

Supported accommodation for people with severe mental illness: an update

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SUMMARY

Appropriate housing and support are essential elements in the care of many people with mental health problems, and housing has a major impact on the quality of their lives. In the post-deinstitutionalised services of most high-income countries, a complex range of supported accommodation is available, mostly in the private (for-profit and not-for-profit) sector. We describe the different forms of accommodation and consider recent trends in policy and practice and the evidence base in this area. We also discuss quality issues and the potential impact of the recovery movement.

DECLARATION OF INTEREST

None.

In England, the process of hospital closure and deinstitutionalisation is effectively complete. One survey showed that in most parts of the UK, rehabilitation services continue to provide short- to medium-term 24-hour nursed care units supporting new long-stay patients (Killaspy 2005). Outcomes for previous long-stay patients moved into community placements have generally improved; they are more satisfied, have better social functioning and costs are no greater than those in hospital – in many cases they are rather less (Trieman 2002; Thornicroft 2005). Asylums have been replaced by a complex network of community services, including a ‘virtual asylum’ of residential and nursing home provision (Holloway 2008).

Reinstitutionalisation

A study in nine European countries by Priebe *et al* (2008) showed that between 2002 and 2006 the number of conventional psychiatric beds fell, but that there was an increase in forensic beds, places in supervised and supported accommodation and in prisons in most countries, including England. This development has been termed reinstitutionalisation, but it is important to note that the new sheltered and supported housing developments are not ‘institutional’ in character

and prison populations are not characterised by the same types of problems that would have taken them to hospital. Although there is some overlap between patients in secure and semi-secure hospitals and those who might have been in mainstream hospitals, the diagnostic profile of those with mental illness in the prison system is different – less than 10% have psychosis and there are high rates of personality disorder, low levels of literacy and more frequent problems of drug and alcohol misuse (Singleton 1998). Thus, although it is possible that there may have been some reinstitutionalisation of people with mental health problems from ‘open’ hospitals to secure and semi-secure settings, it is unlikely that there has been much reinstitutionalisation back to prison.

In their survey, Priebe *et al* (2008) found that increases in supervised and supported housing were not explained by changes in morbidity or prevalence rates of severe mental illness. They suggested that changes in family structures that resulted in the loss of extended support to those with mental ill health may be a factor, or that concepts of mental illness may have broadened, so that people with conditions such as personality disorder may have become more eligible to receive support services. Alternatively, as part of a business model, private providers may have effectively widened their market share in providing for this form of institutional care (Priebe 2005).

Changes in service provision

Another study compared models of community care for 4500 older adults in 11 European countries (Carpenter 2004), finding that social and cultural factors were key in determining whether informal family support or state-provided support was widely used. The highest levels of state care provision were found in the UK. In Northern Europe, people receiving care were less likely to have impaired activities of daily living. Italy had the lowest level of state care provision and people receiving care in France and Italy had higher physical and cognitive needs.

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Changing attitudes to risk may also be in part responsible for changes in service provision, although careful research has tended to show that there is no evidence of greater rates of serious violence by those with severe mental illness living in the community (Shaw 1999). There is, however, evidence of growth in secure psychiatric services in England over the past decades. Between 1994 and 2003, the number of National Health Service (NHS) secure beds rose from 1080 to 2560, and over a similar period, private/third-sector (charitable) psychiatric hospital beds increased in number from 48 000 to 98 000 (Department of Health 2003), with formal admissions increasing from 600 to 1400 per year within this sector. These changes have led to concerns regarding the costs of secure hospital care in private and third-sector hospitals, the geographical separation of these vulnerable patients from their homes, families and community backgrounds, the quality of the care provided and the availability of links to base services for monitoring and return of the patients (Ryan 2006).

Despite apparent growth in services over the past decade, there still seems to be a shortage of appropriate residential places, at least in some areas, particularly for those with the most severe and enduring problems. A study of hospital services in Birmingham, UK, showed that long-stay (more than 6 months) patients were consistently found to occupy 20% of acute beds (Commander 2008). The authors noted that where staff made recommendations for community placements, 'by far the majority' required 24-hour care, suggesting a need to improve access to this sort of provision. Killaspy *et al*'s (2005) survey of English rehabilitation services showed that despite closures of nearly all the long-stay hospitals and wards, most areas still had active rehabilitation units available to help people with complex, treatment-resistant illness. In 93 local authority regions, most (77%) had short-term (up to 12 months) rehabilitation units, with an average 13 beds. Urban areas were no more likely to have rehabilitation units than rural areas. About half of the services surveyed had longer-term facilities. It appears that although services are available in most areas, the level of provision may not meet the need at this time.

The impact of community mental health service developments

In response to the National Service Framework for Mental Health in England (Department of Health 1999), there has been a significant development over the past decade of a range of

specialist 'functional' community-based teams, which has led to a redefinition of the boundaries of community care. Service users who in the past may have spent long periods in hospital are now being supported in the community. Early intervention teams provide intensive support early in the illness history, aiming to prevent development of disability. Service users who are difficult to engage receive intensive, assertive outreach support, and those in crisis may be given home-based treatment, often avoiding hospital admission even in acute illness episodes.

