

The London School of Economics and Political Science

No place like HOME

specialist Housing services for people with
mental health problems, Outcomes,
Movements and Experiences

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A thesis submitted to the Department of Social Policy of the
London School of Economics for the degree of
Doctor of Philosophy, London, December 2013

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Abstract

Background: No exact and reliable data exists on the characteristics and needs of people with mental health problems in England living in specialist housing services (SHSs).

Aims: To describe the cohort of service users' with mental illness aged 18 to 65 living in various types of SHSs (care homes, supported housing, and Shared Lives schemes) as well as their housing satisfaction, taking into account their social inclusion, and social networks. Pathways into SHSs were accounted for: delayed discharge, referrals and move-on accommodation where applicable.

Method: Semi-structured interviews were conducted - using interview schedules designed for the purpose of this study - with 86 service users and 40 managers of SHSs within 7 areas of England.

Analysis: Based on a mixed-methods approach: each interview was coded and string variables were turned into quantifiable ones; anonymised quotes from service users and managers were included in the body of the text. Main analysis is quantitative, with a secondary qualitative study, using framework analysis.

Results: Differing support levels influenced service users' experiences and pathways into SHSs, as well as the outlooks of managers. Analyses revealed several aspects mediating housing satisfaction. Many service users were not very well integrated in the community although managers held different views. Some service users were very much reliant on staff and had small social networks. Discrimination was still persistent and recent policy initiatives, in terms of funding, housing, benefits and employment held a negative impact. Preferences of service users were for the most part not taken into account.

Conclusions: Further research is needed with regard to BME groups as well as other SHSs settings like Shared Lives schemes. Data should be more systematically collected and in more detail and barriers to employment should be tackled. Better advocacy and information for service users should be established.

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Table of contents

Chapter 1	Introduction	17
1.1	Putting specialist housing services for people with mental health problems into context: importance and relevance of topic	17
1.2	Research questions	20
1.3	What lies ahead.....	21
Chapter 2	Developing a specialist housing services model.....	24
2.1	Introduction	24
2.2	A brief history of madhouses and asylums	24
2.3	Deinstitutionalisation	26
2.4	Post-deinstitutionalisation policies.....	27
2.5	The development of specialist housing services.....	38
2.6	Community mental health care in England today and provision of services	45
2.7	Discussion.....	52
Chapter 3	Specialist Housing Services in England: a literature review	55
3.1	Introduction	55
3.2	Search strategy.....	55
3.3	The reviews of the literature on SHSs.....	57
3.4	Key UK studies on SHSs	65
3.5	Discussion.....	78
Chapter 4	Towards a classification of Specialist Housing Services	90
4.1	Introduction	90
4.2	Search strategy.....	90
4.3	Definition of specialist housing services	91
4.4	Classifying Specialist Housing Services	92
4.5	Discussion.....	104
Chapter 5	The study design	117
5.1	Introduction	117
5.2	Research design	120
5.3	Methods of analysis	141
5.4	Discussion.....	148

Chapter 6	Implementing the study and describing the sample	152
6.1	Introduction	152
6.2	Implementing the research design	154
6.3	Contacting directors and managers of consenting organisations	156
6.4	A guide to how interviews were secured	157
6.5	Interviews with service users	164
6.6	Characteristics of the sample	166
6.7	Discussion	178
Chapter 7	Movements, Experiences and Referrals	182
7.1	Introduction	182
7.2	Service users' pathways into and out of SHSs	184
7.3	The movements of care home clients	185
7.4	Supported housing service users' movements	195
7.5	Shared Lives schemes clients' and people in independent living movements	201
7.6	Experiences in psychiatric hospital and delayed discharge	204
7.7	Long-stay psychiatric patients	207
7.8	Further studies and analyses	208
7.9	Discussion	209
Chapter 8	Experiences within Specialist Housing Services	214
8.1	Introduction	214
8.2	Preparing the data and variables used	215
8.3	Housing satisfaction of service users	216
8.4	Concerns of managers	232
8.5	Main challenges service users face according to managers	236
8.6	Discussion	238
Chapter 9	Chapter 9 Social inclusion within specialist housing services	244
9.1	Introduction	244
9.2	Employment and occupational activities	246
9.3	Community involvement	256
9.4	Social security benefits	260
9.5	Social networks	263
9.6	Discrimination: managers' perspectives	267

9.7	Personalised services	270
9.8	Recent policy initiatives	271
9.9	Discussion.....	276
Chapter 10	Exploring the experiences of people living in and managing specialist housing services in England.....	284
10.1	Introduction	284
10.2	Analytical process	285
10.3	Characteristics of the qualitative study sample.....	289
10.4	Introduction to qualitative findings	290
10.5	Within-group differences.....	322
10.6	Discussion.....	328
Chapter 11	Conclusion	338
11.1	Introduction	338
11.2	Thesis summary and discussion	338
11.3	Triangulating the results of the quantitative and qualitative analyses	358
11.4	Strengths and limitations of the study.....	362
11.5	Research implications and policy recommendations	372
Appendices	402	

Table of Tables

Table 2-1: Selected community mental health policies in England: a timeline.....	36
Table 2-2: Number of mental health clients recorded on Adult Placement Schemes, 2007-2012	47
Table 2-3: Who's who in housing (Prior, 1996).....	48
Table 3-1: Principal selected UK studies of SHSs	84
Table 4-1: Final classification of SHSs and description	104
Table 4-2: Types of SHSs as described in the literature: definitions, consistencies, and differences.....	107
Table 5-1: Limitations and gaps in the SHS literature.....	119
Table 5-2: Sample size calculation for a student t-test using a medium effect size	124
Table 5-3: Sample size calculation for a multiple regression – medium effect size	125
Table 5-4: Selection criteria and corresponding measures for each local area	126
Table 5-5: Description of the measures used in this study.....	137
Table 6-1: Responses from the first batch of letters to directors.....	157
Table 6-2: SHSs contacted and response rates of managers.....	161
Table 6-3: Urban/rural classifications and definitions	164
Table 6-4: Service users' response rates by area and per SHS	164
Table 6-5: Number of service users interviewed by SHS type and area.....	167
Table 6-6: Main demographic characteristics of service user sample by SHS type.	168
Table 6-7: EQ-5D-3L ratings by ability: agreement with statements (frequencies)	171
Table 6-8: EQ-5D-3L problems by age.....	172
Table 6-9: EQ-5D-3L ratings by area	172
Table 6-10: Ratings of Activities of Daily Living (N).....	173
Table 6-11: Number of SHSs in sample by support type classifications and area ...	174
Table 6-12: Number of SHSs by support and providers.....	177
Table 7-1: Care homes service users' places of origin (total n=64)	186
Table 7-2: Care home service users' referral routes: frequencies (total n=55).....	186

Table 7-3: Cross-tabulation: having wanted to move to a SHS (care home versus supported housing)	188
Table 7-4: Prior locations of care home residents who did not want to move (total n=31)	190
Table 7-5: Cross-tabulation: wanting to move from a care home (total n=26) or want to remain (total n=31).....	190
Table 7-6: Wanting to move out of a care home: binary logistic regression	191
Table 7-7: Housing satisfaction and wanting to move from a care home: significant differences and means	193
Table 7-8: Care home managers' thoughts on why people moved on and where to (total n=29).....	194
Table 7-9: Supported housing service users' place of origin (total n=15)	195
Table 7-10: Cross-tabulation: want to move out of a supported housing service versus care home	198
Table 7-11: Wanting to move out of a supported housing service: binary logistic regression.....	199
Table 7-12: Supported housing managers' answers on how they promoted independence amongst service users (total n=6).....	200
Table 7-13: Cross-tabulation: experiencing problems in hospital	206
Table 7-14: Length of stay in psychiatric hospital: a comparison between study data (total n=58) and MHMDS data	207
Table 7-15: Long-stay psychiatric patients (total n=4) descriptive statistics: means, standard deviations and frequencies (where applicable)	207
Table 7-16: Cross-tabulations: Wanting to move from a SHS and wanting to work in the future	208
Table 8-1: Service users' housing satisfaction levels by SHS type	217
Table 8-2: Multiple linear regression: satisfaction with privacy.....	218
Table 8-3: Means and significant associations between population density and housing satisfaction ratings	220
Table 8-4: Frequency statistics: satisfaction with social situation.....	222
Table 8-5: Multiple linear regression: satisfaction with social situation	223
Table 8-6: Satisfaction with housing situation: frequency statistics	223

Table 8-7: Linear regression: satisfaction with housing situation	224
Table 8-8: Satisfaction with community activities: frequency statistics.....	225
Table 8-9: Linear regression: satisfaction with community activities.....	226
Table 8-10: Satisfaction with fellow residents/tenants: frequency statistics.....	227
Table 8-11: Linear regression: Satisfaction with fellow tenants or residents	228
Table 8-12: Linear regression: Satisfaction with freedom	229
Table 8-13: Independent samples t-tests: significant associations between variables and general housing satisfaction	230
Table 8-14: Linear regression: General housing satisfaction.....	232
Table 8-15: Importance or non-importance of service users' concerns (as judged by managers).....	234
Table 8-16: Descriptive statistics and significant relationships between concerns of managers of born in the UK and abroad.....	236
Table 8-17: Challenges service users face: a manager's perspective	237
Table 9-1: Fisher's exact test statistics and cross-tabulations between being engaged in an occupational activity or not and ratings of health (EQ-5D-3L)	247
Table 9-2: Cross-tabulation statistics between housing type (care homes/other SHSs) and employment barriers.....	249
Table 9-3: Fisher's exact test statistics and cross-tabulations between population density and employment and its barriers	249
Table 9-4: Cross-tabulation: engagement in occupational activities.....	250
Table 9-5: Binary logistic regression odds ratios: engaged in an occupational activity or not.....	251
Table 9-6: Cross-tabulation: desire to be employed.....	252
Table 9-7: Binary logistic regression odds ratios: desire to work (no/yes).....	253
Table 9-8: Means and relationships between housing type and occupational activities	254
Table 9-9: Service users' involvement in activities in the community and other (frequencies)	256
Table 9-10: Service users' typical days (frequencies)	257
Table 9-11: Pearson's chi-square tests and Fisher's exact test statistics and cross- tabulations: engagement in activities and SHS type.....	258

Table 9-12: Descriptive statistics and significant relationships: going to a day centre on a typical day	259
Table 9-13: Service users' activities: managers' responses (frequencies).....	260
Table 9-14: Descriptive statistics and significant relationships between number and types of benefits by SHS type.....	262
Table 9-15: Number of benefits received: significant Pearson's correlations.....	263
Table 9-16: Social networks: frequencies of answers by category of person	264
Table 9-17: Chi-square tests: cross-tabulations of social network differences by SHS type (care home versus other setting).....	265
Table 9-18: Chi-square tests: cross-tabulations of social network differences by population density (urban versus rural areas).....	265
Table 9-19: Social networks and housing satisfaction ratings: descriptive statistics and statistically significant differences	266
Table 9-20: Manager responses: discrimination towards people with mental health problems (frequencies and percentages)	267
Table 9-21: Residents' on section 117 after-care mean housing satisfaction ratings	273
Table 9-22: Cross-tabulation: living within area or not	275
Table 9-23: Binary logistic regression odds ratios: living within area or not.....	276
Table 10-1: Types of questions and examples from interview schedule used in qualitative study.....	284
Table 10-2: Steps undertaken in this study for the framework analysis	285
Table 11-1: Comparison of service users' mean housing satisfaction ratings and means of service users' concerns (as judged by managers)	348

Table of Figures

Figure 1-1: Scope of the study	21
Figure 2-1: Service users in different SHSs types funded by the Supporting People Programme (Centre for Housing Research, 2013b).....	42
Figure 2-2: Providers of SP-funded accommodation-based services for people with mental health problems.....	43
Figure 2-3: Council supported resident numbers 2003-2011.....	47
Figure 2-4: Growth of investment in direct service categories since 2002 (at 2010/11 pay and price levels in £ millions)	52
Figure 3-1: Search strategy for review of reviews	56
Figure 3-2: Search strategy for post-2005 studies.....	57
Figure 5-1: How participants were to be selected for the study, procedure and progression.....	118
Figure 5-2: Steps to selecting areas for the study	127
Figure 5-3: Number of specialist housing services to be sampled per area and in total	128
Figure 6-1: Timeline of data collection	153
Figure 6-2: How interviews should be secured in principle.....	158
Figure 6-3: How interviews were secured in practice	159
Figure 6-4: Selecting SHSs in area A (step three of figure 6.3)	161
Figure 6-5: Men's EQ-5D as a self-rated index by age	170
Figure 6-6: Women's EQ-5D as a self-rated index by age.....	170
Figure 6-7: EQ-5D-3L 'problem areas' by gender.....	171
Figure 9-1: Barriers to seeking and maintaining employment: service users	248
Figure 9-2: Barriers to service users seeking and maintaining employment: managers' perspectives	254
Figure 9-3: Receipt of social security benefits by type (frequencies).....	261
Figure 9-4: Average number of categories of people across all questions.....	263

Preface

The journey had been nice and pleasant. For once there wasn't much traffic on the motorway, and my navigation system hadn't guided me into some obscure ditch. As I drive past the iron gate, across the gravel, I park my car under some trees in the shade, quite close to the house. It was a warm summer's day in July and I had a feeling I would be there for a while.

I check my map again, and my appointment book. The signage by the door says Dove Farm¹, so I guess I was in the right place.

As I open the car door, I am overcome by a foreign feeling. I was in the countryside, away from the pollution of the city; the nature was overwhelming.

Dove Farm is a quaint detached house set in beautiful gardens. As I look around, it feels so peaceful, and silent, the closest main road was miles away. I take steps towards the house, and notice a barbecue next to the hedges. It looks like it had been used recently, and I make a mental note to ask the manager, Anna, about it.

A chiming sound resonates as I ring the doorbell. I wait a couple of minutes and ring again. I hope they still remember to expect me this morning! Finally, Anna answers the door, looking all flustered in a green t-shirt. "I'm so sorry to have kept you waiting Marya! Was just on the phone to someone's social worker. Please come in!"

As I walk in, I am greeted by a familiar smell, one that seems to be consistent across all homes: I'm not sure what it is exactly, but I can certainly detect cooking, possibly some kind of breaded meat cooked in the oven with some potatoes, laced with a stale odour of tobacco.

I sign myself in, I was the first visitor this morning, and the only one in a couple of days it seems. Anna offers me some coffee, which I appreciatively accept. As she scurries off into the kitchen, I am left waiting in the main hall and start looking around. Joyful photographs align the walls, memories of parties, outings and daytrips, pictures of smiling people, mixed with some pretty hand-made paintings some of the service users had undoubtedly created. I could hear the faint sound of a

¹ Pseudonym

television that had been left on...nobody seemed to be around. Before I am able to venture further into the house, Anna bursts in, coffee in hand. "Shall I show you around the house?"

As we walk from one bedroom to the next - there were six in total - I can't help but notice how personalised each one of them was. "This person is clearly a keen Arsenal fan!", I remark, as I point to the red bedspread and many posters. We walk into another very spacious bedroom and Anna tells me that this was the only one with an en-suite: "He has some bowel problems you see". We go back to the front of the house, past the living room, and enter the dining room where Harry was having lunch. Anna introduces me as Harry gets up to greet me. He was a small middle-aged man, with a warm smile. "Hello!" he says, as he hugs me and strokes my hair, smearing it with the remnants of his lunch from his hands. I think to myself "Ah! Baked beans!" Anna lets out a cry: "Harry! Go finish your lunch!" She looks at me apologetically, and I nod my head, as if to say I don't mind.

As we walk to her office at the top of the stairs, she describes the care home she manages: "All meals are cooked for residents, but they don't all have to eat at the same time. They're really integrated and all, and enjoy each other's company, but I'm sure they don't all get hungry at the same time and have other things to do. I really want to promote choice among them. So if someone wants to go into town, they don't all have to go into town. So everyone gets to do their own thing, when they want."

Paperwork and files clutter her desk. She clears some of it away and finds her computer keyboard buried under it and promptly closes the Facebook window she had open. "I really need to see your credentials before we start, if you don't mind." I quickly produce them and she checks them thoroughly. "I really don't understand why someone would not want to be interviewed or participate in the study...I'm sure that those people are hiding something."

