A Hospital-Connected Halfway House Program for Individuals With Long-Term Neuropsychiatric Disabilities

(aftercare; mental health services; skills, living)

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A three-month, hospital-connected halfway house program was established by two occupational therapists at the Sepulveda Veterans Administration Medical Center, Sepulveda, California. The program emphasized living skills and social skill training for chronic neuropsychiatric patients. The 19 graduates of the program were able to make the transition from the hospital to the community and to maintain themselves in the community for longer periods of time with shorter rehospitalizations. The 5-year follow-up also indicated that for the majority of the patients the quality of community living improved as measured by their satisfaction with their occupational choices (vocational, avocational) and their living arrangements.

The life pattern of many chronic psychiatric patients is characterized by poor community adjustment, which leads to numerous rehospitalizations within short time periods. A major factor in this pattern is a deficiency and/or low confidence in performing day-to-day living skills. Inpatient treatment tends to focus on alleviating symptoms or resolving problems such as financial difficulties. Consequently, these patients are not prepared to handle the social isolation and the responsibilities they often face upon reentry into the community (1). Thus their symptoms may quickly recur, and they may return to the hospital, engaging in a “revolving door” cycle of admission and discharge. Recognizing that hospital-based occupational therapy often does not provide patients with opportunities for learning and practicing living skills in the community, the occupational therapists at Sepulveda Veterans Administration Medical Center (SVAMC) developed a halfway house program located outside the hospital grounds that provides supportive training for the acquisition of community living skills. This paper describes the hospital-connected halfway house program and examines the impact such a program can have on the community adjustment of neuropsychiatric clients based on a 5-year follow-up study of the participating residents.

Literature Review

A halfway house is defined as a transitional residence for people

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with various disabilities, people who need not be confined to an institution but are not ready to cope with family and community life (2). The halfway house idea was in part a reaction to the negative effects of the closed, jail-like hospitals to which most mental patients were confined during the first part of this century. Early halfway house proponents viewed people with emotional illness neither as criminals who needed to be jailed nor as patients who needed to be hospitalized. They viewed them as troubled, anxious, often frightened people, who are in need of support, understanding, and a low-stress, homelike atmosphere in which to work through difficulties, develop self-esteem, and face challenges gradually (3).

The term halfway house appeared in the literature in 1953 (2). In 1960, seven urban halfway houses and three rural "work camp houses" were in operation. In 1963, the number had increased to at least 40; in 1965, 100 houses were functioning. By 1978, a National Institute of Mental Health survey (4) identified 20,385 halfway houses. Of these, 26% provided treatment for individuals with a mental illness, and 46% provided treatment for individuals with alcohol problems.

Factors that promoted the rapid increase of halfway houses included the following: (a) the emphasis on maintaining patients as close as possible to the community; (b) an awareness and recognition of the monetary and psychological costs of institutionalization; (c) the growing awareness of the shared responsibility of family and society for the onset and treatment of emotional disorders; (d) the development of the concepts of therapeutic community, the open ward, and community psychiatry; (e) the reliance on the use of psychotropic drugs; and (f) the development of aftercare services adapted to the needs of different groups at different stages of rehabilitation (e.g., day and night hospitals, expatient clubs, sheltered workshops).

Some of the successful early transitional living programs have been reviewed by Greenblatt and Busson (5), including the Fort Logan Mental Health Center in Denver, Colorado; Training in Community Living Program, Mendota Mental Health Institute, Dana County, Wisconsin; the Southern Arizona Mental Health Center, Tucson; Berkeley House in Boston; and Soteria in San Francisco. These programs ranged from family and home care to halfway houses. In general, patients appeared to make gains in socialization and ability to work and functioned satisfactorily without burdening their families. The authors concluded that approximately 80% of patients discharged from halfway house programs made a successful transition to community life and had lower rehospitalization rates than expected.

Halfway houses use one of two approaches: the "nurturing" or the "high-expectation" approach. In the nurturing approach, the staff assumes responsibility for running the house, recognizes the illness of the resident, acknowledges that progress toward health takes time, and sees the halfway house as a good place in which to make such progress. In the high-expectation approach, the health of residents is emphasized; residents are expected to take on responsibilities and deal with pressures to hasten a move toward independence.

In both approaches, halfway houses deemphasize the patient role, minimize distance between staff and residents, and encourage residents to help each other. The sharing of essential work makes each member an important part of the community.

Unlike a hospital, the halfway house encourages people to become less dependent on others and expect more of themselves. It provides a bridge between the hospital and the community via a therapeutic milieu designed to prepare residents for resuming their roles in society. It encourages normal patterns of living, offers support, and supplies opportunities for trying different roles and behaviors in a safe environment.

A halfway house seemed to be the ideal program to meet patient needs at SVAMC. Rose and associates (6) found that 79% of the applicants for psychiatric inpatient status at SVAMC were "revolving door" patients. Of these, 80% had been discharged within the past year, 50% within the preceding five months, and 32% within the last month. Gross (7) showed that problems of both Vietnam era veterans and older veterans at the Los Angeles Outpatient Clinic could be classified as living skills deficits related to self-maintenance. The aim
of the SV AMC halfway house program was to reduce the rate of rehospitalization by remediating the observed life skills deficiencies.

