Clients’ Perceptions of Discharge Housing Decisions After Stroke Rehabilitation

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Key Words: activities of daily living • decision making

Objective. The purpose of this research was to examine the perceptions of older persons with stroke concerning the discharge housing decisions made during their rehabilitation program. The research explored clients’ locus of control, their perceptions of the role of the rehabilitation team and their family in the decision, and their perceptions of their activities of daily living skills.

Method. Sixty-two subjects with stroke completed four measures: (a) the Functional Independence Measure (FIM), (b) a housing information questionnaire, (c) a semistructured interview, and (d) the Bialer Locus of Control Scale. Rehabilitation team members also completed the FIM and housing information questionnaire for each subject. These instruments were used to collect data relating to clients’ perceptions of their functional status, discharge from the hospital, housing options available, and locus of control.

Results. Despite the team or family opinions on discharge housing, subjects saw housing decisions as primarily their own. The majority of subjects were reluctant to consider alternatives to returning home, even though they have self-care deficits and frequently reported that the presence of a spouse and family members were important to support their return home. Subjects generally seemed unaware of the influence of team and family opinions and the impact of their functional status on their discharge housing. Subjects’ locus of control seemed unrelated to satisfaction with the discharge decision process.

Conclusion. Clients who have had a stroke could use assistance to determine housing that is appropriate for their living skills. Discussions with clinicians concerning accommodation options may lead to a smoother transition from the hospital to longer term housing for clients after stroke.

Despite functional gains made during rehabilitation after stroke, not all clients are able to return to their premorbid housing because of reduced self-care abilities. Appropriate housing ensures an environment where a person is supported yet as independent as possible, safe, and comfortable. Negotiating the best housing outcome for a client who has had a stroke is an important rehabilitation team (i.e., speech therapist, nurse, occupational therapist, social worker, physical therapist) function. These housing decisions can be achieved by matching the client’s level of functional ability with the demands of different housing environments. The types of housing available to older persons with a disabling condition range from independent liv-
ing in the community to nursing homes. Each type of housing offers different amounts of freedom of choice for life-style and physical assistance. A mismatch between a client’s housing and his or her values, habits, skills, and personality can lead to isolation, hardship, and unsatisfactory reliance on others (Coulton, Dunkle, Haug, Chow, & Vielhaber, 1989; Wilson & Calder, 1990).

Theoretically, discharge housing decisions can be made by clients themselves, their family members, health care team members, or any combination of these. However, the evidence suggests that older clients experiencing a wide range of health-related problems are not always involved in these decisions, and members of health care teams are the major decision makers (Deimling, Smerglia, & Barresi, 1990; Minichiello, 1987, 1990). In fact, older clients (aged 60 years and over) are often excluded from care-related decisions (Beisecker, 1988). In consideration of clinicians’ dominance in housing-related decisions, I have conducted two studies examining how teams formulate housing recommendations for older clients being discharged from a rehabilitation program after stroke (Unsworth & Thomas, 1993; Unsworth, Thomas, & Greenwood, 1995). The results indicated that the team focuses on factors such as a client’s activities of daily living (ADL) skills, mobility, social supports (both personal and community), motivation to return home, and choice of housing when making housing recommendations.

Although knowledge of clinician decision making adds to our understanding of the discharge housing process for clients who have had a stroke, we do not know how clients perceive the decision process or whether they are satisfied with their own involvement in the decision. Clients who believe that they have not been involved in the process, or are unaware of the factors that influence discharge decisions, may have difficulty in adjusting to and accepting the discharge housing recommended to them. Therefore, this study examined clients’ perceptions of housing decisions made at discharge, specifically their locus of control, perceptions of team involvement in the decision, perceptions of his or her ADL status, and perceptions of his or her family’s support and involvement in the decision.

Client Locus of Control

Locus of control is the extent to which persons believe that they have control over their lives. Persons with an internal locus of control often exhibit assertive behavior and potency over their environment, whereas persons with an external locus of control may believe that they are powerless to control life events (Lefcour, 1982). In different situations, either of these control typologies may be desirable and appropriate.

