individual relationships with each child in the constantly changing groups. The agency guarantees regular payment for a specified number of children in each of these homes whether or not all the beds are filled. It usually has about five of these homes at any

one time. A child in one of these homes is considered to be ready to return to his own home or to a "nonmedical home" only when he is able to be up and around for eight hours in the course of a day. An agency study done in 1947 showed the median length of care in medical homes to be from three to four months.

The second type of care offered is in a "nonmedical" or "up" home. This type of foster home is for children who are ambulatory at the time of leaving the hospital but still have medical problems. The purpose of the home is to give a natural family setting to children whose activities still need restriction, rest periods, good food, and medical supervision. These children are placed in an individual foster family, and belong to one of two groups. Either they need long term care away from home for health reasons, or else they need care during the summer vacation to get them away from city slums or other unfavourable conditions. A number of these children may be those who are past the convalescent stage of rheumatic fever, but are not well enough to go to a camp. The average length of stay in these "up" homes is about two to three months.

The number of children under care by the agency at any one time is approximately eighty. About half of this number have had rheumatic fever. The majority of the referrals are from the hospitals. The boys and girls who are accepted for care are from two to twenty-one years of age.

These must be without infectious disease, and not acutely or terminally ill, although the prognosis may be poor.

When a request for placement is received, the child's mother and father usually visit the agency to discuss the matter. If they wish the service, and placement is possible, a case-worker talks it over with the child before any arrangements are made. This agency has no residence regulations, and no racial, religious, or financial restrictions. The family is expected to pay all or part of the expenses if possible, but that is not a deciding factor in acceptance. The basis for acceptance is whether the service offered can help the particular child, and whether there is a suitable vacancy.

The foster mother is considered to be the pivot around which the whole plan revolves. The foster mothers in this plan are also chosen for the same qualities as in the Speedwell Plan. They must be warm, calm, and understanding of children. Besides this, they are chosen because of their appreciation of the way children react to illness, and the probable effects of different diseases. Many of the foster mothers are graduate nurses. The provision of equipment is the responsibility of the foster mother, but any expenses incurred for the children such as medicines, hair-cuts, clothing, and transportation are charged to the agency. Financial agreements are usually made with the foster mothers by the agency for one year, but may be changed at any time if so desired. At the end of a year an evaluation of the

foster care given is made, and any adjustments that will improve the service are then made.

During the planning period, parents are always encouraged to see the foster home and judge it for themselves. Later they may go with the child and the caseworker, when the child enters the home. The parents are urged to visit once a week. Visiting hours in the group bed home are arranged to coincide with the visits of the medical director at regular intervals so that parents may discuss their child's progress with him.

The medical director of the agency is a specialist in rheumatic fever who is on part time service in addition to his private practice and his staff work at two hospitals. Since many of the children come from these two hospitals, they have the advantage of continuity of medical care. The medical director makes regular visits to the group bed foster homes, and is on call to these homes at any time. Three afternoons a week, children may be taken to his office for examination. He is also consulted on the admission and treatment of every child with rheumatic fever, cardiac damage, arthritis, or chorea. Children who have had other illnesses than these particular ones are supervised medically by the hospital, clinic, or other referring agency from which they came and are taken to this source regularly for examination and treatment. In the non-medical homes, any illness, no matter how slight it may seem, is reported to the agency or to the hospital or to

the clinic which is supervising the care.

A team of workers is available for visits to these homes in addition to the physicians. These consist of the agency's laboratory technician, occupational therapists, social caseworkers, teachers, and visiting nurses. In this program, the foster mothers often meet together to discuss their common experiences and problems, and to listen to various speakers. At one of these sessions, the foster mothers exchanged recipes with the children's own parents in an effort to give the children dishes they were familiar with and liked. Another evening, the foster parents discussed what books were suitable for the various age groups. At still another meeting, a psychiatrist talked about the emotional difficulties of sick children separated from their families, and how these might be handled.

Miss Bissell in writing about the work of the Children's Mission to Children of which she is the General Secretary, points out that in this specialized field of convalescent foster care, all the principles of good foster care apply as well. In addition to this, she gives as requisites for a good program of foster medical care, the following:

- 1) The teamwork of physician, nurse, foster mother, caseworker, occupational therapist, and other specialists as their services are needed.
- 2) Adequate compensation to foster mothers.
- 3) A planned program of activity in the group homes,

especially in those giving bed care, because of the limited contacts of these children.

4) Casework service that concentrates on family problems which affect the health of the child, and on counsel to the child and foster mother that will make the placement of children with medical problems bring the desired results.

The program of foster convalescent care as undertaken by the Children's Mission to Children is an excellent example of a well-rounded plan that is in line with the best of current thought. It combines all the elements that were seen to be necessary in the planning and caring for the convalescent child. It makes provision for any children who are in need of medical foster care from two to twenty-one years of age. It covers the pre-school child, the school child, the adolescent, and even the young adult. The one exception is that it makes no provision for the infant under two years of age, which may be because of other facilities in the community for this group.

Neither the Speedwell Plan in New York, nor the Children's Mission to Children in Boston, is an isolated program in the community services to children. Both of these plans came into being as a result of a need, and at a time when foster care rather than institutional care was considered the ideal method for most, if not for all children. Gradually, however, both plans have become integral parts of the overall services to children in their respective communities. In New York, a Master Plan for Conva-

lescent Services is still in the process of being worked out, and which includes services to both adults and children. Such a plan aims to eliminate gaps, as well as to prevent the over-lapping of services. In this comprehensive plan, the Speedwell Society program plays a vital part. In Boston, the Children's Mission to Children is a part of the total services to children. As a result of a joint decision of the children's agencies, it is the only agency which gives foster medical care in Boston. It is affiliated with the Children's Medical Center, and is used by all hospitals, doctors, and clinics, when a child is in need of this particular service. Many cities have convalescent institutions for children, but for reasons of age, or diagnosis, are often obliged to refuse more children than they accommodate. Foster convalescent care, if undertaken at all, is often a haphazard affair with the various agencies struggling to find suitable homes for some particular cases that come to their attention. Boston and New York, however, have been outstanding not only for their specific foster convalescent plans, but also for the co-ordination in the planning of total convalescent services to children. Such an accomplishment did not happen overnight in either city. It was the result of foresight and careful planning, and it is a continuous process.

The two long-established programs discussed in this chapter, are excellent examples of foster convalescent care

plans that have grown with the times. In 1931, a foster convalescent program for infants was set up in Montreal. In the next chapter, it is proposed to consider this plan in the light of the standards set by the Speedwell Plan of New York, and the Children's Mission to Children in Boston. An endeavour will be made also to ascertain the reasons for its failure to continue after its first successful year.

## CHAPTER IV

### A PLAN FOR FOSTER CONVALESCENT CARE

#### IN MONTREAL

In the previous chapters, the general concepts of foster home and institutional convalescent care have been discussed, and two successful plans for foster medical care have been described, namely, those in New York and Boston. In this chapter, it is proposed to discuss the situation with regard to the after-care services to children in Montreal in the early 'thirties during which time an attempt was made to organize a program of foster convalescent care for infants.