The interview lasts about 40 minutes. As I put back my recorder and interview schedule, she tells me it's going to be a while until Harry comes back from town, and he's the only person who wants to participate. I'm fine with waiting, as we chat about her upcoming wedding and other things, and Harry appears 30 minutes later. He seemed happy, he had just bought the new NOW CD compilation.

Good talking point, I think to myself. Anna asks me if I want her to be there during the interview, and I politely decline.

Harry's interview lasts a little less than Anna's, but it was certainly worth the wait I think. He tells me all about how he looked forward to going into town, whether to buy food or toiletries or something special. He doesn't go out much otherwise, and spends most nights at home. "There was a disco the other week, and we all went, along with some other people from nearby houses. It was good fun." There aren't many things to do at night-time apparently, so he either sleeps early or watches television.

I thank Anna and Harry profusely, as she wishes me a safe trip home.

The drive back seems longer, and I feel tired, emotionally and physically. So many things to think about, and extract from these talks. It was a good day.

Summer 2011

Chapter 1 Introduction

1.1 Putting specialist housing services for people with mental health problems into context: importance and relevance of topic

1.1.1 The policy context

Over the past 40 years in North America and Western Europe, there have been major changes in mental healthcare provision, leading to a shift from institution-based to community care, and the closure of long-term psychiatric hospitals. This process is termed deinstitutionalisation. More specifically, the National Institute of Mental Health in the United States (National Institute of Mental Health, 1976) defines deinstitutionalisation as the mediation of two main processes: the closure of institutionalised settings for the care of people with mental health problems, and the concurrent expansion of community-based services for the treatment of these individuals.

The main context for this study (carried out in England) thus lies within the community care reforms of the late 1980s (Department of Health, 1989) which accelerated the closure of long-stay institutions. In their review of deinstitutionalisation in England, Thornicroft and Bebbington (1989a) recognised that there were five factors contributing heavily to the case for the closure of long-stay institutions: the recognition of institutionalism or the fact that the social conditions in which people with mental health problems live can influence their symptomatology, especially the negative symptoms; financial incentives and constraints due to decreased spending on psychiatric services and the development of new 'cost-effective' methods and services; treatment developments such as new antipsychotic medication, and the establishment of community mental health centres and hostels; legal influences under the Mental Health Act 1959 with the establishment of Mental Health Review Tribunals and the dissolution of the Board of Control; and finally hospital inquiries into malpractice which provided trenchant criticism of psychiatric institutions and galvanised politicians into action.

Hence, for these, and possibly other reasons, community care was considered as the better option for people with mental health problems. Naturally, the closure of hospitals brought about the need for greater provision of other forms

of accommodation-based settings. In an overview of international studies on deinstitutionalisation, Fakhoury and Priebe (2002) commented that in some countries this has led to people being discharged from hospital with both the community and themselves unprepared, and finding themselves neglected by care agencies and committees.

1.1.2 Previous research on specialist housing services² for people with mental health problems

There has been surprisingly little research conducted on housing services for people with mental health problems. Given that housing is such a basic, ubiquitous and obvious need, it seems paradoxical that it has been so neglected by researchers (Fakhoury et al., 2002). This research neglect is also surprising given that national bodies in the UK such as the Audit Commission (1998) have expressed concern that the range of available housing for people with mental health problems is insufficient or of poor quality. The Audit Commission added that more research was needed; yet 16 years later, the situation has changed relatively little.

Previous studies of housing services for people with mental health problems in the UK have focused mainly on long-stay accommodation services such as care homes, whilst generally ignoring 'lower-level', less intensively staffed and mostly smaller scale service types such as floating support and supported housing schemes (Oliver & Mohamad, 1992; Shepherd et al., 1996). Supported housing schemes, which are one of the most common forms of housing services for people with mental health problems in the UK, provide either semi-supervised or fully supervised living arrangements, with some level of mandatory mental health services (Fakhoury et al., 2005).

Moreover, the research that has been conducted has focussed on specific topics such as the goals of long-stay patients, staff perceptions (Ryrie et al., 1998) and the needs and costs of residents (Cambridge et al., 2003; Chisholm et al., 1997; Järbrink et al., 2001), but generally has not looked at the bigger picture such as service users' needs or satisfaction. In 2009 a large-scale study was commissioned

² Specialist housing services (SHSs) refer to specialist accommodation-based services that cater to people with mental health problems, and will be a term referred to throughout the thesis. A definition will be provided in chapter 4.

to attempt to take the first step towards the identification of users of housing services in England, their needs and other characteristics, what care they receive and what costs are generated (Priebe et al., 2009).

Hence, it is probably reasonable to conclude that most of the research into SHSs is incomplete: Fakhoury et al. (2002) even go so far as to conclude that there is little consensus about what these housing services are or about the philosophy they embrace. Another opinion from a previous commentary in the field was that previous research suffers from a lack of an 'official' typology (O'Malley & Croucher, 2005) making it difficult to compare schemes, processes or outcomes (Anderson et al., 2007).

It is also quite surprising that the experience of living in community-based settings has rarely been reported in research from a service user perspective (Forrester-Jones et al., 2002). As one of the care home managers for this study commented:

"It's really time for service users to be heard. Some of the previous research that has been done is irrelevant, and this is really an important study. We need to learn how to treat people with mental health problems as individuals. You can't beat experience though, and you clearly can't learn this sort of thing in books."

Manager, care home

Available information on the number of people with mental health problems entering and leaving specialist housing services (SHSs) is collected annually by the Centre for Housing Research but only covers individuals funded by Supporting People and is therefore incomplete. Moreover, data on service users' experiences within specialist housing services (SHSs) in England is scarce: no in-depth research has been conducted on how individuals experience movements into or out of housing settings, nor on their housing satisfaction, nor relationships, activities, uptake of personalised services, or social inclusion. Similarly, very little is known on the managers of these services and the ethos that they promote within them.

People with mental health problems constitute one of the most socially excluded groups in society (Social Exclusion Unit, 2004), and their choices and preferences are somewhat infrequently sought or eventually fulfilled.

Personalised services, such as choice based lettings, personal budgets and direct payments, have the potential to empower individuals as well as promote social inclusion. But this, too, is an area where little research exists, and where the potential relationship with housing satisfaction could be explored further.

An individual's activities and relationships all contribute to the bigger concept that is an individual's social inclusion. It is therefore pertinent to explore their levels of community activities, and social networks. Do higher or lower levels of social inclusion in this sense affect housing satisfaction?

The combination of a lack of research on SHSs for people with mental health problems, the lack of routinely available data, as well as a lack of understanding as to the views and preferences of service users leave huge gaps in the field, preventing any evidence-informed strategic policy discussion or local planning.

The research described in this thesis seeks to contribute to the evidence base in a number of ways:

- It illustrates life within SHSs from the perspective of the service user as well as service managers.
- It examines the factors that are associated with the movements of individuals in and out of SHSs, their experiences as well as their housing satisfaction.
- It investigates the level of social contacts and participation within the community, as well as associated factors within specialist housing services.
- It explores the uptake and use of personalised services within the domain of SHSs.
- It explores social inclusion and potential discrimination from both service users' and managers' perspectives.

1.2 Research questions

The main research question to be addressed in this thesis is:

What are the factors that are associated with the housing satisfaction of service users with mental health problems within specialist housing services?

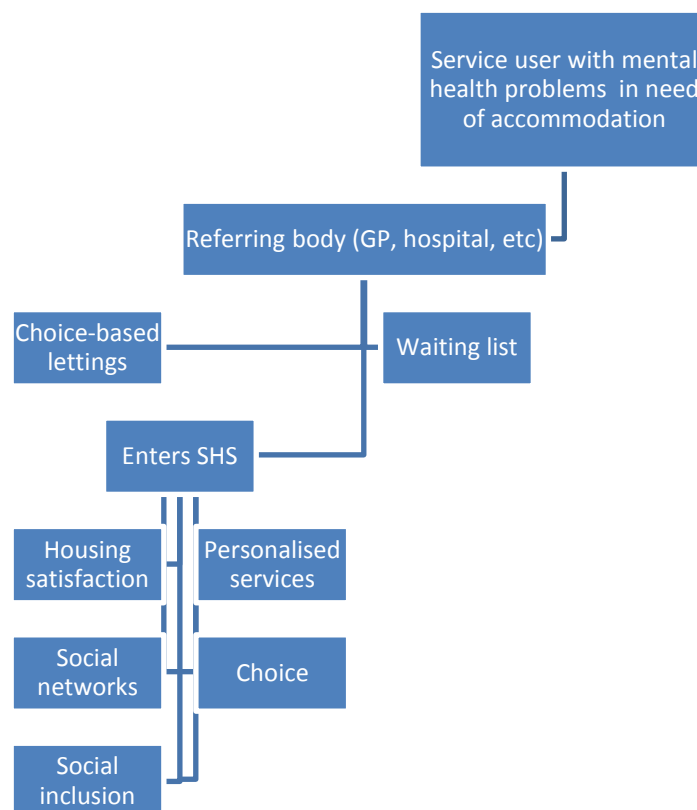
Subsidiary research questions are:

- 1) *What are the pathways into and out of SHSs?*

- 2) *How apparent are social exclusion and discrimination within specialist housing services, in terms of, for example accommodation and employment?*
- 3) *Are peoples' choices and preferences taken into account? Does that affect their housing satisfaction?*
- 4) *Do managers promote independence within their services?*
- 5) *Social inclusion: Are service users fully engaged in the social sphere and the community? How is that associated with their housing satisfaction?*

The scope of the study is illustrated in figure 1.1. For the purposes of this dissertation, only accommodation-based services specifically for people with mental health problems and located in England will be considered, and will be termed Specialist Housing Services (SHSs).

Figure 1-1: Scope of the study



1.3 What lies ahead

The next chapter (Chapter 2) will delve into the history of mental health care, from 1845 up to the present day. These policies helped shape the lives of people with mental health problems, and laid the foundations for more responsive

and hopefully more effective services that suit peoples' needs and preferences. This chapter also describes the roles of local social and health services, and how they interact, and the establishment of community mental health teams – which played a pivotal role in the establishment of care in the community for people with mental health problems.

Chapter 3 reviews the literature on SHSs, starting with available reviews of the literature, and then focusing on key studies based in England. Research gaps were identified following this review.

Chapter 4 introduces a new classification system for specialist housing services in England that will be used throughout this thesis. Definitions and descriptions were synthesised and drawn from previous England-based studies.

Chapter 5 sets out how the study was designed, specifically how the sample was selected, the methods of analysis and data collection, and development of the study materials.

Chapter 6 describes how the research design was implemented, and how interviews with service users and managers were secured. The chapter also presents the characteristics of the study sample. Participants are described in terms of individual characteristics. The SHSs selected are described, in terms of size, provider types, restrictions and rules within the home, as well as other characteristics.

Chapters 7 to 10 report the empirical results of the study.

Chapter 7 deals with movements in and out of SHSs. Descriptions are offered according to a range of dimensions, such as service type or population level. Experiences in psychiatric care are also described and whether people had experienced any delayed discharge.

Focussing more specifically on experiences, chapter 8 reports how service users rate their housing satisfaction with regard to different aspects of their lives, ranging from their social situation to the amount of freedom they feel they have. Managers' views are also important here, and data are offered on concerns they feel are important to service users (such as employment and income) and the challenges that service users face.

Social inclusion as experienced by service users and reported by managers is the focus of chapter 9. Evidence ranges over a number of domains, including employment, community activities and social security benefits. Social networks are also explored here, and any potential associations by population levels or SHS types for example, and their associations with reported ratings of housing satisfaction. Recent policy initiatives are also broached here, such as personalised services and choice-based lettings.

Chapter 10 introduces the qualitative study, and thus completes the mixed methods design for this study. Framework analysis is applied to interpret the accounts of managers and service users, in order to explore in greater depth their experiences within SHSs.

The conclusion (chapter 11) summarises the findings of the study, highlighting its strengths and limitations, triangulating the results of the qualitative and quantitative studies, and proposing some policy and research recommendations.

Chapter 2 Developing a specialist housing services model

2.1 Introduction

The nature and extent of provision of community mental health services in England have undergone radical changes in the last few centuries. The care and support of people with mental health problems is no longer delivered within what have variously been known as madhouses, asylums, and hospitals, but rather primarily within the community. The main drivers of this change have not only been advancements in the fields of psychology and psychiatry, but also the growing influence of considerations of human rights and societal attitudes. One such change is an issue central to this thesis: specialist housing services (SHSs) for people with mental health problems.

2.2 A brief history of madhouses and asylums³

In order to understand the development of SHSs, it is useful to briefly consider their early forms.

Actual treatment of ‘lunatics’ was virtually non-existent in the 17th and 18th centuries. No clear definition of mental disorders existed, and the people who were kept in madhouses suffered from the terrible conditions within them. Those who were reduced to poverty and destitution came within the purview of the Poor Law 1601, and were aided by unpaid overseers of the poor who raised money ‘weekly or otherwise by taxation’ within each parish (K. Jones, 1972, p. 3). Under the 1744 Act, vagrants could be deemed as insane by local magistrates (who held neither legal nor medical training) and placed in a jail or house of correction. Once a person was confined, the only ‘curative’ practice was that of restraint with chains, with the person to be released at the whim of their jailers (Jones, 1972, p. 26).

The Act of 1808 started the process of reforming arrangements for ‘lunatics’ on a national scale, possibly influenced by pressure on the House of Commons from people who had been wrongfully detained, with the establishment of county asylums (Jones, 1955, p. 66). By 1827, there were nine county asylums in operation (p. 116). It was not until a century later, under the Mental Deficiency Act of 1913,

³ Much of discussion on the history of madhouses and asylums has been extracted from Jones (1955, 1972).

that a clearer distinction was made between people with mental health problems and people with learning disabilities (Jones, 1972, p. 216).

The Mental Treatment Act of 1930 hinted at the first signs of community rehabilitation, as well as the possibility of recovery. Further clarifications were made between i) patients who might be received without certification, 'voluntary' patients, who would enter the hospital of their own volition, and could leave at any time after seventy-two hours' notice; and ii) 'temporary' patients, who might be expected to regain the power of volition within six months. The personnel system was reorganised and certified, outpatient clinics were provided, and psychiatric clinics, usually attached to general hospitals, were developed to constitute a valuable bridge between life in the community and the asylum. Patients could be referred to psychiatric care through such a clinic, where they might also receive after-care (Jones, 1972, p. 226).

Indeed, this new 'system' was envisioned as a sort of clearinghouse where acutely ill patients would receive high-quality treatment with the aim of preventing the need for long-term care in an asylum. The after-care clinics were intended to facilitate the follow-up of people with acute problems to ensure their successful return to community life, and centred around the new profession of psychiatric social work (Johnson, 1990, p. 13).

Thereafter, the use of terms such as 'asylum' and 'lunatic' were replaced with terms meant to be less stigmatising at the time, such as 'mental hospital' and 'person of unsound mind' (Jones, 1955, p. 252). The National Health Service Act of 1946 added that the treatment of the mentally ill should be on par with that of the physically ill and disabled. In 1948 the National Health Service (NHS) took over responsibility for the people in asylums from the local authorities.

The Mental Health Act of 1959 put an emphasis on community care and gave greater autonomy to mental health professionals (Szmukler & Holloway, 2000). The Hospital Plan for England and Wales, disseminated by the Ministry of Health in 1961, called for a large decrease in asylum beds, with a corresponding increase in psychiatric beds in general hospitals together with day hospitals and community services (Shorter, 1997, p. 20). General hospitals would therefore

replace the functions of the large hospitals, which would be required only for the older, long-stay patients (Tomlinson, 1991, p. 14).

This paved the way to community care or deinstitutionalisation.

2.3 Deinstitutionalisation

At the beginning of the 20th century, mental hospitals had become notorious for poor living conditions, lack of hygiene and serious overcrowding. The first alternatives to asylums, community-based services, had started to appear in the 1920s and 1930s, but nonetheless by the 1950s there were still more patients in asylums than at any other time. Reforms were championed by mental health professionals and members of the public, eventually leading to the downsizing or widespread closure of asylums.

