fortune Journals

Research Article

Support Issues for People with Mental Disorders in Group Homes in Japan

Noriko Yamada[1*], Yuriko Tanabe[1], Rie Tanaka[2], Kazumi Yajima[3]

Abstract

In Japan, group homes for people with mental disorders are accommodations affiliated with hospitals where residents can live relatively independent lives. However, the scope of their activities is limited to interactions with caretakers, hospital visits, and nearby shopping. Caretakers in such homes often provide insufficient care and commonly lack medical knowledge and skills to manage aging-related situations. Previous surveys conducted byYCU in 2008, 2013, and 2018 among the staff of a sample of such establishments in a major city revealed the challenges posed by residents' aging and the increasing severity of their mental and physical diseases. In the 10 years between 2008 and 2018, the percentage of residents aged 60 and older increased from 25.6% to 28.6%, those who could manage their medication independently decreased from 90.8% to 78.4%, while those needing to be accompanied to medical examinations increased from 7.4% to 15.6%. These results can be used as a basis for creating a model of support by nurses and for implementing improvements in the support system, including qualified mental health nurses who can advocate for the rights of persons with mental disabilities in the community.

Keywords: Group Homes; Japan; Mental Disorders.

Introduction

In Japan, assisted living services for people with mental disabilities (particularly patients with schizophrenia who can become highly agitated) are provided in alignment with various laws, including the Mental Health Welfare Law, the Law for Comprehensive Support for Persons with Disabilities, and the Long-Term Care Insurance Law for persons aged 65 and older. One measure used to provide assisted living services to people with mental disorders (i.e., schizophrenia and borderline personality disorder) is housing development. The development of communal living quarters, also known as group homes (GHs), for people with disabilities to live in the community was legislated in 1992 based on the government-subsidized community life assistance project for individuals with mental disabilities and revisions to the 1993 Mental Health Act. In Yokohama City, Kanagawa Prefecture, Japan, small welfare homes were established in 1990 before the legislation was enacted. By 2017, the number of GHs for people with mental disorders in Yokohama City had increased to 129. However, the policy of shifting from inpatient care to community life-centered care has been promoted since 2000, and GHs have become recipients of socially hospitalized patients from psychiatric hospitals. These patients can remain in these GHs indefinitely. Such GHs are usually affiliated with hospitals. Thus, although patients have been discharged from the hospital, they have merely been moved to a facility without medical staff, from where they still need to attend daycare at hospitals. Minimal interaction

Affiliation:

[1]Yokohama City University, Japan

[2]Sapporo City University, Japan

[3]Kanto Gakuin University, Japan

***Corresponding author:**
Noriko Yamada, 3-9 Fukuura, Kanazawa-ku, Yokohama City Yokohama City University School of Medicine Campus

Citation: Noriko Yamada, Yuriko Tanabe, Rie Tanaka, Kazumi Yajima. Support Issues for People with Mental Disorders in Group Homes in Japan. Journal of Psychiatry and Psychiatric Disorders. 8 (2024): 175-183.

Received: July 04, 2024
Accepted: July 12, 2024
Published: October 03, 2024

Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

occurs with the local community, and the perimeter of activities is limited to hospitals, GHs, and nearby shops. A consequence of the provision of such housing support is that people with mental disorders are aging without the ability to transition to single-person living, given the co-occurrence of physical illnesses over time and deteriorating physical functioning. This trend has evolved into a social problem as people with mental disorders who can lead independent lives age and require more intensive care, which places a continually increasing burden on the nursing staff.

In the second phase of its Plan for Persons with Disabilities, which began in 2009, Yokohama City established "responding to the aging and serious illness of persons with disabilities" as a priority measure [1] and reported several findings. In 2012, a GH for older adults with mental disorders was opened as a model project. This model project provides care and nursing services, including end-of-life (EOL) care, 24 hours a day and 365 days a year. A survey of GHs that collected data on residents' information, such as age, gender, physical illnesses, length of stay, level of care required, contact with family, and use of nursing care, reported that as the population aged, decreased physical functioning and mental disorders, makes it difficult for residents to live alone in GHs.