In the past, Montreal had been faced with this problem of after-care services to children, but in the early 'thirties it was an acute one. Gaps in the services to children had long been apparent. Then, as now, the city had only one convalescent institution expressly for children. This was the Julius Richardson Convalescent Hospital which had been opened in 1917, and was situated at Chateauguay about twenty-one miles from Montreal. This hospital admitted children from three to twelve years of age without regard to race, creed, or colour, but it had no facilities for the care of infants.

Infant care was one of the most pressing problems. In Montreal at that time, it had become the generally accepted philosophy that infants should be cared for in

foster homes rather than institutions. The question, then, was what should be done with those infants who needed the kind of care that could not be given to them in their homes. In 1929, a Child Care Study was undertaken by the Children's Division of the Montreal Council of Social Agencies<sup>1</sup>. The philosophy and standards of care for the dependent child in general were carefully studied, as well as the resources and facilities that were available in Montreal. A number of recommendations were made in this study, and most of them were implemented later. Thus, the foundations were laid for the thinking and planning that went into the plan for the foster care of convalescent children which followed soon afterwards.

A committee was set up under the auspices of the Montreal Council of Social Agencies to study the problem of convalescent care for infants in Montreal. A plan was devised and presented at a joint meeting of the Children's and Health Divisions of the Council on January 5, 1931. An agreement was outlined by which the Montreal General Hospital and the Children's Bureau would place children under two years of age in foster homes for convalescence. The plan was to be put into operation for one year as an experiment. Certain specific conditions<sup>2</sup> were laid

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<sup>1</sup>Montreal Council of Social Agencies, Minutes of the Children's Division, Montreal, 1931.

<sup>2</sup>Montreal Council of Social Agencies, Minutes of the Children's and Health Divisions, January, 1931.

down as follows:

- (1) Protestant children only would be referred for care.
- (2) Children must have had city residence for at least six months, and be Canadian citizens.
- (3) The Montreal General Hospital was to pay the difference between the Crèche allowance of \$10.80 per month and the regular Children's Bureau board rate of \$16.00 per month.
- (4) The Montreal General Hospital was to supply clothing for children under care, the said clothing to be returned to the hospital with the children on discharge.
- (5) Before referral for convalescent care, a week's notice in writing must be given to the Children's Bureau with full details of the financial circumstances of the family to whom the child belonged.
- (6) Applications were to be made and accepted in writing.
- (7) A full statement must be made of the child's illness.
- (8) A medical advisor was to be appointed, and a graduate nurse in the employ of the Children's Bureau was to carry out instructions in the foster homes.
- (9) Responsibility for discharge from the foster homes was to lie with the medical advisor.
- (10) The Montreal General Hospital was to supply free medical supplies, drugs, and dressings.
- (11) The Children's Bureau was to have the right to refuse to undertake any case where the nursing was beyond the care of the foster mother, or necessitated frequent clinic visits.

It was anticipated by the committee that some twenty to thirty children would be cared for during the first year of the experiment. It was felt that should the plan prove successful, other hospitals might desire to join it. If such were the case, the number of children needing care would be increased considerably, and would necessitate other plans for care and supervision. In the discussion of the plan, it was suggested that where surgical dressings were necessary,

the services of the Victorian Order of Nurses could be used rather than refuse foster care to children who needed a little more care than a foster mother could give. It was decided, however, that nursing service and instructions to the foster mothers should be given without the services of another agency. It had been found through previous experience that the entrance of a number of persons into the homes was resented greatly by the foster mothers.

The question of institutional care for such cases beyond the care of foster mothers was brought up. It was felt that this would only become a question if and when the plan was adopted on a large scale. Institutional care was vetoed on the grounds that in cases of malnutrition and other allied conditions, the benefit received by a child in a foster home was superior to that in an institution.

One of the doctors who was present during the discussion, raised the question of the attitude of the mothers toward placing their children in the homes of strangers. It was felt by the meeting, however, that few, if any, of the mothers would object as only children of "indigent" parents would be referred by the hospital for convalescent care.

The plan was endorsed finally by the Montreal Council of Social Agencies on the recommendation of the Children's and Health Divisions.

According to a report in the Minutes of the Council

in 1932, the plan worked well in its first year of operation. The Montreal General Hospital and the Children's Bureau both expressed satisfaction with it. The number of children cared for was not as high as expected, however. A total of 347 days of care were given to seven infants, and the average length of care per child was one month. The minutes state that the plan was to be carried on for another experimental year. But, from that time forward there is no mention of the plan, and certainly no formal dissolution of it is recorded. Apparently, it just fell into oblivion.

A comparison of Montreal's abortive program for convalescent care of infants in foster homes with the programs in operation in New York and Boston is interesting and enlightening. The description of the Montreal plan, as given in the minutes of the Montreal Council of Social Agencies, is that of one drawn up on a "board" level rather than one prepared by professional workers in the field of child care. However, it is largely the administrative details that are given there. Apart from the outline of the plan, and some of the discussions that centred around it, which are recorded in the minutes, little information has been gained about it. It is a curious fact that no one remembers any definite facts about its operation, or why it did not continue.

The Montreal plan was confined in its experimental year to one hospital, to Protestants only, and to one section

of that group, "the indigent". This was quite unlike either the New York or Boston programs which have no restrictions with regard to race or creed, and now serve all the hospitals and clinics in their respective localities. However, these restrictions were natural in Montreal with its sharp divisions between the French-speaking Roman Catholic agencies, and the English-speaking Protestant ones. The Montreal Council of Social Agencies, the Montreal General Hospital, and the Children's Bureau were all English-speaking Protestant agencies. It was natural also that the plan should be centred around those children whose parents could pay little or nothing towards their care. The depression was beginning to make itself felt in Montreal by this time. The use of the term "indigents" savours of the early days of the Charity Organization Movement, but its use here was due, no doubt, to the definition regarding those who were eligible for help under the Quebec Provincial Charities Act<sup>3</sup>. It was about this time that the Montreal Council of Social Agencies had succeeded in gaining recognition for the Children's Bureau under this Act, and to establish the eligibility of this agency to receive the Crêche allowance. In this plan for the foster convalescent care of infants, no thought seems to have been given to those who might need this type of care for other than social or economic reasons.

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<sup>3</sup>Enacted in 1925, and commonly referred to as QPCA.

Most of the administrative details of the Montreal plan resemble those of other foster convalescent plans. The responsibilities of the agencies concerned, and the referral policy, are clearly stated. A medical advisor was appointed to be on call, and was to be responsible for making all discharges from the foster homes. A graduate nurse in the employment of the Children's Bureau was to visit and carry out any prescribed treatments, and to supervise the foster mothers in the care of the children. The Montreal General Hospital was responsible for supplying, free of charge, clothing, drugs, dressings, and any other necessities. The Montreal General Hospital was to make up the difference between the Crèche allowance paid under the Quebec Public Charities Act, and the regular boarding rate of the Children's Bureau.

The child care study done in 1929, and the interest in developing a plan for the foster care of convalescent infants, seemed to show a need for this service. Why, then, did this plan drop out of sight after operating successfully in its first experimental year? Very few of those who had been actively interested in the program in 1931-1932 could be interviewed by the writer. Very little definite information was gained from those who were interviewed. Thus, the real reasons for the failure of this plan to continue, remain in the realm of conjecture. It might be suspected that there was a good deal of resistance to the plan even

in the agencies most concerned. The finances of all agencies in that period were being strained to the limit, and a program of this kind would be an additional burden in spite of the grants from the province. Also, the necessity of this type of care for the sick child may not have been accepted generally, although it was accepted for the dependent child in need of long term placement.