Coulton et al. (1989) examined the degree to which clients from many diagnostic groups exert control over their discharge and the relationship of this to locus of control and posthospital psychological distress. The authors found that lack of involvement in the discharge decision did not result in psychological distress for all clients. They suggested that a client’s reaction may depend on his or her expectations or locus of control. For example, perceived lack of control over discharge decisions was associated with psychological distress for clients with internal loci of control but not for clients with external loci of control. This study highlights the importance of the relationship between clients’ locus of control and satisfaction with their involvement in discharge housing decisions.

Client Perceptions of Team Involvement in Discharge Decisions

Research evidence suggests that health professionals are the primary decision makers regarding client discharge housing (Deimling et al., 1990; Minichiello, 1987, 1990). However, studies have not yet explored clients’ perceptions of the role of the team in decision making and their agreement with this involvement.

Client Perceptions of ADL Status

Although clinicians weigh factors, such as client mobility and personal ADL skills, heavily in their discharge plans (Unsworth & Thomas, 1993; Unsworth et al., 1995), it has yet to be established whether clients consider similar attributes when choosing their own discharge housing. Even if clients consider similar attributes, it is also unclear whether they perceive their abilities in relation to these attributes in the same way as members of the rehabilitation team do. There is some evidence to suggest that clinicians and clients do not always perceive the clients’ ADL skills in the same way. For example, Atwood, Holm, and James (1994) examined the relationship between clinician and resident ratings of functional skills with the Minimum Data Set for Nursing Home Residents (Morris et al., 1990). They reported that residents perceived themselves to be notably more capable of tasks such as locomotion, toileting, dressing, and personal hygiene than did their clinicians. Similarly, Edwards (1990) reported that clients on a geriatric assessment unit consistently rated their ADL performances on the Physical Self Maintenance and Instrumental ADL Scale (Lawton & Brody, 1969) higher than their therapists rated them. If clients and
clinicians disagree about ADL skill level, then clients may not be able to understand the rationale behind a team's housing recommendation, and negotiating suitable housing with the client may be difficult. Jongbloed and Morgan (1990) suggested that clinicians and clients discuss their various perceptions of the client's self-care abilities and that clinicians make explicit the close relationship between independence in ADL and their housing recommendations.

Client Perceptions of Family and Community Support and Family Involvement in the Housing Decision

Family and community support is of central importance in returning persons who have had a stroke to a community-living environment because of the effect of residual disabilities on the ability to manage daily routines (Friedland & McColl, 1987, 1989). The assistance or support required may range from minimal to extensive. For example, although one client may require a community volunteer to deliver meals, do the shopping, or provide help with cleaning tasks, another client may require assistance with these tasks and additional help with personal care tasks such as toileting, showering, and dressing. In some situations, a client may simply need a friend or relative to telephone regularly to ensure that he or she is managing and is safe. In all these cases, if appropriate support is available, the need for the client to enter institutional care is often postponed or prevented. However, in ascertaining the kind of support available, clinicians may spend more time explaining and exploring housing options with the clients' family than they do with the clients themselves (Abramson, 1984). The rehabilitation team needs to understand client's perceptions of their family's involvement in discharge housing decisions, their satisfaction with this involvement, and their perceptions of the importance of family support after a stroke.

With literature indicating that client involvement in discharge decisions may be minimal, the purpose of the current study was to examine the perceptions of clients with stroke concerning their discharge housing after rehabilitation, namely their housing preferences and outcomes and their reactions to and experiences of the discharge housing process. The study specifically explored the following: (a) the clients' locus of control and its impact on their satisfaction with involvement in the discharge decision process, (b) the clients' perceptions of team involvement in the decision, (c) the correlation between client and clinician perceptions of the clients' ADL abilities, and (d) the clients' perceptions of their team and family's involvement in the discharge decision.