Deinstitutionalisation is the process of shifting the care and support for patients with mental illness from custodial asylums to community-based settings (Fakhoury & Priebe, 2007) and saw its real beginnings in England in the 1970s. Generally, studies have demonstrated that deinstitutionalisation has had positive outcomes for service users (Crosby et al., 1993; Killaspy, 2006; Leff, 1997b; Leff et al., 1996; McCourt, 2000; Shepherd et al., 1995; Tansella, 1986; Thornicroft & Bebbington, 1989b).

Yet deinstitutionalisation also had its sceptics, with some arguing that there was a process of 'reinstitutionalisation' (Priebe et al., 2005; Turner & Priebe, 2002). Priebe and Turner (2003) found increasing numbers of people undergoing involuntary treatment in hospital, possibly due to changing professional attitudes as well as placements in SHSs at varying levels of support. There was also a large increase in the number of placements in SHSs, about 40% between 1990 and 2002. Questioning the effectiveness of SHSs, Priebe and Turner (2003) argued that they seemed to be taking the place of the old style asylums, with many establishments being run by private providers.

Overall, the number of community services has steadily increased in the last few decades, and the position has therefore changed from being an entirely hospital bed-based system, to a system where psychiatric inpatient provision deals only with those needing the most acute care (McCulloch et al., 2000).

2.4 Post-deinstitutionalisation policies

Following the deinstitutionalisation movement of the 1970s, several policies were drafted to coincide with this policy stance.

2.4.1 Mental health policies

Although not specifically linked to the development of SHSs, the following policies helped shape the treatment and rights of people with mental illness.

Treating mental health patients

The 1983 Mental Health Act outlined the conditions for ‘sectioning’ people with mental health problems, as well as the maximum duration they could be detained for assessment, and who could discharge them. Defining mental disorder as ‘any disorder or disability of the mind’, it curtailed some powers bestowed to mental health professionals by the 1959 Mental Health Act, by strengthening patients’ rights against paternalistic intrusion (Szmukler & Holloway, 2000). This Act also saw a growing awareness of the treatment of BME (Black and Minority Ethnic) groups, with several studies having reported that a disproportionate number of people from BME groups were being compulsorily detained under both civil and forensic sections of the Mental Health Act 1983 (Bhui et al., 2003; Churchill et al., 1999; Morgan et al., 2004). Along with higher prevalence rates of psychosis (Bebbington et al., 1994), some authors accused the system of racism and racial stereotyping as the cause of this unbalance (Singh et al., 2007).

The lack of capacity in mental health

The Mental Capacity Act 2005 (Department of Health, 2005d) provided the statutory framework to empower and protect adults (people aged 16 or over) who may lack capacity to make some decisions for themselves, including people with mental health problems. The Act clarified who could take decisions and how they should go about doing so, and covered the major decisions about a person’s property and affairs, healthcare treatment and housing arrangements, where the person lacks capacity to make decisions themselves. Its underlying principle was that it ‘presumed capacity’: every adult has the right to make their own decisions and must be assumed to have the capacity to do so unless proven otherwise. Only

in exceptional cases, and after being given all practicable help, can a person be treated as not being able to make their own decisions.

Choice and user involvement

Choice dominates today's discussion of health policy (Secretary of State for Health, 2004). In 2005, the *Independence, Well-being and Choice* Green paper (Department of Health, 2005c) was intended to give service users greater choice and control over the way in which their needs are met, whilst maintaining their independence and well-being. This Green Paper also proposed the wider use of direct payments (DPs) and the piloting of individual budgets to stimulate the development of modern and personalised services. This later developed into experimentation with Individual Budgets (IBs); the offer of Personal Budgets has now taken the personalisation agenda further.

The introduction of DPs hence represented an aspiration to increase opportunities for empowerment, independence, social inclusion and self-esteem (Department of Health, 2003). DPs are "*cash payments made to individuals who have been assessed as needing services, in lieu of social service provisions*" (Department of Health, 2008a). They are aimed at giving recipients greater control over their own lives, enabling them to purchase services other than those provided by the local council, including novel solutions in terms of services and activities. The money a person receives is decided on following an assessment of need.

DPs were found to be provided least commonly to people with mental health problems, compared to other client groups (Davey et al., 2007). It has been recognised that this group has the greatest difficulty in accessing them (Spandler & Vick, 2004), possibly due to a lack of awareness about and promotion of DPs, as well staff concerns about their ability to manage payments (Davey, et al., 2007; Social Exclusion Unit, 2004). Despite low uptake rates, there was great diversity in their use, ranging from support with regard to personal care and transport, to everyday activities (Spandler & Vick, 2004).

IBs were later introduced in a pilot scheme, promising greater personalised purchasing and freedom in the selection of the chosen type of care and support (Department of Health, 2006b). IBs brought together separate funds from a variety of agencies, including and most importantly in this case, the Supporting People

programme (to be discussed below). IBs were to be delivered as a single transparent sum allocated to a person in their name and held on their behalf (like a bank account), allowing the individual to either then choose to take the funds out in cash (as a DP) or as a mixture of cash and services up to the value of their IB.

Equal treatments and services for all

In parallel, the Department of Health (2005a) sought to bring more racial equality to mental health care with their action plan *Delivering Race Equality in Mental Health Care*. It required services to be more culturally appropriate, as well as promoted more community engagement through their involvement in service planning. Finally, higher quality information was to be obtained, for example through the *Count Me In* census (Care Quality Commission, 2010), to monitor ethnicity and better disseminate information and good practice.

Community treatment orders

Until the passage of the Mental Health Act 2007, compulsory treatment in the UK was largely restricted to in-patient hospital settings. The Act established supervised treatment in the community or Community Treatment Orders (CTOs). A person was no longer physically required to stay in hospital accommodation, but the responsible clinician had a duty to review at all stages the appropriateness of resident or non-resident care (Kinderman & Tai, 2008).

Regulating services

In November 2007, the Health and Social Care Act (2008b) outlined significant measures to modernise and integrate health and social care. The Act contained four key policy areas, and established the Care Quality Commission (CQC), to replace the Commission for Social Care Inspection. CQC was to be the new regulator for health and adult social care, integrating former regulators into a single regulatory body, with powers to ensure safe and high quality services.

More service user empowerment

The growing expectation that social care clients should lead full and purposeful lives inspired *Putting People First* (Department of Health, 2007b) which introduced Person-Centred Planning (PCP). This was to be a way of discovering what people want and need, and the support they may require, thereby shifting power

from professionals to service users and focussing on what is important to them (Dowling et al., 2006).

Mental health and well-being

The recent National Service Framework for mental health (Department of Health, 2009) highlighted a clear association between good mental health and better outcomes across a number of domains. It adopted a lifespan approach, laying down the foundations of good mental health in childhood, through promoting and protecting continued well-being into adulthood, to supporting and maintaining resilience in older age. It also focused on tackling stigma.

The Public Health White Paper (Department of Health, 2010) proposed a new approach to public health, with mental health identified as an integral and complementary part of the proposed new direction (National Mental Health Development Unit, 2010). Its 'localism agenda' was intended to encourage local authorities to take responsibility for health improvements locally by providing them with new resources, rights and powers to shape their environment. It emphasised the importance of promoting mental health and the well-being of the whole community, of preventing mental illness and of supporting those experiencing mental health problems. Another objective of this White Paper was to improve health and well-being by strengthening self-esteem, confidence and personal responsibility.

A corollary to the White Paper is the *No Health Without Mental Health* (Department of Health, 2011) outcomes strategy. This outlined several objectives, as set by a wide range of partner organisations, including service user representatives, providers, local government and government departments to promote good mental and physical health and well-being, and better social inclusion. It aimed to support better mental health outcomes, by empowering communities, decentralising control of services, and fostering and supporting social action, social inclusion and volunteering.

Stigma and discrimination

Many attempts have been made to tackle stigma and discrimination against people with mental health problems (Department of Health, 1999b; Social Exclusion Unit, 2004). The Department of Health's *Mindout for Mental Health* campaign

targeted the public at large, specifically employers, the media and young people (Rethink, 2003). Recently, the *Attitudes to Mental Illness* 2011 report (Health and Social Care Information Centre, 2011a) found that public attitudes towards people with mental health problems were changing. The survey showed that members of the public were now more comfortable living next to someone who has a mental health problem, and more than 70% agreed with the care in the community initiative.

2.4.2 Community care policies

The policy stances discussed next pertain to caring for people with mental health problems within the community, shifting the delivery of care and support away from asylums and large-scale psychiatric hospitals following their gradual closures. These were planned in parallel to the previously described mental health policies.

Caring for people in the community

The White Paper (Department of Health, 1989) on community care – *Caring for People: community care in the next decade and beyond* - set the direction of policy for many years (Holloway & Lymbery, 2007). It reaffirmed the government's commitment to promoting the care of people with mental health problems in the community, preferably within the family home or a 'homely environment' whilst also promoting service user choice and independence. Local authority social services departments were to be transformed from service providers to 'enabling agencies', concerned with assessing need, planning services and promoting consumer choice among a range of different organisation types, be it public, voluntary or private organisations, but were somewhat encouraged to make maximum use of the latter sector (Langan, 1990).

Providing accommodation-based services

The 1990 NHS and Community Care Act (House of Commons, 1990) made the link between the provision of adequate housing and the satisfactory integration of psychiatric patients into the community (Glover-Thomas & Barr, 2003). It required local social services and health authorities to jointly agree community care plans, with a clear indication of the local implementation of needs-based individual

care plans for long-term psychiatric patients, and the subsequent provision of the services required. The Act also promoted the development of domiciliary, day and respite services, enabling people to live in their own homes when possible (Thornicroft, 1994). In later circulars (Department of the Environment & Department of Health, 1992, 1997), partnership planning and working between LAs and housing was encouraged and appropriate guidance given.

In 1997, the Department of the Environment and Department of Health published *Housing and Community Care: Establishing a Strategic Framework* (1997). It set out key points some of which remain valid and applicable today (Boyle & Jenkins, 2003). Most importantly, it set out an agreement between those responsible for determining practices for health, social services and housing that services for people with mental health problems should be a priority for the medium and long-term. It made plans to develop, through joint-commissioning, a range of support and housing options from the independent sector, as well as promoted the use of floating support (care in service users' own homes).

Setting standards of community care

In 1999, hard on the heels of the 1998 mental health White Paper, the National Service Framework (NSF) for Mental Health (Department of Health, 1999b) highlighted the impact of poor housing on mental health and embarked on a 10-year programme of reform, including the setting of national standards and defined service models. These covered areas such as mental health promotion, access to services, and effective service models in primary and secondary care. Its stated aims were mainly to drive up quality, and remove wide and unacceptable variations in provision (Thornicroft, 2000). It also aimed to identify the housing status of people with mental health problems within the Care Programme Approach (CPA) and to ensure that their care plan addressed their housing needs (Boyle & Jenkins, 2003).

The CPA was - and subsequent versions continue to be - a programme to manage the care of people with mental health problems, applicable to all individuals in contact with secondary mental health services, as provided by the NHS as well as social care departments (Department of Health, 1999a). Introduced in 1991 to provide a framework for effective mental health care and to keep people in contact with services, its tasks included assessment, care planning, keyworker

support and regular reviews. The CPA was likened to a model of 'extended brokerage case management' – assessing needs and then 'purchasing' (i.e. brokering) appropriate packages of care. Some departments designated some social workers as 'purchasers' in contrast to other staff who were designated 'providers' (Burns, 1997). However, the CPA did not go without criticism. Bindman et al. (1999) found that prioritisation for the use of the CPA did not appear to be closely linked to need, and inequitable treatment resulted, as well as significant cross-country differences (Schneider et al., 1999). Yet Carpenter and Sbaraini (1997) found that most mental health service users on the CPA felt more involved in the planning of their own care and treatment, had more choice and were better informed about their rights and services, compared to people who did not have a care programme.

"Legitimised by the introduction of the CPA in the early 1990s" (National Institute for Mental Health in England, 2003, pp. 3-4), Community Mental Health Teams (CMHTs) are multi-disciplinary means for providing mental health services outside of hospitals; their establishment led to the provision of an increasing number of community services (Bouras et al., 1986).

The North East Public Health Observatory (2007) estimated the number of Community Mental Health Teams in England to be 787 – an average of 37.1 CMHT members per 100,000 population. This integrated approach to mental health care, is accentuated by the presence of social workers (Carpenter et al., 2003), who work alongside community psychiatric nurses (CPNs) and administrative staff (Onyett et al., 1994). CPNs, psychologists, occupational therapists and psychiatrists are employed by health trusts, whilst social workers are seconded by local authority social services departments.

The NSF 1999 argued for a concerted, nationwide departure from reliance solely on generic teams and the NHS Plan; the Policy Implementation Guide (Department of Health, 2001) plumped for a *"functionally differentiated service model of three specialist teams to replace or complement generic CMHTs."* Assertive outreach teams were set up to provide intensive support for people with severe mental health problems who were difficult to engage in the more traditional services, and 24-hour crisis teams, providing a single point of access for people in crisis, were responsive and aimed to prevent inpatient admission on short-term

basis until other services became available (While et al., 2012); in addition, an early intervention psychosis team managed new cases.

Providing good quality housing

In 2000, the first comprehensive review of housing for 23 years was published, with the publication of the Housing Green Paper *Quality and Choice - A Decent Home For All*, and its aim was to offer everyone the opportunity to live in a decent home and so to promote social cohesion, well-being and self-dependence. More specifically, it introduced a new “Supporting People” policy, to more effectively provide the support services that people with mental health problems would need to remain independent within the community. Finally, it established a new fund to pilot customer choice based lettings in different areas of the country (Department of the Environment Transport and the Regions, 2000).

This pilot eventually led to a system where people were able to balance their own ‘felt’ need, as measured by the time they felt able to wait, against the availability of the properties they might be able to secure. Waiting times would become the ‘currency’ that those in the social sector could use to optimise their own decisions about where to live, taking into account all their needs and aspirations. Naturally, those in the highest needs band would have priority over those with lesser needs (Communities and Local Government, 2008; Department of the Environment Transport and the Regions, 2000). Applicants for social housing through choice based lettings (CBLs) are able to do so via openly advertised means, such as the local press or interactive websites, so that they can view the full range of available properties and apply for any home to which they are matched. The successful bidder is the one with the highest priority under the scheme, whilst authorities provide feedback that helps applicants to assess their chances of success in future rounds (National Institute for Mental Health in England, 2006). CBLs were said to overcome the disadvantages of waiting lists, due to their transparent and fair processes (Office of the Deputy Prime Minister, 2004a), yet it was recognised that people with mental health problems may encounter difficulties when applying, and that appropriate assistance should be given where applicable (Communities and Local Government, 2008).

The *Our Health, Our Care, Our Say* White Paper (Department of Health, 2006b) set out to modernise services, establishing national minimum standards, and requiring authorities to develop more choice of provider, and support to help people living at home. It also reiterated the aforementioned Green Paper's vision of high quality support to meet people's aspirations for independence and greater control over their lives, and to make services flexible and responsive to individual needs. This White Paper also pledged to do more to improve access to community services – aiming to provide more care in more local, convenient settings, including the home.

The Supporting People programme

The launch of the Supporting People (SP) programme in 2003 promised to provide better quality of life for people with mental health problems, and enabling people to live more independently in the community and to maintain their tenancies, by providing housing-related support. This support was intended to prevent problems that can often lead to hospitalisation, institutional care or homelessness. At the same time, it proposed to smooth the transition into independent living for those leaving an institutionalised environment. All short-term support was to be provided free, and where long-term support was needed, people would be able to claim a subsidy from their local authority (Office of the Deputy Prime Minister, 2004b). This new funding system for the provision of housing-related support services brought together existing sources of funding from the Housing Corporation, probation services, and housing benefit into a single 'pot' administered by local authorities (Boyle & Jenkins, 2003). The Supporting People programme also collects outcomes data on all of its clients (to be discussed later).

