The Board-and-Care Home: Does It Deserve a Bad Press?

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A survey of 46 randomly selected schizophrenic residents of six board-and-care homes in the Los Angeles area found that the schizophrenic who adjusts to the setting experiences a schizoid-compliant pattern of outcome on antipsychotic drugs that is characterized by blunted affect, passivity, and lack of initiative, interest, and spontaneity. The authors conclude that it is those negative symptoms of schizophrenia, mistakenly attributed to the presumed inadequacies of the board-and-care environment, that have given the board-and-care home a bad press both in the newspapers and in the psychiatric literature.

Board-and-care homes have received some bad press; newspapers have referred to them as "private houses taken over by operators for quick profit" (1) and "so-called halfway houses that are sad travesties of a fine concept" (2) that offer "at best custodial services which, in most instances, are worse than the patients received in the hospital" (3). Those statements are complemented by similar ones in the professional literature. Lamb and Goertzel describe board-and-care homes as "small wards in the community, with little expected of the ex-patients living in them . . . the milieu and lack of expectations in boarding homes contribute greatly to [residents'] lower level of functioning" (4). Wolpert and others describe board-and-care homes as "an expedient solution which has resulted in the creation of a ghetto of discharged patients, an asylum without walls" (5). Reich and Siegel see those homes as places where discharged patients are "unsupervised, unmedicated, uncared for, frequently the prey of unscrupulous and criminal elements" (6). Can it be all that bad? To answer that question, we made a survey of 13 board-and-care homes in the Los Angeles area, including interviews with residents in six of them.

The 13 homes—seven family care homes and six board-and-care homes—were randomly selected from a list of the "better" homes compiled by the Brentwood Veterans Administration Hospital. (Through the years the "better" homes have survived numerous assessments conducted by a VA team that focuses on sanitary conditions, food, and safety factors.)

Forty-six residents were then randomly selected from six of the homes whose sponsors were the most cooperative about volunteering their residents for the study. To be included, the resident had to be taking maintenance antipsychotic medication. All residents interviewed for the survey carried a diagnosis of schizophrenia.

Several rating measures were used for the survey; some were administered by the psychiatrist and some by the sponsor. The psychiatrist administered the Brief Psychiatric Rating Scale (7) and the Extrapyramidal Symptom Rating Scale (8), held a semistructured interview with each of the 13 sponsors, and made frequent informal visits to develop a "feeling" for each of the 13 homes. The sponsors administered a modified 13-item Katz Community Adjustment Scale (9), supplied demographic and movement data, and provided information on daily drug dosages, which were converted to mg. of chlorpromazine equivalents using Davis' equivalency figures (10).

THE TYPICAL RESIDENT AND SPONSOR

The typical board-and-care resident in this sample is a chronic schizophrenic, between the ages of 16 and 70, who has been living in the home continuously for 3.03 years. He spends 8.46 hours of the day in bed, a time limited primarily by the sponsor's continual efforts to keep him out of his bedroom, and 1.46 hours at the dining table. He spends the rest of the day in virtual solitude, either staring vacantly at television (few residents reported having a favorite television show; most were

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puzzled at the question), or wandering aimlessly around the neighborhood, sometimes stopping for a nap on a lawn or park bench.

The resident is virtually free of responsibility. In some homes he is expected to make his bed, in others he doesn't even have to do that. In one large board-and-care home the residents are bathed and shaved by an attendant. The residents' scores on the Katz scale, shown in Table 1, reflect this pattern of isolation.

The mean BPRS ratings, shown in Table 2, are compatible with the residual state. All ratings are below 3, which represents mild symptomatology. These residents score somewhat higher on negative symptoms of blunted affect and withdrawal, but the scores do not reflect the more extreme social withdrawal and blunting seen when the residents are observed from a distance. There is a lack not only of interaction and initiative but of any activity whatsoever.

The typical sponsor is a middle-aged woman, with no formal education or training, who has been in the business of caring for and living with chronic schizophrenics—and a small minority of residents with other diagnoses, primarily alcoholism—for about a decade. (The range is from one to 40 years.) All 13 sponsors saw their role as providers of food, shelter, and a certain amount of tender loving care. Through long experience they resigned themselves to regarding their residents as incompetent, childlike persons who need to have everything done for them. These women reported that they enjoyed their work and took pride in their residents' level of comfort and length of time between rehospitalizations.