One of the doctors who had been concerned in the setting up of the program, stated that his memory was very hazy about its operation. A social worker, who has been at the Montreal General Hospital for a number of years, stated that while she knew nothing definite about this particular plan, she thought it was about this period that the paediatric wards in the hospital were decreased, and finally they were closed altogether. The general consensus of opinion among other informants was that the amalgamation of the Children's Bureau and the Children's Aid Society at about the same time that the hospital dropped its paediatric wards, may have resulted in the disappearance of the program. The Children's Bureau became the Children's Aid Society of Montreal. In addition to this, one informant stated that the Montreal Foundling and Baby Hospital became a convalescent hospital for a time. She felt that the plan for foster convalescent care of infants was shelved in favour of institutional care.

Out of the welter of hearsay information, one fact

which does emerge clearly, is that the early 'thirties was a time of re-organization in Montreal. The minutes of the Montreal Council of Social Agencies are full of detail concerning the pressures put upon the various services to meet the urgent needs brought about by the depression. Agencies were expanded, or re-organized along new lines to meet changing demands. The two agencies most intimately concerned with the plan for foster convalescent care did not escape the re-organization that took place. If the hospital was forced by circumstances to give up its paediatric wards, it would no longer have the same interest in the carrying on of such a program of care. Moreover, the finding of suitable foster homes, always a problem, was probably intensified in the depression era.

The foster convalescent care of children is a specialized service. Because this is so, it needs the support of all the hospitals with paediatric wards in the community as well as the various family and children's agencies. It needs trained workers for the finding and supervision of the homes, and nurses and doctors on full or part time duty. The foster homes themselves must be outstanding to give this type of care, and they should be available at all times. This usually means that a retaining fee is paid even when there are no patients under care in a particular home. Drugs and dressings have to be provided. All these factors make convalescent foster care an

expensive service unless it is on a community-wide basis with sufficient numbers of children under care to make it worthwhile. In a city the size of Montreal, a plan that is confined to two agencies, and to a very small group, namely, seven Protestant babies under two years of age, is insignificant. It is bound to be overlooked with the pressures of urgent, large-scale plans, required in a severe depression. Had times been normal, the Montreal program might have expanded to take referrals from other hospitals and agencies, and might conceivably have become more flexible in its intake policy. However, times were not normal in the early 'thirties, and all but the most urgent plans went by the board.

The organization of the Montreal plan for the foster convalescent care of infants in 1931, and its failure to continue after the first experimental year, have been considered at some length in this chapter. Experience is a good teacher. At a time, therefore, when foster convalescent care for children is again under discussion, a study of the previous plan seemed applicable.

## CHAPTER V

### PRESENT FACILITIES AND NEEDS

#### IN MONTREAL

Chapter IV was devoted to a discussion of the plan for the foster convalescent care of infants which was initiated in 1931, and some mention was made of the existing institutional facilities of the time, namely, the Julius Richardson Convalescent Hospital, and the Montreal Foundling and Baby Hospital. The main purpose of this chapter is to discuss the present resources for the convalescent care of children in Montreal and its environs, and to find out what specific gaps there are in meeting the needs of its children.

The past ten years have shown a few changes in the facilities in Montreal. The discontinuance of the short-lived plan for foster convalescent care of infants left the city without any established resource for this type of care. The closing of the Montreal Foundling and Baby Hospital in the latter part of the 'thirties, left the Julius Richardson Convalescent Hospital as the only established children's convalescent institution. Thus, the city has actually fewer resources than it had in the preceding decade. The aftermath of the second world war, with its terrible housing shortage, the overcrowding, and resultant poor social conditions in many homes, have made for the increasing practice of keeping children longer than medically necessary in hos-

pital. The final result has been a re-awakened interest in the convalescent care of children amongst doctors, nurses, and social workers in particular, and by the general public. A statistical sample<sup>1</sup> showing the numbers of children needing convalescent care who were known to the social service departments of three Montreal hospitals over a period of six months, has shown that the need for more facilities extends into all three main groups of the city, the Protestant, Roman Catholic, and the Hebrew.

As we have seen, there is now no organized plan for the foster care of convalescent children, either for infants or others who may require it. This is a sharp contrast to other well-developed foster care programs for dependent children in Montreal. The general feeling concerning this problem seems to have been that this type of foster care is very specialized, and that this would automatically limit the number of foster homes available for it. Moreover, in Montreal as in most cities, ordinary foster homes are difficult to find, let alone the specialized type required for foster medical care. The financing of such a service has been a problem, too, especially since the Welfare Federations have had difficulty in meeting their quotas in the last few years. Retrenchment rather than expansion has been in the

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<sup>1</sup>The Committee on Convalescent Care for Children, Montreal, 1950. See Appendix p. 90.

air. If, however, the need for a scheme for the foster medical care of infants and other children could be established beyond a doubt, it is possible that means could be found to finance it. This might be done if a higher grant could be obtained under the Quebec Public Charities Act than is now available for this category. A properly supervised program of foster convalescent care would be considerably cheaper than hospital care under QPCA. It would eliminate the keeping of these children in hospital long after the acute stage of the illness is past, and it would lessen the possibility of frequent re-admissions because infants and children are sent home too soon. Both proceedings are harmful to the children and expensive to the community.

The premature baby is a case in point. Such an infant is carefully built up to the required weight and strength in the hospital before being sent home. But, if such a child is sent home to a small, overcrowded, ill-heated flat or house, to an overworked mother, it is no time before the baby is back in hospital with diarrhoea, pneumonia, or other infectious disease. Baby is again sent home when sufficiently well, only to return again shortly with a recurrence of the same or some other condition. Apart from the expense to the family and the community, it gives the mother a sense of failure in not being able to care for her baby well enough, and it is extremely harmful

to the infant both from a physical and a psychological standpoint. Temporary care in a good foster home until the home was prepared to receive it, would spare both mother and baby. It would go far in solving the problem of repeated admissions to hospital also. At the same time it cannot be stressed too much that besides good physical care, babies need their own mothers or substitute mothers who will give them individual care and affection. The constant separation of an infant from the mother by recurrent hospitalizations is damaging to the child's physical, mental, and emotional development.

While there is at present no organized program of foster medical care in Montreal, there have been a number of instances where some special arrangements have been made for such care through the various agencies. Such arrangements, however, have been mainly on behalf of children who are already known to these agencies, and who have had severe handicaps, or who have been chronically, or terminally ill. On inquiry, it was found by the Committee<sup>2</sup> that most of the agencies felt that they could handle a limited number of referrals for convalescent care in foster homes, if requested to do so. They also felt that the specialized type of home needed would be expensive and difficult to

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<sup>2</sup>A Study of Convalescent Care for Children in Montreal, The Committee on Convalescent Care for Children, Montreal, 1950, pp. 5-6.

maintain unless the number of referrals were fairly constant. Generally speaking, the hospital social workers had not requested such care in the past because they had felt it was not available through the agencies. Moreover, it was not requested because of the difficulties in the supervision of medical and nursing care apart from some organized plan.