Delayed discharges

The Community Care Act (Delayed Discharges, etc.) 2003, introduced a disincentive system for delayed discharges: hospitals unable to discharge a patient within three days of their being assessed as being in need of community care services would incur a daily fine (R. Lewis & Glasby, 2006; Office of Public Sector Information, 2003). However, to date the system has not been extended to mental health patients (Department of Health, 2007a).

Mental health patients are discharged from hospital when a clinical and multidisciplinary team decision has been made and it has been deemed safe to do so (NHS Data Model and Dictionary Service, 2010). The last count was of delayed discharges for mental health was said to be 10% of patients in general non-acute beds, and 9% in mental health beds (Department of Health, 2007a).

Causes of delayed discharge of mental health patients are generally thought to revolve around a lack of suitable accommodation (Sainsbury Centre for Mental Health, 1998; Shepherd et al., 1997) as well as inadequate domiciliary-based community support and lack of long-term rehabilitation spaces. In a survey of acute psychiatric care, the Sainsbury Centre for Mental Health (1998) found that 34% of patients who were discharged had any kind of formal or separate meeting to discuss their aftercare plans.

To summarise, table 2.1 shows the timeline of relevant policies and acts that shaped the history of community mental health services in England.

Table 2-1: Selected community mental health policies in England: a timeline

Year	Policy event
1845	Lunacy Act – made no clear distinction between learning disability and mental health problem, stating that “Lunatic shall mean insane person or any person being idiot or lunatic or of unsound mind”
1913	Mental Deficiency Act – made use of the terms ‘idiot’, ‘imbecile’, ‘feeble-minded’ and ‘moral imbecile’. Made it also possible to institutionalise women with illegitimate children who were receiving poor relief
1948	Establishment of the National Health Service
1959	Mental Health Act abolished the Mental Deficiency Acts; advocated community care and established that patients should only be admitted on a voluntary basis unless seen as a danger to themselves or others
1983	Mental Health Act outlines the condition where people with mental health problems can be sectioned, and defines a mental disorder as ‘any disorder or disability of mind’
1989	‘Caring for People’ White Paper sets out principles to shift to community care
1990	National Health Service and Community Care Act required local social services and health services to jointly implement care plans for people to live in the community
1997	Housing and Community Care: Establishing a Strategic Framework sets out the principle that housing is a priority for the medium and long-term and develops a range of housing services for people with mental health problems in the community
1999	National Service Framework for Mental Health highlighted the impact of poor housing on mental health and set out a ten year programme of reform

Year	Policy event
2000	Quality and Choice: A decent home for all Housing Green Paper promoted social cohesion, well-being and self-dependence as well as laid the foundations for the introduction of the Supporting People programme
2003	Launch of Supporting People Programme which promised to provide a better quality of life for vulnerable people to live more independently in the community and maintain their tenancies and also provide housing related support to over 1.2 million people
2005	Mental Capacity Act provided the framework to empower and protect people such as those suffering from mental health problems and clarified who can take decisions on behalf of people who lack capacity
2005	Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England Green Paper sets out proposals for the future of social care for all adults in England. Its vision is mainly to promote greater choice and control over how peoples' needs are met
2005	Delivering race equality in mental health care constitutes a plan for achieving and tackling discrimination in mental health services in England for all people of black and minority ethnic backgrounds
2006	Our health, our care, our say White Paper set out to modernise services, establish national minimum standards, develop more choice providers and support people to remain active and independent in their own homes
2007	Mental Health Act includes the provision of supervised treatment in the community in some cases and the establishment of Community Treatment Orders (CTOs); thus people are no longer required to be detained in psychiatric hospital
2008	Health and Social Care Act 2008 outlined significant measures to modernise and illustrate social care, extended the provision of direct payments and established the Care Quality Commission, the new regulator for social care
2009	New Horizons: a shared vision for mental health highlighted the fact that there is a clear association between good mental health and better outcomes; also that health services must play a greater role in partnership with local authorities and others to deliver quality services that are accessible, integrated and safe
2010	Healthy lives, healthy people public health White Paper makes mental health an integral and complementary part of the proposed new direction for public health in England; also empowers local authorities to take responsibility and health improvements locally
2011	No Health without Mental Health outlines a set of 6 objectives which focuses on prevention in mental health, recovery, good physical health, positive experiences of care and support, also the avoidance of harm as well as stigma and discrimination

2.5 The development of specialist housing services

2.5.1 The importance of housing amongst people with mental health problems

The process of deinstitutionalisation led to an increasing number of people with mental health problems with long-term needs being placed in the community. A key element to community mental health is housing, and is arguably one of the most important factors influencing long-term mental health outcomes (Bigelow, 1998; Halpern, 1995). In contrast, its poor delivery can have a negative effect on mental health states, with reported deterioration in functioning, decreases in quality of life and increased hospital readmissions (Fakhoury, et al., 2002).

Yet experiences of discrimination in housing and employment services were not uncommon (Social Exclusion Unit, 2004). Indeed, in a survey of mental health service users, Hatfield, et al. (1992) found that problems such as social stigma and discrimination could have a significant negative impact on housing choice, with subsequent feelings of powerlessness.

2.5.2 The history of specialist housing services

Abrahamson (1993) and Leff (1997a) provide comprehensive reviews of the history and closure of large-scale county asylums and reprovion for patients in the community.

It is important to make the distinction here between NHS-funded community services and SHSs: the former moved people from a hospital ward into a smaller shared living environment, staffed by clinicians and nurses whilst providing permanent residence; this is a 'health' rather than a housing support service (Pleace & Wallace, 2011). The latter, in contrast, comprised a new concept of housing in the community, or the first specialist housing service (SHS), termed group homes.

Alongside community care, SHSs arose as a policy response to what was described as the 'revolving door' syndrome, where a person would experience a mental health crisis, enter psychiatric hospital, be discharged into community independent living, find it difficult to cope on their own, experience a deterioration of their mental health, have another crisis and enter hospital again (Pleace & Wallace, 2011; Quilgars, 2000).

NHS-funded community services were first developed from the idea of using two offices at the Devon County asylum as houses during the 1850s (Bucknill, 1858). These 'hospital houses' were "*distinct houses built on a simple plan, retaining as much as possible the ordinary arrangements of English homes*", where staff and patients would be lodged together. This gave rise to the idea of 'group homes', as an alternative to hostels, for long-term psychiatric patients. They were intended as 'halfway houses' between hospital and the community, with the length of stay restricted to 12 months, despite the fact that suitable long-term accommodation was rarely available. Group homes thus played a crucial role in deinstitutionalisation, both in practical terms and because they engendered more positive attitudes towards "chronic" patients. They were traditionally unstaffed, where residents, supported by visits from professional staff, lived relatively independently compared to hospital houses (Abrahamson, 1993, p. 209).

A well-known study of hospital closure is the TAPS project, where patient outcomes were well-documented by Leff's (1997a) book on care in the community, following the 1983 announcement by the North East Thames Regional Health Authority of a 10-year programme to close down two of its psychiatric hospitals (these closures were the basis for the establishment of TAPS).

Since 1983, and also writing for the TAPS project, Trieman (1997, p. 51) commented that 100 residential facilities had been established in the area of North London, offering a range of different support services for former long-stay patients. Most had been relocated to then so-called sheltered accommodation, in the form of residential homes and staffed group homes. Less disabled patients were discharged to unstaffed group homes, independent council flats or their family home. This network of facilities in North London was characterised by a rich diversity, in terms of funding and support arrangements, as well as social environments and quality of care. It also provided a comprehensive range of community residential care at the time, characterised by large settings (nursing and care homes) as well as smaller ones, like hostels and group homes.

Homes were relatively small (an average of six residents, p.53), with varying levels of staff support based on need (24-hour to unstaffed, p.61). A common value amongst these homes was the gains in autonomy experienced by people with

mental health problems living in homely settings (p.57). Autonomy in this sense refers to *“less regulation, more freedom of movement and freedom of choice”* (p.57). More specifically, regardless of the support arrangements in place, the ethos was to try to facilitate opportunities for residents to gain independence and be involved in the running of the house, as well as to encourage them to manage their own money and self-medicate. The principles of freedom, privacy and responsibility were hence advocated, perhaps particularly strongly in voluntary-provided schemes (p.62).

In terms of the social environment, the most common arrangement was a mixture of male and female residents of varied ages; there seemed to be no clear concept of the optimal social mix. More crucially, an important question was posed as to whether the objective was to provide a home for life or transitory accommodation. Trieman (1997, p. 64) suggested that the latter option was based on a *“somewhat over-optimistic assumption that the patients would progressively become more independent, and would ‘graduate’ to less supportive homes”*, inspired by a model known as the linear continuum of housing popular in the US at the time (Ridgeway & Zippel, 1990). Yet the prevailing policy at the time for Friern and Claybury hospital ex-patients was to provide permanent homes for people, a stance echoed by the Audit Commission (1994), as *“frequent moves between temporary placements are very disruptive”*, and levels of staff support should be adjusted where necessary rather than making people move as their needs changed.

The establishment of these SHSs also called for experienced staff to run them. Shepherd et al. (1993) suggested that there was no simple agreement on training requirements. A balance needed to be struck between giving staff enough clinical information to make them aware of when professional help should be sought, whilst not ‘over-professionalising’ them and hindering their natural ability to relate to service users as people. Another challenge was to make staff aware of the reasonable expectations for change and improvement, especially given the general tendency for some staff in psychiatric services to sometimes confuse their own expectations with those of service users (Shepherd, et al., 1993, p. 242).

The landscape of SHSs today has further changed, and evolved into a more diverse system of provision, attempting to match service users’ needs as well as

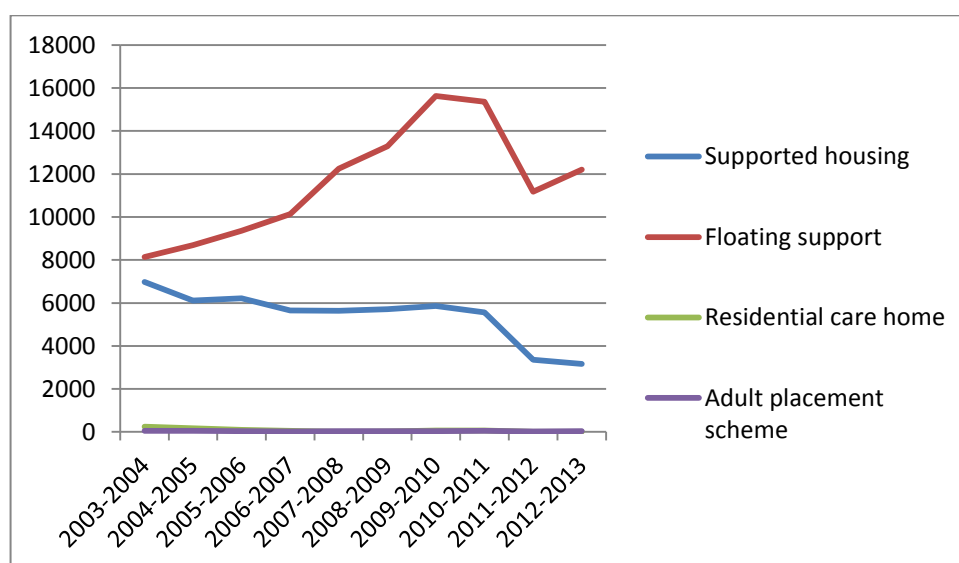
preferences. These structural changes have, however, led to some confusion within the grey and academic literature on how to define and classify SHSs. Chapter 4 describes the current range of SHSs.

2.5.3 Supporting People outcomes data

There is very little information on who is living within SHSs in England, why they have come to be there or how. No statistics are regularly collected regarding referral pathways into SHSs or previous accommodation prior to moving into an SHS, aside from that of Supporting People (SP) clients.

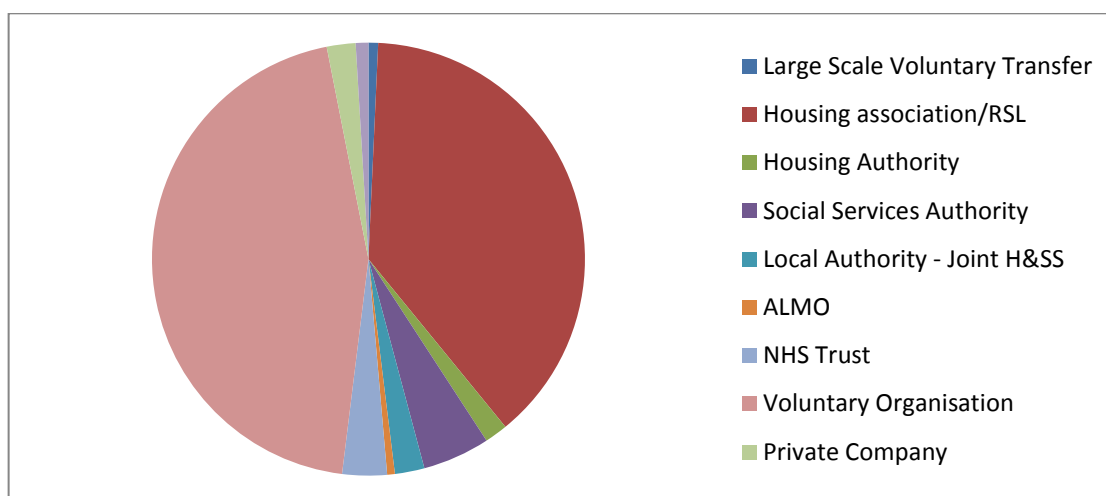
Supporting People launched the Client Record System to independently monitor the delivery of housing-related support (Fusco, 2004): the Centre for Housing Research is now responsible for collecting this information. It provides key performance indicators between and within authorities, locating the routes by which SP services are accessed, as well as information on the personal characteristics of service users. Supporting People is responsible for funding supported housing, defined as support provided with accommodation as an integral package; the service may be shared or self-contained, clustered on the same site or dispersed (Centre for Housing Research, 2013g). Figures from the Supporting People records show that there are currently 3263 mental health service users (aged 18-65) in supported housing (Centre for Housing Research, 2013a). Figure 2.1 illustrates the numbers of people with mental health problems in different housing settings funded by SP from 2005 to 2013. Placements in supported housing services had not grown over the years, and even declined, a possible indicator that more and more support was being delivered within independent flats in the community. Indeed, floating support placements have been rising fast since records began, with a slight decrease in the last couple of years.

Figure 2-1: Service users in different SHSs types funded by the Supporting People Programme (Centre for Housing Research, 2013b)



The Centre for Housing Research also keeps track of SP-funded accommodation services and their provision type. Supported housing services for people with mental health problems (funded by Supporting People) are most likely to be provided by housing associations, Registered Social Landlords (RSLs) and voluntary organisations. Adult placement schemes are usually provided by housing authorities, and residential care homes are provided by voluntary organisations. The voluntary sector, as well as housing associations, play a big role in providing accommodation-based services for people with mental health problems (Figure 2.2).

Figure 2-2: Providers of SP-funded accommodation-based services for people with mental health problems



In terms of previous accommodation (before entering a SP-funded SHS), the most common for a service user with a mental health problem is to have been living in local authority or housing association general needs housing; other common prior locations are the family home and supported housing. Nearly half of all people accessing SP services immediately after a hospital spell are suffering from a mental health problem.

SP further distinguishes between different referral types (Centre for Housing Research, 2012g). Host referrals, which are the most common, are ones where the client receives a service within the administrative authority area in which they have been living immediately prior to receiving that service; whilst non-host referrals are the opposite.

Data from the CHR shows that with regard to SHSs of particular relevance to this study, most referrals are host ones (Centre for Housing Research, 2013d). People commonly stay within their area of residence.

In terms of referral sources, service users living in SP-funded supported housing services had been most commonly referred there by their CMHT, or the local authority housing department (Centre for Housing Research, 2013d). People living in APSs were also most commonly referred there by the latter.