Method

Subjects

A screening team to select applicants for the program comprised occupational therapists, a resident in psychiatry, and representatives from the nursing service. The following criteria were established for program eligibility: (a) applicants must be capable of and interested in moving to independent community life; (b) applicants must be between 20 to 50 years old; (c) applicants must not have substance abuse problems; (d) applicants must be responsible for self-medication; and (e) applicants must be employable, employed, attending school, or participate in other occupational activity (i.e., sheltered workshop or volunteer work).

Applicants approved for the program agreed by signed contract to participate in all aspects of the program, abide by the existing policies, set aside funds for community living, and take part in other occupational activity (i.e., sheltered workshop or volunteer work).

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Procedures

The two occupational therapists were the sole permanent staff members responsible for program development, which included planning, coordination, implementation, and supervision. Dietitians, nurses, medical residents, physician’s assistants, psychologists, and social workers were called on periodically to consult with the residents for an in-service training program. Selected students from these fields also participated in the halfway house program as part of their clinical training.

The halfway house setting provided a homelike atmosphere in a single-story dwelling with wood paneling and a fireplace, two bedrooms, one bathroom, a separate dining room, kitchen, and large lawns in the front and rear of the house. The house was located outside the gates of the SVAMC grounds and was connected with the hospital only through a telephone system that was used primarily for reporting emergencies. The neuropsychiatric officer of the day (i.e., the doctor on call) was available in the evening for emergencies. A pay phone was installed for personal calls.

Residents were introduced into the house in groups of four for a 3-month treatment period. The residents were patients selected from the SVAMC inpatient program who were ready for discharge into the community. During the 3 months in the halfway house program, concrete discharge plans were made and assessed according to each resident’s capabilities (e.g., plans to go home, into own apartment, to find board and care, or arrange for cooperative housing). The inpatient staff agreed to accept a resident on the inpatient ward in the event that a resident required rehospitalization. Residents rotated through the program only once. However, if a resident required rehospitalization for a few days, he or she was returned to the program.

The program focused on developing competence in daily living skills in the following areas: health and hygiene, nutrition, household management, budgeting, interpersonal relationships, community resources and leisure activities, and occupational (vocational and avocational) training.

Each four-person resident group, with the help of the two occupational therapists, set goals for the observed life skills deficiencies.
relationships training, the residents explored the community's agencies and resources for recreation and other services. Problem solving, decision making, and follow-through skills were expanded. The weekly sessions on finance were expanded to include payment schedules, budgets, and the handling of a bank account. Residents identified interests, planned activities, and followed through on scheduled and spontaneously initiated activities.

The second segment was more difficult for the residents because they began to realize that discharge into the community was imminent. Awareness of the cost of living with little left over for leisure activities produced mild to high anxiety. The therapists were prepared to deal with more intense clinical issues and provide support and acceptance for residents (especially for those who began to regress).

During the third segment, supervision was minimal. Residents were involved in work, school, and/or volunteer programs (finding their own placements), or in problem solving during individual sessions with their assigned counselor. They were responsible for managing and balancing their day. Weekly assessment, weekend planning groups, and leisure and social network groups were maintained. Emphasis was placed on finding adequate living arrangements in the community, including selecting a community, being aware of community resources, and planning for individual or shared living. Residents who wished to start a cooperative (i.e., a house or apartment to which a group lives and shares household responsibilities and finances) were assisted by the social work staff.

After completing the program, each resident returned one evening per month for alumni meetings to share experiences and obtain guidance and support. When feasible, alumni members assisted the current resident group in programming and served as role models. When indicated or requested, the staff visited alumni members in the community for consultation.

**Results**

Five years following treatment, 63% of the 19 patients who completed the halfway house program reentered the community. The halfway house program produced significant changes in rehospitalization rate, length of rehospitalization, living environment, and occupational behavior (i.e., vocational and avocational activities).

Table 1 shows the recidivism rate for this group before and after treatment. For example, eight patients had no rehospitalizations, and four patients had multiple rehospitalizations. In two of these four patients, the duration of hospitalization markedly decreased (from a 3- to 6-month period to a 2- to 4-week period).

Table 2 illustrates the participants' living patterns before and after treatment. Major environmental changes were made by 13 patients. Twelve patients who had lived with their parents before treatment moved to independent living in an apartment, home, or in cooperative housing after treatment, and one patient moved into a Veterans Administration-sponsored cooperative. Eleven of these 13 patients moved into their own apartments. Of these eleven, two returned briefly to their parents and then moved into an apartment; two married shortly after moving to their own apartment and then...
The occupational behavior of 17 patients was altered. (Nothing was known about the occupational behavior of two of them.) Including those displaying job stability, 13 expressed discontent with their vocational choice and changed vocations through formal or on-the-job training. Five patients changed jobs. Nine working at a vocation and/or odd jobs terminated employment to prepare for a new career; six attended junior college, three attended a trade school. Three patients experiencing difficulty in balancing avocational activities began attending a Veterans Administration Satellite Center (a community-based outpatient treatment center) and participated in an outpatient social club and support group. Two had previously participated in little or no daily activities, one had poor work adjustment and social skills on the job. One patient, who had previously attended college was able to continue with his vocational goals. One patient with a master's degree accepted menial jobs but remained unhospitalized and is currently working consistently as a waiter.