The Julius Richardson Convalescent Hospital, mentioned in the previous chapter, is still the only specific convalescent institution for children. As we have seen, this hospital will accept children from three to twelve years of age. So far as age groups are concerned, this takes care of the pre-school child, and the school child up to the early adolescent period. According to present day concepts, however, we have seen that it is not generally considered good practice to place children under four years of age in an institution for even temporary convalescent care if it can be avoided. A case which the writer handled at the Children's Memorial Hospital may illustrate the validity of this concept:

Marcelle was a three year old French Canadian child, who had been in the Children's Memorial Hospital about two months suffering from acute nephritis. Marcelle was the second youngest in a family of eight children. As she had been in a very dirty condition on admittance to hospital, the doctor suspected that her home conditions might not be suitable for convalescence, especially as she would need rest, warmth, and proper nutrition.

When the worker visited the home, it was found to be dirty, cold, and crowded to overflowing with

children. The mother showed the worker a couch in a draughty hall, and another in the front room, either of which would have to be shared with one or more children. The mother felt that it would be impossible to keep Marcelle in bed at all, or give her the proper care. This was later discussed with the father. He, too, felt that the child could not be cared for at home, and the advisability of sending so young a child to the Julius Richardson Convalescent Hospital in mid-winter, was discussed. It was finally arranged that Marcelle should be transferred to the convalescent hospital, but this was delayed for a time due to quarantine on the hospital ward. After her transfer to the Julius Richardson Convalescent Hospital a quarantine for chicken pox was imposed there for two weeks. As a consequence, Marcelle's parents were not able to visit her then, and later they apparently found it too difficult to make the trip to Chateauguay.

When Marcelle had been on the ward in the hospital, she had been full of life, and quite a handful to manage. She was, however, very upset after her parents' visits. When the worker visited her at the convalescent hospital, she was told by the nurse on duty that Marcelle was a very good child, and no trouble at all. Marcelle was in the playroom at the time of the worker's visit, and was playing by herself. Most of the other little patients at the time were English-speaking. Marcelle stuck her finger in her mouth and would speak to no one even when spoken to in her own language. The worker tried to play with her, but the only response was from other children who wanted the attention. It was the worker's impression that the child was both unhappy and confused.

With a view to strengthening the home for Marcelle's return, the family, with their consent, had been referred to the Bureau d'Assistance aux Familles to whom they had been known previously. This agency had agreed to give casework services, but after the worker's visit to the convalescent hospital, ways and means were discussed with a view to getting the child home sooner than first thought possible. The agency worker was able to procure a cot for Marcelle, and arrangements were made to supplement the family income for a time under the Quebec Provincial Charities Act. This would be administered by the agency. Marcelle was sent home as soon as the doctor considered it was safe to do so.

This case seems to illustrate many of the points which have already been raised with regard to the child who is under about four years of age. Marcelle's long stay in the hospital had been a traumatic experience involving as it did separation from her family, many strange people, a strange language, and many strange procedures. At the convalescent hospital, she was again among complete strangers, and without her parents' visits. It was more than the child could bear. She got a cold the first week and had to be kept in bed. By the time the worker visited her, she was up and around, but showed signs of regression in her withdrawal and thumbsucking. The worker felt that in this case a French-speaking medical foster home would have been ideal. This would have given her a mother person to whom she could relate, and someone of the same cultural background whom she could understand. Such care is very difficult in the impersonal atmosphere of even a small institution. A child of this age is usually quite able to form an attachment to a new mother figure, but repeated separations and changes of environment such as come from frequent placements or transfers from hospital to convalescent home and back again, may be very painful and difficult. The end result may be that the child may only establish superficial, shallow attachments which, in turn, could interfere with his ability to make strong and lasting relationships in later life.<sup>3</sup>

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<sup>3</sup>Edith M. Baker, "The Effects of Long Term Illness on the Family and the Patient," a paper given at the National Conference of Social Work, Atlantic City, 1950, p. 3.

Within certain limits, the Julius Richardson Convalescent Hospital does take care of the school age child. In the past, one of the chief difficulties in using that resource was its distance from the medical centres in the city. It has had no resident interne, and no treatment facilities. This lack of facilities for physiotherapy, special diets, for checking sedimentation rates, urinalysis etc., considerably restricts the admission policy. However, numbers of cases were accepted and transported back and forth for treatments and check-ups. It is now known that the Board of Directors of this institution are planning to build their new plant on a site within easy access of doctors, social workers, and parents. The new building is said to be planned to accommodate 120 patients, about twice as many as the present structure. This should do much to ease the problem of care for this particular age group, from four to twelve years of age, and increase the number of diagnostic categories acceptable.

Since the Julius Richardson Convalescent Hospital admits patients regardless of race or creed, it is potentially a resource for all sections of the city. Only one hospital,<sup>4</sup> admitting children in the French-speaking community, had a social service department until very recently. Consequently, it is known that children have been kept on the

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<sup>4</sup>See Appendix, p. 90, for list of hospitals serving children in Montreal.

wards for want of convalescent planning. As more social service departments are organized, the Julius Richardson Convalescent Hospital will likely receive a great many more French-speaking children as patients than in the past. Thus, a bilingual staff is an utmost necessity.

There are no convalescent services in Montreal for the young adolescent. The Montreal Convalescent Hospital, an adult institution, has often been prevailed upon to accept a special case. But, since it is an adult institution, it is not possible to separate the adolescent from the adults. This is not a satisfactory plan for any young boy or girl who goes there, and it can be very disturbing for the older people. In addition, there are no teaching, vocational, or recreational programs with which to occupy a young person's time constructively. Thus, when the Montreal Convalescent Hospital does accept a case of this kind, it is only on an emergency basis, and it is stipulated that case-work services are offered to the family.

In the French-speaking community, the Hôpital St. Jean Baptiste des Convalescents, also an adult institution, will admit boys from fourteen to sixteen years. This is a Quebec Public Charities Act institution run by Religious Brothers. While the boys are accommodated in separate rooms, meals and recreation are shared with adults. Any case, with the exception of tuberculosis, is admitted for a maximum of one hundred days. No medical certificate or consent is

necessary.

The Hôpital St. Joseph des Convalescentes will take girls for convalescent care between the ages of fourteen to sixteen years. Acute or contagious cases are excepted. This is also an adult hospital, and care is given along with adults. This institution is operated by a Religious Order, and also receives grants under the Quebec Public Charities Act. A medical certificate with the parents' consent is necessary, and maximum care is one hundred days.

Thus, in the English-speaking section of Montreal, any child over twelve years of age must be accommodated in an adult institution, while in the French-speaking community there is a gap between twelve and fourteen years of age when no institutional care at all is available. Certainly, any placement for a child from twelve to fourteen years of age in an adult institution would be done only on an emergency basis, if at all.

The survey of the facilities and resources in Montreal shows many gaps in the convalescent services for its children. Infants and pre-school children have no facilities suitable to their age groups due to the lack of a convalescent foster care plan. The only existing institution for the school age child is inadequate to meet present needs with its limited accommodation and its distance from the city. There are no established facilities for the young adolescent, institutional or otherwise. Young adolescents,

chiefly between the ages of fourteen and sixteen years may be accommodated by the adult convalescent hospitals, but as there are no separate wards for these in-between groups, the situation is not a happy one. There is no specialized institutional care for any child who is seriously disturbed, and who needs group therapy. This type of care, of course, needs trained personnel, and the availability of psychiatric consultation. There is no provision in the city for the individual child in any of the age groups who needs foster care for either medical or emotional reasons. The available institutions are lacking in facilities for the continuance of medical treatments, and, therefore, a number of medical categories cannot be accommodated, especially children who have had rheumatic fever, diabetes, or acute nephritis.