2.5.3.1 Moving out of Supporting People-funded accommodation

Supporting People reviews a service user's tenancy every two years, to assess whether that person is ready for accommodation with less support, as the main aim of a tenancy is to help people regain skills to be able to live more independently. The Centre for Housing Research (2013f) collects data on 'short-term outcomes', including where people move after their tenancies. Short-term outcomes services are basically defined as such by the funding teams, where clients are likely to receive support for less than two years; long-term outcomes services may be delivered for a longer period of time or for life (Supporting People Helpdesk, 2012). The latest data show that of the 1438 people with mental health problems who had their short-term outcomes recorded and had been living in supported housing funded by Supporting People, most had moved on to another supported housing service, a local authority or housing association general needs tenancy. Accommodation with floating support was also a popular projection for this cohort. It would seem that the majority of people moved on to lesser support. Otherwise, 5.3% of ex-supported housing tenants had moved back into hospital (Centre for Housing Research, 2013f).

2.5.3.2 Service user characteristics

Detailed characteristics of people living in SHSs are relatively scarce; yet some information is available on individuals with mental health problems funded by Supporting People.

Focussing solely on supported housing services, as this is Supporting People's largest client base after floating support, the majority of people living in these services were younger than 38 (Centre for Housing Research, 2013b). There were many more men than women (Centre for Housing Research, 2013e). People of white British descent were over represented (Centre for Housing Research, 2013c), compared to BME groups.

The Centre for Housing Research also provides employment statistics, and not many people were in full-time or part-time employment, and these were all living in supported housing schemes.

Traditionally, work schemes for people with mental health problems have been associated with large mental hospitals in the form of 'sheltered' workshops. The shift to community-based services in the last 20 years has meant that current responsibilities for providing work and employment activities were not clearly defined among the various organisations dealing with health and employment issues, such as the NHS, local authority social service departments and the Department for Education (Boardman et al., 2003). Employment initiatives for people with mental health problems fall roughly into three broad categories (O'Flynn & Craig, 2001): sheltered employment, 'open' supported employment and 'social firms' – market-oriented businesses with a social mission to create employment for people with disabilities. In terms of job types, entry-level service jobs (e.g. food service or janitorial work) are the most common type of placement, followed by clerical positions, and finally skilled ones.

2.6 Community mental health care in England today and provision of services

Understanding how Supporting People works is only one side of the story. There is a need to obtain a more complete picture of the provision and characteristics of SHSs and their users. Information is available from various sources, such as the Information Centre or the National Centre for Social Research, on the number of reported council residents.

2.6.1 The current provision of specialist housing services

Provision, or plans for provision, might be expected to go hand-in-hand with need. Yet a mismatch occurs when comparing the combined total of psychiatric beds, residential and nursing care places and SHSs with a measure of the needs of people with mental health problems. The Audit Commission (1998) warned that care must be taken when comparing need indices with particular forms of provision: it is possible that variations in the provision of SHSs reflect explicit local decisions to use specific forms of SHSs, or to support people in their own homes as far as practicable, using floating support.

Bayliss (1987) described provision of housing at that time. Both housing and local authorities had the powers to provide accommodation by giving nomination

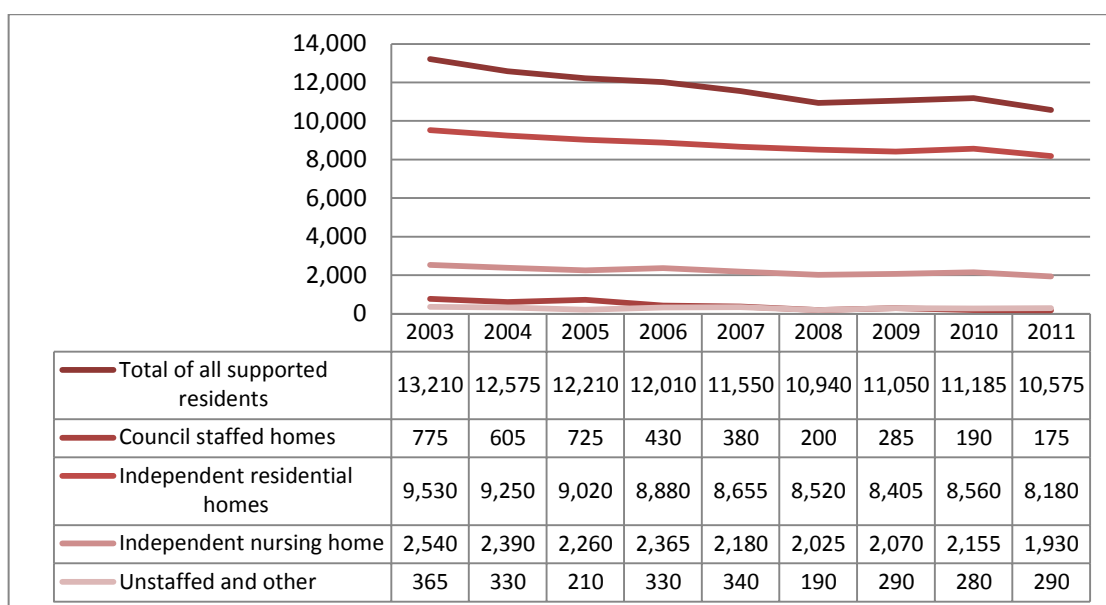
rights to social services or voluntary agencies. Although local authorities were a major provider of housing services, the resources available to them were limited and thus the voluntary and private sector supplied many services. Indeed, most residential care was provided by the independent (voluntary and private) sector commissioned by local authority housing departments as well as by national agencies (McDaid et al., 2007).

Today, many people with housing support needs are identified and supported following an initial request to a social services department. One of the most reliable sources for data on people receiving social care packages is Community Care Statistics (Health and Social Care Information Centre, 2013). In these statistics, community care is defined as the process by which requests for social care help made to Councils with Adult Social Services Responsibilities are translated, via assessment and care planning, into appropriate services.

When contact is initially made to a Council, service users are screened to verify whether the information or basic service provided by them meet their needs, and whether further assessment is required. A decision is made as to whether their needs can be met with a basic service at or near the point of contact (Health and Social Care Information Centre, 2013). Nearly half of mental health service users received a completed assessment within two days of initial contact – the fastest assessment period of all client groups.

Twenty percent of supported residents (aged 18-65), defined by the Health and Social Care Information Centre as a person receiving care in residential and nursing accommodation funded by Councils, met the diagnosis of mental illness (Health and Social Care Information Centre, 2013). These are the second largest population in residential care, after people with learning disabilities. The numbers have steadily decreased from 2003 to 2011 (Figure 2.3), particularly among those living in council staffed homes (Health and Social Care Information Centre, 2012).

Figure 2-3: Council supported resident numbers 2003-2011



(Health and Social Care Information Centre, 2008, 2012)

The Health and Social Care Information Centre uses many terms for accommodation with on-site staff support. It distinguishes four accommodation categories for supported residents aged 18-64 with mental health problems: council residential care, independent residential care, nursing care, and unstaffed and other (including Shared Lives schemes, formerly known as adult placement schemes). All of these fall under 'registered care homes' (Health and Social Care Information Centre, 2008). Adult Placement Schemes (APSs), although formerly recorded as part of 'Other Registered Accommodation', became a separate category from 31 March 2007; their numbers have steadily increased (table 2.2).

Table 2-2: Number of mental health clients recorded on Adult Placement Schemes, 2007-2012

	2007	2008	2009	2010	2011	2012
Number of clients	240	190	290	280	290	290

(Health and Social Care Information Centre, 2013)

Adult Placement Schemes (APSs) are now generally known as Shared Lives schemes. These are highly flexible accommodation as well as care or support inside or outside the home provided by individuals or families currently living in the local community (Department of Health, 2004). At the national level, in 1993, there were 250 APSs in Great Britain (Fiedler, 2005) and an updated directory recorded about

5,000 Adult Placement Carers (APCs) and 7,500 service users (National Association of Adult Placement Services, 2000).

A survey of 130 APSs, compiled jointly by NAAPS and Topss England, (Bernard, 2004) found that the majority of schemes (86%) were run by local authorities and all of the 18 independent schemes were registered charities. Nearly half of the sample provided services solely to people with mental health problems (although the biggest client group of APSs is people with learning disabilities).

To sum up the organisation of housing services, a useful guide compiled by Prior (1996, p. 90), and updated for this thesis is depicted in Table 2.3.

Table 2-3: Who's who in housing (Prior, 1996)

Body	Responsibilities
Department for Environment, Food and Rural Affairs (DEFRA, formerly Department of Environment)	Central government department responsible for housing and planning
Homes and Communities Agency (HCA, formerly part of the Housing Corporation)	Quango appointed by DEFRA; funds and regulates housing associations
Local authorities	District and borough councils are the housing authorities and are still the largest providers of rented housing; increasingly moving to the 'enabling' role of planning, assessing need, and prioritising and funding development
Housing associations	Main developers of social housing; made up of charities or not for profit companies regulated by the HCA
Voluntary agencies	Or charities, run much of specialist housing with support for people with mental health problems; may be large national agencies or smaller local providers

2.6.1.1 Social security benefits

People with mental health problems living in SHSs are eligible for a range of benefits, depending on their income, capital, national insurance contributions and overall household circumstances. Most benefits are means-tested by conducting an assessment of need in relation to income; examples are income support, housing benefit, council tax benefit, income-based jobseekers' allowance, income-related employment and support allowance and pension credit (Rethink, 2010).

Disability Living Allowance

Disability Living Allowance (DLA) is the most relevant benefit in the case of people with mental health problems. According to the Department for Work and Pensions (DWP), DLA provides a non-contributory, non means-tested and tax-free contribution towards the disability-related extra costs of severely disabled people, provided they claim for these costs before they reach the age of 65 (Department for Work and Pensions, 2012c; Rethink, 2010). DLA has two 'components', care and mobility, which can be paid together or separately. The former is for individuals who have needed personal care help for at least three months and are likely to go on needing it for a further six and the latter is for people who have experienced walking difficulties for a minimum of three months and suspect that these will persist for a further six.

DLA is to be gradually replaced by the Personal Independence Payment (PIP), and is intended solely for people of working age; its focus is on supporting individuals who experience the greatest challenges to remaining independent and leading full, active lives. People will be invited to apply for PIP and be assessed for that benefit, the award of which may be lower or higher than their previous DLA rate, with some not qualifying for it at all, with the consequent reduction or removal of their total benefits (Department for Work and Pensions, 2012b).

Incapacity benefit/Employment Support Allowance

Incapacity Benefit (IB), starting in 1995, was paid to individuals assessed as incapable of work and who met certain contribution conditions. It replaced Sickness Benefit and Invalidity Benefit, but was then replaced by Employment Support Allowance (ESA) in October 2008 (for all new claims) (Department for Work and Pensions, 2012d). More recently, the ESA replaced Income Support (received on the grounds of disability), Incapacity Benefit (IB), and Severe Disablement Allowance; the Department for Work and Pensions (DWP) hopes to move everyone gradually over to ESA (Rethink, 2011a).

The Work Capability Assessment (WCA) measures a claimant's ability to perform a range of everyday activities, and all new claimants of ESA, as well as IB recipients as of February 2011, are required to undergo it; the assessment lasts around 13 weeks.

As of November 2011, there were 352,080 people of working age with mental health problems in receipt of ESA, receiving an average of £84.46 per week (Department for Work and Pensions, 2012d).

A back-to-work programme, called 'Pathways to work' (Department for Work and Pensions, 2003) was also set up, and was available to all claimants of IB, IS on the grounds of incapacity, SDA, and ESA; it was mandatory for new ESA recipients who had been placed in the 'work-related activity group' (Jin et al., 2010). It allowed recipients to choose from a range of voluntary schemes with the intention of improving their labour market readiness and opportunities, and eventually getting them back to paid work, whilst also providing financial incentives for claimants of income support and their partners (Jin et al., 2010). The programme ended in April 2011 (Department for Work and Pensions, 2011).

Housing benefit

People in SHSs are also eligible for Housing Benefit (HB) which covers the rent of their accommodation (where applicable). HB is a means-tested benefit, and according to the DirectGov website (Directgov, 2012c) is suitable for people who have capital of less than £16,000. The amount of HB awarded greatly depends on the local housing allowance of the particular local authority (this varies by area). The DWP does not collect information specifically on the number of HB claimants with mental health problems and their respective average weekly rates, but more generally, the average is of £89.46 per week (Department for Work and Pensions, 2012a).

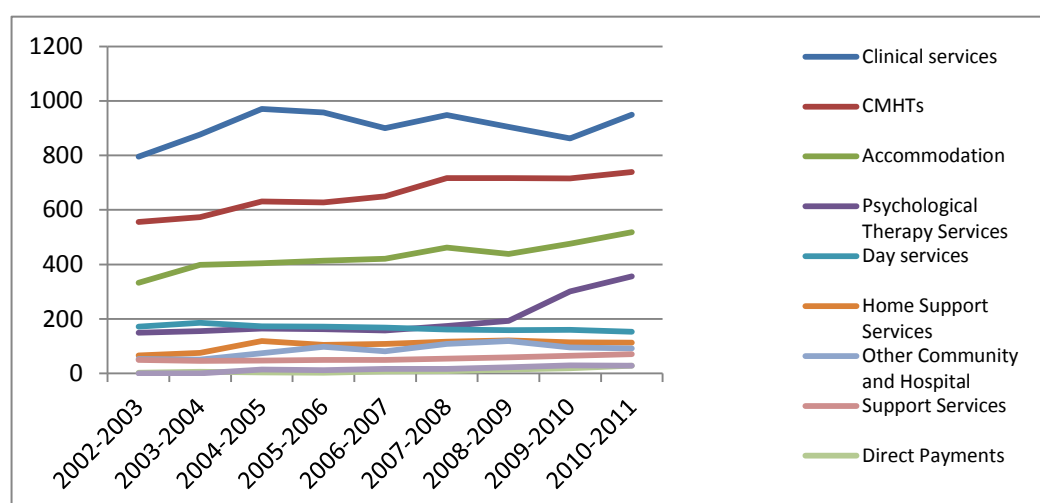
In April 2011, the Government introduced benefit caps, meaning that a claimant's HB would be reduced if they were receiving more than a certain amount in total benefits. Furthermore, the lower age limit for claiming HB while living alone was recently raised from 25 to 35. This prompted the mental health charity MIND to warn that people with mental health problems may be required to move into unsuitable accommodation and thus may become detached from their health, social and support networks, with potentially devastating effects on their mental health (MIND).

2.6.1.2 The cost of mental health problems in England

Mental health problems generate huge social and economic costs for societies. A report by McCrone et al. (2008) reported the costs of mental illness to be £50 billion, with service costs estimated at £22.50 billion. The latter costs were projected by these authors to rise by 45% to £32.6 billion in 2026 (at 2007 prices). More recently, the Centre for Mental Health (2010) has estimated the aggregate costs of mental health problems in England to £105.2 billion in 2009/10. A report prepared for the Department of Health England, Mental Health Strategies (2011), estimated that since 2001/02, total investment on adult mental health services for the working age population has increased by 58.5% in real terms: at 2010/11 prices, £4.132 billion was spent in 2001/2002 and £6.550 billion in 2010/2011. Whether it continues to increase in the new fiscal environment is open to question.

Information derived from Primary Care Trusts, Mental Health Trusts and LAs allowed for a mapping of the growth of investment in mental health services since 2002 (Mental Health Strategies, 2011). Relevant categories of annual expenditure are shown in Figure 2.3. It can be seen that areas such as CMHTs, accommodation, direct payments and personality disorder services saw steady increases from previous years. The only category that decreased substantially was day services, for which investment in 2010/11 was at its lowest point in eight years. This could suggest that day centres were gradually closing with other forms of activities becoming available to people with mental health problems. This may also allude to possible greater use of DPs or IBs to pay for activities.

Figure 2-4: Growth of investment in direct service categories since 2002 (at 2010/11 pay and price levels in £ millions)



Considering these very high costs, it comes as no surprise that one of the drivers for community care was cost reduction, along with concerns about quality of life (Pleace & Wallace, 2011). There is some evidence that community care does provide a cheaper alternative to hospital care (Beecham et al., 1996; Knapp et al., 1994).

At the individual level, accommodation represents a very considerable element of the costs of an overall package of care received (Chisholm, et al., 1997).