Despite these new approaches to community care, there continues to be a group of people with severe mental illness such as schizophrenia and bipolar disorder who are not able to cope with community living without substantial practical and emotional support. The development of new, largely private forms of supported accommodation in a mixed economy of care has therefore necessitated partnership working between mental health services and private housing providers. The limited research into partnership working and the evidence of the impact of these changes on service users will be considered later.

The impact of the recovery movement

Anthony (1993) has argued that, in the past, mental health systems were based on the belief that people with severe mental illness do not recover. We now know that this is not true in terms of clinical recovery (Warner 2009). Since the 1990s, the recovery movement has extended its influence from consumer groups, through professional groups, to influence national policy in most high-income countries. In recovery-based practice, mental health professionals focus on the individual and their experience, recognising their strengths and resources. Service users are considered 'experts by experience'. Emphasis is placed on the importance of their own efforts to control their illness and on their right to seek goals that they value rather than those favoured by professionals and carers, which might reflect lower expectations (Shepherd 2008). Nevertheless, a recovery orientation is consistent with the use of medical treatment approaches. An interesting study by Dinniss *et al* (2007) used the Developing Recovery-Enhancing Environments Measures (DREEM) to develop recovery-based practice in a 14-bed rehabilitation ward in England, through staff-service user collaboration.

A recovery-based mental health service promotes re-engagement in work and social activity (Roberts 2006) as part of building a satisfying life beyond illness. True social integration through

involvement in the ordinary social structures of life – employment, social networks, community activities – are just as important, if not more important, for people with serious mental health problems as they are for the general public. Non-statutory accommodation providers may be well placed to work in a recovery-oriented way with service users, who may have experienced control, enforced treatment and a reductive approach to their problems in poorly functioning community mental health teams. The ideas of the recovery movement are increasingly shaping statutory mental health services, for example, in policy papers by the Care Services Improvement Partnership *et al* (2007) and the Sainsbury Centre for Mental Health (Shepherd 2010).

Forms of supported accommodation

The Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry has produced a template for rehabilitation services, which specifies definitions and core components of a rehabilitation service and has a detailed section on the range of accommodation which should be available in each locality (Wolfson 2009). In presenting a recent national survey of housing services for people with mental disorders, Priebe *et al* (2009) provided a useful summary of the different supported accommodation that may be found in a locality.

- Longer-term high-dependency in-patient care is increasingly available within the private sector and may not necessarily be provided within the service user's locality.
- Nursing/residential care – 24-hour staffed care provided to individuals in a communal setting, with a greater proportion of qualified nursing staff in nursing homes *v.* residential care homes. The term hostel is rarely used these days as it is imprecise and tends to suggest supported housing, which includes all forms of supported tenancies with staff (usually unqualified) on-site (i.e. group homes, hostels and supported flats).
- Floating outreach – where support is not tied to a specific building but provided with flexible intensity to individuals with a shared or individual tenancy. These may include core and cluster supported flats, which provide core communal facilities and staff support to a cluster of service users housed in flats in a complex or within an area.
- Adult placements – a type of adult foster care (the number of such placements is very small).

In practice, the range of accommodation seems to depend on many factors, including whether

charitable organisations or major private providers have been active locally and the focus of the local Social Services department. Essentially, the way services were provided following the asylum closure programme tends to determine what is now available, and there is substantial variation. It is important to note the advantages to the service user of having a tenancy (e.g. supported housing where staff are on-site or tenancies supported by floating outreach services) compared with not having one (e.g. nursing/residential care). Having a tenancy provides security and opportunities for the tenant to make decorative and other housing improvements.

The impact on service users' welfare benefits is also worthy of mention. Some supported accommodations previously registered as residential care are changing their registration status to supported housing (without changing the level of support provided) to ensure their tenants are not disadvantaged in terms of the benefits they are eligible for. Financial considerations can act as a powerful incentive to clients accepting such placements in the short and longer term. It is worth describing two types of supported accommodation in more detail.

Twenty-four-hour nursed care units

These units have also sometimes been called high- or medium-staffed hostels, staffed group homes or wards in the community. These services were originally developed as part of the asylum closure programme, to support the rehabilitation of service users with more complex care needs and have subsequently been recognised as having a role to play in supporting the 'new long-stay patient', a term developed by Mann & Cree (1976) to describe service users who spent over 1 year as an in-patient, despite modern treatments and support from community mental health teams. Twenty-four-hour nursed care units have higher staffing ratios than other supported accommodation and are generally transitional, as patients are expected to move on to less supervised accommodation within 1 to 3 years. Box 1 provides a description of the typical characteristics of these units (for a review see also Macpherson 1999).

The staffing of 24-hour nursed care units ranges widely, generally from 8 to 20 whole-time equivalent staff members per unit. These may be nursing staff (typically in NHS units) or care staff with training in mental health. The provision of 24-hour nursed care facilities for patients with complex needs in England was promoted in the National Service Framework for Mental Health (Department of Health 1999).

