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TRANSITION FROM HOSPITAL TO COMMUNITY: A LITERATURE REVIEW ON HOUSING

DIVISION OF MENTAL HEALTH
WORLD HEALTH ORGANIZATION
GENEVA

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This document reviews the literature on housing for people with mental illness, which is particularly relevant for deinstitutionalisation programmes.

It is part of WHO's Initiative of Support to People Disabled by Mental Illness.

Key-words: chronic mental illness / mental health care / rehabilitation / deinstitutionalisation / psychosocial interventions

ON THE INITIATIVE

WHO's **Initiative of Support to People Disabled by Mental Illness** is part of WHO's work on the prevention and treatment of mental disorders. It is an attempt to speed up the dissemination of information to governments and professionals about good community services for those with chronic mental illness and about new developments in this field.

The Initiative aims to help in reducing the disabling effects of chronic mental illness and to highlight social and environmental barriers which hinder treatment and rehabilitation efforts and which add to the stigma of chronic mental illness. It also stimulates consumer empowerment and involvement with planning, delivery and evaluation of mental health services.

The following sites have so far officially joined the Initiative and have participated in its various activities:

* The Queensland Northern Penninsula and Mackay Region Mental Health Service (centred in Townsville, Australia).

* British Columbia Ministry of Health - Mental Health Services (Vancouver, Canada).

* Centro Studi e Ricerche Salute Mentale - Regione Autonoma Friuli Venezia-Giulia (Trieste, Italy).

* Highland Health Board - Mental Health Unit and Highland Regional Council (Inverness, Scotland, U.K.).

* Ministry of Health (The Netherlands).

The Dowakai Chiba Hospital (Funabashi, Japan) also takes part in some of the Initiative activities; other centres are at different levels of discussion concerning their joining the Initiative.

Further information on this Initiative can be requested from:

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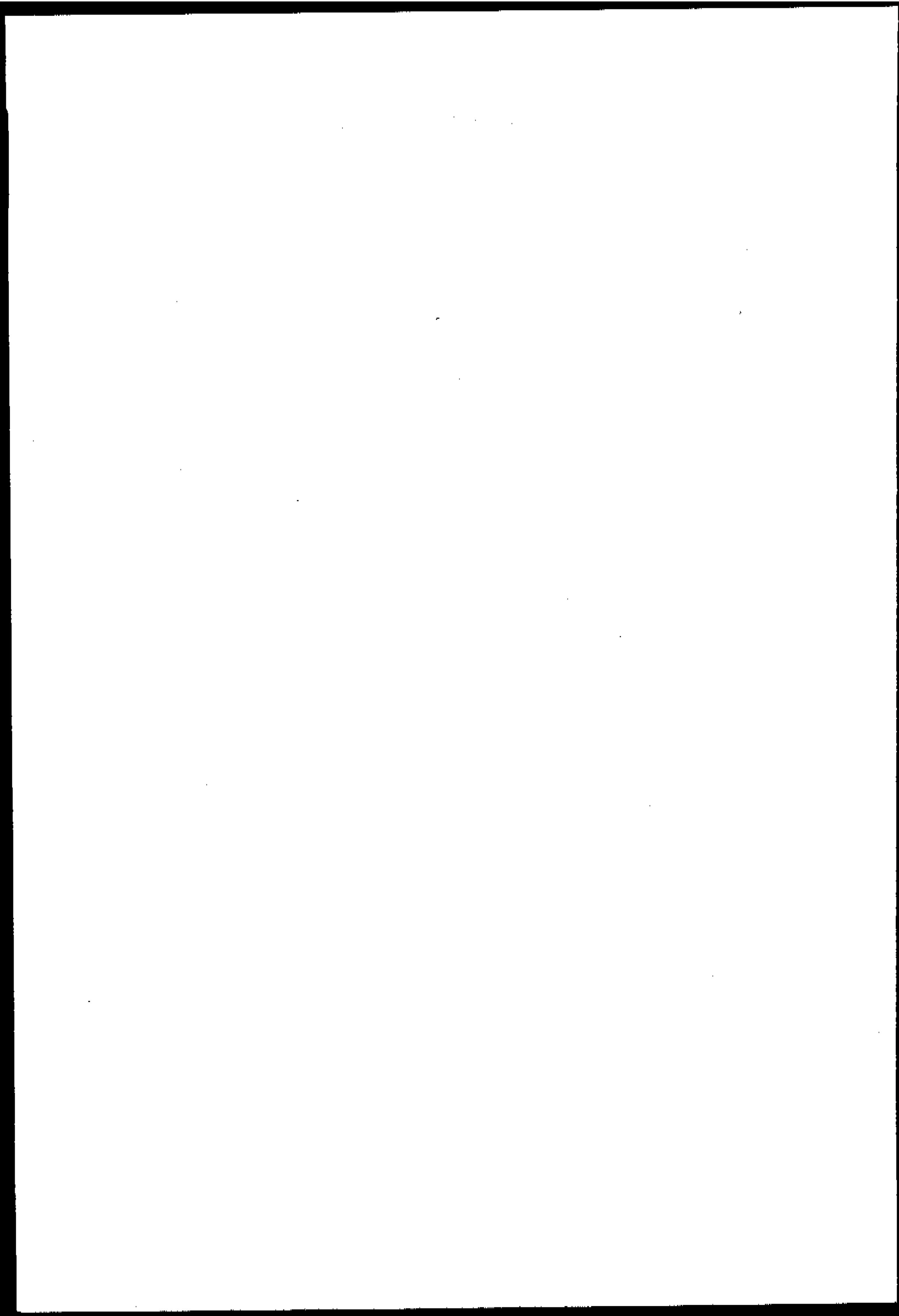

