FAMILY LIFE IN A COMMUNITY RESIDENCE
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Chronically ill psychiatric patients have long been neglected by society and isolated from their families. They have been hospitalized for long periods of time in dehumanizing institutions. Recently, large numbers of patients have been placed into the community. Unfortunately, this has often resulted in little or no posthospital care leading to the well recognized revolving-door syndrome or to large numbers of chronically ill patients wandering about the community.

Chronically ill psychiatric patients were placed into the community into domiciliary-care facilities, single-room occupancy hotels, and numerous other settings. These placements allowed for little socialization, family interaction, or active psychiatric treatment.1-4

In 1974, the South Beach Psychiatric Center began a pilot program in one of these adult domiciliary-care facilities located in Brooklyn, New York. The home was viewed in terms of its psychotherapeutic potential instead of as a liability. The idea was to develop a therapeutic residence utilizing a therapeutic community-family life model. Before the initiation of the South Beach program in the home, limited therapeutic services were available to residents. Basically, only psychotropic medication maintenance, a few limited socialization experiences, and crisis intervention were provided. Overall, life at the adult home was unorganized with residents being free to come and go. The day was structured around the mealtime schedule. Social interactions were most frequent in the evenings when entertainment was occasionally provided by the management. During the day, residents could be found mainly sleeping in their rooms, sitting silently in the lounge, or going for a walk in the neighborhood.

The impression conveyed by the home’s milieu suggested that regardless of the socialization and psychiatric status of residents upon admission, they all must soon adapt to a norm of social avoidance. This norm was
maintained and defined by institutional structure as well as an elaborate system of behaviors and symptoms. The community in that area of Brooklyn frequently complained about the appearance and behavior of residents who they would see on the streets. They frequently demanded that the home be closed and the residents sent back to the hospital.

Before a program to deal with these issues could be established, the parameters which formally and informally govern the home's institutional functioning had to be considered. In return for a statewide fixed rate for publicly funded residents (few are privately funded), the adult-home management is responsible for the provision of all meals and housekeeping services. Although the 15 adult-home staff members have had no formal psychiatric training, they are required to assist residents with hygiene and in taking medication. One staff member must be available to organize recreation and entertainment.

The 226 beds in the home tend to be filled equally by men and women. Residents live on all six floors of the home. Rooms mainly sleep two persons, although some house two or three. Sexes are mixed within floors, but segregated within rooms. The building is well maintained and furnished in contemporary style.

The age range of residents is from 20 to 90 years with two-thirds of the residents over 50 years of age. A large segment of the population has a history of lengthy multiple hospitalizations, best measured in decades, with little or no experience living without institutional support. There are a small number of elderly residents without any psychiatric history, but with some degree of cerebral dysfunction.

Because of the relatively unsupervised nature of the home, capacity for self-control is a primary factor in choosing residents. Residents must also be continent, ambulatory, and able to clothe and feed themselves. Symptomatology that does not grossly interfere with living conditions of other residents is accepted.

PROGRAM

The pilot program that was initiated was designed to promote social skills and vocational training based on a family-life model. A therapeutic community approach was utilized to foster relationships among residents and between staff and residents. The idea was to make the residence into a home so that the patients would view one another in a family context. The surrounding community was also seen in a similar manner, and an attempt was made to utilize the community as an extended-family network. Initially, little work was done in the surrounding community. Instead, the staff concentrated on the residents and the structure of the home.

The program staff consisted of six full-time staff members (director-psychologist, one nurse and four paraprofessionals) and a part-time psychiatrist.