BOX 1 Characteristics of 24-hour nursed care

- A homely, domestic, non-institutional setting
- Ideally 6–12 residents
- Resident involvement in social/domestic activities
- A high level of professional care, individualised treatment programmes
- Good access to community facilities

(Shepherd 1995)

Individual care packages with flexible, domiciliary based support

These have been developed recently in some areas, sometimes as an alternative to highly supported hostel/24-hour nursed care provision. Typical characteristics are:

- the service user has their own tenancy
- practical and emotional support is provided by care workers, usually through a private/third-sector provider agency
- the form of housing is often a flat or a small shared house
- individuals have tenancies and apply for housing benefit (or pay rent and other charges if they have the means)
- commissioners of the service monitor the effectiveness through support contracts, with a complex relationship between care package providers and statutory mental health services
- there is often an implicit expectation that over time the level of support provided will reduce
- local mental health services should be involved in care coordination of service users.

The model of individual care packages has been used in some areas of the USA and in the UK and is gradually becoming more established in mainstream mental health services. It is sometimes called supported housing, reflecting its use of standard housing stock, and the move away from transitional, staffed, shared accommodation models such as 24-hour nursed care and group homes, which have become less acceptable to service users. Supported housing can be provided by a variety of organisations – the voluntary sector, housing associations, local authorities or private/independent organisations. Sometimes partnerships between these organisations and the NHS are in operation, with one organisation owning/running the building and another providing staffing/outreach support. Such services may have been developed through intelligent commissioning

at the local authority/primary care trust level, and block/spot contracting arrangements are often in place from local authority/primary care trust commissioners to ensure that provision is financially viable and appropriately prioritises clients with a specific level of support needs. The funding and management of these placements are complex and some mental health services have specialist teams that work across providers and with commissioners to ensure that vacancies are appropriately managed according to priority of need.

In addition to their deployment in mental health fields, individual care packages have been established to decrease homelessness (Hopper 2003). Perhaps because it is a relatively new development, emerging in the 1990s, there is relatively little literature regarding this form of supported accommodation, but Rog (2004) has provided a useful overview of where this type of supported accommodation fits in the spectrum of services. She reviewed the evidence from 15 studies comparing supported housing with other models of supported accommodation and concluded that housing with support in any form improves housing stability and that there was good evidence that individuals with severe mental illness can live effectively in mainstream housing, with support. There was insufficient evidence to evaluate which forms of supported accommodation were more effective, or whether individuals with specific problems may be particularly suited to different forms of accommodation. She noted that from a purchaser's perspective, the economic advantages of using standard housing stock and the alliance between the values of individually focused care packages and the preferences of service users suggest that this model will continue to develop.

Assessing need for supported housing

The assessment of local need for accommodation (Box 2) is at best imprecise, but where local surveys have been undertaken (e.g. Shepherd 1997; Commander 2008) they have tended to identify unmet need for 24-hour rehabilitation units in particular. National data have also indicated a shortage of high-intensity community support placements (Department of Health 1998).

Recent policy and service changes

For several decades, successive UK government policy has increasingly promoted a market philosophy encouraging competition between different private residential care providers (not-for-profit and for-profit), at times in direct competition

BOX 2 Assessment to determine housing need

- Current psychiatric symptoms and effects on social functioning
- Strengths: work, hobbies, interests, relationships with friends and family
- Lifestyle issues: alcohol and substance use, smoking
- Recovery factors: hope, aspirations, motivation for independence and self-management
- Personal preferences for accommodation type, location, support
- Forensic issues: any previous problems with tenancy or disturbed behaviour in community
- Engagement with services, including employment and educational needs
- Living skills, including ability to self-care, cook, shop, care of environment
- Physical health and any specific needs owing to physical disability
- Carer assessment (where appropriate)

with state providers (Department of Health 1998). This has also happened across Europe (Fakhoury 2002a). The most recent specific policy in this area – the Supporting People strategy (Office of the Deputy Prime Minister 2002) – was set up explicitly to ring-fence and coordinate all housing support for vulnerable people, including those with mental health problems. The initiative seems to have been implemented variably, in some areas leading to greater understanding and coordination of supported accommodation, but elsewhere a lack of clear priorities has led to concerns about reduced access to services. In an evaluation of the Supporting People programme, Cameron *et al* (2007) concluded that integrated services worked best when the service was determined by service user characteristics rather than pre-existing organisational structures, and that statutory services tended to be less flexible and more defined by professional and organisational priorities compared with the voluntary sector.

The commissioning of residential care in the community has been further complicated by the development of NHS trusts, which commonly combine the provision of Social Services related to mental health with statutory health services. These trusts may also directly manage some budgets for supported accommodation, leading to a complex commissioning relationship between the primary care trust, local authority and mental health trusts. Recent strategy documents such as

New Horizons (Department of Health 2009) and the Cross-Government Mental Health Outcomes Strategy (HM Government 2011) set out a vision for improved prevention and innovation, challenging inequality and stigma, but pay little attention to housing support. Compared with preceding strategy, promoted through the National Service Framework for Mental Health (Department of Health 1999), recent policy appears less clear and does not address how comprehensive provision for those with the most severe problems will be achieved.

The focus appears to have shifted to the challenge of developing and improving services in an adverse economic climate. The Social Exclusion Unit (2004) found that tenants with mental health problems were three times more likely to try to cut down on basic utilities (gas, electricity, water, telephone) and one in four was likely to be in serious rent arrears. Furthermore, adults on the lowest 20% of incomes were twice as likely to develop mental health problems compared with those on an average income. Given the pressure on national and local budgets, these figures are likely to get worse. Cuts to the Supporting People budgets, and the potential impact of these on a highly disadvantaged group may now add to problems of social exclusion and disadvantage in those with severe mental illness. The Royal College of Psychiatrists (2009) has published a collaborative document on the possible impact of the economic downturn on people with mental health problems, considering service-level solutions.