2.7 Discussion

The history of mental health services has gone through three main periods: the rise of the asylum, deinstitutionalisation and the reform of mental health services (Thornicroft & Tansella, 2004). The succession of various Acts and policies has transformed the perception of a person with mental health problems from a 'leper', to a public concern, to a more empowered individual with rights, choices and preferences. Now, different and wider needs are recognised, such as well-being, shelter and care, employment, social networks, choices and preferences, social inclusion as well as the need for co-ordinated and personalised services. All of these needs – and their fulfilment – are the focus of this study.

Deinstitutionalisation thus gave way to community care and with it a whole new framework to govern the newly displaced long-stay patients, who had previously been 'forgotten' in county asylums. What ensued was the establishment

of community mental health services, an intricate interplay between social and health services. Community mental health teams, whose presence was instrumental in facilitating the shift to community care, jointly agree care plans with the service user, their family, and other people involved in their care. A Cochrane review of CMHTs conducted by Malone et al. (2007) found that CMHT management may reduce suicide, decrease hospital admissions as well as lengths of stay in psychiatric hospital.

The provision of SHSs has undergone an overhaul as well, with the introduction of a specially dedicated fund, Supporting People. In 1983, about four-fifths (82%) of residential provision for people with mental health problems was managed by the NHS, but by 1993 this had fallen to about 58% (excluding hospital beds for people with mental health problems aged 65 or over) – thus allowing for a growth in the private sector. The reduction in the availability of residential places with 24-hour cover almost certainly accentuated this shift (Lelliott et al., 1996).

The Supporting People programme has generally been seen as a great success, albeit an expensive one. It has opened up opportunities for people with long-term needs, including people with mental health problems, to access more independent living arrangements, such as supported housing schemes.

There are no complete or exact data on the number of people living in SHSs, and most of it is obtainable from different information sources. The Health and Social Care Information Centre data shows that the total number of supported residents is falling, as is the number of people funded by the Supporting People grant. Also, actual expenditure on accommodation for people with mental health problems is in decline (Health and Social Care Information Centre, 2013). Unit costs are also on the rise.

Data from the CHR generally show that most people with mental health problems moved to accommodation with reduced support after two years, although some did move back to hospital. Different provider types (private, charity/voluntary) play a growing role, due to the implementation of relevant policies, shifting away from LA-provided SHSs.

The number of cases of delayed discharge due to lack of suitable accommodation might be an indication for the need for better planning, including

better co-ordination of health and social services. Indeed, it is argued that shortages of housing in some parts of the country are severely limiting the extent to which service users can move to greater independence (Levenson et al., 2003). It may also be an indication of a lack of empowerment amongst mental health patients. It may alternatively suggest the need for better information management (collecting statistics for example).

With regard to choice and control, CBLs were not much in use amongst the mental health population, compared to other populations; this applies as well to other aspects of personalisation, such as direct payments and personal budgets, in spite of relevant governmental policies actively promoting choice.

Moreover, service users still experience discrimination in terms of renting and buying properties from private landlords. Some service users reported that they had very little choice as to where they lived, and there was a general sense that they were forced into living in poor quality SHSs due to the fact that they had a mental health problem (Social Exclusion Unit, 2004).

Chapter 3 Specialist Housing Services in England: a literature review

3.1 Introduction

At the start of their chapter on residential care, Shepherd and Murray emphasise that *“the provision of an adequate range of good quality accommodation must [...] be at the centre of attempts to develop community-based systems of care”* (2001, p. 309).

People with severe and enduring mental health problems vary in their accommodation arrangements. More than four-fifths live in mainstream housing (Boardman, 2010b; Social Exclusion Unit, 2004; Watson, 1996), while the remainder live in a range of types of residential care. Responsibility for managing residential care lies with local authorities, the NHS and other agencies (Shepherd & Murray, 2001, pp. 311-312).

This chapter reviews the literature on the accommodation options that have developed in the community since the closure of large psychiatric hospitals.

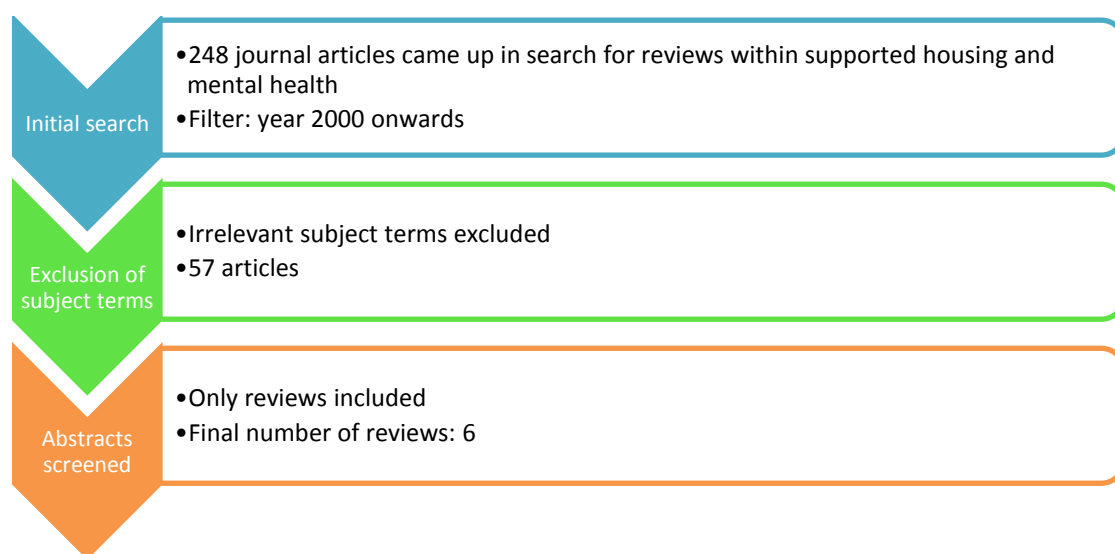
3.2 Search strategy

Systematic reviews of literature can be time-consuming to undertake, but nonetheless, it is essential to understand what data exists prior to undertaking a study. Therefore, it was decided to search for existing reviews of literature on SHSs for people with mental health problems, as these will have already identified the relevant studies (see figure 3.1).

For this purpose, the online search function (“Summon”) of the LSE Library was utilised, which takes into account 204 separate databases, making it a very comprehensive literature search. A cut-off date of publication was set at 2000 onwards, to identify only the most recent studies. Keywords of interest here were “review” AND “supported housing” AND “mental health problems”: the search yielded a total of 248 journal articles. This number was narrowed down to 57 by excluding irrelevant subject terms, such as “clinical neurology”, “nursing”, “older people”, “public health/gesundheitswesen”, “medicine & public health”, “families”, “health informatics”, “education”, “learning disabilities”, and “veterans”.

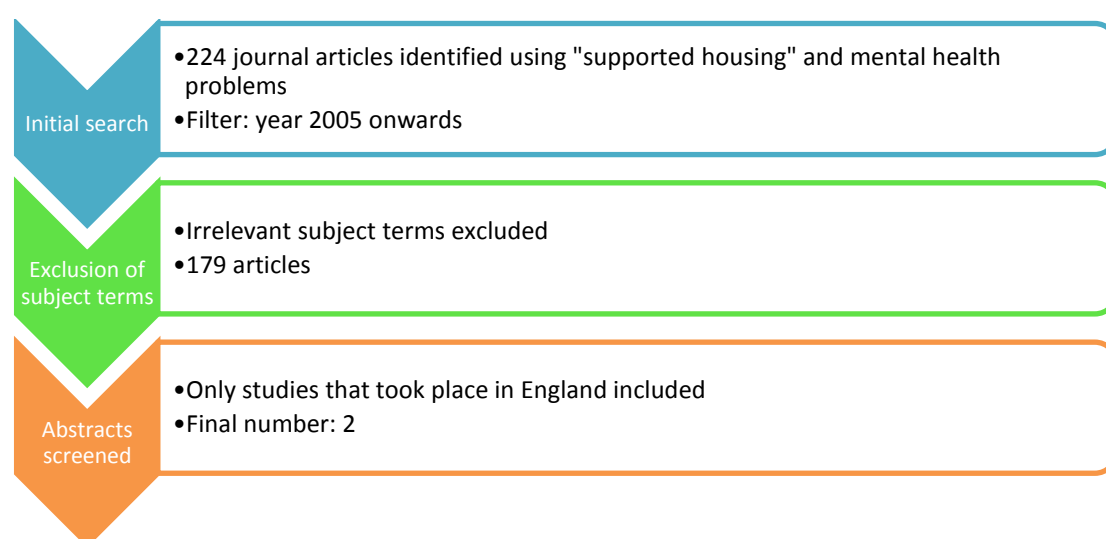
Of these 57, abstracts were screened to include only studies that were reviews of the literature on SHSs, resulting in 6 studies, the most recent being conducted in 2005 and 2010. A review of these reviews aided in the identification of key studies on the establishment of SHSs in England and served to identify important themes in the literature. These are critically reviewed in more detail below.

Figure 3-1: Search strategy for review of reviews



Thereafter, a second literature search was conducted (Figure 3.2), taking into account all studies conducted within SHSs for people with mental health problems in England after the year 2005, since these would not have been picked up by the most recent (English) review (O'Malley & Croucher, 2005). Keywords used for the search were “supported housing” AND “mental health problems”, adding a filter of studies published after 2005. The search in LSE’s Summon database returned 224 journal articles. This number was further narrowed down to 179 by excluding irrelevant subject terms like “older people”, “public health/gesundheitswesen”, “law” and “children”. Abstracts were then screened to include only studies that took place in England, as this is the geographical basis of this thesis. This resulted in only two journal articles of relevance. Others were either focused on other geographical areas, mainly North America or Australia or were looking at specific service user population (homeless people, people with learning disabilities or substance misuse problems).

Figure 3-2: Search strategy for post-2005 studies



3.3 The reviews of the literature on SHSs

Several authors have reviewed the research already conducted within SHSs.

Review 1: Fakhoury et al. (2002)

Fakhoury et al. (2002) reviewed studies of what they termed 'supported housing', which are settings where housing and support (for more than six months) were intrinsically linked. Studies were excluded if they focused primarily on housing for people suffering drug or alcohol misuse, accommodation catering to old or young (less than 18 years) populations, or to people with learning disabilities. In all, there were 87 studies meeting the aforementioned criteria, including keywords such as 'supported housing', 'sheltered housing', 'protected housing', 'supervised housing', 'mentally ill' and 'schizophrenia'. The authors did not discuss why or how they included particular search terms – problematic due to the fact that sheltered housing is sometimes reserved for people above the age of 65. Of the 87 studies, 21 were of an empirical nature as identified by the Medline database.

This international review focused on the development of community care, concepts of supported housing, characteristics of residents, design and limitations of the research, as well as outcomes and factors affecting those. The authors recognised that there were problems in defining supported housing due to the diversity of existing models, but suggested a method of doing so was the multi-dimensional system adopted by Lelliott and colleagues (1996). This classified

'supported housing' facilities on the basis of the availability of different kinds of staff cover, number of beds and staff to resident ratio. In terms of characteristics of service users in supported housing, Fakhoury et al. (2002) discussed mainly their differences with people in independent living. According to their international review, people in supported housing were more likely to be older, less educated, unemployed, male, having had longer hospital stays, and most likely to be suffering from schizophrenia (Friedrich et al., 1999; Middelboe et al., 1998). With regard to daily living skills and general functional abilities, those with the lowest abilities were found to be placed in supported housing as opposed to independent living (Arns & Linney, 1995; Cook, 1994).

Fakhoury et al. (2002) also pointed to the differing characteristics of 'new' long-stay patients. They did not provide a detailed description of this cohort of people, but they mention that they suffered from behavioural difficulties which made it difficult for them to be looked after in traditional models of housing in the community (Lelliott & Wing, 1994), alongside a number of former 'old' long-stay patients (Trieman & Leff, 1996).

In their review of service user outcomes, Fakhoury et al. (2002) found moderate to high satisfaction levels being reported by most clients in supported housing (Elliott et al., 1990; Middelboe, et al., 1998). Compared to hospital, the British TAPS study found significant improvements in social behaviour and domestic and life skills and an enlargement of social networks (Leff, 1997b; Leff, et al., 1996; Leff et al., 2000). However, social isolation was still reported amongst people living in accommodation with staff visiting, as opposed to 24-hour care (Friedrich, et al., 1999). A lack of privacy in some settings was sometimes an issue and had a negative effect (McCarthy & Nelson, 1993; Nelson et al., 1995). Fakhoury et al. (2002) indicate that there has been little research on staffing levels and best case mix, with one study finding that there was a poor match between levels of disability and staffing levels. One study reported a less restrictive environment with better outcomes for residents (McCarthy & Nelson, 1993), as they felt less institutionalised. This depended greatly on the culture imposed by staff, which in turn was influenced by their skills and attitudes; this coincides with findings from a study by Shepherd et al. (1996). Massey and Wu (1993) found that factors such as

privacy, independence, personal choice, convenient location and proximity to mental health services are significantly more important to residents in community housing than to their case managers.

No attempt was made in the Fakhoury et al. (2002) review to differentiate between types of housing services; rather, these were grouped together under 'supported housing'. This makes it difficult to differentiate the characteristics of people who would go to a residential care home as opposed to other forms of accommodation and support, for example. As for research design, most studies on supported housing were uncontrolled follow-ups, non-randomized controlled trials or cross-sectional surveys. Research to date was also affected by small sample sizes and unrepresentative sampling. Generally, in terms of outcomes, research from supported housing had been positive, especially when outcomes were compared to those from people in hospital. Fakhoury et al. (2002) concluded that there were inconsistencies in the use of terminology to describe supported housing, making the comparisons of outcomes and processes difficult. Some future recommendations include conducting RCTs, or large-scale studies, as well as qualitative and observational studies.

Review 2: Taylor et al. (2009)

The review by Taylor et al. (2009) had a broader scope than that by Fakhoury et al. (2002), aiming to identify key components of institutional care for people with long-term mental health problems, as well as the effectiveness of such care through a synthesis of the international literature. The review included papers reporting studies of people living in the community and hospital, but operated additional exclusion criteria to the Fakhoury et al. (2002) review. Of the 110 articles included in the review, and for the purposes of this thesis, mostly studies (n=18) categorised under the 'living conditions' domain are covered here. The reviewers found five studies reporting that people with mental health problems preferred community settings to hospital, one of which was a purely UK-based empirical study (Fakhoury, et al., 2005), discussed more thoroughly below. A study of Italian community-based residential facilities for people with mental health problems found that increased restrictiveness and fewer links with community-based activities increased hospital readmissions (Santone et al., 2005). Overall, greater satisfaction with their living

situation was correlated with positive social environments where independence is encouraged (Mares et al., 2002). Taylor et al. (2009) also noted that some studies highlighted the importance to service users' quality of life of a good therapeutic relationship between staff and service users (Johansson & Eklund, 2004). Otherwise, a positive correlation was found between quality of life and the degree of control over their lives and the running of the home given to service users in SHSs (Timko et al., 1993; Lewis, 1995). One study found that security, the physical or built environment, and social interaction were considered important by both residents and staff; staff stressed the importance for service users gaining practical skills (Brunt & Hansson, 2002). Taylor and colleagues (2009) stressed the importance of the quality of the physical environment and a degree of privacy in mediating service user outcomes in Fakhoury and colleagues' (2002) study of supported housing. They added that Corrigan (1990), whilst investigating mental health inpatients' satisfaction with their accommodation, found lack of privacy to be a major concern, specifically having a place to be alone. There was no clear consensus on the optimum number of residents. In conclusion, Taylor and colleagues (2009) indicated that the ideal 'institution' would be based in the community, have little restrictions, have a low density of residents, and maximise privacy.

Review 3: Chilvers et al. (2010)

A review conducted for the Cochrane collaboration (Chilvers et al., 2010) attempted to identify relevant randomised or quasi-randomised trials of people with serious mental health problems who were living in supported housing. This review focused on two types of supported housing: i) dedicated supported housing schemes, comprising self-contained apartments located in one building or site where tenants are supported by office-based professional workers usually during office hours, helping them to maintain their tenancies and thereby prevent homelessness; and ii) tenancies within private, local authority or housing associations where tenants are visited by professional outreach workers to help maintain their tenancies and prevent homelessness. In the latter, tenants do not share the site with another person with a mental health problem. The aim of this review was to identify studies that compared these types of supported housing schemes using a randomised or quasi-randomised design, to evaluate their

effectiveness. However no studies met the inclusion criteria. The authors (Chilvers, et al., 2010) still drew out several useful implications for practice, including a recommendation that trials should be conducted that assess the efficacy of supported housing so people could make more informed choices on their accommodation, instead of relying on a combination of personal preference, professional judgement and availability of resources.