Method

Subjects

Sixty-three clients who were consecutively admitted to three large rehabilitation centers in Victoria, Australia, were selected for the study on the basis of three criteria: (a) a new condition of cerebrovascular accident (CVA), International Classification of Diseases-9 codes 430–438 (World Health Organization, 1986); (b) aged 60 years or over; and (c) a rehabilitation period lasting longer than 6 days (indicating an appropriate rehabilitation admission). Of the 63 subjects, one died during inpatient rehabilitation, leaving a total of 62. The subjects were 32 women and 30 men between 60 years and 90 years of age, with a mean age of 75 years. Of the sample, 28 subjects had right CVA, 32 had left CVA, and 2 had brainstem CVA. Thirty-one subjects were married and 31 were single (never married, divorced, or widowed). Some subjects had language or cognitive deficits that limited their full participation. The mean subject length of stay (LOS) in rehabilitation was 57 days. This LOS is also typical in the United States, with studies citing a mean LOS of 64 days \((n = 113)\) (Oczkowski & Barreca, 1993) and 63 days \((n = 73)\) (Osberg, Haley, Ginnis, & Defong, 1990).

Instrument

Four measures were used in the study. The Functional Independence Measure (FIM) (Hamilton, Granger, Sherwin, Zielezny, & Tashman, 1987) was used to record the subject's functional status on discharge. This measure consists of 18 items covering the areas of locomotion, mobility, self-care, sphincter control, social cognition, and communication. Each item is scored on a 7-point scale ranging from completely independent (FIM Level 7) to total assistance (FIM Level 1). This standardized tool has been found to be both reliable and valid (Dodd, Martin, Srolov, & Deyo, 1993; Fricke, Unsworth, & Worrell, 1993; Hamilton, Laughlin, Fiedler, & Granger, 1994). For this study, the FIM data collected by the three participating hospitals as part of their rehabilitation protocol were used.

A second measure consisting of eight housing-specific functional items was designed for the study (see Appendix). These items included the subjects' instrumental ADL skills, general health status, social support, choice of housing, relatives' choice of housing, team's choice of housing, premorbid housing, and financial resources. Subjects were scored for these items on the 7-point scale used in the FIM. Four items on this measure required clinicians and subjects to nominate types of housing from a predetermined list of seven levels of independence.
dence: (a) high dependency, skilled nursing facility or nursing home; (b) low dependency, skilled nursing facility or nursing home; (c) assisted living retirement village or special-accommodation house or hostel; (d) retirement village or senior residence or living with a relative, foster family, or friend; (e) own home with social support such as Meals On Wheels, Visiting Nurse Association (VNA), Home Health Aid, or family members and friends; (f) own home with adaptive equipment; and (g) complete independence with no assistive devices or assistance from others.

The third measurement tool was a semistructured interview composed of 20 questions. The interview was designed to investigate the subjects' perceptions of their discharge housing options, their involvement in housing decisions, and the involvement of their family and rehabilitation team in these decisions.

The fourth tool was the Bialer Locus of Control Scale (Lefcourt, 1982), which was used to measure subjects' locus of control. The scale consists of 23 questions relating to subject perceptions of their control over life events, and responses were tallied to determine locus of control. Normative data are available for this tool (Lefcourt).

Procedure

During the final rehabilitation team meeting, the team members rated each subject on the FIM (routine procedure; measure 1) and on housing-specific items (measure 2). Between 1 day and 5 days before discharge, subjects were interviewed (measure 3), asked to rate themselves on the FIM (measure 1) and housing-specific items (measure 2), and asked to complete the Bialer Locus of Control Scale (measure 4). To assist subjects in their FIM ratings, a large chart was devised to show the 7-point scale. All subject interviews were conducted in one sitting and lasted between 10 min and 1 hr, with an average duration of 30 min. The interviews were recorded on audiotape. Three months after discharge, all subjects or their relatives were contacted by telephone to determine whether the subjects had moved or had remained in their discharge housing arrangement.