Until now, GHs for people with mental disorders have accommodated those who have maintained their independence in performing activities for daily living (ADLs). However, as the residents age, the demand for support with daily living and personal care increases. Therefore, maintaining sufficient support for people with mental disorders is difficult under the current staffing standards of corporate-run GHs (Type B), a welfare service that supports communal living for those with mental disorders.

In the third phase of the Yokohama City Plan for Persons with Disabilities from 2015 to 2020, strengthening the overall support system for GHs was promoted to assist the older adult population in continuing to live in their familiar communities as they age and prepare for the increasing severity of their disabilities.

In the fourth phase, from 2021 to 2026, it is necessary to develop GHs that meet the needs of users and their families, and a financial subsidy has been granted to support the renovation of buildings to make them more accessible, thereby addressing residents' declining physical functions. The expected standards for addressing further functional decline, providing EOL care, and establishing GHs that meet the needs of users and their families have not been defined. Corresponding support measures should be based on careful consideration of the needs of the mentally disabled and their caregivers about where they will spend their remaining time, their treatment plans, and how their wishes will be expressed, accepted, and fulfilled.

EOL support for people with mental disorders has made little progress in Japan. EOL care is practiced only marginally and informally out of the nursing staff's goodwill, as hospitals can no longer retain a terminally ill patient for whom treatment is no longer effective. GHs can only accommodate mentally impaired people who can manage themselves independently. This study thus aimed to collect data that will support the formulation of policies that ensure terminally ill people are supported through EOL care.

According to international literature, a person should not die because of a lack of knowledge about their prognosis [2, 3]. High treatment costs cannot be avoided [4], and many older people tend to die in hospitals [5]. Deaths in hospitals are correlated with being 65 years and older, as well as poor social circumstances such as a lack of acceptance of having a mental disorder [6]. Nursing homes are the second most common place where older people die [7], and as they age, they die without adequate treatment [8]. The prevalence of diabetes and kidney damage among people with mental disorders is high, and palliative care is required for chronic renal failure [9], heart disease [10], and end-stage chronic obstructive pulmonary disease [11]. Home-based palliative care team interventions have proven effective in enabling older people with disabilities to die where they wish [12]. However, the frequency with which palliative care has been provided to terminally ill older people with chronic non-cancer diseases admitted to acute care hospitals varies [13], with the most aged receiving even less adequate care [14].

However, in a web survey of Americans' Assessment of Care Provided in the U.S. Healthcare System (National Institutes of Health, 2018), participating health and welfare facilities surveyed found that most respondents had a positive perception of hospital emergency rooms (47%), followed by pharmaceutical companies (33%) and health insurance companies (31%), with nursing homes lagging behind (25%).

In the United Kingdom, guidelines have been developed to address the lack of professional collaboration [15, 16]. In the United States, people with mental illnesses with low life expectancy have a lower rate of hospitalization and a higher rate of nursing home admissions than those without mental illnesses. Furthermore, several of the studies reviewed in this study note that when people with mental disorders enter hospice, they often receive comparatively poor care. In Japan, previous research has shown that the premature death of people with mental disorders in the complications ward of psychiatric hospitals is frequently caused by inadequate palliative care for cancer, often provided in an inadequate environment.

Methods

Research Objectives

To clarify issues regarding aging and the increasing

fortune Journals
Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

severity of mental disorders among GH residents in Yokohama City and to help develop a support system, the Department of Psychiatric Nursing conducted surveys of in 2008, 2013, and 2018 on the actual conditions of these establishments. Since these surveys are conducted every five years, existing publicly available data were analyzed to clarify the aging status of residents, changes over time, and support issues. The purpose of this research is to create a support model based on historical data.

