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Journal

Adult Residential Care Journal, 3(1)

Authors

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Publication Date

1989

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Do We Need Board and Care Homes?

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ABSTRACT: Board and care homes have proliferated in an unplanned ad hoc manner as a consequence of the deinstitutionalization of the mentally ill. Although board and care homes have received their share of negative publicity, they are a necessary component of the community mental health system. Four major societal functions provided by board and care homes are (a) bed of last resort (b) diversity (c) potential to prevent social deterioration (d) respite care. Some problems facing these homes are (a) need for closer monitoring (b) increased personal spending money for residents (c) utilizing multiple market strategies to fill the demand for more homes.

Increased longevity and medical technology have combined to create an ever larger population of people who are dependent upon society for food and shelter. These are people who do not need the complete care found in institutions but who are not able to live alone and support themselves. They can be found among the ranks of the elderly, the mentally retarded, the mentally ill, and the physically ill.

As the population ages, and in particular, the "baby boom" generation ages, the numbers of people who are in such need will grow ever larger while the number of people available to support them will grow ever smaller. At the same time, it is increasingly clear that we live in a time of diminishing resources, that it will not be possible to provide everything to all. It is therefore incumbent upon us to develop models for the care of these groups which can be applicable in the future. Most generally, this will mean developing systems for group living. One such system—the board and care industry—has grown up in response to the deinstitutionalization movement.

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This research was supported by National Institute of Mental Health grant # MH 41441 and the Robert Wood Johnson Foundation.

Deinstitutionalization in California, a response to the development of psychoactive drugs, the iatrogenic effects of mental hospital facilities, the extension of Social Security benefits to the adult mentally ill living in the community, and the passage of legislation restricting civil commitment led to the closing of four of ten mental hospitals between 1970 and 1973. Between the years 1976 and 1980, the population in state and county facilities dropped from 40.8 per 100,000 to 24.9 per 100,000 (National Institute of Mental Health, 1986). Thousands of patients were released into the community, many of whom had been institutionalized for years and had developed no skills for community living.

During this period, the board and care industry developed in an unplanned and ad hoc fashion. Frequently, homes which sheltered ex-patients were opened and operated by former state hospital employees who wished to continue working with the mentally ill. Unfortunately, some board and care homes have received much negative publicity over the years, creating a negative perception of the entire industry in the public mind.

We contend that residential care facilities are a necessary component of a complete community mental health system and that although poor and squalid facilities do exist, many homes are of good quality, staffed by warm and caring people. The beginnings of an adequate system of residential care are in place; however, more care and resources must be put into this system to ensure that the dependent mentally ill have adequate housing.

In this paper we focus on four major functions that board and care homes fill for our society in caring for the chronically mentally ill. We then discuss certain problems with the industry. In considering the functions and problems of the board and care industry with regard to the care and shelter of the mentally ill, it should be clear that the lessons learned and the principles developed in this particular situation can be applied equally well to the care of other dependent populations.

Four Functions of Care

The Bed of Last Resort

The New York State Care Act of 1898 provided a model for most state mental hospital systems: it guaranteed provision of care to all dependent insane. If nowhere else, the indigent mentally ill could find

a bed in the state hospital. But now, because of restrictions placed on civil commitment of the mentally ill, the state hospital is unable to shelter the substantial population of mentally ill who do not meet the criteria for commitment but who are unable to live on their own. These people, however, still need somewhere to live. Although many are living alone, with friends and family, or are homeless, a substantial minority have found a place to live in various residential care facilities. Estimates are that from 15% (Goldman, Gattozzi, & Taube, 1981) to 23% (Lamb & Goertzel, 1977; Van Putten & Spar, 1979) of the known chronically mentally ill live in such facilities. Although there is no accurate census of the number of people living in residential care, the most accurate estimates are that from 300,000 to 400,000 of the known chronically mentally ill are in residential care facilities (Goldman, Gattozzi, & Taube, 1981; Segal & Kotler, in press). In contrast, there were 117,084 people in state hospitals in 1983 (Greene, Witkin, Atay, & Fell, 1986). This means that there are approximately 2.5 to 3.5 times more people in residential care than in state hospitals. Residential care now clearly shares the bed of last resort function with the state hospital.

Diversity

Perhaps the key function of the residential care system is the diversity of environments it can offer people. The mentally ill are not a homogeneous group: just as in the general population, people have different needs which they must meet through their environments. The strength of board and care homes is that they too, are not homogeneous; different homes can meet the needs of different people.