A well-rounded plan for the convalescent care of children cannot lose sight of any of these groups or categories. It would include foster care for infants, and also for those children for whom institutional care of even a temporary nature is not deemed advisable. It would include a convalescent institution for children ranging in age from about four to fourteen years of age, with good standards of care, proper laboratory facilities, teachers, occupational and physiotherapists on part time basis, and, if possible, a group worker. Adolescents, over fourteen years of age, might be accepted in adult institutions if there were sufficient numbers to warrant a separate ward, or in a sep-

arate ward of the children's institution. Much depends on the maturity of the individual adolescent, and the nature of the illness as to whether the adult or children's home would be preferable.

Montreal has the nucleus of good convalescent services which could be expanded to meet the needs of every child. In the new Julius Richardson Convalescent Hospital, it will have greatly expanded institutional services. In the foster services which have been developed throughout the city by the various agencies, it has the basis for an integrated program of foster medical services. Above all, it has a representative committee from the hospitals and child and family agencies which have been studying the resources and needs from a total point of view.

In the following chapter, it is proposed to consider some of the conclusions reached by this committee, and the recommendations made by it to the Montreal Council of Social Agencies.

## CHAPTER VI

### THE COMMITTEE ON CONVALESCENT CARE FOR CHILDREN IN MONTREAL

The Committee on Convalescent Care for Children in Montreal has been referred to many times already in this study. This committee which grew out of an urgent need, was set up by the Executive Committee of the Case Work Section of the Montreal Council of Social Agencies following a meeting on February 3, 1949<sup>1</sup>.

The committee, in the first instance, consisted of members from the child caring agencies and hospitals in the Montreal Council of Social Agencies only. The chairman was Mrs. Christina James of the Children's Memorial Hospital. After the first meeting, it was decided to extend the committee to include representatives from the other hospitals serving children, the convalescent homes, the family agencies of all the welfare federations, and the City Health Department. From this main committee, three sub-committees were appointed. One of these sub-committees investigated the extent of the problem as seen in the three representative hospitals. Another studied the present facilities in the community, and the third reviewed standards of convalescent care for children.

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<sup>1</sup>A Study of Convalescent Care for Children in Montreal, p.1.

The extent of the problem in Montreal, and the facilities that are available, have already been considered in this thesis, as well as some of the current concepts in child care. While the findings of the various sub-committees do not differ substantially from what has been discussed in previous chapters, it proposed here to consider some of the findings and the recommendations of the committee in the light of past history and present thinking.

The report of the present committee in its entirety represents a great advance in thinking and planning from that recorded in the minutes of the Montreal Council of Social Agencies in 1931-1932<sup>2</sup>. However, the present committee, unlike the former one, represented a cross-section of the whole city, irrespective of race or creed.

The sub-committee which investigated the extent of the problem in Montreal, was under the chairmanship of a worker in the Social Service Department, the Royal Victoria Hospital. This sub-committee collected a statistical sample from the social service departments of three hospitals in order to determine how many children in different age and medical categories would have benefited by convalescent care<sup>3</sup>. This sample represented an eight months period, and

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<sup>2</sup>Supra, pp. 43.

<sup>3</sup>Op. cit., A Study of Convalescent Care, pp. 2-4.

included cases which were known to the social service departments only.

In the sample obtained from all three hospitals, fifty-six cases were considered, and of these, thirty-seven were Roman Catholic, sixteen were Protestant, and three were Hebrew. Most of these children in need of care were under three years old, and no foster home placements were available. Twenty-three of the children from three to twelve years of age who might have been sent to the Julius Richardson Convalescent Hospital, were unsuitable because of diagnosis. Some could not be placed in an institution because of emotional needs which could not be met there. Any of the children who were over twelve years of age could be accepted at the Montreal Convalescent Hospital by special arrangement only.

In the sample study of fifty-six cases, twenty of these children were recovering from rheumatic fever. If the Julius Richardson Convalescent Hospital had been able to undertake the necessary laboratory tests, sixteen of these children were within the age group which might have been admitted there. In most cases, the homes were not conducive to recovery from rheumatic fever, although after the convalescent period most of them could be cared for at home. Six children were orthopaedic cases who needed regular physiotherapy. In seven cases, malnutrition was the diagnosis, and intensive casework with the family was needed before

the child could be allowed to go home. The remaining cases consisted of those who were recovering from pneumonia, bronchitis, gastro-intestinal upsets, and other disorders. Since careful investigations had precluded care at home, and other convalescent care was not available, most of these children were kept in the hospital. Some were sent home in spite of unsuitable conditions.

The sub-committee members were agreed that because of the months of hospital time occupied with caring for convalescent children, as well as the emotional damage done to children by prolonged stay in hospital, there was a need for improved facilities. It recommended:

1. A convalescent home, near the city and the children's parents, accessible to the medical and laboratory facilities of the city hospitals, staffed and equipped to meet the emotional and physical needs of children.
2. Foster homes that could be used for convalescent babies and older children whose emotional needs might contra-indicate institutional placement.

The sub-committee noted that the statistical sample used, merely indicated something of the extent of the problem as it exists in Montreal. They suggested keeping a record of cases for a further period of six months. Nevertheless, the sub-committee apparently felt the figures warranted their recommendations for more adequate institutional care, and the setting up of foster homes that could be used for convalescent care.

The sub-committee on facilities for the care of

convalescent children<sup>4</sup> was composed of members from the children's and family fields. The chairman was from the Jewish Child and Family Welfare Bureau. The sub-committee approached the problem of facilities by asking the various agencies in the field to submit to them the number of requests received from hospital social service departments and physicians in 1949<sup>5</sup>. They also asked how the agencies were able to meet the requests, and any alternative plans resorted to in attempting to find solutions. With the exception of those agencies whose intake policy prohibits the acceptance of convalescent cases, most agencies had had a few requests during the year. These they handled by working out a plan with the family, relatives, or other homes, using special Quebec Public Charities Act grants, or the Julius Richardson Convalescent Hospital. Some agencies felt that the hospitals did not request such care because it was believed that it was not available.

As a result of the information gained from the family and child care agencies, this sub-committee found that the care of convalescent children has not been given definitely to these agencies. In fact, the policy of one agency, the Children's Aid Society, excludes this category. The general opinion was, however, that if a formal request

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<sup>4</sup>Ibid. p. 5.

<sup>5</sup>Ibid. pp. 5-7

were made to all agencies concerned directly or through their federations, this class of care could be included. It was felt that the agencies could absorb a reasonable demand for such service under their present set-up, if money were available.