Study Sample

This survey covered staff at all 76 GHs and the Life Support Association members for the Mentally Handicapped in Yokohama City. To conduct a multifaceted evaluation, we invited staff members closest to the residents to participate. The resident survey was distributed to 639 residents in 69 facilities. Responses were received from 318 residents in 57 facilities (49.8% response rate) and 58 staff members.

Residents were asked about their current treatment plan, level of independence, and family connections. Staff were asked about the GH's capacity, type of work, number of volunteers, and the supports they provide. The 2018 survey asked five staff members at facilities where more than 60% of the residents were over age 65 about the actual supports they provide and the issues they face. There were variations in the survey questions and response items in each year's survey. Therefore, we decided to examine the issues based on comparable items.

Results

Respondent Demographics and Survey Results

Table 1 shows that in the 10 years between 2008 and 2018, the percentage of residents aged 60 and older increased from 25.6% to 28.6%. At the same time, residents' ability to administer their medication decreased from 90.8% to 78.4%. The percentage of residents who require a staff member to attend health checkups due to physical illness also increased from 7.4% to 15.6%.

Insufficient Caregivers and Staff Concerns Regarding Assistance

The GHs faced significant difficulties due to a lack of manpower, and the following concerns were reported:

“No nursing staff are available from 8:00 p.m. until 12:00 p.m. the next day, so there is no follow-up during that time.”

“As residents are getting older, the frequency of accompanying them for cancer, orthopedic surgery, internal medicine, and other psychiatric medical visits has increased.”

“Many of our residents are single and it is difficult for them to find an accompaniment to the hospital.”

“We had to hire additional staff due to insufficient human resources, which resulted in high personnel costs.”

“A resident once had an epileptic seizure and collapsed during the night when no staff was present, which made it difficult to respond to the emergency.”

Current Situation and Issues Related to Aging Residents

In previous surveys, the following opinions were expressed: People with mental disorders have lower physical function compared to citizens of the same age without disorders.

“Many group homes are old buildings that are not accessible, so people with whose physical abilities have deteriorated cannot get up and down the stairs. This [situation] makes it difficult for staff to provide aid and support.”

“The building does not have an elevator, so if the residents lose muscle strength in their legs, they cannot go to the daycare.”

“Since the group home is a rented house, it is difficult to install handrails without permission, and it is difficult to make home improvements, which limits residents' activities. In addition, residents said that “moving to an apartment is difficult due to lack of a guarantor.”

“They do not want to go to other facilities or nursing homes and they do not want to leave the group home they have become accustomed to. However, if the number of residents who need nursing care increases, the group home will not be able to handle it.”

“As the amount of nursing care required increases, its quality decreases, and the burden on staff increases even if nursing care insurance services are used,” one staff member said, expressing concerns about caring for aging people with mental disorders.

Thus, people with mental disorders deteriorate rapidly, and improving their environment is economically challenging.

Need for Additional Human Resources

The following categories were extracted from the 2018 survey regarding the aging-related physical condition of GH residents and the nursing care burden on GH staff.

“The residents are aging, and unqualified staff cannot handle the situation, so it is necessary to introduce nursing professionals."

“We need to increase the number of staff and improve the environment so that care can be provided 24 hours a day when people are bedridden due to aging.”

“We need to increase the number of staff and establish a system to provide care at night and early in the morning.”

“We need to assign personnel who understand the symptoms of mental illness.”

Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

Table 1: Common answer items and trends over 15 years

Year	2008	2013	2018	X^2
N	N=163	N=302	N=315	
Age				
Age range				0.517
20s	2(1.2)	15(5.0)	8(2.5)	
30s	26(15.9)	35(11.6)	28(8.9)	
40s	45(27.4)	94(31.1)	92(29.2)	
50s	48(29.3)	82(27.1)	93(29.5)	
60s	42(25.6)	62(20.5)	59(18.7)	
70s		14(4.6)	26(8.3)	
80s			5(1.6)	
No answer			4(1.3)	
Management of medications related to mental illness				
Medicine manager				1.119
Myself	148(90.8)		247(78.4)	
Staff	10(6.1)		56(17.8)	
Others	5(3.1)		11(3.5)	
Accompanying person when visiting a psychiatrist				
Someone to accompany you to your medical appointment				0.007
Myself (alone)	148(90.8)		254(80.6)	
Group home staff	12(7.4)		49(15.6)	
Family	5(3.1)		12(3.8)	
Others	7(4.3)		10(3.2)	
Physical illness (multiple answers)				
Physical disease name				
High blood pressure		25(8.3)	50(15.9)	
Diabetes	27(16.6)	33(10.9)	42(13.3)	
Respiratory disease	6(3.7)	34(11.3)	14(4.4)	
Liver disease	11(6.7)		12(3.8)	
Gastric/duodenal ulcer	5(3.1)	15(5.0)	12(3.8)	
Heart disease	9(5.5)	12(4.0)	11(3.5)	
Kidney disease	4(2.5)	16(5.3)	8(2.5)	
Others	32(19.6)	1(0.3)	51(16.2)	
Management of medicines related to physical diseases				
Medication management				
Myself	129(92.4)		240(76.2)	0.018
Staff	10(7.2)		48(15.2)	
Others	7(5.0)		11(3.5)	
Accompanying person when receiving information regarding physical illness				
Someone to accompany you to your medical appointment				
Myself (alone)	122(85.9)		233(74.0)	0.915
Group home staff	26(18.3)		57(18.1)	
Family	4(2.8)		12(3.8)	
Others	3(2.1)		6(1.9)	
Status of contact with family				
Yes	120(73.2)	239(79.1)	206(65.4)	
None	43(26.8)	63(20.9)	89(34.6)	

Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

“We need to assign nurses who can deal with both functional decline due to aging and physical illness and secure financial resources.”

“We need training to improve the skills and knowledge of the nursing staff.”

“We need to have reserve medical staff available for emergencies.”

Other pressing difficulties were also mentioned (see Table 2).

Table 2: Difficulties and challenges faced by facility staff as group home residents age

Category	Subcategory
Difficulties associated with aging residents	Physical function is declining
	It is interfering with life
	Unable to attend activities during the day
	Residents themselves feel anxious about the future
	Employees are confused by changes in mental symptoms
	Resident applicants are aging
Burden on staff	Care for mental disorders is increasing
	The frequency of accompanying patients to the hospital is increasing
	Nursing care is increasing
	Unable to delineate the scope of responsibility of the caretaker
	Employees are exhausted due to increased workload
	I don't have time to listen to what the residents have to say
Supporters, financial resources, service content, and facility functions are insufficient.	I'm worried about what to do if something happens
	Facility equipment and services cannot keep up
	System/additional charges are not worth it
	Repeated efforts to be unconventional
	Obtain cooperation from other organizations and professions

Discussion

The challenges associated with GHs in Japan have been summarized by Masuda and Izu [18] as follows: “Opening a group home for individuals with mental disabilities is challenging due to the high costs involved, the need to understand the local community, and the increased responsibility towards residents' self-determination, which can cause anxiety. Despite these difficulties, a group home offers disabled individuals a stable living environment. It is mandatory for group home staff to have caretakers; however, their roles are extensive and burdensome, resulting in a high turnover rate.” In a study on community living support in GHs for people with mental disabilities, Okuyama states that “it is necessary to reduce the sense of quantitative work burden and maintain employees’ mental health in a good state” [1].