FOREWORD

Housing is a pressing problem in many parts of the world. In developing countries it is created, to a great extent, by migration from rural to urban areas, which are unprepared to receive the huge influx of newcomers; lack of sound policies, poor planning strategies and lack of resources compound the difficult picture. In many developed countries the problem is not as generalized as in developing countries, but it also exists and concerns mainly some vulnerable groups, among which outstand people with mental illness.

The deinstitutionalization (read: dehospitalization) movement which has occurred (and is still occurring) in many countries creates an additional burden in terms of finding suitable places to accommodate people leaving hospitals. In some countries (e.g. UK, USA. Italy) this movement has discharged hundreds of thousands of people now in need of a place to live.

Several solutions have been found or proposed, some of which take into consideration the special needs of people with mental illness but some others do not. Some solutions are part of broader social support programmes whereas some are just a punctual intervention.

Given this diversity, it was decided during a meeting of Heads of the centres participating in WHO's Initiative of Support to People Disabled by Mental Illness which took place in Trieste[1] that a review paper on housing for people with mental disorders leaving mental hospitals should be produced.

The paper was commisioned to David Peck, a clinical psychologist working for the Highland Health Board, in Inverness, one of the centres participating in the Initiative. Earlier drafts of the manuscript were circulated and reviewed by people in other centres participating in the Initiative, as well as by Members of the Initiative's Consultative Network. The current version has incorporated their comments and suggestions.

Rather than being the final word on the topic, this paper is intended to stimulate discussions and to help find more favourable solutions to housing people with mental disorders, particularly those moving from long periods in hospital to live in the community. Comments and suggestions are welcome and should be addressed to:

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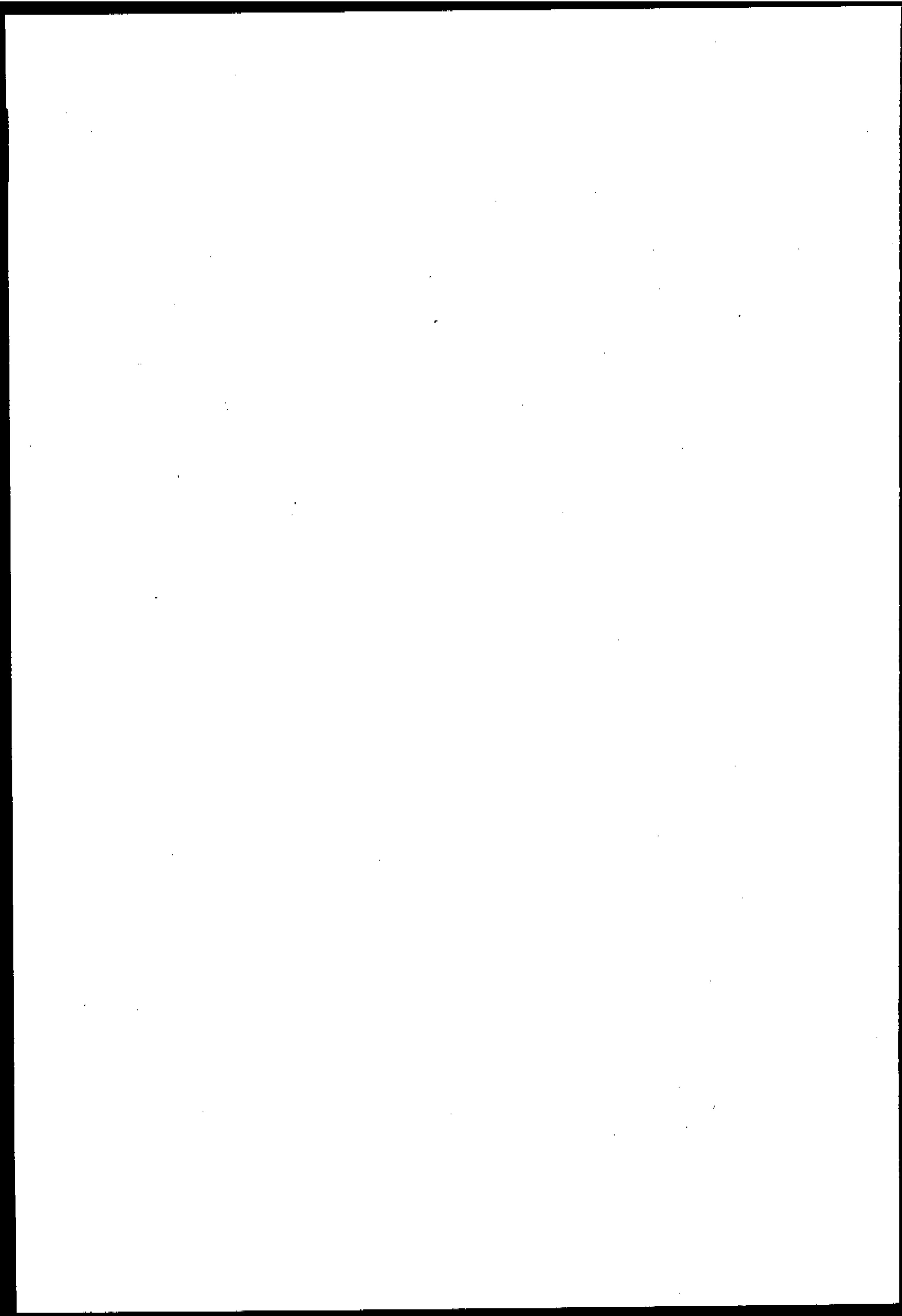
[1] **Report of a meeting. Trieste, 9-10 September 1991** (Doc.: MNH/MND/91.20). Geneva, WHO, 1991.



INTRODUCTION: WHO INITIATIVE

The World Health Organisation has established an 'Initiative on Consumer Participation in Mental Health Services'. The essence of the initiative is the involvement of longterm psychiatric clients and their carers in the assessment of needs, and in the provision, running and evaluation of support services in the community; and to foster and encourage self advocacy and self improvement. This is consistent with the increasing recognition over the last few decades that people should be enabled to play a more active role in decisions about the health care services that will affect them. The Initiative is a multi-site study, and several participating sites have undertaken to conduct a local empirical study in the area of rehabilitation and community care, and to prepare a discussion document on a key topic of general relevance to the Initiative. This discussion document on housing has been prepared by staff of the Highland Communities Health Unit, Highland Health Board, which is a participating site from Scotland, UK.

1 HOUSING AND MENTAL HEALTH

There is much evidence to suggest strong links between housing, and health and general well-being (*1*). The direction of causation is difficult to establish; poor housing can be a reflection of poor health, it may cause poor health, other factors may cause both poor health and poor housing (e.g. poverty), or most likely the relationship is a complex causative cycle involving all these factors. Improvements in housing can be associated with better health, particularly in vulnerable populations such as the longterm mentally ill who may lack the necessary skills to cope with the consequences of poor housing (*2*).

