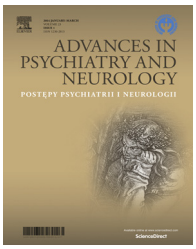
Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/pin



Original research article/ Artykuł oryginalny

Who are shelter housing users and what do they expect?

Kim są i czego oczekują użytkownicy mieszkań chronionych?

Paweł Bronowski *, *Maryla Sawicka, Paulina Rozya*

Institute of Applied Psychology, the Maria Grzegorzewska Academy of Special Education, Warsaw, Poland

ARTICLE INFO

Article history:
Received: 06.11.2015
Accepted: 16.02.2016
Available online: 23.02.2016

Keywords:
- Sheltered housing
- Schizophrenia
- Community support

Słowa kluczowe:
- mieszkania chronione
- schizofrenia
- wsparcie środowiskowe

ABSTRACT

Objectives: Answers were sought to the following questions: who are sheltered housing users?; how do they evaluate the accommodation offer?; and what is the position of sheltered housing in the support systems for the mentally ill? **Method:** Participants in the study were 302 people diagnosed with schizophrenia (F-20), who had been users of support systems in Warsaw, Cracow and Lublin for at least 3 months. In this sample, 34 participants lived in sheltered accommodation. The Sociodemographic Questionnaire, the Community Support System Use Questionnaire and the Global Assessment Scale (GAS) were administered to each sample participant. **Results:** Sheltered housing users turned out to be relatively young and well educated. They presented with low levels of psychopathological symptoms and difficulties in social functioning. Many of them were users of other rehabilitation programs, such as Community Self-Help Centers, patient clubs and supported employment programs. Accessibility of contacts with other people, learning new skills and a sense of security were considered to be the most important benefits of sheltered housing. **Conclusions:** Sheltered housing should be a part of broader support systems, since only under such circumstances, living in sheltered accommodation can have a truly positive impact on the recovery process. When people with mental illness are offered sheltered housing, they should participate in the planning of a comprehensive psychosocial intervention, including also more active forms of support and rehabilitation.

In the concept of the "recovery process" known for many years, an assumption is made that effective support to the mentally ill should cover all spheres of their functioning, extending far beyond the narrowly defined "psychiatric treatment" [1]. Recovery can be, to a great extent, understood as based on fulfilling the individual's needs, which is reflected in the degree of his/her life satisfaction. These personal needs include, among other ones, the need for autonomy and contacts with other people [2, 3]. One of the ways to attain autonomy is independent living, which often requires support

* *Corresponding author at*: Akademia Pedagogiki Specjalnej, ul. Szczęśliwicka 40, 02-353, Warszawa, Polska. Tel.: +48 22 589 36 09; fax: +48 22 658 11 18.
E-mail address: pawel.bronowski@icar.org.pl (P. Bronowski).

http://dx.doi.org/10.1016/j.pin.2016.02.004

in the framework of community-based treatment. Sheltered housing enables the users to fulfill their personal needs by ensuring their privacy, peace, sense of security and freedom from external demands. Relations with co-residents based on sharing their daily life experiences contribute to the development of a sense of belonging to the community [4].

Sheltered housing users

On the grounds of Western European and US experiences, several categories of sheltered housing users can be distinguished:

1. "Long-term patients" de-institutionalized from mental hospitals. This group of patients practically does not exist in Poland.
2. "New long-term patients" who despite treatment and psychosocial rehabilitation are not eligible for hospital discharge, and the only form of assistance available to them is sheltered housing. In Poland, they are admitted to state-owned nursing homes where the stay is extensively supervised.
3. The largest group of sheltered housing users comprises those who have successfully completed in-patient treatment but require further support. They usually have no family or no place they could return to. This often results from a prolonged hospital stay.
4. Persons who successfully cope with daily life difficulties despite their continuing severe psychotic symptoms. This group comprises also the mentally ill highly dependent on family members. In such cases, sheltered accommodation helps the patients in their striving for self-dependence or autonomy [5].

Sheltered housing effectiveness depends on the extent to which the users' needs are fulfilled. Thus, when planning sheltered accommodation, other available support programs, different from the services offered in sheltered housing, should also be taken under consideration [6].

As shown by the study by Durbin et al. [7], supportive housing may be a useful solution also for patients after a short-term hospitalization. Almost 60% of inpatients of mental health facilities would be capable of independent living if provided with appropriate assistance. Availability of such an accommodation could be a residential alternative for people with mental disorders after acute psychiatric hospital admission due to various reasons. Bartlett and co-workers having analyzed 730 admissions of this type concluded that 35% of these patients would be able to live in sheltered housing settings with more or less extensive support from professionals [8]. This type of sheltered accommodation utilization enables service providers to respond effectively to crisis situations experienced by the mentally ill, including not only their psychotic breakdowns, but also family crises.

Types of sheltered housing

Sheltered housing offered to the mentally ill can be divided into several most common categories:

- custodial housing – the mentally ill person is a patient there, being provided with care and controlled by the staff; his/her influence on the therapeutic program and daily lifestyle is limited,
- step housing (there is no Polish equivalent) – consists in gradation of support provided to patients after their hospital discharge. The first step is the provision of 24 h care by a community nurse; the next step is sheltered housing. Finally, the person is offered independent living in a self-contained accommodation, with limited assistance from therapists,
- hostels (supportive housing) – facilities where rehabilitation programs aimed at the development of social skills and vocational activation are conducted by on-site staff. The person with mental illness turns there from a patient into a resident. However, he still has little influence on where he lives, with whom he shares his accommodation, and what assistance he gets. The only exception consists in household decision making shared with his co-residents,
- supported housing – in this form of housing (designed in the 1990s) the main assumption is that the mentally ill person should choose and maintain his accommodation himself. He is a legitimate tenant of a self-contained flat and receives external assistance appropriate to his needs. The supported housing tenant has the full right to decide about the choice of other support programs he would like to participate in,
- sheltered housing – operates by the same rules as supported housing, but differs in the extent of the staff involvement in the residents' life. Therapists encourage the residents to be more active, monitor their symptoms, and ensure their treatment continuity on the outpatient basis [9],
- halfway house – accommodation available for patients with most severe psychotic symptoms, with a considerable involvement of staff members,
- hospital-hostels for patients de-institutionalized from psychiatric hospitals. Such transitional forms of accommodation are high-staffed, also by medical professionals [10],
- community residential facilities – a self-contained accommodation for long-term psychiatric patients who prefer living alone or may be too troublesome for a potential roommate. Such flats are systematically monitored by the staff, and if needed, immediate assistance is available in case of daily life problems, or support is provided to deal with worsening of the patient's condition [9].

Lelliot et al. attempted to clarify the ambiguity of the term "sheltered housing" – namely, they proposed a categorization based on the number of staff at the facility and the frequency of the staff members' contacts with residents [11]. The following classification ensued:

- hostel – with residential staff, 24 h on the premises,
- low-staffed hostel – 0.16 full-time staff member per resident. Such facilities are usually group homes, and immediate availability of the staff is limited. In the night, staff members can be contacted by phone,
- mid-staffed hostel – 0.39 full-time staff member per resident,