In Japan, the fundamental structural reform of social welfare in 2000 promoted the marketization and privatization of welfare services. Consequently, maintaining GHs became the responsibility of non-governmental business operators. People with severe disabilities were able to use GHs, and the need for nursing and medical care arose. However, the work of caretakers is inaccurately evaluated, and their remuneration is incommensurate with their efforts. Private businesses have responded by enhancing efficiency by hiring part-time staff or assigning them to multiple communal residences adjacent to each other. However, staff retention rates are low. Securing human care resources is becoming increasingly difficult. An urgent need exists to review the system to rigorously evaluate the GH staff’s work to normalize users’ lives [19]. Additionally, a few of the problems encountered by older people with disabilities regarding EOL care are: “the older you get, the more limited treatment can be,” “it is difficult to seek the understanding and cooperation of family members,” and “facility staff lack knowledge about end of life and have difficulty dealing with it.”

Challenges in GHs for People with Mental Disabilities

As GH users age and their physical functions deteriorate, the most crucial goal is to improve their quality of life. Four types of care need to be comprehensively implemented: physical, mental, social, and spiritual. Physical care consists of (1) alleviation of physical pain, (2) care for physical symptoms, (3) care for a clean and healthy body, and (4) care for ADLs. Psychological care includes (1) alleviation of psychological distress, (2) care for emotions such as anxiety, fear, irritability, anger, and depression, and (3) support for a peaceful life. Social care comprises (1) reduction of social distress, (2) prevention of role loss within the family, and (3) support for relationships with family members and others. Spiritual care consists of (1) alleviation of spiritual suffering, (2) helping to experience the meaning of life and satisfaction with one's life, and (3) emotional care for acceptance of

fortune Journals
Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

death. Physical and mental care can improve the quality of life in people with mental disorders residing in GHs, and social and spiritual care can help them achieve a "life that is unique to them" [1]. However, the human resources available are insufficient to help them achieve these aims [20].

2018 survey of all GH staff in Yokohama City found that 65% had accompanied residents to hospitals due to physical illness, and 51% had provided EOL care to residents. At the time of admission to the psychiatric GHs, residents with mental disorders maintained their ability to live independently. However, over time, the progression of their illness and functional decline due to aging required hospital visits, disease management, ADL assistance, financial management assistance, and full-time supervision. With no overnight duty service, the GH staff could not continue to meet residents' individual needs. Some facilities were reluctant to accept new users even after seeking placement in assisted living facilities. This reluctance makes establishing a nighttime nursing system a critical issue. With the current system, GH staff do not require qualifications. We must consider whether people with mental disabilities require treatment and whether they should pay for long-term care insurance contracts to receive nursing or home care and their general welfare. Decision-making support for treatment choices for those with mental disabilities, including the use of systems, is inadequately covered. People with mental disabilities face difficulty in contracting for the treatment and services they need. To eliminate discrepancies in understanding and interpreting contractual acts for nursing care system utilization, sustained discussions with people with mental disorders are necessary.

Differences Between Group Homes for Older Adults and Those for People with Mental Disabilities

Schizophrenia was the most common mental illness, affecting approximately 80% of residents [21, 22]. Schizophrenia is characterized by slowed movement and prominent negative symptoms. The patients showing an early decline in ADL performance exhibited further functional decline as they deteriorated to a more advanced degree than expected for their age. Additionally, cognitive dysfunction was aggravated with age, requiring assistance in daily activities. The group home staff required knowledge about dementia in addition to mental disorders to care for the patients.

GHs for older adults and those specializing in care for people with mental disorders differed in the relationships between residents and their families. A survey conducted by Ikegami revealed that decision-making support that is considerate of people with dementia at EOL care requires cooperation between the person, their family, and healthcare professionals to determine family roles in decision-making practices and skills, family psychology and circumstances that affect the realization of the person's personality, and the adjustment of family influence [23]. However, family members rarely provide decision-making support to people with mental disorders.

Additionally, a survey on integrated care by in-home nursing and long-term care for older adults with dementia who require medical assistance and live in an environment similar to their home showed that "solving the issue of creating opportunities to adjust gaps in perception of collaboration requires forming a flexible team structure" [24].