Data Analysis

Interview recordings were transcribed verbatim and loaded as on-line documents into a computer running the qualitative data analysis software package entitled Non-numerical Unstructured Data Indexing, Searching and Theorizing (Richards & Richards, 1987). Content of the interviews were coded with thematic procedures advocated by Minichiello, Atoni, Timewell, and Alexander (1990). The FIM scores, Bialer Locus of Control Scale scores, housing-specific item scores, and housing outcome levels (1 through 7) were entered into the Statistical Package for the Social Sciences (SPSS, 1990). These data were subjected to univariate inferential statistics and non-parametric techniques, such as cross tabulations.

Results

Of the 62 subjects, 2 died just before the 3-month follow-up. All calculations, except those relating to follow-up, include data from these two subjects.

The rehabilitation team completed FIM (measure 1) and housing-specific data (measure 2) for all 62 subjects. Thirty-six of the subjects completed all four measures, and 15 subjects completed all measures except the Bialer Locus of Control Scale. Eight subjects did not complete any of the measures because they did not have English language skills, or they had no means of reliable communication as judged by the treating speech therapist. Additionally, three subjects declined to participate in the study when they were approached to be interviewed and sign consent forms.

Subjects’ Housing Preferences and Outcomes

Of the 51 subjects who were able to express a housing preference (measure 2), 42 (82%) elected to be discharged home with family or community support (Level 5 housing), adaptive equipment (Level 6 housing), or complete independence (Level 7 housing). Six subjects chose to move to a more supported form of housing than they had lived in before their hospitalization, and three chose to return to their premorbid-supported housing. Although three subjects believed that they could manage at home without support, none of the subjects were discharged without some support (e.g., delivered meals, house cleaning assistance, or a friend or family member calling in regularly to ensure that they were safe).

Of the 49 subjects who had a definitive housing outcome (a community placement rather than discharge to an acute medical facility) and who had been able to express a preference, 40 (82%) were discharged to their preferred form of housing. A Pearson product–moment correlation indicated that the relationship between subject choice of housing and housing outcome was \( r = .6 \), a moderate correlation.

The interview transcripts consistently reinforced the subjects’ wish to return to their premorbid homes (generally community-based housing), for example:

Interviewer: The first thing I wanted to ask you is...where are you going to when you leave here?
Two subjects stated that although they were pleased to be returning home, they felt somewhat anxious about the prospect of managing their daily tasks with residual physical disabilities. Four subjects expressed a desire to enter supported housing, one of whom returned home to the flat (apartment) she had previously lived in after spending only 2 months in a hostel (supported group living). Although 11 (22%) of the 51 subjects interviewed conceded that supported housing might be required either in the immediate or distant future, 21 (41%) clearly stated that they would never consider nursing home placement.

When the subjects' discharge housing was compared with their residence at 3 months follow-up, 53 (88%) of the 60 surviving subjects were found to have remained in the same housing. Seven subjects had moved — 2 from a long-term rehabilitation facility to their homes, 2 to more independent housing, and 3 to more dependent housing.

**Relationship Between the Subject Housing and the Team Housing Recommendation**

Thirty-three (67%) of the 49 subjects who had a definitive housing outcome chose the same housing that members of the rehabilitation team recommended, 13 (27%) chose a more independent form of housing, and 3 (6%) chose a less independent form of housing.

The rehabilitation team's housing recommendations had a large impact on actual discharge housing. A cross tabulation of team housing recommendations and actual place of subject discharge indicated that for 53 subjects (85%), the Pearson correlation coefficient was $r = .70$. Of the nine subjects who did not follow the rehabilitation team's recommendation, three were discharged to hostels (Level 3 housing) despite the team's recommendation of home with supports (Level 5 housing). Three months after discharge, only one of these subjects had returned home with supports. Six of the subjects were discharged to less supported forms of housing than that recommended by the team, but at 3 months follow-up, two of these subjects had moved to more supported forms of housing. This finding supports what rehabilitation clinicians intuitively know; that clients with stroke may not follow a rehabilitation team's housing recommendation until they find out for themselves that they cannot manage at home.