These issues are complex, and controlled studies of the factors related to the success of housing initiatives for the mentally ill are difficult to conduct. However enough research has been conducted to permit firm conclusions to be reached. A recent review (*3*) found fourteen controlled studies comparing hospital care with community care; consistently across client groups and treatment methods, community care emerged as superior on measures such as life satisfaction, symptoms, independence, relapse and social dysfunction. These improvements continue provided that clients remain within a community care programme and in contact with support services. A caveat must be sounded: the results of these studies, as is usual practice in empirical research, represent data averaged over many clients and indicate general trends. The findings will not necessarily apply to all clients and it appears that there is a small but important minority for whom the benefits of community care are not positive (*4*). Identifying who will benefit, and under what circumstances, is an important research priority.

A broad philosophy of approach is useful in clarifying the aims and objectives of community care initiatives. However this area has witnessed many ideologies and movements, espoused with a fervour that has outstripped any knowledge base. Programmes arising from untested, simplistic and dogmatic assertions concerning the causes and cures of mental disability have sometimes predominated over empirical evidence on the realities of deinstitutionalisation, and this has been to the disadvantage of client welfare. The emphasis in this review will be on controlled empirical studies.

Deinstitutionalisation is more than a process of bed reductions and hospital closures; it should be conducted from a perspective that includes integrating the setting up of community services, adjusting the control of resources, encouraging new working practices, developing new skills in mental health professionals and advocating relevant changes in legislation.

It has consistently been shown that longterm care in institutions is neither clinically nor cost effective. Most discharged clients can remain successfully and happily in the community, sometimes requiring low levels of mental health care. Good community care services may be expensive, especially when institutional and community based services exist side-by-side, a situation which may be inevitable in the early stages of rehabilitation programmes. However it must be emphasised that economic considerations, although important, must take second place to humane ones. (*5,6*). Without adequate planning for housing provision and rehabilitation services, many clients will become homeless or entrapped in the criminal justice system (*7*). Housing problems, with unemployment and poverty, are the main reasons for client dissatisfaction and for failure to remain in the community.

This discussion document will concentrate on the following issues in relation to housing: range of accommodation, location of housing, need for support, preparation for discharge, readmission, and community responses to discharged persons. It is acknowledged that because of different health, social service, financing and other administrative structures, problems and solutions will differ across the countries that are participating in the Initiative.

2 RANGE OF ACCOMMODATION

2.1 <u>Introduction</u>

A range of accommodation should be available to clients. This should not be as a "ladder" up which clients are expected to progress; but as a "menu" from which the most appropriate type of accommodation, preferably non-temporary, can be selected. Most clients should, as far as possible, be discharged into non-temporary housing immediately upon discharge so that stability and continuity of accommodation can be achieved. Moves, if they occur at all, should be kept to a minimum, be organised well ahead and only occur as part of a systematic plan. Moving house is a stressful life event, and is particularly so for emotionally vulnerable people. For some clients, however, a certain amount of mobility may be adaptive, and more flexibility in accommodation may be necessary for them.

Not all clients will be able to achieve or maintain high levels of independence, and hospitals or "hospital-hostels" should remain as an option for some, if only temporarily. Hospitals should be seen as a vital component of overall balanced and comprehensive service provision but ordinary housing should remain the norm.

It is important that clients and carers should be closely involved in setting policies and in the day-to-day management of housing schemes; this could include clients or carers

working as staff.

2.2 Menu of Accommodation

The boundaries between the types of accommodation listed below are not rigid, and it is acknowledged that not all rehabilitation schemes will want to provide all types and that the full range is unlikely to exist in all countries.

1. Client's Own Home

   Single flat or bed-sitting room in ordinary residential block with all facilities for independent living; no communal facilities. Minimal support (e.g. one staff visit per two weeks) which could be discontinued if client specifically requests this.

2. Supervised Flats or Lodgings

   Single or shared accommodation as above, but with more staff support (e.g. daily staff visits).

3. Supportive Residences

   Single or shared rooms in special residential block, with easy access to communal sitting room. Individual kitchen and bathroom arrangements if possible. No more than twelve clients in block, preferably about six. Daily visits from a variety of staff.

4. Supportive Group Homes with Active Rehabilitation Programme

   Preferably not located in hospital grounds, but economic considerations may dictate this. Rooms as above in 3. Several staff on duty during the day, whose main function is to train clients in self-care and "survival" skills for subsequent independent living. Communal kitchens, also used for training in self-care. Explicitly temporary with clear goals for each client.