Although studies were included in the literature review that compared the incidence of behavioral and psychological symptoms among older adults with dementia [25], many of them have been performed in GHs for people with dementia. Little research has been conducted on people with mental disorders living in GHs, and directly surveying a sample of this population is difficult because responding to questionnaires requires support from the staff [26]. We believe this issue was related to the lack of contact with family members willing to participate in a survey of GH residents.

Study implications

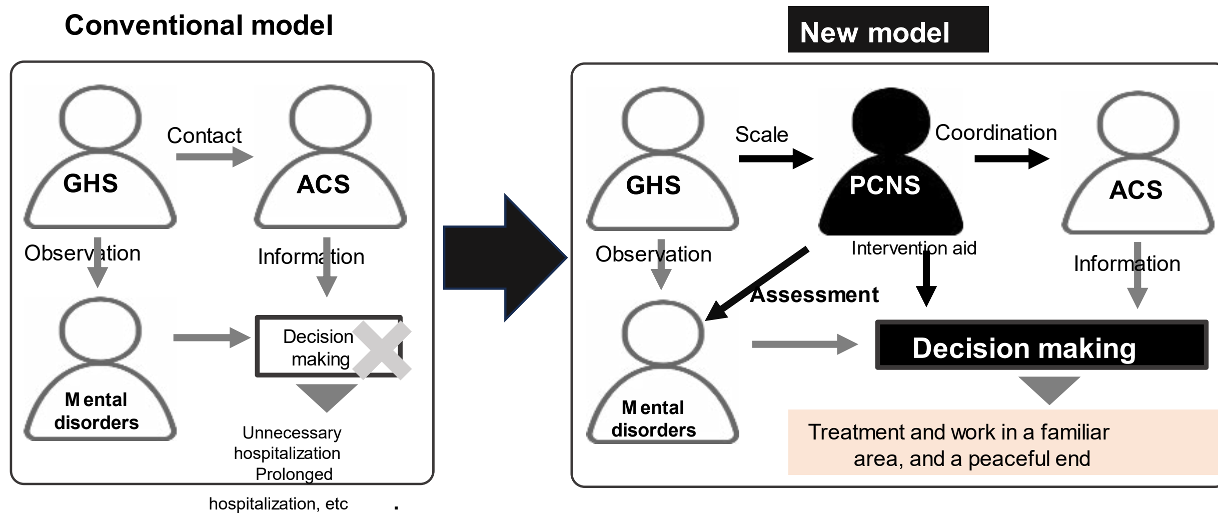
In this study, it was predicted that the intervention of advanced practice psychiatric nurses was a necessary human resource to understand the attributes, health status, and level of care of people with mental disorders residing in GHs and to support residents' independent living and decision-making. In April 2024, the revised version of the Mental Health Welfare Law will come into effect. Accordingly, we would like to create a system wherein psychiatric clinical nurse specialists can advocate for the rights of people with mental disorders and support their decision-making, not only in the wards, but also in the local community. Specifically, we will build a consultation model for personal custody and rights advocacy, financial management skills necessary for daily life, and support for continued employment.

Under current Japanese law, GHs for people with mental disorders can only accommodate people whose symptoms are controlled and who can live independently. Consequently, GH staff are often unlicensed caregiver. Many GHs for the mentally ill do not even have nurses with medical knowledge, making medical coordination increasingly difficult.

Residents of GHs in Yokohama City require hospital visits and nursing care, which is a burden for GH staff. Additionally, because the building is not barrier-free, no staff members are available at night, and the difficulty in medical coordination has increased over the years. This information can support the development of more effective measures to address the declining physical functioning of GH residents with mental disorders and implement protective measures.

The results of this survey will be used as a basis for addressing the aging of GH residents with mental disabilities in Yokohama City and as a resource for the city's welfare

Yamada N, et al., J Psychiatry Psychiatr Disord 2024
DOI:10.26502/jppd.2572-519X0224



Group home staff (GHS)
Provide daily care for mentally disabled people, such as feeding, toileting, and providing someone to talk to.
Anshin Center staff (ACS)
Assisting disabled and older people with diminished cognitive abilities with contract activities such as financial management and nursing care services.
Psychiatric Certified Nurse Specialist (PCNS)
Nursing personnel who have the knowledge, skills, and abilities to provide outstanding nursing care to people with mental dis abilities.