The sponsors did not stifle initiative. Rather, they encouraged their residents to participate in therapeutic activities such as group meetings, arts and crafts, and neighborhood sheltered workshops, even though all sponsors agreed that motivating their residents for such activities was next to impossible. The sponsors also did

TABLE 1 Mean ratings of 46 board-and-care home residents on the Katz Community Adjustment Scale

Activities	Mean[1]	SD
Helps with household chores	2.06	.889
Visits friends	2.02	.906
Visits relatives	2.17	.887
Entertains friends at home	1.72	.834
Dresses and takes care of self	2.67	.519
Remembers to do important things on time	2.26	.828
Gets along with residence members	2.47	.660
Goes to parties and other social activities	2.21	.840
Gets along with neighbors	2.56	.586
Goes to church	1.47	.809
Takes up hobbies	1.65	.874
Works	1.34	.640
Supports family	1.13	.500

[1] A score of 1 indicates the patients perform the activity almost never; 2, sometimes; 3, often; and 4, almost always.

TABLE 2 Mean ratings of 46 board-and-care hom[e] residents on the Brief Psychiatric Rating Scale

Symptoms	Mean[1]	SD
Somatic concern	1.42	.99
Anxiety	2.46	1.51
Emotional withdrawal	2.90	1.35
Conceptual disorganization	2.33	1.50
Guilt feelings	1.46	.869
Tension	2.86	1.35
Mannerisms and posturing	2.34	1.57
Grandiosity	1.43	1.20
Depressive mood	1.78	1.17
Hostility	1.43	1.11
Suspiciousness	2.19	1.52
Hallucinatory behavior	2.46	1.60
Motor retardation	2.02	1.42
Uncooperativeness	1.57	1.35
Unusual thought content	2.31	1.59
Blunted affect	2.80	1.38
Excitement	1.33	1.05
Disorientation	1.07	.46

[1] The scale ranges from 1, not present, to 7, extremely severe.

not conceal disapproval—they frequently admonished and corrected the residents, much as one would a child.

The average daily dose of antipsychotic drug for 4[...] residents was 760 mg. of chlorpromazine equivalent. Another five were on fluphenazine decanoate, 25-50 mg. i.m., q. 2-3 weeks. Fifty-six per cent were on anti-parkinson drugs, and 15 per cent were on concomitant tricyclic or lithium therapy. Drug refusal was not [a] problem in any home.

The schizophrenic who adjusts in the board-and-care home is probably not representative of the average discharged chronic schizophrenic, at least not in California. Out of 104 chronic schizophrenic patients discharged consecutively from our inpatient service, board-and-care placement was recommended for 63 (6[...] per cent). Only 24 patients accepted this recommendation, however, and 17 of them made an actual adjustment at the board-and-care home, staying three months or longer. Of the remaining 87 patients, 32 live alone, 30 live with family, 22 ran away from the hospital to resume an itinerant existence, and three are in a closed nursing home.

A 1976 survey in California's San Mateo County o[f] 99 people receiving Supplemental Security Income because of a "functional psychotic diagnosis" revealed [a] similar pattern: 14 resided in board-and-care homes, 2[...] lived alone, 55 lived with family or friends, and three lived in a halfway house or satellite apartment (11). [A] 1970 survey in the same county showed that 32 per cent of long-term hospitalized patients were living in board-and-care homes five years after discharge (4). Thus, although it is commonly assumed that most discharged chronic schizophrenics live in a board-and-care home, the fact in California, at least, is that they constitute only a highly visible minority.

Our BPRS and Katz ratings are strikingly similar t[o]

the ratings obtained by Murphy and others who studied 106 Canadian board-and-care residents (12). What our ratings cannot show, however, is that the residents who adjust are those who experience a schizoid-compliant pattern of outcome on antipsychotic drugs. As Klein points out, these patients are the easiest to maintain in the community, albeit in a parasitic role (13). They are bland, passive, lack initiative, have blunted affect, make short, laconic replies to direct questions, and do not volunteer symptoms. And it is precisely these negative symptoms of schizophrenia, mistakenly attributed to the presumed inadequacies of the board-and-care environment, that have given the board-and-care home such bad press.

EVALUATING THE HOMES

The success or failure of the board-and-care home cannot be judged by any single criterion. If one looks at recidivism, the board-and-care homes are a success, for they keep the patient out of the hospital. In terms of symptomatology, the homes keep the patient in the schizoid-compliant or residual state, and, over time, small but statistically significant symptomatic improvements have been reported (12,14). The residents' basic needs—security, food, shelter, and basic caring—are well taken care of, and the residents themselves are not neglected. Our survey indicated that a psychiatrist visited each resident 1.72 times a month, each sponsor knew a great deal about the personal history of each resident, and the relationship between the sponsor and resident resembled moral therapy—the sponsor made the patient comfortable, aroused his interest, invited his friendship, and encouraged him to discuss his troubles.