Personalisation

A further policy change which is starting to have an impact on mental healthcare is the drive towards greater choice and control among service users. Personalisation (Department of Health 2008) is a new way of organising services which seeks to move control over decisions about services as far as possible to the service user, based on the premise that people do better if they control their own care. In this model, an assessment of needs made jointly by service users and professionals generates a support plan with funding (e.g. to improve family contact, or enable specific work-, leisure- or housing-related initiatives). Personalisation therefore implies the need for a new relationship between the professional and the service user, which focuses explicitly on the service user's priorities and promoting autonomy. However, a recent report suggested that uptake of this new approach has been slow and patchy (Social Care Institute for Excellence 2009).

The evidence base for supported accommodation

The Team for the Assessment of Psychiatric Services (TAPS) project (Leff 1997, 2000) was an extensive, long-term, prospective controlled follow-up study of the closure of two north London asylums in the 1990s. This demonstrated that the social functioning of long-stay patients moved into the community (mostly into residential and group homes) was generally improved and they were more satisfied when living in the community. Psychiatric symptoms tended to remain stable and there were relatively few long-term readmissions. These findings have been replicated in other countries such as Australia, the USA, Northern Ireland, Norway and Italy (Shepherd 2011).

Supported accommodation services do not lend themselves to the use of randomised trials and most studies have been more descriptive, using a mixture of methods. Some authors have questioned the value of methods such as the randomised trial to evaluate socially complex services (Wolff 2000), pointing out the limitations of this method, with its reductive paradigms, which fit poorly in this context, to the complex staffing arrangements, ambiguous protocols, hard-to-define study samples and unevenly motivated participants.

A review of the research into supported accommodation by Fakhoury *et al* (2002b) showed a limited number of studies, largely from the USA, Australasia, Canada and Europe. They concluded that the research was of variable quality, with problems of definition, design and methodology making it difficult to draw firm conclusions, regarding the clinical and cost-effectiveness of differing forms of supported accommodation.

Meta-analyses

Kyle & Dunn (2008) systematically reviewed 29 studies, allocating levels of evidence according to the robustness of the research method. They examined the effect of housing on health, quality of life and healthcare use for people with severe mental illness, finding good evidence that housing interventions reduced the need for hospital admission in the homeless mentally ill, but not for people with severe mental illness who were not homeless. There was weak or very weak evidence of a beneficial effect of supported housing on psychiatric symptoms, and at best medium evidence of an association between housing and quality of life. Their report demonstrated the wide variety of study methods used and the complex and at times conflicting results of studies in this area.

Leff *et al* (2009) carried out a meta-analysis of 30 studies, comparing forms of model housing

(which they subdivided into residential care and treatment, residential continuum, and permanent supported housing) with control/treatment-as-usual accommodation. The residential care and treatment model referred to early forms of supported accommodation, such as room-and-board supervision and group homes, with support services on site and expectations of abstinence from substance use. Residential continuum housing overlapped with this, but referred to newer models with added interventions aimed at improving consumer functioning and independence, allowing them to move through a continuum of housing support as they recovered. Permanent supported housing allowed residents to remain in settings and maintain relationships, regardless of support needs, by flexible 'wraparound' staff support as needed. Non-model housing was essentially treatment as usual and referred to studies which made no reference to any specific housing support or help. The authors found that all forms of model housing achieved better stability than non-model housing, with permanent supported housing achieving the best results. In comparisons with non-model housing, only residential care and treatment units demonstrated reductions in psychiatric symptoms, but all the forms of supported accommodation were associated with reduced hospital admissions. User satisfaction was greatest with permanent supported housing, then residential care, then residential treatment models.

Randomised trials

McHugo and colleagues (2004) found that integrated housing programmes provided by teams within a single agency were associated with greater stability in housing and satisfaction than parallel services in which housing was accessed through standard local systems. It seems that there is fairly good evidence of overall benefits of model housing programmes, set up through providers who develop skills and experience over time.

There have been some interesting findings from other studies looking at different aspects of supported accommodation. In their study of Housing First, Tsemberis *et al* (2004) randomly allocated 208 participants with severe mental illness and substance misuse to a housing programme which offered immediate housing without expectation of psychiatric treatment adherence or abstinence from substance use, compared with transitional housing which required adherence and sobriety. They found no differences in psychiatric symptoms or substance

misuse and their results challenge the common practice of linking access to housing with a requirement to accept treatment and sobriety.

Reviews

Given the huge variation of services available in different localities, there remains an important question about how best to advise service users, in the absence of clear evidence, about differing accommodation options. In their Cochrane review which compared the use of self-contained flats within a housing scheme with outreach support provided in dispersed ordinary housing, Chilvers *et al* (2002) reported no controlled studies. They argued, based on existing evidence, that the form of supported accommodation should be chosen on the basis of three factors: available resources, service user choice and professional judgement.