Cross tabulations were also performed between the subjects' actual place of discharge and their premorbid housing and follow-up housing (see Tables 1 and 2). The findings indicate that the subjects generally were discharged to more supported forms of housing than they had resided in before their stroke but that they had been able to remain in their discharge accommodation for at least 3 months.

**Subject Reactions to and Experiences of the Discharge Housing Decision Process**

Subject perceptions of who should make housing decisions and the impact of locus of control on subject satisfaction with decision involvement. Of the 46 subjects who answered the interview question relating to who should make discharge housing decisions when a person leaves the hospital after stroke, 25 (54%) believed that they alone should make housing decisions, 7 (15%) stated that they should make such a decision with their spouse and family, and 6 (13%) stated that the decision should be a compromise between their choice and the wishes of their family and rehabilitation team. Only 3 (7%) subjects believed that rehabilitation professionals should make the discharge housing decision, for example:

**Scores on the Bialer Locus of Control Scale**

Scores on the Bialer Locus of Control Scale ranged from 7 to 18, with the mean, median, and mode at 14 ($\mu = 36$). This distribution of scores suggests that subjects' locus of control tended to be more external than internal. This mean is slightly lower than the mean of 15 obtained for white, middle-class subjects, as outlined in the normative data for this tool, and considerably lower than the mean of 18 that Lefcourt (1982) reported for white men. Subject satisfaction with the discharge housing decision process was not formally measured; however, subjects' comments in relation to their discharges were compared with their locus of control scores. Although 15 subjects...
obtained scores on the Bialer Locus of Control Scale questionnaire that would suggest an external locus of control (a score of 13 or lower), most of these subjects believed that they should be involved in all aspects of their discharge and expressed some dissatisfaction if they had not been involved. Hence, subject satisfaction with involvement in the discharge process did not appear to be directly linked to locus of control.

Subject perceptions of team involvement in the housing decision. When asked to comment on their perceptions of where the rehabilitation team thought they should live, 18 (35%) of the 51 subjects interviewed stated that the team had had little to do with their housing decision, and 14 (27%) explained that they had not discussed their discharge housing arrangements with members of the team at all. Several of these subjects added that the rehabilitation team seemed supportive of their decision to return home. Three subjects reported that they had no idea where they would be discharged to and that no one from the hospital had discussed their discharge with them. When subjects were asked to name where they believed the rehabilitation team thought they should live and why a particular recommendation had been made, few subjects could formulate an answer. However, 8 subjects said that their ability to conduct self-care activities influenced their clinicians’ opinions of suitable housing; 2 subjects said that they were walking well and therefore could return home; and 2 subjects, who had been advised by members of their team not to return home, commented on the clinicians’ fears that they could fall and hurt themselves, for example:

Interviewer: Why do you think the staff want you to go to the special accommodation, why do you think they have said that you can’t go home?
Subject 2: I don’t think I am capable enough, I don’t think.
Interviewer: In what way...
Subject 2: Well, they said, “You might fall over and break your hip, and your husband couldn’t pick you up,” and my husband is only a little bloke, he is as wiry as anything, he would pick me up alright! As a fact you have only got to get on to the doctor. Our doctor would be there in 5 minutes because he is not very far; if he was busy, he would send one of the others.
Interviewer: Right. So the staff here think that you might hurt yourself if you go home?
Subject 2: Yes.
Interviewer: That means that you would be taking a risk if you went home, doesn’t it?
Subject 2: Oh, it does.
Interviewer: Are you allowed to take that risk...
Subject 2: You are not allowed to take that risk.

Few subjects commented on the trial home leave periods that clinicians evaluate when formulating a housing recommendation. Despite describing “unsuccessful” home visits during the interview, some subjects persisted in the belief that they could manage at home.