This function assumes particular importance today in light of the emergence of a large group of people who have never been socialized into the role of mental patient. As both Lamb (1982) and Minkoff (1987) have commented, the new young chronic population has not tended to mesh well with the existing treatment system, which requires that people define themselves as mental patients. To appropriately provide for this population, a variety of environments is necessary so that the new chronic patient can utilize resources without having to compromise his/her identity. The heterogeneity of this young adult chronic population as well as the need to serve the older, more institutionalized former patient points to the need for a system of care with great environmental diversity. To the extent that a system offers such diversity, it will be possible to find environmental fits for

individuals. Recent studies have begun to delineate the relationships between personal, facility, and community characteristics that will provide residents with the greatest potential for social participation. For example, Linn, Klett, and Caffey (1980) have found that facility characteristics associated with enhanced social functioning differ for schizophrenic and nonschizophrenic residents. They found that, while the presence of children in the home was associated with improved social functioning regardless of diagnosis, manager-initiated activities were associated with improvement among nonschizophrenics and deterioration among schizophrenics. Segal and Baumohl (1981) indicate that it is possible to fit people to facilities and communities in order to maximize their social integration. Using statistical procedures, they were able to estimate the social integration scores which would result if the individual were placed in various environments. Interestingly, individuals did well in a number of settings and the individual characteristics associated with doing well in any particular environment were often different. For example, the personal characteristics associated with higher external integration in the liberal, racially mixed, working class community in a programmatic group home were a high socioeconomic status, youth, relatively little involvement with psychiatric hospitals, absence of paranoid ideation, and self-selection of the facility. In conservative, middle-class communities, personal characteristics associated with higher levels of social integration in group home facilities included youth and the availability of spending money but were not directly related to socioeconomic status or psychopathology. Kruzich and Kruzich (1985) have attempted to examine specific aspects of the facility and community environments which might interact with resident characteristics to promote social integration within the facility. Coulton, Fitch, and Holland (1985) categorized 40 residential care facilities along 11 dimensions and created four types of homes. They then suggested that matching residents on the basis of such personal characteristics as the ability to tolerate environmental stimulation, would enhance resident adaptation and integration.

Thus, it is a mistake to view the board and care industry as a monolithic enterprise suited mainly for the warehousing of passive chronic patients who spend their days glued to the television. Sheltered care is an important resource for a heterogeneous population of people with mental illness who, given the opportunity and some sensitive assistance, will find environments suited to their tastes and capacities for improved functioning, if these environments are available. The substitution of the diversity of sheltered care for the more monolithic mental

hospital has certainly been one of the more positive features of the de-institutionalization movement.

Potential to Prevent Social Deterioration

No magic bullet has been discovered to cure schizophrenia and the major psychoses. While drugs are generally agreed to be a stabilizing factor in the life of the persistently mentally ill, particularly in controlling acute episodes of major mental disorder, the quality of the social environment in which the mentally ill live is crucial to self-respect and the prevention of social deterioration. Lengthy confinement in state hospitals has produced the syndrome of negative social behaviors known as "institutionalism" (Wing & Brown, 1970) and such negative social symptoms as acting out behavior and incontinence (Gruenberg, 1966). The openness of sheltered care settings has ameliorated these symptoms to some extent and has been responsible for a reduction in the frequency of their occurrence among the chronically mentally ill (Linn, Caffey, Klett, & Hogarty, 1977).

Effective community living by the chronically mentally ill is based upon a combination of medication management and manipulation of environmental supports in order to minimize stress (Talbot, 1987). Persons who are noncompliant with their medication or who have a family situation characterized by hostility and criticism are at greater risk of relapse and subsequent rehospitalization. In these situations, a board and care home may provide medication supervision and relief from unresolved and stressful family situations (Fleischman, 1985). In a 1973 survey of 214 board and care homes in California, 93% of the operators provided supervision of medication to at least some of their residents (Segal & Aviram, 1978). If, in fact, this management does prevent subsequent rehospitalization, it could result in tremendous cost savings since the cost of a day in a board and care home in San Francisco is \$19.00, compared to \$550.00 in the psychiatric unit of an acute care hospital.

Our experience has shown that the residential care system can also be a source of social support, both through involvements with other residents and by providing ongoing relationships with family care home managers that are longer and more intense in character than could ever be expected from case managers. It is these social supports which, ultimately, may prove the most crucial factor in giving residents the ability to successfully cope with life in the community.

Further, it must be remembered that only in conducting their pri-

vate lives can the mentally ill develop a social self. This can only occur in a flexible environment that is not a totally public place, such as a hospital. In effect, the mentally ill have frequently been asked to live most of their lives in public places and then been expected to engage in "normal behavior." But normal behavior often requires a good deal of private space. The board and care facility may provide the opportunity to separate the treatment component from the social component of life, so that the primary view of the individual does not become that of the person continuously under treatment, under the microscope. While this is something to strive for in most places, our experience shows that in many facilities an interesting balance between clinical assistance and social support has been achieved.