There is generally more better-quality evidence looking at 24-hour nursed care than other forms of supported accommodation. In their review, Macpherson & Jerrom (1999) found that 24-hour nursed units were effective in improving the functioning of up to 40% of residents sufficiently for them to be resettled into the community after an average of 2–3 years. On moving from hospital to 24-hour nursed care, service users were found to increase their social networks and to have more structured activity, but there was no evidence of changes in psychopathology. Levels of satisfaction increased in service users and families. Changes occurred mostly in the first 2 years. About a quarter of patients were readmitted, mostly for short periods, due to aggression or antisocial behaviour. It was not possible to predict which patients would be helped through 24-hour nursed care units and it seemed that some patients appeared to need the space, lower staffing levels and a loose, informal programme, which were features of long-stay wards.

Qualitative studies

Qualitative studies by Chesters *et al* (2005) and Forchuk *et al* (2006) have shown the value of an idiographic and narrative approach to research in this field, the former emphasising the challenge to service users trying to rebuild their lives after mental illness who find that not all communities are welcoming and that friendships can be even less easy to secure than housing and professional support.

Summary

Overall, there is a lack of good-quality research evidence in this field and a pressing need for better-quality, well-conducted studies that compare

outcomes and consider the service user experience in different forms of supported accommodation.

Accommodation and service user choice

Surveys from across the world have consistently found that service users express a preference for more independent living in ordinary housing, and for flexible, domiciliary based support rather than living with staff (Tanzman 1993; Owen 1996; Hogberg 2006). Research has also highlighted the benefits of enabling choice of supported housing. A well-designed American study by Srebnik *et al* (1995) found that greater perceived choice related to life satisfaction a year later. Similarly, a longitudinal study by Nelson and colleagues (2007) from Ontario, Canada, found that choice and control over housing contributed to quality of life and that apartments generally gave more choice, control and support than group living.

However, it is known that mental health professionals and service user assessments of need often diverge significantly (Slade 1996), and there are examples in the literature where staff or family perceptions of need for supported accommodation conflicted with the service user's preference.

Friedrichs and colleagues (1999) found that for service users living independently, they and their families reported isolation to be a significant problem and family members tended to prefer housing which provided support and structure. An interesting UK study by Fakhoury *et al* (2005) found that the most frequently reported goals among a group of service users in supported housing were to achieve independent housing, stay healthy and improve living skills. The service users formed two clusters, a more symptomatic group with fewer goals, and another with better quality of life who were more likely to aim for independent living. It was suggested that supported housing may helpfully be viewed as providing a long-term placement for some, but also needs to provide active rehabilitative and move-on opportunities for those who wish to achieve greater independence. Interestingly, goals defined by professionals working with these service users showed poor or no agreement with the service users' goals and it was suggested that staff may need specific training to enable better communication and to support service users effectively to achieve their goals.

Minsky and colleagues (1995) found that long-term in-patients generally chose to live alone, with family or a chosen room-mate, with only 4% preferring the option of live-in staff. By contrast, 61% of staff felt the latter to be the best option. Massey & Wu (1993) surveyed service users in a Florida mental health centre and found that

they prioritised personal choice, location and (interestingly) proximity to mental health services more often than staff.

Overall, staff seem to value safety and support more (Piat 2008), whereas service users value independence and privacy. Obviously, a good solution to the dilemma of conflicting professional/service user preference would be to have a range of accommodation and support options facilitating choice, but also providing support where needed.

Quality issues and partnership working

A systematic review of the international literature relating to the quality of institutional care for people with longer-term mental health problems (Taylor 2009) found eight domains of institutional care that were key to service users' recovery (Box 3). This paper emphasised the need for staff supervision to support therapeutic relationships and for service user involvement in decision-making. Differences in the experience of service users in supported accommodation appears often to be down to small factors – access to the kitchen, choice over food and meal times, the ability to lock one's living space, and so on. These relatively small differences seem to make a disproportionately large impact on residents' quality of life judgements (Borge 1999).

The growth of provision by a variety of non-statutory agencies has meant that many of the staff now involved in delivering care do not have formal mental health training or qualifications. Although this may help to avoid institutional attitudes, staff who feel themselves to be untrained to deal with difficult clinical problems are also more likely to be reluctant to accept such individuals (hence contributing to the stereotype of avoiding difficult referrals).

Raskin *et al* (1998) developed a psycho-educational programme for staff in community

residences, finding positive responses among caregivers, who liked the networking and mental health component. Service users became more active and had fewer admissions. Snyder and colleagues (1994) studied staff in 15 residential care homes, finding that more negative staff attitudes appeared to be associated with greater severity of service users' symptoms. More research is needed to understand how to develop positive practice in these staff groups.

Within the new, dispersed services there is a need for effective partnership working between statutory and private care providers and there is great potential for collaboration, particularly around staff training and support/supervision. The development of effective leadership skills is also of central importance and it has been shown that the management style of project leaders may have more influence than any other single factor on the quality of care experienced by residents (Shepherd 1996). However, the questions of how to identify good leaders for residential projects and how to support them effectively are almost entirely unexplored areas. The importance of partnership working was emphasised by Priebe *et al* (2009), who surveyed the characteristics of service users in 250 randomly selected housing services in 12 representative local areas in England. Only about half the service users were supported by specialist community mental health services. Care and costs differed widely between care homes, supported housing and floating support services, and it was argued that quality standards were needed to ensure that service users received appropriate care. Greater involvement of mental health services was required to ensure both the provision of effective services and ultimately the recovery of service users.