Subject and team perceptions of ADL skills. In general, the subjects seemed to underestimate the influence that self-care abilities had on their returning home. However, subjects and teams usually agreed on the level of daily living skills, communication skills, and cognitive skills as measured on the FIM. The Pearson correlation coefficients calculated for the ratings collected on the FIM and housing-specific item measure ranged from .38 to .99. These coefficients were transformed with the Fisher’s z test to yield a mean correlation coefficient of .82 (p < .001). This correlation coefficient suggests a strong relationship between subject and team perceptions of ADL skills.

To determine whether there was greater agreement regarding functional status for subjects returning home
compared with those subjects who were not, further analyses were performed with these correlational data. A Student’s paired \( t \) test for independent groups revealed no differences in agreement concerning skill level among the ratings of the 37 subjects who returned home and their team’s ratings \( (Mr = .83) \) and the ratings of the 12 subjects who did not return home and their team’s ratings \( (Mr = .82) \); \( k = -59 \) \((p = .5578)\). However, of the seven correlations between clinician’s perceptions and subject’s perceptions of functional status that fell below .65, five were for subjects and clinicians who also disagreed on appropriate discharge housing.

Subject perceptions of family involvement in the housing decision. During the interview, subjects were asked where they thought their spouse or relatives wanted them to live and about the role that family members played in their discharge. Thirty-four (67%) of the 51 subjects interviewed, including those with and those without supports, discussed the importance of a spouse, family members, neighbors, and friends in facilitating a home discharge, for example:

Subject 53: If you were alone, well, that makes a difference.
Interviewer: ...how does that make a difference if you are alone?
Subject 53: Well, you have got nothing, you have got nobody that cares about you...You have got no wife, you have got no daughter, no son, so you would be alone in the world.
Interviewer: So then would you be more likely to go to a nursing home [if you couldn’t care for yourself]?
Subject 53: Oh, of course, 100%, you would go to a nursing home.... Somebody else has decided for you if you have got no family.

Twelve (25%) subjects mentioned the need for services such as Meals On Wheels, house cleaning services, and the VNA to assist them in residing at home. The availability of social supports seemed an important factor not only for the subjects but also for members of the rehabilitation team when considering appropriate housing. For example, for 11 (18%) of the entire 62-subject sample, the team recommended the most appropriate housing option as being either nursing home (Level 1 or Level 2 housing) or home with supports (Level 5 housing), with the determining factor being the number, level, and type of supports available to the subject. These subjects were not sufficiently independent to manage at Level 3 or Level 4 housing.

Twenty (54%) of the 37 subjects who were to be discharged home stated that their families were supportive of their return, provided that the subjects were able to “manage.” Subjects generally perceived this ability to manage as the ability to walk and to be mentally aware. Seven (19%) subjects explained that their family members did not want to be burdened by caring for an elderly relative and discussed their own reluctance to burden their family.

Only nine of the subjects who were interviewed were not discharged home. When asked what their family members thought of their discharge housing, four subjects said that their family members believed that they would be safe in a supported environment. One subject, who was eventually discharged home, discussed her struggle with relatives who wanted her to enter supported housing and who she thought had interfered unnecessarily in the housing decision:

Subject 32: See I’m in a [flat]. They say a retirement village would be good.
Interviewer: Who suggested the retirement village?
Subject 32: Oh, you know, cousins and so on; they are only young and they try to put you out to pasture sort of business, and I’m not ready for that. I’ll go on as long as I can please God.
Interviewer: ...is that because home is the best place?
Subject 32: Yes, of course, you’ve got your own things and privacy...
Interviewer: ...so...are [your family members] trying to put you in an [older persons’] home...
Subject 32: Yes, they can’t understand why I want to live in a unit, and they irritate me. I am not a fool, I might act like one sometimes, but I still have an opinion of my own... Until that goes from me, well, they can do what they like with me till then, but at the time, I’ll live in my own place, please God...

Although subjects perceived their families’ role in their housing decision as fairly minimal, most subjects’ relatives were involved in discharge plans as evidenced by their attendance at discharge planning family meetings that were held for 42 of the subjects. Topics discussed at these meetings included housing options, family perceptions of the subject’s ability to manage, and how much support the family members would be able to offer on discharge. However, only eight subjects attended any part of these meetings; the others were excluded or unaware that such meetings had been held. Several others seemed unconcerned at being excluded, possibly because they were to return home anyway.

