Predicting the required number of sheltered housing places

ALAIN D. LESAGE

Predicting the need for hospital beds has long been a subject of debate. In 1961, Tooth & Brooke examined the trend in the decline of the British mental hospital population and predicted a complete closure of psychiatric hospitals in the next decade. After three decades, closure of mental hospitals has taken place or is being pursued in some catchment areas. Long-stay inpatients are still a reality at the national level in the United Kingdom, in all European countries and in the Americas (Lesage & Tansella, 1993). None of these countries has managed to construct a system of care where all psychiatric hospitals have disappeared. This includes Italy where admissions to psychiatric hospitals have officially ceased, but where long-stay inpatients still reside. More importantly, this deinstitutionalisation movement, still under way in all countries, has attracted regular criticism for its shortcomings in meeting the needs of long-term mentally ill patients in the community.

To some extent, Tooth and Brooke's national prediction failed and lessons can be learned from this. First, group predictions of needs should be based on individual patients needs. In considering the population-based needs for housing places, recognition should be paid to the functions of the asylums with regards to patients' needs. Secondly, it cannot be assumed that the characteristics, needs and outcome of long-stay inpatients discharged in the community over the last three decades is comparable with the years ahead. Prediction relies on a series of explicit assumptions and steps: 1. the aims of the prediction should be stated - prediction for whom, at a national or local level? 2. catchment-area based services with a patients' needs orientation should set targets, taking into account national policies, local history, local expertise with community care and housing, resources, users' views and community tolerance; 3. targets should be confronted by regular assessement of outcome and process through individually-based needs assessment, clinical audit, as well as catchment-area based information on services deployment and utilization, flow of patients and whether particularly vulnerable groups of patients' needs are being met (Wing *et al.*, 1993). These issues will now be considered in turn to demonstrate how the prediction of the size and the array of required community supported housing facilities in a given catchment area can be reasonably achieved.

Major thinkers in the field of deinstitutionalisation have felt the need in the last years to describe the asylum functions of psychiatric hospitals (Bachrach, 1984; Wing & Furlong, 1986; Lamb, 1993). Without calling for a return to psychiatric hospitals, they have been questioning past practices to enlighten our understanding of community care and the development of comprehensive catchment-area based psychiatric services. The asylums provided shelter from the pressures of the world with which, in varying degrees, most of the patients were unable to cope. At one point or another in time, psychiatric hospitals were intended to, or tried to provide three key dimensions: therapeutics, rehabilitation and shelter. Rehabilitation in particular cannot logically be practiced without some shelter being provided to the patient. Since treatment and services that did exist were in one place, psychiatric hospitals had the advantage of providing integrated services without the need of case managers. The need for case management has emerged as it was recognized that many severely mentally ill patients in the community required support in just finding the various dispersed services, and attending them. The issue of whether case

Indirizzo per la corrispondenza: Dr. Alain D. Lesage, National Health Research Scholar, Centre de recherche Fernand-Seguin, 7331 Hochelaga, Montréal, Québec, Canada H1N 3V2.
Fax (+1) 514-251.2617.

management should be provided by generic case managers or by multidisciplinary teams (Stein, 1992) depends on the needs of various types of patients (destitute mentally ill men would do better with a single case manager) and local practices. More recently, a criterion-oriented approach has emerged in psychiatric rehabilitation (Shepherd, 1990), which nicely parallels a more consumer-oriented approach and higher sensitivity to families -still the fulcrum of community for most psychiatric patients. These bottom-up developments and advances in individual patients needs assessment (Brewin & Wing, 1993) support the position that prediction of required services should be patient's needs oriented rather than services oriented (Wing *et al.*, 1993).

It can reasonably be assumed that patients discharged in the first decade of deinstitutionalisation were affected by less severe handicaps than the long-stay inpatients now envisaged for discharge into the community (Lesage & Morissette, 1993). In any given country, in any given area, increasing levels of community support has been set up for chronic mentally ill patients discharged into the community, as well as for those new chronic mentally ill patients who, in the past, would have been admitted into psychiatric hospitals. Every area has met this challenge with varying degree of success but most countries acknowledge the fact that they have failed to meet this challenge at a national level (Grob, 1992).

The development of proper housing facilities, including sheltered housing places has been a key to success or failure, since without proper shelter, therapeutics and rehabilitation cannot be effected. There has been a continuing debate over the extent to which new sheltered housing facilities represent new institutions in the community (Geller & Fisher, 1993). Radical positions have been taken by Carling (1993) with community supported housing movement which advocates that housing for chronic mentally ill in the community should avoid congregate settings like group homes or 24-hour supervised housing, and, instead, provide individual appartments or rooms with intensive supervision. It was also envisaged as a complete alternative to psychiatric hospital beds and sheltered housing settings. Such movements certainly introduce new models of delivering care in the community. They also gain a point with their consumer-oriented approach since most users prefer independent housing. But when such movements verge on the ideology reminiscent of the '60s «any place is better than mental hospital», one becomes concerned that, once again, service providers needs will take precedence over patient's needs.

Epidemiology still has a central role to play in the planning for, and assessing patient needs oriented services. Epidemiological tools such as psychiatric case registers, and surveys of services have been instrumental in documenting successes and failures in delivering adequate community psychiatric services. From a population-based services needs perspective, most model areas have developed an array of sheltered housing provision. Following expert discussion at British national level, Thornicroft and Strahdee have proposed ranges of acute and continuing care places, including 24-hour staffed residences; day-staffed residences; acute psychiatric care; unstaffed group homes; adult-placement schemes; local secure places; respite facilities; regional secure unit places (Thornicroft, 1993; Strahdee & Thornicroft, 1993). These projections have taken into account major factors that affect the need for services in a catchment area. First, prevalence is affected by socio-economic factors. Moreover, large urban areas tend to attract and maintain more severely mentally ill patients. Large differences in hospital beds and sheltered housing needs can be found among British model areas monitored by case registers (Gibbons *et al.*, 1986). It has also been shown that socio-economic indices of deprivation relate to the number of psychiatric admissions across a country (Hirsh, 1988). Secondly, cultural and socio-political issues influence the interaction between the community, the available services and the needs for services. Again, case register data from British and Italian areas showed similar incidences, but different prevalences among areas of comparable socio-economic indices (Lesage, 1989). Thirdly, it can be argued that even model areas are influenced by local history, the responsibility for remaining psychiatric hospitals, local initiative in determining the types and mix of various types of continuing care places. Indeed, it should be understood that the various types of places are dependent on each other: if less supervised housing is not available, local clinical teams tend to maintain patients in more supervised settings than may be required.

Even if it can safely be predicted that the psychiatric hospitals population will decrease in the next decade, such prediction is of little help to planners at a national and local level. It has been assumed in this

editorial that locally based services and planning can best meet the needs of long-term mentally ill patients (National Institute of Mental Health, 1987). For this group, prediction of how many sheltered housing places represents a process involving on the one hand locally determined targets and, on the other, continuous assessment of individual needs and services needs. At a national and international level, prediction involves the recognition that a range of sheltered housing types and places should be targetted instead of absolute numbers.

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