This sub-committee also outlined certain considerations which it considered basic to the development of additional facilities. For the purposes of the study, a child was defined as in the age range from birth to sixteen years to conform with the Quebec Public Charities Act. It was unanimous in concluding that infants from birth to two and one half years should not be considered for any type of care except in a foster home. It stressed the fact that when placement is necessary because of an inadequate home situation, it is essential that casework is offered the family during the convalescent period in order that a recurring pattern of hospital care, convalescence, and return to hospital would be avoided. New cases should be assessed by the hospital medical social worker as to the family's ability to cope with the problem of convalescence, and where necessary to refer them to the appropriate agency. In cases active with any agency, co-operative assessment should be made between the medical social worker and the agency social worker. All available resources, including family relationships should be explored in establishing eligibility. The use of visiting homemaker service was explored, but it was con-

cluded that this service could seldom be used to meet the needs of convalescent children in the way it could when the mother is the patient. The sub-committee also contended that the provision of convalescent foster home care would mean paying higher board rates than those already being paid for foster homes because of the specialized type of care. Agency budgets would not be able to stand this extra expense unless additional allocations were requested from and granted by the various financial federations. They would also need additional grants under sections B<sup>1</sup> and B<sup>2</sup> of the Quebec Provincial Charities Act available to agencies giving the care. This would require direct interpretation to provincial authorities to gain inclusion in the definition of agencies that are eligible.

The third sub-committee on Standards of Convalescent Care for Children was chaired by the Director of the Social Service Department, Royal Victoria Hospital<sup>6</sup>. This sub-committee began its report by defining the term "Convalescent Placement" by stating that:

"- a child requiring convalescent placement is one who, for medical reasons, needs care which cannot be adequately carried out at home."

The sub-committee report then goes on to say that the inability of the parents to provide the care might be the result of emotional, economic, or environmental factors.

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<sup>6</sup>Mrs. Caroline E. Elledge.

Three main groups are distinguished in discussing the type of placement needed for different age groups. The first of these groups is from birth to two and one half years of age, or the infant group. The sub-committee state that without exception these are best cared for in foster homes, both because of the emotional needs of babies, and the danger of cross-infections, if the child's own home is unsuitable. The second age group takes in the pre-school child from two and one half to four years. Here the feeling was that the type of care depended on the needs of the individual child. Some of these children would do well in an institution, and others should have foster home care, therefore, each case should be evaluated on its own merit. The third group constitutes those from five to sixteen years old. It was agreed that children up to fourteen years should be included in a children's convalescent institutional program, but that those over this age presented additional problems. On the whole, it was felt that the children's institutions were more able to meet the needs of this group than adult institutions are, because these adolescents are for the most part still children. If there were enough adolescents needing this care, a whole floor in either a children's or adult institution might be given over for their use, and a program geared to their needs. If there were not enough adolescents, it was felt that the intake policies for both children's and adult institutions should

be flexible, and each case should be carefully evaluated.

The sub-committee also noted that some school age children would do well in foster homes rather than in institutions. These might be children who are emotionally disturbed or those who have certain medical diagnoses that might make institutional care difficult, e.g., blind children, diabetics, those with allergies, or some congenital difficulties such as hyperplasia, questionable tuberculosis, or rehabilitation cases. In cases of severe disfigurement, such as burns, there was some disagreement about the best place for convalescence. It was thought that it would probably depend on the individual child.

In its report, the sub-committee go into some detail as to what constitute good standards of institutional<sup>7</sup> and boarding home care. They state that the intake policy of a convalescent institution should be related to the limitations of the institution. If there are no facilities for sedimentation rates, or for physiotherapy, then rheumatic fever and poliomyelitis cases might have to be excluded. Intake would be limited also by the age groups accepted.

The sub-committee felt that discharge policy should be based on the intake requirement of a total plan. It was noted, however, that the convalescent institution should reserve the right to recommend discharge for medical or

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<sup>7</sup> op. cit., A Study of Convalescent Care for Children in Montreal, pp. 10-13.

social reasons before the prescribed time is up. The referring agency is then responsible for other plans. There ought to be a high degree of co-operation between the referring agency and the convalescent staff if the convalescent period is to be worthwhile.

A referring agency should furnish the convalescent institution with certain information if sound intake and discharge policies are to be established. The sub-committee summarized these as follows:

1. Complete medical information
2. Social data
3. Plans for discharge
4. Certain financial arrangements

The convalescent institution itself should have adequate paediatric supervision and specific arrangements for children who require special care. The institution should be accessible to other hospitals and to the locations from which the children come. There should be good transportation facilities for the parents' visits. There should be sufficient grounds and adequate outdoor play equipment to allow for a playground for ambulatory cases. The convalescent home should be designed to meet the needs of the convalescent child by the provision of ramps, elevators, or cottage type accommodation if possible. Otherwise, there should be small wards for appropriate groupings, a homelike atmosphere, and adequate play space within the institution.

In their report, the sub-committee describe the various functions of a Board of Directors, the Superintendent,

and the staff of an institution in some detail. Briefly, it was felt that the entire personnel should be well qualified educationally and vocationally, as well as being mentally and physically in good health, and emotionally well-balanced. The size of the staff itself is determined by the number of children under care, but a minimum requirement would demand two paediatrically trained nurses. One of these would be responsible for night duty, and the other nurse for day duty, and they would be assisted by nurse's aides as needed. There should also be a social worker on a full time or part-time basis who would be responsible for intake and discharge. She would also plan the day to day program with the nurses and doctors so that the children would have a satisfactory social and emotional experience within the institution. The institution should employ occupational and physiotherapists, dietitians, and other experts as indicated by their intake policy. There should be qualified teachers in sufficient numbers, and adequate facilities for teaching.

With regard to the requirements for adequate boarding home care,<sup>8</sup> the sub-committee felt that the intake and discharge policies for the convalescent foster homes should be similar to those for institutions. The referring agency should assume the primary responsibility for the referral to the Child Care Agency, and the discharge from the foster

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<sup>8</sup>Ibid. pp. 13-14

home. Boarding homes for convalescent children should be under the supervision of recognized child care agencies, each of which might maintain a few homes for this purpose. The foster mothers for these children should have had previous experience either as foster mothers or as nurses, and should have an understanding of the total needs of a sick child. The general health supervision in the home should be given by a nurse employed on a full-time basis by all the child care agencies for the convalescent plan. The medical supervision should be retained by the referring doctor or hospital, and periodic visits to clinic arranged. Certain of the general paediatric problems could come under the doctor connected with the children's agency. A paediatrician could be employed for the overall supervision to convalescent children of all the child care agencies. The medical social worker would help to prepare for the child's homecoming and work through any problems in connection with the illness. The social worker at the children's agency works with the foster parents and supervises the child's adjustment in the foster home. While the worker at the referring agency might visit the child if there is a good casework reason for doing it, and both workers agree to it, the responsibility for casework service in co-operative cases should be decided at a conference.

Finally, this sub-committee point out that any plans for children should recognize their total needs in

terms of their cultural, religious, and educational background, as well as individual emotional needs. The staff of any foster care program should be equipped to meet all these needs. It was the impression of this sub-committee that all convalescent care planning should be on a non-sectarian, bilingual basis in keeping with the philosophy of medical care which does recognize such barriers as race, creed, or language. With this in mind, it was recommended that consideration should be given to the formation of a non-sectarian advisory committee, composed of doctors, nurses, social workers, and other community leaders. This advisory committee would handle such matters as the appointment of a nurse and a doctor, and any other questions arising in connection with an overall convalescent foster home program.