5. Supervised Group Homes or Hostel with Residential Staff

   Rooms and facilities as above in 4. Mainly for highly dependent clients who require extensive care. Staff permanently on duty. Explicitly temporary, with comprehensive training programmes and clear goals.

6. Hospital Accommodation

   Individualised rehabilitation programmes should be developed for all clients who remain in hospital, and therapeutic nihilism should be discouraged. Discharge should remain the goal for all clients, but it is acknowledged that this goal may be distant for some.

   Community living schemes should aspire to obtain ordinary homes or supervised flats

for most clients (1. and 2. above); the services required in support of clients in this type of accommodation will be labour-intensive and in the absence of enough trained staff of the right calibre other types of accommodation will have to be considered.

Supportive residences and group homes (3. and 4. above) may be necessary for clients who have lived successfully in the community but for whom there has been a major crisis or change in circumstances (e.g. death of parent); where there is an enduring shortage of ordinary standard housing; and when the client still lacks a basic but crucial "survival" skill.

Supervised group homes and hostels (5. above) may have few advantages over good hospital care, but they may be necessary if the mental health service is undergoing a hospital closure programme.

Hospital living should be retained as an option for clients who require high quality intensive care and who are considered unlikely to achieve more independent lives (but this should be regularly reassessed) because of: risk of harm to self or others; poor self-management; danger of exploitation; or gross public unacceptability. They may have physical as well as mental disabilities. Hospitals can provide a refuge for discharged clients who may require temporary readmission at times of crisis; in the past the alternative to readmission has often been incarceration in a penal institution, a clearly less desirable outcome.

2.3 Is There a Need for Special Housing?

There is continuing debate about the need for special housing. Some argue that it is required as a period of transition between institutional dependency and independent living, when intensive rehabilitation training can be given. Others maintain that it can be another "institution," and as such is segregating and stigmatising; that rehabilitation training can be carried out as easily in clients' own homes; and that repeated moves through a "transitional" scheme are against clients' interests. The controversy is fuelled by a lack of general agreement about the meaning of terms such as " hostel", "group home" or "special housing".

Based on the available evidence, this document supports the view that ordinary housing with extensive support services is likely to prove most beneficial for clients. Special housing, particularly of a "transitional " type, should not be necessary in all rehabilitation schemes, but may be required in some places because of local circumstances (for example imminent closure of a hospital). One large-scale controlled study (*8*) compared two groups of clients over two years, interviewed at six-month intervals. One consisted of clients living in supervised group housing, the other of clients who lived alone. There were no differences in readmission rates, in duration of admissions, in emergency consultations or in measures of functioning. The clients in group housing began to manifest more thought disorder than the controls, possibly related to the stress of living with other mentally disabled clients. An earlier study also reported a deterioration in clients' behaviour after they were placed in large-scale group housing which had eighteen clients in three apartments within one building (*9*). Other studies however have concluded that clients can adjust well to living in close proximity to each other, if there is a range of abilities and if clients can provide mutual support (*10*).

Clients usually express a strong preference for normal independent living (*11*), rather than special housing or group homes. They tend to prefer single rather than shared accommodation.Those who experience problems when sharing a room may settle successfully in single accommodation.

Special housing does exist as part of most schemes for community living. Where it does, a system of inspection should be set up by a body that has powers to enforce standards. The regimes should be flexible so that clients have maximum choice of meals, daily routines, inviting friends, and other aspects of daily living. There should be a choice of communal areas for recreation in larger establishments, with opportunities for privacy.

Each type of accommodation has advantages and drawbacks. One study (*12*) examined the quality of life of clients in four types: own homes, local authority homes, private homes and mental hospitals. Their findings were complex but it is interesting to note that own homes were superior for client preference and autonomy but poor for health, personal care and companionship; whereas hospitals were good for health and activities, but poor for privacy and autonomy. Further systematic studies in this area would help to determine the generality of these conclusions.

3 LOCATION OF HOUSING

Location of housing may be more important than type of housing in its effects on mental health, at least in the general population, with flats in inner city problem areas being associated with high levels of psychological distress (*13*). If discharged without the necessary follow-up, long-term clients, especially the more severely disturbed, tend to concentrate in inner city areas, reflecting the availability of cheap housing and of services (*14*). Unfortunately much of the housing available for rent to clients is likely to be located in socially and physically rundown neighbourhoods, unsuitable for vulnerable people (*15*). Rehabilitation schemes must ensure that clients are not housed in rundown neighbourhoods; otherwise the danger of readmission will be great.