While rehabilitative ideals must be tempered with realistic expectations and a realistic view of the environments we currently have available, what can be gained through investment in the board and care system will be far beyond that which can be gained through investment in large institutional facilities.

Respite Care

A fourth function which today is seldom fulfilled by the state mental hospital and only beginning to be provided by board and care homes is the provision of respite care. Many of the individuals who left state hospitals went to live with a family member or relative (Lamb & Goertzel, 1977; Van Putten & Spar, 1979). Many of these families feel the burden. Board and care homes offer an opportunity for respite care, an opportunity which should be utilized to the fullest so that families do not become overwhelmed. This will require a continuing investment in board and care homes.

Problems in Board and Care

As we said at the outset, the beginnings of an adequate residential care system are in place. There are however, numerous problems with the system and we should not be blind to those problems. First, it is clear that board and care homes need closer monitoring. Poor homes do exist and should not be allowed to continue to exploit the mentally ill. Better monitoring will never happen however as long as the board and care industry is viewed as an "accident" or a temporary measure, rather than an integral part of a comprehensive mental health system.

Secondly, the amount of personal spending money available to residents of board and care homes needs to be raised so that people do not leave the board and care homes to find cheaper, but usually inadequate, shelter which leaves them with more spending money. Currently, a resident of a board and care home in California receives \$648.00 per month, of which only \$76.00 is left after paying the home. In contrast, a person living independently can receive \$575.00. This provides a tremendous incentive for the mentally ill to leave board and care and seek cheaper lodging in SRO hotels or on the street. To the extent that board and care homes can prevent relapse and rehospitalization, economizing on SSI benefits to those in board and care is a questionable strategy.

A third problem is the need for more beds in board and care homes. Over the past ten years, 42 homes in San Francisco (accounting for 265 beds) have closed. Few new homes are opening and the number of people who need beds has remained the same or increased (Blaustein & Viek, 1987). In addition, there is a tremendous need for greater access to board and care homes for the younger, more difficult clients of today, the clients who are using drugs or are more violent. A related problem is the need to provide backup support for managers of facilities who are dealing with difficult problems in their facilities.

Given the functions filled by the board and care industry, it seems likely that it is here to stay unless SSI regulations change or the state hospitals are reopened. How then can accommodation be made with facility operators to address some of the problems which exist?

Creating more beds should be the first priority, both to assure places for the homeless mentally ill and to pressure the system for higher quality beds. As long as the demand is greater than the supply, there is little incentive to raise quality in order to be more competitive. However, if there were enough beds, operators would need to compete by offering decent quality homes or beds for unique groups. Multiple market strategies could be used to increase the supply of beds; for example, real estate entrepreneurs could build new board and care homes, derive the tax advantages, and then hire private management to run the homes. County governments could allow tax savings or use other financial inducements to attract such business investment.

Alternatively, county mental health agencies or nonprofit agencies could build and insure facilities and hire private providers to manage them. While the county would not actually be running the facility, it would have greater influence over the quality of care provided and thus be able to set a higher standard of care.

Furthermore, if the county were willing to develop relationships with providers of sheltered care, it would be possible to offer backup assistance to facility operators in the form of personnel who would be available as temporary or respite help. This could be used as a bargaining tool in negotiating for shelter for more difficult clients. The placement of people in residential care has always had political overtones, and the results depend upon the relative bargaining position of the two parties involved. If the county could actually bargain with a provider by promising the placement of an easy resident if the provider would take a "difficult" client, there would be room for the more difficult clients. This change would only be feasible over time if the county could provide backup support to the managers of facilities so that they did not become overburdened.

Conclusion

An ambivalent attitude exists toward board and care homes. There is clearly a need for such facilities. They fill the needs of the chronically mentally ill as no other facilities do. However, many fear that we are creating dependencies within the communities, that the board and care homes are becoming nothing more than "back wards in the community" (Allen, 1974, p. 5). What we must move toward is understanding that some people with mental illness continue to need the kind of care and supervision that was once available in the state hospital but without the oppression that was a concomitant of that care. In the board and care system, we have the opportunity to provide the "asylum" that is still needed by some (Lamb & Peele, 1984) without the totalitarianism of the hospital. This may mean that some residents will choose a life that we would not choose for them, that watching television or "spacing out" may become a way of life for them. Others may blossom in the community, utilizing available programs and gladdening the hearts of mental health professionals. The point here is that a diverse system, such as board and care, can offer a choice.

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