The findings and conclusions reached by this last sub-committee were, in general, much the same as those already discussed in this study as being necessary to a good program of institutional and foster home convalescent care. In view of the peculiar problems of Montreal, the most significant contribution this sub-committee made, was in its recognition of the fact that all convalescent care planning should be on a non-sectarian, bilingual basis, and its recommendation that a non-sectarian advisory committee should be appointed to handle questions common to an overall convalescent foster home program. The philosophy of medical care has long ago disposed of the barriers of race

and creed in theory, if not always in practice. If convalescent care is a continuation or a part of total medical care, language, race and creed should not be made barriers as often they are. In this case, the setting up of a representative advisory committee would give unity to the planning of the various child care agencies, while still preserving their own cultural and religious character. Such a committee could be an integrating force in the community, bringing about a new understanding and unity, but not necessarily uniformity.

In view of the reports of the three sub-committees, the Committee on Convalescent Care for Children in Montreal as a whole, made a number of far-reaching recommendations<sup>9</sup>. These recommendations, if implemented, would give the city of Montreal and the surrounding territory, an integrated program of convalescent services to children that is in accord with some of the best thinking on the continent. Specifically, the committee recommended that an advisory committee sponsored by a recognized co-ordinating organization such as the Hospital Council, or an inter-federation council be set up. It would be composed of doctors, nurses, social workers, and community leaders, and its main function would be to co-ordinate the efforts in the community to provide convalescent care for children. It would advise on

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<sup>9</sup>Ibid. p. 16.

appropriate programs for such care in the institutional area as well as in the foster home area, so that a unified community program of convalescent care on a non-sectarian basis would be the result. The Committee on Convalescent Care further recommended that the Board of the Montreal Council of Social Agencies institute proceedings with (a) the boards of the various institutions to evaluate their facilities and practices in comparison with the standards of convalescent care submitted by the committee, (b) that the boards of the various agencies and/or the appropriate federations concerned in child placement consider the extension of their services in the foster home area.

To take care of the gaps in institutional services to children, the committee recommended that the Montreal Convalescent Hospital give consideration to the additional services necessary for it to accommodate adolescents of fourteen years and over adequately. It also recommended that the Julius Richardson Convalescent Hospital consider extending the age limit to include the twelve to fourteen year old group for whom services have been lacking entirely.

The committee recommended with regard to foster home convalescent placement, a request be made to the Children's Aid Society of Montreal to revise their intake policy to include convalescent placement for infants, young children, and such other children as would benefit from foster home care. This was the one child caring agency in the

city whose intake policy definitely excluded this class of care, and a revision of policy would mean that care could be given to the English-speaking Protestant group. The French and English-speaking Catholics, and the Jewish group had already intimated that their services could be extended provided they had the funds. To take care of this situation, the committee recommended that the inter-federation council and/or the Hospital Council approach the City of Montreal Department of Social Welfare, and the Provincial Ministry of Health for additional grants under the Quebec Public Charities Act to cover convalescent care for children.

It was felt by the committee that conferences of workers concerned should be held before a child is placed, in order that the best plan may be devised, and also to clarify responsibility during the placement. Cases ought to be reviewed frequently to make sure of co-operation in planning so that the time element, which is so important in child placement, is not prolonged unnecessarily. Other referral sources should be informed by the receiving agency if it is necessary to provide casework service to the family during the child's placement.

The committee wisely advocated that the Ministry of Health should license and inspect convalescent homes to maintain the approved standards of care in both equipment and staff in the present institutions, and to avoid the development of undesirable projects springing up in the

attempt to meet the need.

The committee followed up their recommendations by recording the need for inquiry into the field of care for children with chronic illnesses such as diabetes and epilepsy, as well as the exploration of long term convalescence in certain diagnostic categories. It further recognized the lack of medical and nursing supervision for a convalescent program in areas where there are now no organized health services. It was felt that the provision of these services should be explored with the Department of Health of the City of Montreal and other municipalities in the metropolitan area. Ultimate leadership in medical and nursing supervision should be taken by this Department.

The various findings and tentative recommendations of the sub-committees were thus clarified and welded together into a plan taking care of both the institutional and foster home convalescent needs for children in Montreal. The nucleus of these services was already there, although the gaps were woefully apparent. The extension of both institutional and foster home convalescent services in the directions indicated by the Committee on Convalescent Care, and the formation of a representative advisory committee to unify the whole program, would seem to be the answer. In these uncertain times, the problem of convalescent services is likely to become worse instead of better unless the present need is met by a program that can be expanded at

will. Such a plan as the committee outlined is an expansion and development of existing services on a city-wide basis, and should avoid the weaknesses inherent in isolated attempts to meet the need. The plan for the foster home convalescent care of infants undertaken in 1931, was an example. It was a small isolated program that was dropped in the face of the dire needs of depression days, and in the re-organization within the agencies which sponsored it. The present plan would avoid these difficulties, and it would cover both institutional and foster care needs of all children in want of convalescent care.

Thus, the 1950 Committee on Convalescent Care for Children has made specific recommendations for the achievement of an integrated community program of convalescent services on a non-sectarian basis. The time is now ripe for the follow-up action. The achievement of a plan of this kind may take some time, but eventually Montreal will be given a program which is in line with the best thinking and practice on the continent.

## CHAPTER VII

### FINDINGS AND CONCLUSIONS

The need for more adequate facilities for the care of convalescent children in Montreal had been apparent for some time. For this reason, a committee, under the auspices of the Montreal Council of Social Agencies, had been set up to investigate the situation. The committee was to study the present resources of the community, the gaps in the services, and present standards of care. This thesis, however, was undertaken because it was felt that there was certain additional information that would be of value in the planning of any overall program of convalescent services for children in Montreal. This included an inquiry into some of the historical background of child care on this continent as well as modern concepts, some outstanding programs of foster care in other centres, a previous experiment in foster convalescent care in Montreal, and the relation of all these to the present situation.

A study of the word "convalescence" showed that it means that slow process by which a person grows strong again after a period of illness. It is a state which involves the whole person, physically, mentally, emotionally, and socially, and yet affects each human being in his own peculiar way.

Today, "convalescent care" is more and more considered to be a continuing service in which the total needs of

the patient are taken into consideration, and without which no medical history is complete. This is true whether the convalescent period is spent at home, in the country or in an institution.

In recent years, child care studies have shown that the process of convalescence is much more complicated when the patient happens to be a child. Time has a different meaning for a child than it has for an adult, and separation from those he knows and loves, for even a short period, can be a traumatic experience for any child, but especially for a sick one. Moreover, since a child is growing physically, mentally, and emotionally, illness and separation are bound to affect the process, and may have profound effects on the development of personality.

It was found that the last fifty years have seen great changes in the realm of child care. The end of the nineteenth century was often referred to as the institutional era since institutions sprang up all over the country replacing the almshouse and the indenture system. The turn of the century, however, brought the Charity Organization Movement to this continent with its tendency to consider people as individuals rather than en masse. This led to a questioning as to the value of the institution in giving the kind of personal care a child needs. From this sprang the movement for foster home care. For a time institutions were threatened with extinction. The past few years, however, have

brought about a new understanding of the role of the institution as well as of the foster home. Both have their respective parts to play in the field of child care. This new conception is due largely to the work done during the war years by paediatricians, psychologists, psychiatrists, and social workers. There is now an entirely new understanding of the development of personality. Thus, with certain age groups, or in the meeting of some particular needs, it has been found that foster home care is preferable to institutional care. Likewise, with other age groups, or special needs, institutional care may be preferable.