Review 4: O'Malley and Croucher (2005)

A scoping study on 'supported housing' for people with mental health problems in the UK aimed to provide an overview of what is known about models of good practice (O'Malley & Croucher, 2005). Alongside the key electronic databases, relevant organisational websites were trawled for material (e.g. The Sainsbury Centre for Mental Health, National Schizophrenia Fellowship); this identified 131 studies and reports (one systematic review).

The authors acknowledged that one limitation was the diversity of terminology used to describe types of accommodation and mental health problems. Relying heavily on evidence from the TAPS studies as well as others (Leff, et al., 1996; Leff, et al., 2000; Petch, 1992; Shepherd, 1995; Shepherd, et al., 1996), research seemed to confirm the benefits of community living over hospitalisation, reporting high levels of satisfaction and improved quality of life and the maintenance of social functioning and psychiatric symptomatology. However, some authors commented on the lack of attention paid to the care provided for those with the most severe mental health problems (Shepherd, 1995; Shepherd, et al., 1996).

Their review (O'Malley & Croucher, 2005) of high-level support accommodation demonstrated that these services form a crucial part of the spectrum of supported housing services, and often deal with individuals who have challenging problems. However, only five studies were identified that specifically described residential care homes for adults aged 18-65 with mental health problems: it was found that these reduced hospital admissions (Abrahamson et al., 1995; Hawthorne et al., 1994; Hugman & Rimmer, 1987; Thornicroft et al., 1992) and there was some evidence to suggest that these were a cost-effective alternative to other forms of provision for longer-term placements (Kinane & Gupta, 2001).

One of the strengths of the review is that it distinguished and then focused on accommodation with relatively low levels of staff and support, having identified 16 related studies. There were five types of accommodation identified: generic low intensity support provided to people in ordinary housing, community support workers dedicated to people with mental health problems, floating support, group homes and supported lodgings. There were not many studies that focused on this type of support, and even fewer within accommodation-based support (the focus of this thesis); therefore, only group homes and supported lodgings are relevant, as other forms of support take place within an individual's own private dwelling. O'Malley and Croucher (2005) borrowed Petch's (1992) definition of group homes as *"accommodation without resident staff, generally providing longer-term provision rather than preparation for a subsequent move"*. Although only three studies examined effectiveness, it would seem that for a cohort of older patients, group home living provided a stable replacement to long-stay psychiatric hospitals (Pritlove, 1983). However, concerns have been raised as to their appropriateness for younger, more mobile and possibly more disruptive residents (Gardner & Pugh, 1996; Melotte & Pritlove, 1989). Supported lodgings, on the other hand, cover a variety of accommodation such as Bed and Breakfast and 'family placements' provided on an either long- or short-term basis. Again, only three studies covered this type of support, which tended to recognise the relative freedom of residents (Arnott & Smith, 1993; Barnes & Thornicroft, 1993). It is somewhat surprising that newer forms of accommodation and more recent studies were not picked up by this literature review search.

The review identified a mismatch between needs and accommodation provision (Järbrink, et al., 2001; Lelliott, et al., 1996), prompting calls for more research to understand needs and plan for the future, although noting that not everyone is capable of independent living. Nonetheless, there was a consensus that community living with differing levels of support should be the ultimate goal (O'Malley & Croucher, 2005).

Review 5: Kyle and Dunn (2008)

Kyle and Dunn (2008) reviewed empirical studies of people with chronic mental health problems, focusing on housing-related independent variables and

health-related dependent variables including quality of life (excluding qualitative studies). Evidence from the U.S. and Canada showed improved outcomes for hospital leavers and that housing interventions aimed at homeless people were beneficial in terms of healthcare utilisation.

Several studies were identified that looked at housing quality, albeit none from England. Several factors in this case mediated mental health outcomes. Having one's own room was very important to residents, and hence relates to a sense of privacy (Goering et al., 1992; Massey & Wu, 1993); not having one's own room was positively related to negative affect at one year (Nelson et al., 1998). Another was housing stability, length of tenure, and types of housing moves: over time, there was evidence of a large reduction in symptoms of psychological distress (Wong, 2002) as well as psychiatric distress, but a worsening of independent functioning (Segal & Kotler, 1993).

Kyle and Dunn (2008) found numerous promising studies on factors affecting quality of life, but warned that these should be treated with some caution due to the weakness of some study designs, and in particular the lack of a housing variable definition (number of residents for example) (Middelboe, 1997; Okin & Pearsall, 1993). In an American study of supported housing, a greater degree of perceived choice among people with mental health problems was positively correlated with life satisfaction (Srebnik et al., 1995). Housing type was not a reliable predictor of quality of life outcomes: Aubry and Myner (1996) found that ratings of well-being did not differ among different settings, while an Ontario study found that residents in care homes had higher total life satisfaction scores compared to their counterparts in supervised apartments or group homes, although the latter were considered to be more desirable options (Nelson et al., 1997). A possible reason for this discrepancy, as Nelson et al (1997) later suggested, was that care home residents were comparatively older and had been in their home for longer. A decrease in total life satisfaction was associated with an increase of the number of resident concerns about housing quality and comfort (Nelson, et al., 1995). Housing appropriateness was also an influential factor; service users moving from appropriate to inappropriate settings showed a significant deterioration in perceived quality of life (Baker & Douglas, 1990). Satisfaction with living situation

was also positively associated with a supportive social climate within the home (one characterised by residents as being cohesive and comfortable and promoting independence and choice); in this study, the larger the home the greater the frequency of social contact and hence general well-being (Mares, et al., 2002).

The authors commented that current research (at the time of the review) was insufficient to draw concrete conclusions about the diversity of individual factors that affect housing needs and the likely efficacy of housing in improving health and quality of life. Their recommendations included the use of qualitative methods to *“more fully understand individuals’ lived experiences of different housing arrangements”* (p.13). Surprisingly, the only UK study identified by their literature search was that by Oliver and Mohamad (1992).

Review 6: Sylvestre et al. (2007)

A slightly different issue was addressed by Sylvestre et al. (2007) who focused on housing values in studies appearing from 1990 to 2004. Their keywords included principles, preferences and goals, alongside the usual derivations of mental illness and housing. This resulted in 40 studies or reports. Twenty-two documents identified a housing value categorised as choice (people can choose their housing and related support service not limited to predetermined selections or by a professional assessment) and control (able to control the services received).

Findings show that housing choice and control are important for service users’ well-being, and choice and preference are closely linked. A review of 26 studies by Tanzman (1993) found that service users preferred living alone or with a relative or friend, rather than with other service users, and have support available as needed. Moreover, a Canadian study by Nelson et al. (2003a) found that individuals living in their preferred housing type reported significantly higher levels of quality of life than their counterparts. More evidence of a positive association between housing satisfaction and perceptions of choice and control, as well as a democratic management style within the home, was given by Parkinson et al. (1999) in their review. Evidently, people who lived in apartments had more choice and control, compared to people living in other settings (Nelson et al., 1999; Tsemberis et al., 2003).

The review authors (Sylvestre, et al., 2007) found that quality of life was mediated by aspects of safety, privacy and the physical quality of the residence (Nelson et al., 2007; Parkinson, et al., 1999), and a lack of these can lead to negative affect (Nelson, et al., 1998). For example, a US-based study by Tsemberis et al. (2003) found that individuals living in residential care homes were the least satisfied with their privacy and most satisfied with their safety, compared to people in less restricted and supported settings.

Another value in Sylvestre and colleagues' (2007) review was community integration. The authors applied Wong and Solomon's (2002) interpretation: 1) a physical presence in the community, 2) the maintenance of social relationships with other community members and 3) the development of a psychological sense of efficacy and belonging in relation to the community. This value was found to be intrinsically linked with well-being among people with mental health problems. Other overarching findings were that reduced network size was linked to poverty and mental health service use (Anderson et al., 2001; Wilton, 2004), homes that were physically integrated in the community (do not differ in appearance from other houses) increase social integration (Parkinson, et al., 1999), and consumers living in deprived neighbourhoods experienced less social stigma than those living in high-income areas because their neighbours were more disenfranchised (Mares, et al., 2002). Finally, people living in residential homes close to community resources were more integrated than their counterparts (Wong & Solomon, 2002). Hence, choice, control, quality and community integration all figure prominently in the North American research literature on housing for people with mental health problems; much like the review by Kyle and Dunn (2008), there was an absence of articles from the UK, despite a geographical filter not being applied.

Sylvestre and colleagues (2007) provided a useful approach to understanding the literature, suggesting that these values should be taken into account when planning for future services.

3.4 Key UK studies on SHSs

This review of reviews allowed for the identification of key studies – and their grouping into distinct themes – that trace back the history of SHSs in England.

The reviews by the UK-based authors (Fakhoury, et al., 2002; O'Malley & Croucher, 2005) included considerable overlap with regard to several studies. These are described in more detail here.

3.4.1 The first studies following hospital closures

One of the first studies to consider newly discharged patients into the community was conducted by the Team for the Assessment of Psychiatric Services (TAPS), which surveyed hospital leavers from Friern and Claybury in London and Essex. TAPS was originally created in May 1985 to evaluate the new care in the community policy, or the replacement of psychiatric hospitals with community-based services (Leff, et al., 2000). As the summary report states (Leff, et al., 2000), 670 psychiatric patients participated in the study, all meeting the selection criteria (over one year in hospital and not suffering from Alzheimer's or any form of dementia) and discharged from Friern and Claybury hospitals.

Most (80%) had been discharged to staffed houses containing an average of eight residents, and five years on, most were still living there. Twenty-one patients had "long and winding" pathways, where they were frequently readmitted to hospital or changed residences (Trieman et al., 1998). Psychiatric symptoms and social-behavioural problems had not improved or worsened in the five years, but skills were gained with everyday living tasks, as patients made the most of, and appreciated, their newly acquired freedom (Leff, et al., 2000). Social cohesion depended greatly on the size of the home the patient was discharged to: in a study of two group homes, a greater sense of cohesion was noted in the smaller home (five residents), whilst people in the larger one (12 residents) had failed to develop friendships (Dayson et al., 1998).

Another study that evaluated the community care reforms (Department of Health, 1989), was the *Care in the Community* study, commissioned by the Department of Health and Social Security (now the Department of Health); although not included in any of the previously mentioned reviews of the literature. Knapp and colleagues (1992) compared peoples' lives in hospital and in the community thereafter, i.e. whether their outcomes had improved, and the associated costs. For the 122 people with mental health problems who were assessed both in hospital

and in the community (now living in various forms of accommodation like residential homes or group homes for example, or independently), there were no changes in symptoms or behavioural problems; this was consistent with findings from the TAPS study. In terms of activities, there was increased participation compared to when clients were in hospital: 61% expressed a liking for outdoor activities (walking, sports, cycling, etc.) and 86% engaged in indoor activities (arts and crafts, cooking and reading). Nearly all (96%) reportedly spending their days listening to music and watching television. Three-quarters visited friends or social clubs. With regard to social networks, the study reported an increase in clients' social contacts, in contrast to the TAPS study. Yet, most of these contacts were now with professional staff, following the move into the community. Also, aside from those clients who were living independently and who completed their own records, it was staff who reported on peoples' frequency of social contact – and they may have been overly generous in their estimates. Nevertheless, self-reported indicators of satisfaction with the environment and social interaction, psychosocial functioning, and general morale revealed some minor improvements between hospital and the community.

As discussed in the review of the reviews, Fakhoury et al. (2002) found that the new long-stay (NLS) psychiatric patients were a product of the closure of the asylums, but failed to provide a more detailed description of the characteristics of this cohort of people. They are essentially defined as people who had been continuous residents of a psychiatric hospital from one to five years (Mann & Cree, 1976). Shepherd (1991, p. xxxi) further added to this definition; patients were also usually between 18 and 65 and were people for whom it had not been possible to find alternative accommodation outside hospital despite repeated attempts to do so.

An example of a residence where NLS patients were housed was described by Shepherd (1995), who evaluated a 'ward-in-a-house' service within Cambridge Health Authority. These were highly staffed, with nurses on duty all day and night, and with regular part-time input from psychiatrists, psychologists, occupational therapists and social workers. These homes were located near the hospital site with easy access to its services, and aimed to provide high quality, long-term care for the

most 'difficult' new patients for as long as required. The 'ward-in-a-house' was to offer a new model of institutional care, one that was small, homely and personal, as opposed to the large institutions. Individualised care was paramount, and there was no 'one-size-fits-all' approach to care and support. Basic community skills (self-care, daily living skills, occupation, social functioning, mental health, etc.) were assessed through observational methods, and then compiled into a report submitted to a multidisciplinary team, setting goals and objectives for the person. The approach to 'treatment' was to focus on functioning rather than on symptoms (Shepherd, 1995). The main outcomes from 'ward-in-a-house' projects are summarised elsewhere (Shepherd, 1995). It would seem that these new units were significantly more effective at improving social functioning and maintaining activity levels compared to hospital, and residents had higher contact with the community, in part perhaps because people in those wards did not have the same restrictions imposed on them. Most importantly, residents seemed to prefer living in these 'wards' compared to hospital.

The TAPS study reported that, four years after the closure of Friern Hospital, for the 72 patients who had been labelled 'difficult to place' in the community and were subsequently transferred to highly staffed facilities, everyday living skills had improved significantly. There was also a 50% reduction in behavioural problems; 40% of the group had been discharged to standard community homes by the end of five years, thus providing evidence for high staff input in this case (Leff, et al., 2000).

3.4.2 Evaluating the newly established SHSs and quality of life of their residents

Having compared the lives of psychiatric hospital leavers after the closure of the asylums, the focus of research shifted from a comparative approach to evaluating peoples' lives within SHSs.

One of the first studies to do so was by Oliver and Mohamad (1992) which interviewed psychiatric hospital leavers in the Preston and Chorley area of the UK. They aimed to conduct a small survey of the well-being of these ex-patients, who were now living in three types of residential accommodation in the community: staffed hostels (modelled on half-way houses intended to smooth the transition between hospital and community living), boarding out homes, and group homes.

For group homes, they borrowed Capstick's (1973) definition as "*ordinary residential accommodation in the community, in which a small group of people, having been discharged from a mental hospital, are able to live together like a family unit, without residential supervision*". In total, 61 people were interviewed, of whom eight were representative of the growing population of chronic patients, who had been admitted directly into community facilities, following short episodes in acute care; most were male and averaged 52 years of age. In terms of quality of life, more than half of the sample had evaluated their present life favourably, whilst the rest were either undecided or held negative views. More specifically, most of the sample was satisfied with their living situation and accommodation. Significant differences were reported in terms of different accommodation and provision based on objective measures. Indeed, hostels (public sector) provided the least material comfort, but residents enjoyed the most frequent contact with family and friends – mostly due to the fact that residents were very independent. People living in group homes (voluntary-sector) were the least likely to engage in paid employment compared to boarding-out (private-sector) residents who were the most likely to do so. The latter, however, reported having the least independence, lowest care level for mental health, and lowest frequency of external social contacts and social activities.

Oliver and Mohamad's (1992) study was one of the few early studies that concerned itself with independent-sector or private homes. A follow-up study (Oliver et al., 1996) also focused on these types of homes, but in addition tried to relate quality of care provided with quality of life experienced by residents. Also based in the North-West of England, it sampled people from homes run by one organisation – an acknowledged caveat of the study, as the organisation's ethos may not be representative of other homes (its philosophy was that some form of residential care will always be needed for mentally ill people). In this sample, the homes ranged from ten to 30 places, were all staffed, and predominantly occupied by male residents who were relatively older, possibly implying a more serious level of disability (p. 113). In total, 140 residents living in independent sector hostels (ISHs) were recruited for the quality of life study, and their data subsequently compared to that compiled by Oliver and Mohamad (1992), as well as to

information obtained for people living in the community as identified by the CMHTs (n=384) and all residents living in local authority hostels (LAHs) living in one locality (n=36). Generally, people living in ISHs scored their subjective well-being (work/education, leisure, religion, finances, living situation, legal/safety, family relations, social relations and health) higher than those living in LAHs and independently (pp. 121-122). They also felt significantly happier about the prospect of remaining in their respective homes in the foreseeable future (p. 123).