Figure 1: Conceptual model of a new support system for psychiatric certified nurse specialists

plan. The difficulties and challenges that GH staff face, as well as the residents' needs were identified from multiple perspectives. This information can support the development of more effective measures to address the declining physical functioning of GH residents with mental disorders and cope with the prospecting process.

We will implement the construction of a care model to protect the rights of people with mental disabilities and enable them to continue to live in the community through the intervention of advanced practice psychiatric nurses. The current model is shown in Fig. 1. The nursing staff is not involved in decision-making for mentally ill patients.

The diagram on the right shows how advanced practice psychiatric nurses can help people with mental disabilities make decisions based on their physical conditions and coordinate and collaborate with related organizations to support the community life of people with mental disabilities. This model has been proposed for support.

This study established that highly qualified psychiatric nurses are necessary as a human resource in GHs for people with mental disorders to ensure a proper understanding of the attributes, health status, and level of care needed for this population and to support the self-decision-making necessary to maintain residents' independent living in familiar communities.

Conclusion

The analysis of GH residents with mental disorders in Yokohama City indicates that their aging and increased need for hospital visits and nursing care places a burden on the staff. There is a general sense of increased difficulty in coordination among aging residents, staff, and hospital doctors because the old buildings lack mobility-assistance systems and accessibility to staff members at night; furthermore, the GHs' caretakers commonly do not have medical or nursing qualifications. People with mental disorders may find it difficult to inform their doctors about their physical ailments accurately. A staff member should accompany them to ensure the patient is appropriately examined and accurately diagnosed. However, logistical and administrative shortcomings make such communication and coordination difficult.

This study identified the multi-layered needs of GH residents and the challenges faced by the staff of these establishments. Its results will be used as a basis for Yokohama City's welfare plan to implement a better support system for all involved, considering the declining physical functioning associated with aging.

Acknowledgements

We want to thank the staff and residents of the group homes who participated in the survey.

Disclosure of interest

The authors report there are no competing interests to declare.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

Code availability: Not applicable.

Consent to participate

Informed consent was obtained from all individual participants included in the study.

Ethics approval

This study was approved by the Ethics Committee of Yokohama City University and was based on a literature review of previously published data. Care was taken to faithfully reproduce what was described.

Authors' contribution statements

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by Tanabe Yuriko, Yamada Noriko, Tanaka Rie and Yajima Kazumi. The first draft of the manuscript was written by Yamada Noruko and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding

The authors did not receive support from any organization for the submitted work.