Although the comparison of progress between the nine patients with schizophrenia and the ten with other psychiatric disorders was not the major focus of this study, the similar outcomes of the two diagnostic groups is interesting. Of the patients with schizophrenia, four had no rehospitalizations, and two had one rehospitalization within 2 years following treatment. Prior to treatment, five of these six had at least one hospitalization for approximately 1 year. Seven living with parents moved to independent living; six made major vocational changes. Of those with other psychiatric disorders, three had no rehospitalizations, and two

The veteran had multiple hospitalizations at other facilities, the exact number and length of which is unknown.
were rehospitalized for about 1 month. For two patients with multiple rehospitalizations the duration of each rehospitalization decreased after treatment. Five who were living with parents moved to independent living, and six made major occupational changes.

Discussion

All of the 19 participants in the halfway house program had multiple rehospitalization histories, which characterize them as a chronic group. They are representative of veterans requiring psychiatric treatment at SVAMC. The rate of rehospitalization as a measure of chronicity is the most common statistic cited for a schizophrenic population. In Great Britain, Todd and associates (8) studied a group of patients who had “hard core” chronic schizophrenia and found them to have an average of 3.3 previous admissions and 15 years of illness. Studies in the United States show a shorter readmission period (1).

For the majority of the chronic patients in these studies (1, 8), the quality of community life improved in terms of duration in the community, length of rehospitalization, living environment, and occupational behavior. An outcome of 63% avoiding rehospitalization was superior to the findings of at least two earlier studies. Mosher (9) and Talbot (10) demonstrated that 50% to 60% of patients with schizophrenia who are released into the community cannot sustain a successful rehospitalization outcome for 2 years. In another study (11), 45% were readmitted within 6 months of discharge.

In this study, 86% of the halfway house patients requiring rehospitalization increased the duration of their stay in the community and required a shorter rehospitalization. In addition, 57% of these patients were able to maintain and return to apartments and jobs.

These findings suggest that chronic patients may be highly vulnerable to stress and have difficulty coping with the demands of daily living despite intensive life skills treatment. Three of the six patients who required multiple rehospitalizations after treatment were manic depressives. Their recidivism may have been a result of the cyclical nature of the illness or the possibility that the halfway house program may not be the treatment of choice for this type of patient.

Three of the four patients who returned to their families showed high recidivism rates after treatment. Records and an interview with one patient showed that a major problem was family conflict. Studies in London (12) and in the United States (13) concluded that, in addition to life skills deficits, the most powerful predictor of symptomatic relapse among schizophrenics is the return to relatives where there is negative “expressed emotion” in terms of criticism and overinvolvement. This finding suggests that family therapy may be indicated as an additional treatment modality.

In running a program that provided structured training in self-help and independent living skills for a population of chronic, hospitalized, mental health patients, Tyler (14) found a greater portion of those with schizophrenia completed treatment than of those with other personality disorders. These findings are at odds with this study in that both groups had similar treatment outcomes. Although the nonschizophrenic participants had great difficulty maintaining themselves in the community and consistently holding jobs, they entered the program at a higher level of functioning: 89% already had vocational skills and 40% already had experienced living independently. The schizophrenic participants, as a group, entered the program at a lower level of functioning and demonstrated a greater range of improvement from their baseline. Of great significance is the fact that five of those with schizophrenia had at least one hospitalization of approximately 1 year prior to treatment, whereas 5 years after treatment only two of these required rehospitalization and for only 1 month. Thus, both groups demonstrated an ability to learn and use a variety of living skills.

Implications for Future Programming

The positive results of the halfway house program for individuals with chronic schizophrenia have generated interest in further program development and formal research from the Veterans Administration Psychiatry Service. Interest arose because the chronic schizophrenic patient is the most visible of the psychiatric population and because there are few reports that focus on the training of daily
living skills with schizophrenic patients. Additionally, it would seem that occupational therapy treatment modalities need to be validated.

For these reasons, a standardized life skills training program and research project for an exclusively schizophrenic population was developed by the occupational therapy staff in collaboration with staff in the Department of Psychiatry, Behavioral and Mental Health Research and Education Section, UCLA/SV AMC.

Conclusion

Follow-up data on 19 veterans suggests that a hospital-based halfway house intervention as a transition between the hospital and the community can have a significant impact on the length and the quality of community life for the patient with a chronic neuropsychiatric disorder and that they may be particularly beneficial for individuals with chronic schizophrenia.

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