Quality indicators in supported accommodation were summarised in our last review in this area (Macpherson 2004) and include those listed below.

BOX 3 Domains of institutional care key to service users' recovery

- Living conditions
- Interventions for schizophrenia
- Physical health
- Restraint and seclusion
- Staff training and support
- Therapeutic relationships
- Autonomy/service user involvement
- Clinical governance

(Taylor 2009)

Integration with other key service components

Integration with other services includes, for example, close working links with community mental health teams and functional mental health teams. It also involves maintaining good links with other providers of accommodation and local therapeutic day care and employment facilities.

A reflective, values-based team approach

Regular clinical review meetings should focus on service user strengths and involve a range of multidisciplinary professionals (e.g. psychiatrists, psychologists, occupational therapists, social workers) and family where possible. Reflective

practice meetings may help to address complex systems problems in helping service users. Audits of clinical outcomes and the process of team/unit working will help to develop services, and adoption of a model of working such as rehabilitation and recovery, with goals that are clearly understood by all team members, will help to focus the team's work. There should be opportunities for service user involvement, feedback and collaboration at all levels in the organisation.

Training

There should be training at different organisational levels and in various therapeutic modalities such as Thorn Training in psychosocial family interventions for psychosis, but there remains a substantial gap between our understanding of the theory in these areas and their implementation in practice (Baguley 2000). Approaches that cover staff teams as a whole ward or unit include RAID (Reinforce Appropriate, Ignore Disruptive; Davies (1993)), and these can be useful to strengthen the relationship between staff and service users, and to try to deal with challenging behaviour, but there seem to be few descriptions of the use of these in practice. Dealing with high expressed emotion can help individually and at team level (Snyder 1994). Training in risk management and the value of therapeutic risk-taking is particularly important in staff groups which can be isolated and potentially develop idiosyncratic practices. Training as a team is to be preferred, rather than training individuals and then putting them into unchanged teams (Thorn 2000), and collaborative training across different services is likely to bring wider benefits.

Conclusions

We have come a long way from the asylums. However, it is apparent that there are still some service users with severe mental illness who need ongoing, high levels of practical and emotional support integrated into their living environment. The majority of the next generation of people with severe and long-term needs will prefer flexible, domiciliary-based support which gives them more privacy and autonomy. There is certainly a need for more and better research in this area, but we already know a lot about what works and what is needed in each locality to provide the spectrum of different supported accommodation required. If modern mental health services are to be seen as helpful, they must collaborate with the service user, recognising the strengths, experience and preferences of each individual and trying to support their optimal functioning and recovery.

Effective partnership working between staff in statutory services and supported accommodation providers will play a large part in the success of supported housing initiatives for people with mental health problems.

It is vital for service users to have well-functioning care pathways in supported accommodation. Accommodation should be available that meets a wide range of support levels, and service users should be helped to move to lower levels of support as they progress in their recovery. Access to effective, good-quality, supported accommodation must be seen as an essential component of comprehensive mental health services. It is the responsibility of senior mental health professionals and managers, working with service users and carers, to try to influence the commissioning of services to ensure that this is available to those in need.

Acknowledgment

This article is based on the chapter 'Residential care' by Geoff Shepherd and Rob Macpherson, which appears in the *Oxford Textbook of Community Mental Health* (eds G Thornicroft, G Szmukler, KT Mueser), pp. 178–187.

References

- Anthony WA (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal* 16: 11–23.
- Baguley I, Butterworth A, Fahey K, et al (2000) Bringing into clinical practice skills shown to be effective in research settings: a follow up of 'Thorn Training' in psychosocial family interventions for psychosis. In *Psychosis: Psychological Approaches and their Effectiveness* (eds B Martindale, A Bateman, M Crowe, et al): 96–119. Gaskell.
- Borge L, Martinsen EW, Ruud T, et al (1999) Quality of life, loneliness and social contact among long-term psychiatric patients. *Psychiatric Services* 50: 81–4.
- Cameron A, Macdonald G, Turner W, et al (2007) The challenges of joint working: lessons from the Supporting People Health Pilot evaluation. *International Journal of Integrated Care* 7: 1–10.
- Care Services Improvement Partnership, Royal College of Psychiatrists, Social Care Institute for Excellence (2007) *A Common Purpose: Recovery in Future Mental Health Services. Joint Position Paper 08*. SCIE.
- Carpenter I, Gambassi G, Topinkova R (2004) Community care in Europe. The Aged in Home Care project (AdHOC). *Aging, Clinical Experience and Research* 16: 259–69.
- Chesters J, Fletcher M, Jones R (2005) Mental illness, recovery and place. *Australian e-Journal for the Advancement of Mental Health* 4: 89–97.
- Chilvers R, MacDonald GM, Hayes AA (2002) Supported housing for people with severe mental disorders. *Cochrane Database of Systematic Reviews* 4: CD000453.
- Commander M, Rooprai D (2008) Survey of long-stay patients on acute psychiatric wards. *Psychiatrist* 32: 380–3.
- Davies W (1993) *The RAID Programme for Challenging Behaviour*. Association for Psychological Therapies.
- Department of Health (1998) *Partnerships in Action – New Opportunities for Joint Working between Health and Social Services: A Discussion Document*. Department of Health.