References

1. Okuyama N. Research on community life support in group homes for the mentally disabled. Graduate School of Comprehensive Human Sciences 6563 (2013): 640-642.
2. Hunt KJ, Shlomo N, Addington-Hall J. End-of-life care and preferences for place of death among the oldest old: Results of a population-based survey using VOICES-short form. Journal of Palliative Medicine 17 (2014): 176-182.
3. Fleming J, Farquhar M, Brayne C, et al. Death and the oldest old: Attitudes and preferences for end-of-life care–qualitative research within a population-based cohort study. PLoS One 11 (2016): e0150686.
4. Chao LW, Pagan JA, Soldo BJ. End-of-life medical treatment choices: Do survival chances and out-of-pocket costs matter? Medical Decision Making 28 (2008): 511–523.
5. Perrels AJ, Fleming J, Zhao J, et al. Place of death and end-of-life transitions experienced by very old people with differing cognitive status: Retrospective analysis of a prospective population-based cohort aged 85 and over. Palliative Medicine 28 (2014) :220-233.
6. Pocock LV, Ives A, Pring A, et al. Factors associated with hospital deaths in the oldest old: A cross-sectional study. Age and Ageing 5 (2016): 372-376.
7. Bravell ME, Malmberg B, Berg S. End-of-life care in the oldest old. Palliative & Supportive Care 8 (2010): 335-344.
8. Gielen B, Remacle A, Mertens R. Patterns of health care use and expenditure during the last 6 months of life in Belgium: Differences between age categories in cancer and non-cancer patients. Health Policy (Amsterdam, Netherlands) 97 (2010): 53-61.
9. Pommer W. Das akute Nierenversagen bei älteren Patienten–entscheidend für die Gesamtmortalität? Deutsche Medizinische Wochenschrift 140 (2015): 250–255.
10. Chen HY, McManus DD, Saczynski JS, et al. Characteristics, treatment practices, and in-hospital outcomes of older adults hospitalized with acute myocardial infarction. Journal of the American Geriatrics Society 62 (2014):1451-1459.
11. Corsonello A, Scarlata S, Pedone C, et al. Treating COPD in older and oldest old patients. Current Pharmaceutical Design 21 (2015):1672-1689.
12. Sarmento VP, Higginson IJ, Ferreira PL, et al. Past trends and projections of hospital deaths to inform the integration of palliative care in one of the most ageing countries in the world. Palliative Medicine 30 (2016): 363-373.
13. Formiga F, Lopez-Soto A, Navarro M, et al. Hospital deaths of people aged 90 and over: End-of-life palliative care management. Gerontology 54 (2008): 148-152.
14. Abarshi E, Echteld MA, Van den Block L, et al. The oldest old and GP end-of-life care in the Dutch community: A nationwide study. Age and Ageing 39 (2010): 716-722.
15. National Institutes of Health (2018). National Healthcare Quality and Disparities Report (2022).
16. British Medical Association. Withholding and withdrawing life-prolonging medical treatment. Guidance for decision making. 2nd edition. London, England: BMJ Publishing Group (2001)
17. Withholding and withdrawing life-prolonging treatments: Good practice in decision making. London, England: General Medical Council (2002)
18. Masuda Y, Izu I. Literature review on the status of group homes for people with mental disabilities. Bulletin of Faculty of Nursing of Chukyo Gakuin University 5 (2015): 91-101.
19. Tsuchida M. Research on the group home system for people with disabilities. Bukkyo University Graduate School Bulletin, Graduate School of Social Welfare Edition 46 (2018): 99-115.

Yamada N, et al., J Psychiatry Psychiatric Disord 2024
DOI:10.26502/jppd.2572-519X0224

20. Endo M. Reflections on support activities at GH for the mentally disabled. Tottori Journal of Clinical Psychology 4 (2012): 81-86.

21. Ikebe T, Sato A, Sugawara M, Uchiyama S, et al. The unique support issues from the viewpoint of the establishment process of a residential facility for the mentally disabled. Yokohama Journal of Nursing Science 1 (2008):88-93.

22. Ikebe T, Uchiyama S, Otomo M. Aging of the group home for the mentally disabled and actual conditions of nursing care and end-of-life care. Bulletin of Chiba University of Science 9 (2016): 233-241.

23. Ikegami N. An exploratory study of a decision-making support model respecting the intention of the person with dementia in the terminal stage. Medicine and Society 33 (2023): 97-135.

24. Yokokura S. About community transition and community life support for elderly hospitalized mentally disabled people. Toyo Eiwa Graduate School Bulletin 16 (2020): 59-74.

25. Makimoto K, Kang Y, Kobayashi S, et al. Prevalence of behavioural and psychological symptoms of dementia in cognitively impaired elderly residents of long-term care facilities in East Asia: A cross-sectional study. Psychogeriatrics 19 (2019):171-180.

26. Matsushita T. Survey Report on the Current Status of Group Homes for the Mentally Disabled in Yokohama City. Yokohama City University Psychiatric nursing course (2018): 1-89.