Clients will benefit from being close to bus routes, shopping areas, recreational facilities and medical, dental and other general health services. This will be easier to achieve in urban as opposed to rural areas. There may be advantages in locating more than one scheme in the same general area, to increase opportunities for peer support and socialising; but too high a concentration of schemes may serve to raise fears of "ghettos" in the locality and inhibit integration with the general community.

4 NEED FOR SUPPORT

Support services are needed if clients are to be helped to survive and prosper in the community; this will be particularly important in the first few weeks after leaving hospital. Regular staff visits to clients' homes, daily at first, are essential. In addition, "Drop-in" centres (where there is social contact and where recreational activities, use of a telephone, snacks and other simple support can be provided) are a minimum requirement for clients in all types of accommodation. These functions can be performed by day hospitals, possibly

under joint client-staff management. Opportunities should also be available for financial advice, general counselling, and help with specific social and self-care skills. Such centres should not be in the same building as the residences, since clients should not be confined throughout the day and night in one setting.

It should not be assumed that clients will comply with exhortations to contact mental health authorities at times of crisis. Active, regular but brief contacts must be maintained (in some cases indefinitely) to detect early signs of difficulties, but in a sensitive and unobtrusive way. Difficulties should be anticipated and handled at an early stage, rather than dealt with intensively when they have developed into a crisis. Support may be peer-based and if so it should be clearly distinguished from more formal treatment facilities.

An American study (*16*) followed up over 100 clients discharged from psychiatric hospitals and found that over 50% of them had changed housing at least once within a year, often at stressful times. Similar mobility figures have been reported more recently in Scotland (*17*). This level of client mobility supports the need for regular contact with staff, so that problems can be recognised and dealt with quickly.

5 CASE MANAGEMENT

Long-term clients often have multiple needs for supportive services but may, at least initially, lack the skills to obtain them for themselves. The concept of case management has been widely accepted as a useful approach to this problem. Case managers' functions include assessing needs and formulating a comprehensive treatment plan; liaising with a wide variety of service providers and other resources, and facilitating clients' access to them; keeping regular contact with clients in order to monitor progress and changes in needs; assisting the clients to establish, as far as possible, an independent life; being available to intervene at times of crisis; acting as an advocate for individual clients; identifying if there are any deficits in service provision, and if so taking appropriate action (*18*). Case managers normally work closely with clients' families in carrying out these functions. In some rehabilitation schemes, case managers are responsible for only a small number of identified clients (about 10) to whom they are available 24 hours per day. They should have a clearly defined locus within an organisational structure that has control over the necessary resources. A good example of a case management system is the "Training in the Community" model in which active and vigorous community care is combined with intensive support and a training programme in social skills. In a formal evaluation, this method was found to be successful, particularly in terms of client and carer satisfaction, compared to traditional methods (*19*). It is notable that these positive findings were supported in an independent rigorously controlled trial (*20*).

In some schemes, case managers appear to have less clearly defined powers, role and status, and little relevant training or experience; therefore the resources, coordination and commitment necessary for a successful community care programme may be lacking (*21*). This may account for the findings from several controlled studies that case management is not predictably effective in terms of increased adaptive functioning or quality of life (*22*).

6 PREPARATION FOR DISCHARGE

For people who have spent many years (perhaps most their lives) in institutions, moving into the community will be a source of stress and anxiety. The transition will be eased if clients can spend small but increasing amounts of time at their intended community accommodation, before discharge. Clients should also be consulted about furnishings, colour schemes, pictures and other domestic matters before taking up residence.

Rent arrears and other financial matters are often a source of difficulties. Government regulations on benefit payments and other financial support may be incompatible with a smooth transition to tenancies, and ways around such bureaucratic obstacles must be actively sought.

Assessments must be undertaken, before discharge, of clients' abilities in cooking, cleaning, handling money, taking medication, recognition of clinical deterioration, and expertise in using a wide range of community facilities such as public transport, shops, general health services, telephones and restaurants. The rights and obligations of tenancy should be clearly outlined. Deficits in any of these skills should be addressed by staff. Physical appearance is important in determining the acceptability of clients, especially in the community. Clients should receive training in grooming, dressing and general appearance, bearing in mind the clients' own tastes.