MCQ answers

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Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health.

Department of Health (2003) Average daily number of available and occupied beds by sector, England. Department of Health (http://www.dh.gov.uk/en/Publicationsandstatistics/statistics/performanceandstatistics/beds/dh_083781).

Department of Health (2008) An introduction to personalisation. Department of Health (http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/DH_080573).

Department of Health (2009) *New Horizons: A Shared Vision for Mental Health*. Department of Health.

Dinniss S, Roberts G, Hubbard C, et al (2007) User-led assessment of a recovery service using DREEM. *Psychiatric Bulletin* 31: 124–7.

Fakhoury WKH, Priebe S (2002a) The process of deinstitutionalization: an international overview. *Current Opinion in Psychiatry* 15: 187–92.

Fakhoury WKH, Murray A, Shepherd G, et al (2002b) Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology* 37: 301–15.

Fakhoury WKH, Priebe S, Quraishi M (2005) Goals of new long stay patients in supported housing: a UK study. *International Journal of Social Psychiatry* 51: 45–54.

Forchuk C, Ward-Griffin C, Csiernik R, et al (2006) Surviving the tornado of mental illness: psychiatric survivors' experiences of getting, losing and keeping housing. *Psychiatric Services* 57: 558–62.

Friedrichs R, Hollingsworth B, Hradeck E, et al (1999) Family and client perspectives on alternative residential settings for persons with severe mental illness. *Psychiatric Services* 50: 509–14.

HM Government (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. TSO (The Stationery Office).

Hogberg T, Magnusson A, Lutzen K (2006) Living by themselves? Psychiatric nurses' views on supported housing for persons with severe and persistent mental illness. *Journal of Psychiatric and Mental Health Nursing* 13: 735–41.

Holloway F (2008) The community psychiatrist in 2008: anachronism, Cinderella or pioneer? *The Psychiatrist* 32: 161–3.

Hopper K, Barrow SM (2003) Two genealogies of supported housing and their implications for outcome assessment. *Psychiatric Services* 54: 50–4.

Killaspay H, Harden C, Holloway F, et al (2005) What do mental health rehabilitation services do and what are they for? A national survey in England. *Journal of Mental Health* 14: 157–65.

Kyle T, Dunn JR (2008) Effects of housing circumstances on health, quality of life and healthcare use for people with severe mental illness: a review. *Health and Social Care in the Community* 16: 1–15.

Leff J (1997) *Care in the Community: Illusion or Reality?* Wiley.

Leff J, Trieman N, Knapp M, et al (2000) The TAPS Project: a report on 13 years of research, 1985–1998. *Psychiatric Bulletin* 24: 165–8.

Leff HS, Chow CM, Pepin R, et al (2009) Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. *Psychiatric Services* 60: 473–82.

Macpherson R, Jerrom B (1999) Review of twenty-four-hour nursed care. *Advances in Psychiatric Treatment* 5: 146–53.

Macpherson R, Shepherd G, Edwards T (2004) Supported accommodation for people with severe mental illness: a review. *Advances in Psychiatric Treatment* 10: 180–8.

Mann S, Cree W (1976) New long stay patients: a national survey of 15 mental hospitals in England and Wales 1972/3. *Psychological Medicine* 6: 603–16.

Massey OT, Wu L (1993) Important characteristics of independent housing for people with severe mental illness: perspectives of case managers and consumers. *Psychosocial Rehabilitation Journal* 17: 81–92.

McHugo GJ, Bebout RR, Harris M, et al (2004) A randomised trial of integrated parallel versus integrated housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin* 30: 969–82.

Minsky S, Riesser GG, Duffy M (1995) The eye of the beholder: housing preferences of inpatients and treatment teams. *Psychiatric Services* 46: 173–6.

Nelson G, Sylvestre J, Aubry T (2007) Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness. *Administration and Policy in Mental Health and Mental Health Services Research* 34: 89–100.

Office of the Deputy Prime Minister (2002) *The NHS and the Supporting People Strategy: Building the Links*. ODPM.

Owen C, Rutherford V, Jones M, et al (1996) Housing accommodation preferences of people with psychiatric disabilities. *Psychiatric Services* 47: 628–32.

Piat M, Lesage A, Boyer R, et al (2008) Housing for persons with serious mental illness: consumer and service provider preferences. *Psychiatric Services* 59: 1011–7.

Priebe S, Badesconyi A, Fioritti A, et al (2005) Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. *BMJ* 330: 123–6.

Priebe S, Frottier P, Gaddini A, et al (2008) Mental Health care institutions in nine European countries, 2002 to 2006. *Psychiatric Services* 59: 570–3.

Priebe S, Saidi M, Want A, et al (2009) Housing services for people with mental disorders in England: patient characteristics, care provision and costs. *Social Psychiatry and Psychiatric Epidemiology* 44: 805–14.

Raskin A, Mghir R, Peszke M, et al (1998) A psychoeducational program for caregivers of the chronic mentally ill residing in community residences. *Community Mental Health Journal* 34: 393–402.

Roberts G, Wolfson P (2006) New directions in rehabilitation: learning from the recovery movement. In *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry* (eds G Roberts, S Davenport, F Holloway, et al): 18–37. Gaskell.

