Psychotherapy Guidebook

Halfway House

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DEFINITION

The psychiatric Halfway House is a residential facility specially designed to enable those persons who are or have been severely psychologically impaired to develop and maintain a life within a nonhospital community. As the term "halfway" suggests, emphasis is most often on the transitional functions of the Halfway House, on its "bridging the gap" between mental hospital and community.

HISTORY

Although there were precursors to Halfway Houses and one currently active facility was founded as early as 1913, a formal definition of the Halfway House as a transitional facility between hospital and community did not appear before 1953. An American survey reported in 1960 found ten psychiatric Halfway Houses, seven of which had been founded since 1954. By 1963 some forty facilities in the United States were identified as Halfway Houses. A British report noted approximately the same number of Halfway Houses in England and Wales for that same year. By 1969 the number of

houses in the United States had increased to about 130, and by 1973 there were over 200 psychiatric Halfway Houses. There have been parallel expansions in the development of Halfway Houses to serve other populations — alcoholics, mentally retarded, drug addicts, and ex-prisoners.

TECHNIQUE

The Halfway House is not a form of therapy. It is a living arrangement designed to enhance living in and relating to the ordinary social community. The emphases are primarily rehabilitative — helping residents develop and maintain social relationships, manage tasks of daily living, get and hold jobs, and move toward independent living. Staffs are generally nonmedical, institutional-type rules are minimal, men and women usually are not segregated by group, the median population is small (estimates range from medians of fifteen to twenty), and architecture and atmosphere are homelike. Unlike the hospital, the Halfway House is within the community, most often a large house in an anonymous section of an urban community, close to public transportation and shopping. A few Halfway Houses have made use of large urban apartment houses that may include families and a few offer a rural farm setting with emphasis on communal living and communal self-support. Typically, residents participate in the care and maintenance of the house and in establishing house rules; very often, with some supervision, they manage house decorating, menu planning, shopping, and cooking. Costs, unlike that of

hospitals, are comparable to the living costs of persons living independently.

Like work and recreational activities, therapy in most halfway-house settings takes place outside the house. Houses often have psychiatric or other professional consultants who serve as advisory resources for day-to-day live-in staff on problems such as medication, psychiatric emergencies, or simply daily management. There may or may not be arrangements for regular consultation between individual psychotherapists and house managers about the client-resident they share. Moreover, almost all Halfway Houses require attendance at weekly group meetings where issues of house functions and interpersonal problems within the house are discussed. Some houses view such meetings as therapy, but most are content to confine such "therapy" to the immediate problems of daily communal living.

Although the Halfway House is not a type of therapy, its aim toward enhancing residents' entry into the social community demands special sensitivities and skills on the part of operational managing staff. Staff must develop techniques for motivating residents toward developing and sustaining vocational and social relations with the outside world. The administrative structure of the house and its routines must be designed to further residents' socialization. Engagement in ordinary household tasks must be recognized as providing opportunities not only for learning task skills but for developing interpersonal exchange and social intimacy. Staff-

resident interactions can serve to enhance residents' capabilities to manage critical events and to promote a capacity for reality-oriented self-determination and growth. Unlike the hospital situation, opportunities to engage in and test multiple roles are fostered. However, when staff members lack the aims, sensitivities, or skills required to enrich the living experiences of residents and to further integration into the community, the Halfway House degenerates to a boardinghouse offering low-quality custodial care.

APPLICATIONS

As noted, the most common conception of the Halfway House is as a transitional bridge between hospital and community. Close to 90 percent of residents have been hospitalized previously and about 75 percent come to the Halfway House directly from a mental hospital. Most residents are in the Halfway House for less than a year (summary data on median length of stay range from five to twelve months), and most residents reenter the community on leaving the Halfway House. Some 15 to 20 percent return to a hospital from a Halfway House, a rate that compares very favorably with reported results on hospital readmittance for ex-patients.

The fact that as many as 10 percent of residents have no prior history of hospitalization suggests that for some the Halfway House may serve a preventive function and as an alternative to hospitalization. At the opposite

pole from the resident for whom the Halfway House can serve as a temporary protective "moratorium" setting is the resident — most often a long-term hospital patient — for whom the Halfway House tends to become a permanent home. Although most houses avoid such "hard-core," chronic clientele, there is increasing awareness of a need for residential settings that can serve an "in-between" rather than transitional function. Current programs to eliminate mental hospitals or to reduce hospital populations by discharging patients into the community accent the need for "quarter-way" houses or community care facilities. Ideally, such institutions can provide relatively permanent care in a protective setting, with richer personal and social life than is possible in a hospital. Ideally, too, hospitals can then serve their more legitimate functions of emergency care and treatment and avoid the debilitating problems of the large-scale custodial institution. The dangers are that financial, personnel, and social support resources for such community-care residences are apt to be underestimated, with a resulting proliferation of so-called Halfway Houses that are nothing more than small-scale custodial institutions.

Whether or not Halfway Houses succeed wholly in effecting the entry of their residents into full-scale independence in the community, what they have to offer may be valued for itself. A comfortable setting, a supportive social community, work that contributes to social and personal life are in themselves worthwhile. To the extent that the Halfway House provides these,

whether for a few days or for the remainder of a lifetime, it meets human needs and succeeds in its humane functions.