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Need for Licensure and Regulation of Group Homes

University of Alabama

NUR 740-902: Health Policy & Politics

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**I. Introduction**

**Difficulties of Having a Mental Illness**

Mental disorders affect people’s ability to think and how they behave. These disorders often decrease their ability to protect their own interests and make their own decisions. There is the ongoing battle of the stigma against mental illnesses leading to discrimination and marginalization. Often these people cannot attain what they need; sometimes they may be offered services, but the services are of subpar quality compared to the services for those without mental illnesses. Finally, the risk is high for people with mental illnesses to have their civil, political, economic, social, and/or cultural rights violated (WHO, 2003).

People with mental illnesses suffer financially, thus their lives are further complicated by lack of funds for needed resources such as safe housing. They have been found to make an average of 1/3 less money in a year compared to people without a mental illness. This comes from a survey of people who live in 19 different countries including the United States (Levison, et al., 2010). In other countries as well, such as Canada, there remains much community resistance for housing for the mentally ill. People in the community resist which results in development delays, higher housing costs, and longer waiting lists for services and support (Finkler & Grant, 2011).

Amongst those who are able to obtain housing, some of the worst living conditions are sustained by people with mental illness. Because of stigma and discrimination, they often cannot obtain an education, cannot hold a job, and cannot appreciate the benefits of public facilities. Even when there is mental health legislation, this does not guarantee protection of the rights of people with mental illnesses in group homes (WHO, 2003).

People who have a mental illness are vulnerable to abuse and having their rights violated. It used to be that legislation was needed to protect the public from those with mental illnesses by separating them from the general public. A huge shift occurred as the focus on community care increased (Chandrashekar, Math, & Murthy, 2011). The purpose of this paper is to establish the need for legislation that mandates licensure of group homes and ongoing supervision by licensed professionals of group homes in the United States.

**II. Body**

**Evolution of Public Housing Policies for Mental Disabilities**

The United States Department of Labor (2008) identifies the residential care industry as any place that provides residential social and personal care for any of the following: children, the aged, and special categories of people that have diminished ability for self-care (such as people with mental illnesses). An important fact to be aware of is that medical care is “not a major element.”

Before the 1950s, people with mental disabilities were deliberately separated from society in isolated psychiatric institutions; this was known as “institutionalization." The main reason for the segregation was mostly fear of and social stigma associated with disabilities (Riley, 2011).

During the 1950s, a change in perspective occurred. The “deinstitutionalization” movement occurred as society recognized the poor conditions of the psychiatric institutions and the inhumane treatment that the patients were receiving. Society desired to provide housing where people with disabilities could have increased autonomy, privacy, individualized treatment, and not be segregated from society (Riley, 2011).

Advocates for deinstitutionalization assumed there was no need for housing policies as individuals with mental illnesses transitioned to mainstream society. Politicians liked the idea of eliminating institutions, advocating for the “progressive ideal of increasing autonomy and equality.” The states were obligated to downsize public institutions; however, there were no places to send the patients following discharge. Thousands of patients, formerly in institutions, were discharged. From 1955 to 1994, the number of people in institutions decreased by about eightfold (Riley, 2011).

States eventually introduced the idea of licensing private group homes. The goal was to provide community-based places to live and provide treatment for individuals with mental disabilities. Group homes provide boarding and services for individuals with disabilities. Non-government entities operate private group homes for profit (Riley, 2011).

**Present-Day Group Homes**

For many years, day treatment programs and group homes have been the cutting edge effect of deinstitutionalization. They do not necessarily result in people with mental illnesses leading more normal lives, but they offer an in-the-middle level of care between institutionalization and being completely independent in the community without supervision

(Stawar, 2010).

Although many people with disabilities can enter a group home for adequate housing, many private group homes operate under abusive conditions. They are often large, isolated, permanent living facilities. Second, residents are confined and segregated, depriving them of the opportunity to interact with the outside world (Riley, 2011).

Discrimination, isolation, and mistreatment has not ended. Segregation of people with mental disabilities continues within the smaller facilities and in group homes. The former president of the American Psychiatric Association has stated that the outcome of deinstitutionalization has been that "the chronic mentally ill patient [has] his locus of living and care transferred from a single lousy institution to multiple wretched ones." The change from state psychiatric hospitals to state-supported private facilities has now been called “transinstitutionalization" (Riley, 2011).

**Case Study Examples**

In England and Wales, there have been reports of the following: a male staff taking a picture of a female patient using his cell phone while the patient was naked in the bathroom; a patient being restrained by three staff members by holding a towel across his mouth; and a staff member dismissing a female patient’s complaints of sexual abuse from male patients without investigation (Allen, 2008).