Yet the apathy, withdrawal, and lack of initiative of residents have prompted such assessments as the following from a consumer of mental health care in California: "Regardless of what treatment programs exist in the community, they surely are not providing enough therapy. I, myself, see many people who, so far as I can tell, are untouched by anything that resembles treatment. . . . I believe the majority of board and care residents live in an isolated, removed, seldom-changing, untouched world. There is a very real possibility that yesterday's back wards of state mental hospitals are becoming today's board and care homes" (15).

It is easy to romanticize about treatment, but the usefulness of social rehabilitation techniques, sheltered workshops, and day care centers for the board-and-care home resident is not established; views of their effectiveness rest on an a priori optimism untempered by clinical experience. The zeal for community treatment must be matched against available data. So far, published reports are limited to rhetoric, polemics, and promissory statements; there is not one controlled study that assesses the contribution of enriched care in a board-and-care population. Well-analyzed, controlled studies that report a modest improvement in social functioning in discharged mental patients as a result of

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enriched living situations do exist, but we suspect that these studies may not include many of the schizoid-compliant schizophrenics such as are naturally selected for living in a board-and-care home.

Could the acceptance and lack of expectation, however well meaning, contribute toward the do-nothing existence of these residents? The widely quoted controlled study by Lamb and Goertzel, in which chronically hospitalized schizophrenics who could have gone to a board-and-care home were assigned to board-and-care homes or to a "high expectancy" setting, did demonstrate a modest improvement for the experimental group in the longer run, albeit at the expense of more frequent readmissions (16,17). (The absence of any data on medication or aftercare in the control group, however, makes assessment of the actual treatment effect uncertain.)

On the other hand, Goldberg and others, in a well-controlled study of 374 discharged, mid-prognostic-range schizophrenics, found that major role therapy, an avuncular form of counseling that encourages the patient to behave like a responsible adult, actually hastened the relapse of the more symptomatic chronic patient (18).

Jilek, in a naturalistic study of patients in the residual state—exhibiting symptoms of fatigability, impassivity, impairment of action, and lack of interest and spontaneity—also noted that the demands of normal adult role behavior produced florid symptoms, while "acceptance, in spite of reduced functioning, would afford the emotional security the patient is seeking without infringing upon his self-esteem" (19).

Lamb and Goertzel, in their latest survey, also concluded, "If a person has made a firm decision and opted for a life of isolation, then that is his prerogative and perhaps his need. For some, isolation and the avoidance of even minimal stress may be a necessity, enabling them to remain in the community" (11).

PSYCHOPHARMACOLOGY

Although the undemanding, tolerant board-and-care home appears to be good placement for the schizoid-compliant patient, surely it can be improved. Perhaps the first place to look for that improvement is in the

dosage of antipsychotic medication: 760 mg. of chlorpromazine equivalent per day seems high, although there exist virtually no normative data on dosage requirements for discharged chronic schizophrenics, let alone for those in foster homes.

By comparison, in a recent study by Hogarty, "drug survivors" were maintained on 270 ± 140 mg. per day (20). Troshinsky studied 43 chronic schizophrenics who had been maintained for more than two years in the community on a mean daily chlorpromazine dose of 225 mg. (21), and the better adjusted discharged patients of Hargreaves and associates were maintained on 408 mg. of chlorpromazine per day (22).

Dosage is likely to be important. Even a mild akinesia, to which both patient and physician can become accustomed, can result in a behavioral state characterized by lessening of spontaneity, diminished conversation, apathy, and a disinclination to initiate social activities. In our sample, 59 per cent demonstrated a mild or moderate akinesia; on a scale of 0 as not present, 1 as mild, 2 as moderate, and 3 as severe, the average akinesia rating was .90 ± 83.

It seems quite possible that such an akinetic state could exacerbate the symptoms of blunting of affect, lack of interest, fatigability, and impairment of action. To what degree we do not know; the board-and-care sponsors are quite invested in these rather high maintenance doses, and the necessary study will meet with understandable resistance on their part. And it is not fair to "blame" the operators, for it is the physician who prescribes. The community also has an interest in the docility that the higher doses afford. Perhaps it is a matter of value; the patients do not complain, the sponsors have a stable and docile population, and the community isn't bothered.■

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