7 READMISSION

Some clients may need to be readmitted to hospital at times of crisis; requests for readmission by clients, relatives or other carers should be sympathetically considered. This may be crucial in sparsely populated rural areas, where travelling distances and relative lack of locally based staff may preclude regular close support. Clients' accommodation must be kept available for them to return to on leaving the hospital. Mechanisms should be set up to ensure that rent arrears do not build up after readmission.

8 COMMUNITY RESPONSES TO DISCHARGED CLIENTS

A sophisticated analysis of arguments often used to oppose the establishment of community housing for clients has been conducted (*23*). Four broad themes of opposition emerged: group homes may be harmful to the welfare of clients; group homes may be harmful to the community as a whole; economic and ideological objections; and procedural problems with the opening of the group home. Although this study was concerned with people with learning disabilities, many of the findings apply equally well to long-term psychiatric clients. Ways of reducing community resistance have been advised (*24*): set up apartments rather than group homes; locate them in less organised neighbourhoods, where housing for special groups has not previously been developed; and do not inform the local community in advance. Others advocate more open consultations with, and education of, the public and all interested parties (e.g. 23). Steps should be taken to anticipate neighbourhood concerns about

the effects of client housing schemes. For example, the influence of client group homes on neighbourhood property values has been examined (*25*) and no evidence of a reduction in values was found. Effective ways of facilitating neighbourhood acceptance of client housing schemes need to be further explored.

Managers of public and private housing schemes, who may have little or no experience of the needs of clients, may refuse to consider them as tenants (*26*) and this constitutes a major barrier to successful rehabilitation. Landlords should be reassured that they can contact the hospital or other body for advice, and that "respite" care can be quickly arranged, should the need arise. Contact with housing managers and landlords should be regular and not simply at times of difficulties. An educational programme for them may help to avoid crises.

For those clients with relatives who are willing and able to become involved in the community care, education about the client's problems and training in how to respond and to interact is beneficial (*27*). Relatives should feel secure in the knowledge that they can obtain help whenever they need it, and should be informed how to obtain this help.

Once community homes have been established, neighbours may be more likely to tolerate the premises when they have regular contact with clients (*28*). Tolerance is likely to be reduced in the absence of good supportive services.

9 SUMMARY AND CONCLUSIONS

1. There is compelling research evidence that most long-term mentally ill clients can live successfully and happily in the community, as long as support services are available and accessible.

2. The support services should be wide-ranging, should actively follow up all clients regularly and sensitively, and must be well integrated and carefully coordinated.

3. There should be a range of accommodation available so that the needs and preferences of individual clients can be met.

4. Most clients should be discharged to single accommodation in ordinary housing, but special housing or hospital accommodation may be necessary for some clients under some circumstances.

5. Clients should be assessed to determine if they have the necessary skills for independent living; any necessary training or other services should be provided in their own homes.

6. Clients should be discharged into non-temporary housing and should not be required to change accommodation as their clinical condition changes.

7. Clients should be housed in locations that are not impoverished; are close to support services; are convenient for shopping, recreational and medical facilities; and are well

served by public transport.

8. Case management can be an effective approach to supporting clients in the community, provided that the caseload is not excessive, that the scheme is well resourced, that extensive training is given to the case managers, and that they have clearly defined roles.

9. A high concentration of clients in a small area should be avoided, and ways to combat community resistance to rehabilitation schemes may need to be explored.

10. Clients' relatives and managers of housing schemes need to be reassured that they can contact support services at any time and that "respite" care can be organised if necessary.

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*** Recommended reading.

INITIATIVE OF SUPPORT TO PEOPLE DISABLED BY MENTAL ILLNESS

LIST OF PUBLICATIONS

1. Initiative of Support to People Disabled by Mental Illness.
2. Consumer Involvement in Mental Health and Rehabilitation Services.
3. Proposal for a Multisite Research and Action Programme on Consumer Participation in Services.
4. Schizophrenia: Information for Families.
5. Innovative Approaches in Mental Health Care: psychosocial interventions and case management.
6. Descriptive Study of Centres Participating in the Initiative of Support to People Disabled by Mental Illness.
7. Transition from Hospital to Community: a literature review on housing.

FORTHCOMING ISSUES

Innovative Approaches in Service Evaluation: consumer contribution to qualitative evaluation and soft indicators.

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