In recent news around the country, there are stories of people with mental illnesses receiving negligent to outright abusive care from group home staff. In Atlanta, Georgia one person wandered the streets daily. His parents paid more than $25,000 to a group home thinking he was receiving psychotherapy, one-on-one support, and other services. Instead, he was being dropped off at homeless shelters because he had failed to follow the rules of the group home (Willmsen, 2012).

 In New York City, residents with mental illnesses in an adult home were having unnecessary surgery performed on them. The ophthalmologist surgeon billed the government thousands; the residents had never complained about vision or eye problems prior to the surgeries (Levy, 2002).

In La Mesa, California, a treatment clinic was opened. The company also bought three homes nearby and rented two other homes. They quickly filled the homes with people with schizophrenia, bipolar disorder, and drug addictions or other mental illnesses. They charged $100,000 a year. Complaints surfaced from nearby residents who said the company provided inadequate care and did not obtain government oversight. The owners bypassed any problems because they explained that treatments were done at the clinic; no professional, licensed staff was needed at the homes because there was no treatment being done there. The company’s homes are not regulated by any state or federal agency (Willmsen, 2012).

 In San Antonio, Texas, four men with mental illnesses died in a fire in an unregulated group home. It was only years earlier that Texas officials had proof that the owner neglected the clients and breached health and safety codes. Unfortunately, in 2010, Texas removed any licensing requirements for group homes such as this (Willmsen, 2012).

 The director for policy and legal affairs for the National Alliance on Mental Illness (NAMI), tires of stories such as these. Furthermore, without regulation mandating licensure he states “there’s no way to independently determine if they provide quality care” (Willmsen, 2012).

**Optimal Care in Group Homes**

 It seems that housing for people with mental illness is not an easy topic solely for the U.S. An article in a Canadian journal reports that research on housing for this group of people has continued with no framework to guide and integrate the findings. The author of this article proposes a model in which housing stability includes a dynamic relationship between the person, housing, and support (Sylvestre, Ollenberg, & Trainor, 2009). There is little research on group homes for children. One article studied 5 treatment models for effectiveness in group homes for children. It concludes that implementing the different models will have different outcomes. The different models increased various domains of functioning in the children (James, 2011). Another report focuses on improving services for people with learning disabilities in group homes. Depending on the resources, the outcomes varied but there is support to show that the clients can have good outcomes in group homes (Walmsley, 2010). A Taiwanese-based study reports that residents in smaller group homes have better outcomes at lower costs than those in larger group homes or institutions (Chou, Lin, Pu, Lee, and Chang, 2007). These articles support the need for group homes; furthermore, while these articles imply that optimal care is expected when working with people with mental illnesses, they do not address the need for legislation to ensure that quality care occurs.

**III. Summary**

**Recommendation**

In Texas, House Bill 1168 passed in 2007 which required regulation of boarding homes, but the bill has yet to be fully enforced as the discussion of how to carry it out is now the obstacle. Homes may be checked by fire marshals and city code inspectors but only if the owner of the group home applies for a certificate of occupancy. Most of them do not bother with this step. Medicaid funds the services for the mentally ill, but it does not help with housing (Stoeltje, 2012).

There simply is no precedent to draw from in any state that has been effective and can be used as an example; furthermore, there is an ethical need for legislation across the country to eliminate the abuse of the mentally ill. Any person can have a place with space enough for several beds, get people with Medicaid to live there who have nowhere else to live, bill their Medicaid for supplies, and do nothing about giving them the treatment and care they need or even to help them with basic activities of daily living. Until there is legislation requiring that group homes be both licensed and regulated, the abuse will continue. One person put it in perspective when someone told him “Well at least [group] homes are better than sleeping under a bridge.” His response was “Surely we can have more compassion” (Stoeltje, 2012).

For regulation purposes, the recommendation is to require a person who is trained in mental illnesses such as a psychiatric nurse practitioner, an RNC (registered nurse certified in psychiatry), or a psychiatrist to be responsible for overseeing the care of people in group homes. This can be done by the person going to the group home to do evaluations and follow ups or the clients can go to a clinic and be seen by a provider. Evidence of this occurring can allow for licensure of the facility. The idea is to have someone with a license overseeing the care of the residents, but it must be someone specially trained for this population. A regular medical-surgical nurse, for example, would not be adequately trained for such oversight.

One author notes that this population cannot “make informed choices themselves about where they live, who they live with, or how they are supported to live their life.” This should remind healthcare workers of their responsibility to ensure that the lives of people with intellectual disability and social inequality, such as can be said about people with mental illnesses, are not also limited by poor practice (Fyson, 2010).

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