Best Practices in Serving Persons Exiting Institutions

Across the country, there are many individuals who are inappropriately residing in institutional care such as nursing homes or other mental health facilities. Such persons could successfully live in the community with appropriate housing and services. In 1999 the U.S. Supreme Court's *Olmstead v L.C.* decision mandated that states develop plans and move people out of these institutions and into the most integrated, appropriate setting possible in the community.

In designing and delivering services to former residents of institutional care in supportive housing, observe the following principles to ensure you meet the needs of this group:

Prepare to Provide Intense Support Initially

In many cases, individuals residing in institutional care have not had the opportunity to build or use key life skills, such as cooking and housekeeping since these services have been provided for them. Many institutional residents also participated in a set schedule for a number of years and may find independence to be overwhelming and anxiety-causing. When desired, a case manager can work with a tenant to help them develop regularly scheduled activities in the community that may help to provide structure to the day and ease the transition from the institutional setting. Service providers will want to ensure that they have the flexibility within their service provision model to work more intensively with such tenants during and after move-in.

Connect Tenants with Support Networks

Feelings of loneliness can be particularly acute for former residents of facilities who lived in close proximity to other individuals, in many cases for extended periods of time. Service providers will need to work with tenants to help strengthen and develop their connections with the community, so that they feel integrated into the neighborhood and have a strong social support network. This includes supporting tenants in connecting with neighbors, peers, friends and family if desired and participating in community activities of interest.

Coordinate Among Multiple Systems of Care

Persons exiting institutional care in many cases receive services from multiple systems. For instance they may be receiving mental health services as well as home health care. The lead service provider organization for the supportive housing and the tenant's designated case manager are responsible for working to ensure that the tenant continues to meet eligibility criteria for and receives any needed services. The case manager must also work with the tenant to ensure that the overall package of services is comprehensive and complete despite coming from multiple systems of care. In this process, the tenant's choices with regard to the services they want to participate in should always drive the conversation regarding service provision and care coordination.

The Project Profiles section of CSH's Quality Supportive Housing Toolkit includes existing supportive housing projects that are serving persons exiting institutional care and have designed their services with the needs of that population in mind.