Other evidence of the influence of a spouse, family members, or both in subject discharge plans emerged from the data. Cross tabulations were performed between subject’s choice of housing and marital status and between team housing recommendation and subject’s marital status to determine the extent to which spousal support influenced both subject and clinician perceptions of suitable housing (see Table 3). These cross tabulations revealed that all 27 married subjects who were interviewed, but only 18 (75%) of the 24 single subjects, elected to return to community-based housing. Only 4 (13%) of the 31 married subjects, but 12 (41%) of the 29 single subjects, were rec-
ommended by rehabilitation teams to be discharged to supported housing (Levels 1, 2, and 3).

To investigate this result further, independent t tests were conducted to establish whether married and single subjects differed in relation to other variables that might account for these differences in housing choices and recommendations. It was found that the married and single subjects did not differ in age, t(58) = −.13 (p = .8136); length of rehabilitation stay, t(58) = .08 (p = .9343); or FIM and housing-specific item score, t(58) = .11 (p = .9098). However, married and single subjects differed significantly in their premorbid housing, t(58) = 2.47 (p = .0166); the type of housing recommended to them by members of their rehabilitation team, t(58) = 3.02 (p = .0038); and the type of housing they chose for themselves, t(49) = 2.05 (p = .0458). Although the mean premorbid accommodation for married subjects was Level 6 (independent with aids), for single subjects it was Level 5 (home with supports). A similar trend was found in the team recommendations. Married clients tended to be recommended to Level 5 housing, but their unmarried counterparts were more likely to be recommended to Level 4 or 3 housing (retirement village or move in with relatives, or special-accommodation house or hostel accommodation).

Discussion

Of the 60 subjects (excluding the 2 subjects who were discharged to other hospitals), 47 (78%) were able to return to their premorbid housing after rehabilitation, whereas 13 (22%) entered supported housing for the first time. In general, subjects seemed unaware of the range of housing options open to them and the ADL skills required to reside in the different types of housing. For example, although clinicians routinely explained the housing entry criteria, only one subject commented on the need to be mobile and continent to reside in a hostel. Several of the subjects who were not returning home expressed dissatisfaction with the discharge process and stated that they had been excluded from the housing decision. These subjects also appeared to have a limited understanding of how their stroke had affected their physical functioning and self-care abilities (as indicated by comparing their FIM scores with their teams members' FIM scores). This finding suggests that rehabilitation professionals, such as occupational therapists, may need more time with clients to discuss the implications of the clients' disabilities on their discharge housing options. Occupational therapists could also enhance clients' perceptions of the value of their treatments by elucidating the links between ADL skills and independent living (Jongbloed & Morgan, 1990). Although the subjects seemed to underestimate the relationship between independence in ADL and ability to return home, they generally agreed with their clinicians concerning their current ADL skill level. This finding was not consistent with the findings of Atwood et al. (1994) or Edwards (1990) that clients often rate themselves as more skilled than do the clinicians.

The finding that subjects generally viewed the discharge housing decision as their's alone, and perceived the rehabilitation team's and their family's involvement to have been minimal, may have been promoted by two factors. First, because the team and family members did not suggest any alternatives to returning home to the majority of subjects, there was no reason for these subjects to question what the team or family thought of their discharge housing. True examination of decision power is only possible when the subject, family, and team are all in disagreement over the most suitable type of discharge housing. Second, 86% of subjects did not attend their family decision-making meeting; therefore, they may have underestimated their team and family members' involvement in a range of discharge-related decisions. The fact that so few subjects were included in these decision-making meetings is also of considerable concern. Involving clients in the discharge decision-making process is desirable because it is believed to enhance their perceptions of control that may in turn increase satisfaction with the decision outcome (Coulton, Dunkle, Chow, Haug, & Vielhaber, 1988).

