Shared Housing Arrangements for People with Dementia in Germany

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Overview

- Introduction and background
- Development of SHA
- Current state of research
- Conclusion
Background

- in Germany, we have currently **about 2.9 Mio care-dependent persons increasing to 4.5 Mio in 2050** (Statistisches Bundesamt 2017)
- **dementia** is one of the most frequent neuropsychiatric diseases in old age (Weyerer 2005)
- people with dementia (PwD):
  - 2015: **1.6 Mio.**  ➔ 2050: **3.0 Mio.** (Bickel 2016)
- older **care-dependent persons** are mostly **community residing** (Hallauer et al., 2000)
- 75% of all **persons with dementia (PwD)** live **at home** with support of family members (Grass-Kapanke et al. 2008)
- dementia is a **major reason for relocation** into institutional care arrangements (Schäufele et al. 2008)
Background

- Institutional care arrangements are frequently criticised (Schäffer et al. 2008)
- Increasing demand for self determination in old age concerning accommodation and care (Fischer et al. 2011)

→ Development of Shared-Housing Arrangements (SHA) for PwD

→ SHA are characterized by a multiprofessional network of stakeholders
Characteristic of Shared-Housing Arrangements (SHA):

- German kind of **small-scale living facility** (Verbeek et al. 2009)

- **6-8 older, care-dependent persons** share one apartment (Wolf-Ostermann 2007, 2011)

- **disconnected** from institutional care (Pawletko 1996)

- care providers & landlords are bound by contract to each person not to the SHA as a whole (at least **two service providers**) (Roßbruch 2009)

- **no** temporary service (Steiner 2006)
Background

- **network of service providers** (relatives / volunteers / care providers / physicians / therapists / landlords)
  (Wolf-Ostermann et al. 2010, Pawletko 2006)

- **self-determined living within a group**
  (Burbaum 2001, Brinker-Meyendriesch 2006)

- **daily routine is “family-like”**
  (Reder 2004, Pawletko 2002)

- **connection to neighbourhood**

- **mostly “home-for-life“-principle**
  (Wolf-Ostermann 2011)
Background

1995: **first SHA in Berlin** (Pawletko 1996)

2003: **143 SHA** (Kremer-Preiß 2004)

2006: **200 SHA (160 SHA in Berlin)** (Brinker-Meyendriesch 2006)

2007: **230 SHA in Berlin** (Wolf-Ostermann 2010) → **ca. 1,000 residents**

2009: **331 SHA in Berlin** (Wolf-Ostermann 2011) → **ca. 2,000 residents**

2012: **465 SHA in Berlin** (Heimaufsicht Berlin) → **ca. 3,300 residents**

2014: **1,400 - 1,600 SHA** (Wolf-Ostermann 2012,KDA 2014)

2016: **3,902 SHA** (Wolf-Ostermann 2017) → **ca. 18,000 residents**
What do we know about SHA from research?

**expected(!) Outcomes:**

- prevention of relocation into institutional care arrangements
- better quality of life (QoL) of residents
- prevention: maintaining functional and cognitive resources, avoidance of apathy and depression
- less prescriptions of psychotropic drugs
- avoidance of «Burn-Out»-symptoms concerning professional staff
- less burden of care for family members / informal carers
Systematic review of literature: CareLit, CINAHL, GeroLit, PubMed

n = 109 identified publications, n = 47 (43.1%) being included regarding resident- and care-specific characteristics, residents’ related health outcomes, and setting-specific quality management systems.

Current state of research: Residents

- **on average 6-8 residents** per SHA

- **predominately female** and on average **80 years old**
  (Wolf-Ostermann et al. 2012, Steiner 2006)

- **residents with all degrees of dementia severity and care dependency**

- **passing away is the major reason for leaving the SHA**
  (Wolf-Ostermann et al. 2010)
Current state of research: provision with care

- **24/7-support common**

- **relation staff* – resident ca. 1:1 *(full time equivalent)**
  (Wolf-Ostermann et al. 2012)

- **some SHA do not employ qualified nursing staff/personnel**
  (Wolf-Ostermann et al. 2012)

- **greater number of staff, but less qualified nursing staff**
  (special qualification for gerontopsychiatric issues) compared to nursing homes (NH)
  (Wolf-Ostermann et al. 2011)

- **only few results about medical and therapeutical supply,**
  **NH: better supply concerning medical specialists**
  **SHA better supply concerning therapists** (Wulff et al. 2011)
Current state of research: Outcomes

- at moving-in residents of SHA show lower care dependency levels than residents of nursing homes (NH) (Steiner 2006)

- better nutritional status of residents in SHA compared to NH (Meyer et al. 2013)

- less neuro-psychiatric symptoms (depression, aggression) in SHA than in NH (Nordheim et al. 2011)

- prevalence of agitation/aggression (43.3 %), irritability (41.3 %), depression (34.6 %), apathy (34.6 %) (Wolf-Ostermann et al. 2013)
Current state of research: Outcomes

- quality of life (QoL) is on average moderate to high (67 of 100 points, Qualidem) (Wolf-Ostermann et al. 2013)

- no impact of staff-resident ratio on residents’ QoL → in line with results from Xu et al. in nursing homes

- progression of dementia results in decline of functional and cognitive abilities over time, no differences between SHA and NH
  (Wolf-Ostermann et al. 2012b)

- active involvement of relatives results in better QoL
  (Gräske et al. 2011)

- but: no greater involvement of relatives and volunteers in SHA compared to NH (Gräske et al. 2011)
Conclusion

SHA:

→ are no longer a niche in care but a regular service

→ are chosen consciously by residents and/or their relatives as an alternative to long-term care in nursing homes

→ are more and more specialised for care and support of PwD

→ have a relatively stable type of clientele over time

→ show an increasing percentage of residents staying until end of life
Conclusion

- results on health outcomes and QoL seem to back the assumption that living in SHA can be beneficial to PwD
- however, the results of the studies indicate no superiority over long-term care in NH in principle.
- setting-specific concepts for developing and evaluating quality of care and support are still missing widely
- currently only few scientific reliable data are available

→ SHA are one component in a multitude of different healthcare services which have to be tailored to personal demands
Thank you for your attention!

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