According to modern concepts, it was found that all infants without exception, if not cared for at home, should have foster home care. The reason for this theory is to be found in the infant's need for the love and care of some one person. In general, the pre-school child also needs the care of his mother, or a mother substitute as found in a foster home. The school child and the young adolescent, having experienced some separation from their families, generally make better adjustments in an institution, and in the company of other children. Each case, however, should be carefully evaluated according to the child's total needs.

Since convalescent care for children is a form of child placement, even though it is usually of relatively short duration, these concepts, also apply. Convalescent care involves the additional factor of the medical condition

as well. Consequently, any decision regarding the type of care a child should receive, must take into consideration his medical and physical needs, as well as the mental, emotional, and social ones. This demands teamwork on the part of all concerned, including the co-operation of the child and his family, as well as the resources to carry out the plan.

The lack of adequate resources for the convalescent care of the infant and pre-school child in Montreal was one of the reasons for the inclusion in this study of two types of foster convalescent programs in other communities. These were the Speedwell Plan in New York, and the Children's Mission to Children in Boston. Both of these programs started as the result of a recognized need, and they were outgrowths of the movement to give foster home care to children rather than institutional care. While these two plans were found to differ somewhat in their terms of reference, their main function is the same in that they provide supervised convalescent foster care for children in varied age groups and diagnostic categories. In New York, the Speedwell Plan is a vital part of the Master Plan for Convalescent Services which is gradually being worked out. In Boston, the Children's Mission to Children is affiliated with the Children's Medical Center, and is used by all hospitals, doctors, and clinics when a child needs this particular service. From being somewhat isolated programs in the beginning, both these

plans have gradually become integral parts of the overall services to children. Foster convalescent care in these cities is not a haphazard affair with the various agencies struggling to find foster homes suitable for the particular cases which happen to come to their attention. It is a planned and co-ordinated service. Both programs are worth the attention of any community that is thinking in terms of foster convalescent care for children.

A plan for the foster convalescent care of infants under two years of age was actually started in Montreal in 1931. This involved an agreement between the Montreal General Hospital and the Children's Bureau, and was under the auspices of the Montreal Council of Social Agencies. The program included only Protestant children of "indigent" parents, and it was financed by the Montreal General Hospital, and the Crèche allowance under the Quebec Provincial Charities Act. The plan was reasonably successful the first year, and the experiment was to continue for another year, but no more was heard of it. Apparently, this was due to the difficulty of finding foster homes, the exigencies of the depression, the general re-organization of the agencies concerned, and possibly a good deal of resistance to the plan.

In a survey of the present facilities and resources for the convalescent care of children in Montreal, several serious gaps became apparent. Since there is now no convalescent foster home program, there are no facilities suit-

able for infants and the young pre-school child. The Julius Richardson Convalescent Hospital is the only existing institution devoted to the convalescent needs of children. While it will take children from three to twelve years of age, its present plant is situated at a considerable distance from Montreal, and is inadequate and out-dated. It has no facilities for special medical treatment. For young adolescents between the ages of twelve to fourteen years, there is no accommodation. Three adult convalescent institutions in the city will admit those over fourteen years of age if necessary. There is no institution that can care for the emotionally disturbed child who may need group therapy, or for children in various medical categories that require the continuance of treatment in the convalescent period. There is no provision for the individual child in any age group who for medical or emotional reasons needs foster home care, unless that child is already under the care of one of the children's or family agencies.

In spite of the gaps in services to children in Montreal, it is concluded that the city has the nucleus of a good program. Many of the gaps that are now present could be taken care of with the opening of the proposed new and greatly expanded Julius Richardson Convalescent Hospital, the site of which will be within reasonable distance of the city's medical centres. The opening of a separate ward for young adolescents in this institution, and a ward in

the Montreal Convalescent Hospital for older adolescents would take care of the gaps in this type of care. The foundations for a complete program of foster convalescent care exist in the various child and family agencies throughout the city, and these, if given the financial means, and some co-ordinating agent, could develop into a very adequate resource for any child in need of this type of care. A foster convalescent program that is city-wide, and which includes the various age groups, and diagnostic categories as far as possible, would avoid the weaknesses of the old plan of 1931. It would be a part of the total convalescent services for children, rather than an isolated affair that is likely to fall through when times become hard.

The findings of the Committee on Convalescent Care for Children in Montreal were not substantially different from those discussed in the early chapters of this study. The committee, however, did make a number of very significant and important recommendations. When implemented, these should make for an excellent program of convalescent services for children in Montreal and its environs. An important recommendation made, was that an advisory committee sponsored by some such body as the Hospital Council or that an inter-federation council be set up. Such an advisory committee would act as a co-ordinator among the various child-caring agencies in the city. This is a necessity in a city like Montreal which has been divided into four

major welfare federations because of the problems presented by race and religion. If there is to be an overall program of convalescent services, there must be some unifying factor such as the proposed advisory committee. The proposed advisory committee would give direction on appropriate programs for institutional as well as for foster home convalescent care so that an integrated community program on a non-sectarian basis would result.

These recommendations made by a committee representing a cross-section of the entire city, are a far cry from those made twenty years ago. This 1950 plan, when implemented, will be on a sufficiently large scale so that it will not drop out of sight under pressure of other needs. Many problems still face the members of the Committee on Convalescent Care for Children and the other interested citizens who would like to see a unified program of convalescent care services for all children. The difficulties will not be ironed out in a short time, but the very fact that such recommendations have been made, is a tremendous advance.

The Committee on Convalescent Care for Children has suggested that further inquiry be made into the long-term needs for children with chronic disabilities. Other studies are being done in the adult field. The results of such studies as these might conceivably result in a

Master Plan for Convalescent Care Services in Montreal,  
such as that which is in the process of being developed  
in the city of New York.

APPENDIX

A.

TABLE I

Age Grouping of 56 Children Needing Convalescent Care According to Religion and Sex Covering a Period from September 1948 to May 1949 in the Children's Memorial Hospital, Jewish General Hospital, and the Royal Victoria Hospital, Montreal										
		Religion and Sex								
		Protestant			Roman Catholic			Hebrew		
		Total	Male	Female	Total	Male	Female	Total	Male	Female
Age	56	16	11	5	37	16	21	3	1	2
0- 3	23	7	5	2	15	8	7	1	0	1
4- 6	4	0	0	0	4	1	3	0	0	0
7- 9	7	1	1	0	5	1	4	1	1	0
10-12	12	3	1	2	9	5	4	0	0	0
13-15	9	4	3	1	4	1	3	1	0	1
over 15	1	1	1	0	0	0	0	0	0	0
SOURCE: <u>A Study of Convalescent Care for Children in Montreal, 1950</u> , Committee on Convalescent Care For Children, Montreal Council of Social Agencies, page 2.										

B. Hospitals Serving Children in Montreal:

Hôpital Notre Dame

Hôpital Ste. Justine

St. Mary's Hospital

The Children's Memorial Hospital

The Jewish General Hospital

The Julius Richardson Convalescent Hospital

The Royal Victoria Hospital

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