Despite subject perceptions of limited involvement, clinicians and members of the subjects' families appeared to be influential in the subjects' discharge. Eighty-five percent of the teams housing recommendations were enacted at discharge. This finding supports research that identifies health care professionals and teams as guiding most dis-

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<th>Table 3</th>
<th>Cross Tabulation of Team Housing Recommendations Versus Subject Choice of Housing and Marital Status</th>
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<td>Housing Level</td>
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Note: Housing levels: 7 = home; 6 = home with aids; 5 = home with supports; 4 = other home; 3 = hostel or special-accommodation house; 2 = nursing home, low dependency; 1 = nursing home, high dependency.

\[ n = 60 \text{ for Married, } n = 51 \text{ for Single]
charge decisions (Deimling et al., 1990; Minichiello, 1987; Volland, 1988). Further research is required to investigate more fully the role of the spouse and family members in discharge housing decisions for clients after stroke.

Although family input to the housing decision was not always obvious to the subjects, the need for social support to return home was. Rehabilitation teams and married subjects were more likely to choose community-based housing, whereas teams and single subjects chose supported housing. This finding reflects not only the assistance that a spouse can offer after stroke, but also the extreme reluctance for partners to be separated. This housing trend was also identified in subjects' premorbid living arrangements. Therefore, the choice and selection of housing for single versus married subjects seems related to social support for all older persons, not just those with disabilities (Friedland & McColl, 1989).

Given that the subjects' marital status appeared to have a considerable effect on discharge housing, clinicians should pay special attention to this variable to avoid possible discrimination of single clients who choose and have the functional capacity to return home.

Limitation
This study did not adopt formal measures to examine the relationship between subject locus of control and satisfaction in the discharge housing decision. Although it appeared that a relationship did not exist between these factors, quantitative measures of subject satisfaction are required in future studies. Another limitation of this study was the small number of subjects who did not return home. The perspectives of persons who are not returning home after stroke rehabilitation may assist rehabilitation teams in providing a smooth transition from hospital to long-term-care environments.

Conclusion
This study examined the perceptions of 62 subjects with stroke concerning their discharge housing arrangements after rehabilitation. After stroke, residual disabilities may limit the number of environments in which a client can successfully interact. The decision to return home, move in with relatives, or enter supported housing requires major life adjustments and, therefore, is of considerable importance during the client's rehabilitation. This research suggests that although clients believe that they are fully involved in discharge decisions, this may not be the case. To facilitate the discharge process, I advocate that occupational therapists work with clients to make the relationship between functional abilities and housing arrangements more explicit and that the members of the rehabilitation team involve clients fully in family and team decision-making meetings.

Acknowledgments
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Appendix
Items Rated on the Functional Independence Measure (FIM) and Housing-Specific Assessment With the FIM 7-Point Rating Scale

<table>
<thead>
<tr>
<th>FIM Items</th>
<th>Housing-Specific Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locomotion</td>
<td>Instrumental ADL skills</td>
</tr>
<tr>
<td>1. Stairs</td>
<td>General health</td>
</tr>
<tr>
<td>2. Locomotion</td>
<td>Social support</td>
</tr>
<tr>
<td>Mobility</td>
<td>Subject's choice of housing</td>
</tr>
<tr>
<td>3. Bed transfers</td>
<td>Relatives' choice of housing</td>
</tr>
<tr>
<td>4. Toilet transfers</td>
<td>Team choice of housing</td>
</tr>
<tr>
<td>5. Bath transfers</td>
<td>Premorbid housing</td>
</tr>
<tr>
<td>Social cognition</td>
<td>Financial resources</td>
</tr>
<tr>
<td>6. Social interaction</td>
<td></td>
</tr>
</tbody>
</table>
FIM Rating Scale

No helper
7. Complete independence
6. Modified independence (use of adaptive equipment)

Helper
5. Supervision or setup
4. Minimal contact assistance
3. Moderate assistance
2. Maximal assistance
1. Total assistance/dependence

Note. ADL = activities of daily living

References