Rog DJ (2004) The evidence on supported housing. *Psychiatric Rehabilitation Journal* 27: 334–44.

Royal College of Psychiatrists, Mental Health Network of NHS Confederation, London School of Economics (2009) *Mental Health and the Economic Downturn: National Priorities and NHS Solutions* (Occasional Paper OP70). Royal College of Psychiatrists, NHS Confederation, LSE.

Ryan T, Pearsall A, Hatfield B, et al (2006) Long term care for serious mental illness outside the NHS. A study of out of area placements. *Journal of Mental Health* 13: 425–9.

Shaw J, Appleby L, Amos T, et al (1999) Homicide, mental disorder and clinical care in people convicted of homicide: national clinical survey. *BMJ* 318: 1240–4.

Shepherd G (1995) The "ward-in-a-house": residential care for the severely disabled. *Community Mental Health Journal* 31: 53–69.

Shepherd G, Muijen M, Dean R, et al (1996) Residential care in hospital and in the community – quality of care and quality of life. *British Journal of Psychiatry* 168: 448–56.

Shepherd G, Beadmoore A, Moore C, et al (1997) Relation between bed use, social deprivation, and overall bed availability in acute psychiatric units and alternative residential options: a cross sectional survey, one day census data and staff interviews. *BMJ* 314: 262–6.

Shepherd G, Boardman J, Slade M (2008) *Making Recovery a Reality*. Sainsbury Centre for Mental Health.

Shepherd G, Boardman J, Burns M (2010) *Implementing Recovery: A Method for Organisational Change*. Sainsbury Centre for Mental Health.

Shepherd G, Macpherson R (2011) Residential care. In *Oxford Textbook of Community Mental Health* (eds G Thornicroft, G Szmukler, Mueser KT): 178–87. Oxford University Press.

Singleton N, Meltzer H, Gatward R (1998) *Psychiatric Morbidity Among Prisoners in England and Wales*. Department of Health.

Slade M, Phelan M, Thornicroft G, et al (1996) The Camberwell Assessment of Need (CAN): comparison of assessments by staff and patients of the needs of the severely mentally ill. *Social Psychiatry and Psychiatric Epidemiology* 31: 109–13.

Snyder KS, Wallace CL, Moe K, et al (1994) Expressed emotion by residential care operators and residents' symptoms and quality of life. *Hospital and Community Psychiatry* **45**: 1141–3.

Social Care Institute for Excellence (2009) *The Implementation of Individual Budget Schemes in Adult Social Care (SCIE Research Briefing 20)*. SCIE (<http://www.scie.org.uk/publications/briefings/files/briefing20.pdf>).

Social Exclusion Unit (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. Office of the Deputy Prime Minister.

Srebnik D, Livingstone J, Gordon L, et al (1995) Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal* **31**: 139–52.

Tanzman B (1993) An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry* **44**: 450–5.

Taylor TL, Killaspy H, Wright C, et al (2009) A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. *Biomed Central Psychiatry* **9**: 55–73.

Thorn K, Machray A (2000) *Worldclass Training*: 37. Stylus Publishing.

Thorncroft G, Bebbington P, Leff J (2005) Outcomes for long-term patients one year after discharge from a psychiatric hospital. *Psychiatric Services* **56**: 1416–22.

Trieman N, Leff J (2002) Long-term outcome of long-stay psychiatric in-patients considered unsuitable to live in the community: TAPS Project 44. *British Journal of Psychiatry* **181**: 428–32.

Tsemberis S, Gulcur L, Nakae M (2004) Housing First, consumer choice and harm reduction for homeless individuals with a dual diagnosis. *Research and Practice* **94**: 651–6.

Warner R (2009) Recovery from schizophrenia and the recovery model. *Current Opinion in Psychiatry* **22**: 374–80.

Wolff N (2000) Using randomised controlled trials to evaluate socially complex services: problems, challenges and recommendations. *Journal of Mental Health Policy and Economics* **3**: 97–109.

Wolfson P, Holloway F, Killaspy H (eds) (2009) *Enabling Recovery for People with Complex Mental Health Needs: A Template for Rehabilitation Services* (Faculty Report FR/RS/1). Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists.

MCQs

Select the single best option for each question stem

1 Reinstitutionalisation:

- a occurred in asylums in the 19th and 20th centuries
- b is a form of supported accommodation
- c was studied by Goffman
- d implied a growth of institutional support for people with mental illness over the past two decades
- e does not include secure hospital care.

2 The evidence for supported accommodation:

- a includes many randomised controlled trials
- b is of a consistently high quality

- c includes some qualitative studies
- d suggests that model accommodation services are generally ineffective
- e suggests that 24-hour nursed care units are ineffective.

3 The quality of care in supported accommodation:

- a is not influenced by the quality of leadership and management in units
- b requires attention to the training of staff
- c is overseen by the local Social Services department
- d relates mainly to the level of payment that care staff receive
- e has been found not to relate to quality of life in residents.

4 The following research programme focused particularly on supported accommodation:

- a TAPS
- b CATIE
- c OCTET
- d CUTLASS
- e the UK 2000 trial.

5 Twenty-four-hour nursed care:

- a is no longer needed
- b has a weak evidence base compared with other forms of supported accommodation
- c is available in most regions
- d is generally transitional
- e is only effective if managed within statutory services.