Also addressing quality of life, Shepherd and colleagues (1996) conducted a cross-sectional comparison between community residential homes and rehabilitation wards in outer London. The sample consisted of 20 'community homes' spanning four provider types (health/housing association, private, voluntary, non-profit and social services) and five rehabilitation wards in long-stay mental hospitals. Although more than 200 people with mental health problems were sampled and participated in the study, only 22% (n=19) of the hospital sample and 60% (n=86) of the community sample completed the Lancashire Quality of Life interview. Community residents were found to be generally much more satisfied than people in wards, especially in terms of living situation, number of friends and physical health. Differences between provider types within the community sample were small, but residents of joint homes (health/housing association) reported the highest satisfaction, possibly due to the fact that most of these homes were new, and residents therefore appreciated this substantial change from their hospital conditions. Satisfaction with finances was remarkably low in the private-sector homes. The marked dissatisfaction among the ward sample was felt to be due to the poor conditions of their accommodation, relative isolation, and greater levels of dependency.

No significant differences were reported between community and ward residents in terms of self-reported global well-being (although fewer of the latter were able to complete the interview, suggesting that their well-being might be much lower). This contrasts with results from the TAPS and Care in the Community studies which found significant and positive differences in well-being after the move from hospital into the community.

Residents in joint homes (Shepherd, et al., 1996) were the most satisfied, and in general, the more restrictive the setting, the lower the general well-being score; a finding that coincides with that of McCarthy and Nelson (1993).

Finally, higher well-being scores were reported where there was greater perceived influence within the setting, and also depended greatly on managers. As discussed in the review of reviews, not many UK studies have highlighted the importance and positive effect of choice and control amongst service users, in contrast to the numerous Northern American studies (Mares, et al., 2002; Massey & Wu, 1993; Nelson, et al., 2003a; Parkinson, et al., 1999; Srebnik, et al., 1995; Sylvestre, et al., 2007). As Shepherd et al. noted, the sample of homes was small and located strictly in London, which may limit the generalisability of the results.

3.4.3 Describing and exploring current housing options and resident characteristics

Acknowledging the fact that there was very little consensus on what SHSs were and what they provided, the *Mental Health Residential Care Study* (Lelliott, et al., 1996) collected data on 1951 residents living in 368 residential care facilities within seven English and one Welsh districts. This paper aimed to classify the SHSs and describe provision, as well as to characterise who was living in these services, using data provided by facility managers through interviews (about the fabric, staffing and services of facilities). Information about residents was obtained through interviews with individual key workers using a 'resident profile'. A large proportion of people living in residential care in the 1990s had long-term severe mental illness, as well as significant impairments in carrying out tasks that were essential for independent living.

It was found that the less capable individuals and those suffering most from their mental illness were also more dependent and needed more care; a view not shared by Shepherd and colleagues (1996), who found that, in their study, disability bore no significance to staffing ratios.

Although one of the strengths of this study (Lelliott, et al., 1996) was its large scale, hence accounting for deprivation and rural/urban mix, this also meant that many data collectors were employed, decreasing reliability. Also, for resident

profiles, information was based solely on key worker accounts, which could easily vary from one person to the next according to their knowledge, experience and training, but also according to their personal opinions and biases.

Järbrink and colleagues (2001) obtained a relatively more personal account from 238 people living in different levels of supported accommodation (supported living and group/residential homes) as well as general housing, by not only obtaining their basic client characteristics from housing associations' records, but also by administering the Camberwell Assessment of Needs (Phelan et al., 1996) through interviews, as well as the Client Service Receipt Inventory (Knapp & Beecham, 1990). The Psychosis Screening Questionnaire (Bebbington & Nayani, 1995) was used in order to detect active psychotic illness, while interviewers filled in a modified version of the Living Units Environment Schedule (Wing, 1989) which measures the state of repair, attractiveness and suitability of the accommodation.

According to the authors (Järbrink, et al., 2001), the supported living (self-contained or shared living units, where tenants receive regular visits from housing officers or community care workers) category was the most common living arrangement in this study, although detailed information on how people were sampled, and from which sites and locations, was unavailable. People living in group/residential homes were significantly older than those living in supported housing; this is in line with findings from Lelliott et al. (1996). There were a greater proportion of people from a white ethnic background.

People in supported housing were also more likely to be employed. Furthermore, people living in higher support categories also had more frequent contact with psychiatric services. In terms of needs, significant differences appeared according to different accommodation categories: people in group/residential homes expressed more needs than those in supported housing (however the latter were also significantly younger).

With respect to living environment, group/residential homes were awarded higher scores in terms of cleanliness and comfort, compared to the other two categories. It is somewhat surprising that this study had found differences in living environment by housing type, given the heterogeneity of residents. In their review of the literature, Kyle and Dunn concluded that housing type was not a stable

predictor of well-being; one of the only UK-based studies to look at discrepancies between housing types did not find a significant difference (Oliver & Mohamad, 1992).

With regard to costs, average weekly costs were highest for group/residential homes; people in these settings were more likely to have gone to a day centre.

This study confirmed the importance of the assessment of individual-level needs for housing provision, the physical environment and quality of the accommodation; all of which had a subsequent effect on costs. The authors also highlighted the fact that they did not know the extent to which participants had the opportunity to choose the level of support they received, and whether they were placed in a certain accommodation category following a thorough evaluation of their needs. Hence, their recommendations were that housing associations should state goals and monitor the extent to which these are being met, while taking into account service users' needs and preferences, and regularly evaluate the suitability of placements. This calls for further research to be conducted with regard to service user preferences.

However, no information was supplied about service user diagnosis (if any). Only a measure of 'experience of psychosis' was employed, hence not the entire sample was suffering from a mental health problem. The sample may include people with a diagnosis of learning disability for example. Without this information, it is difficult to draw comparisons from the different housing settings.

More recently, Fakhoury et al. (2005) aimed to report on the 'new' 'new long-stay patients' who differed from the NLS ones described above (Shepherd, 1995), who they considered as the 'old' 'new long-stay patients'. The patients in question were those usually presenting to supported housing services with multiple needs and co-morbid substance misuse problems. An exploratory study was conducted to examine clients' goals whilst residing in supported housing within eight settings in London and three in Essex. Managers were asked to identify service users who had not been in an inpatient setting for more than five years at any single time (thus excluding 'old' long-term hospitalised patients), spoke fluent English, were under the age of 65 and had a primary diagnosis of schizophrenia or related

psychotic disorder. A 57% response rate meant that 41 service users were interviewed, as well as 39 staff.

Semi-structured interviews designed for the study were analysed using a mixed-methods approach. Content analysis of service users' reported goals showed that the main goal (22% identified it as their primary goal) was to move to independent housing. Other goals included increasing work or study skills (20%), staying mentally and physically healthy (17%) and increasing their living skills (17%). Nearly a fifth of the sample was unable to identify any goals whatsoever.

Two separate clusters of people emerged in terms of goals, quality of life and psychopathology: one group had no goals at all, while the others wanted to increase their living skills and social contacts outside of care, and to further their education.

Cluster A (no goals) had higher levels of psychopathology, and were significantly less satisfied with their living conditions; none were in voluntary or paid employment. Further, results from the Manchester Short Assessment of Quality of Life Scale (Priebe et al., 1999) found that people in cluster A were significantly less satisfied with their housing, physical health, mental health and life in general, compared to those in cluster B.

This study attempted to identify the goals of people in supported housing, but in the absence of a clear definition of supported housing, it is hard to interpret these results. The sample size was relatively small, and may not have been geographically representative since 11 supported housing sites were visited. Still, the authors did acknowledge these limitations, and did propose that the exploratory nature of the study provided valuable information to guide further research into supported housing.

3.4.4 Studies post-2005

Priebe et al. (2009) conducted a large-scale study of specialist housing services in England focussing on characteristics, care provision and costs, bringing together data from 414 service users. Managers of 153 services were asked to provide information on up to three service users (socio-demographic information, and occupational and social activities). Managers also provided information about

the housing service itself (number of places, funding arrangements, turnover rate, activities organised, etc.). A strength of this study is that it aimed to obtain data from a range of different services (residential care homes, supported housing services, floating support services and adult placement schemes). However, the selection procedure for services ended with only a relatively small number of adult placement schemes (11 service users from five schemes).

For many service users, it was not their first time in SHSs (information on previous location was lacking). The sample consisted mostly of men suffering from a psychotic disorder; 17% were from BME groups, 3% were in open-employment and 8% were in voluntary or sheltered work. According to managers, service users met staff and residents on a daily basis, and friends outside the service twice per week on average – many had no regular contact with family. People in floating support most frequently saw friends, followed by those in supported housing. No information was provided on the rules within the homes (if any).

This study provides helpful descriptions of the people living in different support types, especially with regard to those who use floating support services. It also provides descriptions of the structures within different types of homes, providing a better understanding of the provision of services. Yet the information was provided by managers on behalf of service users, which may not paint a realistic picture: they may have provided incomplete or inaccurate information, or been overly positive about certain aspects (such as frequency of social contacts). Another limitation of this study is the terminology used: it refers to service users as 'patients' when they were not in these facilities primarily to receive health services. Also, the authors may have obtained an inaccurate definition of supported housing services as being a Registered Social Landlord tenancy linked with support. This raises the question of how to define and classify SHSs, an issue mentioned by authors, alongside the need for more research which evaluates care processes in housing services and alternative services, using quantitative and qualitative methods.

Macpherson and colleagues (2012) provide a useful update of their review a few years earlier (Macpherson et al., 2004) of the supported housing literature (without reviewing it), by focussing on several key aspects: reinstitutionalisation,

changes in service provision, the impact of community mental health service developments and the recovery movement, forms of supported accommodation, assessing need for supported housing, the evidence base for supported accommodation, accommodation and service user choice, and quality issues and partnership working.

Starting with service provision, the number of places in supported housing had risen in England, what Priebe et al. (2005) termed 'reinstitutionalisation'. Macpherson et al. (2012) argue that, in essence, the new sheltered and supported housing services are not institutional. They note the importance of social and cultural factors which determine whether family or formal support is used (I. Carpenter et al., 2004) as well as the rise of rehabilitation units which, post-deinstitutionalisation, continue to provide short- to medium-term 24 hour nursing care for new long-stay patients (Killaspy et al., 2005).

In terms of classification, Macpherson et al. (2012) comment that Priebe et al. (2009) had provided a useful summary of the different supported accommodation settings, adding that in practice, the range of services seemed to depend on many factors, such as whether charitable organisations or major private providers had been active locally, and the focus of each local social services department.

More importantly, they highlight two important factors that had not been apparent in the previous literature. First, the value of an individual having a tenancy (like in some supported housing services) compared to not having one (for example in residential care): this provides them with security and opportunities for personalising their accommodation. Second, the impact of a specific placement on service users' welfare benefits: some residential care homes were now 'de-registering' to supported housing (without changing the level of support provided) to ensure that their tenants were not disadvantaged in terms of the benefits they were eligible for – financial incentives being a major factor influencing the decisions of people accepting such placements.

The authors also touch on the personalisation agenda, and the benefits of according more choice and control to service users, but that within the population of mental health service users, uptake had been slow.

In terms of the evidence for supported housing, Macpherson and colleagues (2012) observe that there was a lack of good-quality research, using evidence from the review by Fakhoury et al. (2002), and there was an obvious need for better-quality and well-conducted studies that compare outcomes whilst considering individual experiences in different forms of housing.

Existing evidence was seen to be generally positive, and there was a documented preference from people who wanted to more live more independently and in ordinary housing (Hogberg et al., 2006; Owen et al., 1996; Tanzman, 1993), despite the fact that there were examples in the literature where staff or family perceptions of need conflicted with those preferences. Macpherson et al. also highlight the importance of enabling choice of supported housing (Fakhoury, et al., 2005; Friedrich, et al., 1999; Massey & Wu, 1993; Nelson, et al., 2007; Srebnik, et al., 1995); this literature on choice also figured prominently in the review by Sylvestre et al. (2007). Macpherson and colleagues also feature studies that compared staff and service users' perceptions of choice, with the latter often under-estimating their need for supervised arrangements compared to the former (Minsky et al., 1995). Staff also seemed to place a higher value on safety and support, while service users valued independence and privacy (Piat et al., 2008).

Macpherson et al. (2012) suggest that with such poor agreement between professionals and service users over goals, better staff training was needed as well as having a range of accommodation and support options facilitating choice as well as support as required.

They conclude that, even though there have been major advances since the closure of asylums, there are some service users who need on-going, high levels of practical and emotional support, similar to the conclusions put forward by O'Malley and Croucher (2005). More specifically, the support must be adapted to service users' needs and be flexible, and enhance privacy and autonomy: a successful service will depend on the involvement of the service user, and focus on their strengths and experiences, as well as have well-functioning care pathways.

3.5 Discussion

The review of reviews revealed several underlying themes, such as the community care reforms, and the importance of quality of life. This also made it possible to identify gaps in the literature, where research is still needed. These can be grouped into eight over-arching statements about the current body of research.

The overall lack of an evidence base

In general, not much research has been conducted within specialist housing settings. The literature reviews (the most recent in 2008) revealed a total of 305 studies (with possible overlap), the majority of which are U.S.-based. The earliest recorded study was in 1969 and the latest in 2006, making an average of only 8.2 studies on housing published every year. More specifically to the UK, O'Malley and Croucher (2005) identified 131 UK-based studies in their review, from 1984 to 2001: this averages 7.7 UK housing studies per year. With housing being such a basic and ubiquitous need, it is concerning that little research has been conducted on the topic.

Poor quality evidence base

Research on specialist housing services has been beset by challenges of unrepresentative or small samples. It is appreciated that the target population may be hard to reach, but nonetheless efforts to reach them have not generally been made. At times, only a small number of sites were visited, and many studies lacked variability within the housing environments covered. Samples were sometimes not generalisable to the rest of the population, for instance where data were collected from a specific town or primarily urban location (Oliver, et al., 1996; Oliver & Mohamad, 1992; Shepherd, et al., 1996). Sub-samples used for comparative purposes between differing housing support types were often unequal in size (Järbrink, et al., 2001). Moreover, some studies (Oliver, et al., 1996; Oliver & Mohamad, 1992; Shepherd, 1991, 1995; Shepherd, et al., 1996) had not properly defined their sample population, by not reporting or including in their analyses psychiatric diagnosis or similarly important characteristics.

Lack of information on housing pathways

There has been robust evidence of improved outcomes for service users living in the community compared to hospitalised care in England (Knapp, et al., 1992; Leff, et al., 1996; Leff, et al., 2000; Shepherd, 1991; Shepherd, et al., 1996; Trieman, et al., 1998), in terms of higher satisfaction with their living situation, quality of life and increased participation in community activities, particularly from studies that followed the trajectories of people as they moved out of long-stay institutions.

Individual information on pathways in to and out of SHSs is lacking. The TAPS study usefully provided some information about the housing trajectories of a special cohort of people following the closure of two major psychiatric hospitals (Trieman, et al., 1998), Fakhoury et al. (2005) found that most people in supported housing aspired to live in more independent settings, and Priebe et al. (2009) requested previous locations of clients from managers. However, there has been no study that combined both issues from a service user perspective – where they came from and whether they were moving anywhere; such information would deepen the understanding of the mismatch between need and provision (Järbrink, et al., 2001; Lelliott, et al., 1996) and inform discussion of delayed discharge (Lelliott & Wing, 1994; Macpherson, et al., 2004; Shepherd, et al., 1997).

The Supporting People (SP) databases contain updated information on the number of people, referrals, previous and move-on accommodation provided by services, who have been required to return data on their clients since 2004 (Centre for Housing Research, 2013g). Covering mostly floating and supported housing services, very little is collected on more intense forms of support, such as residential care homes, and is purely statistical data.

The absence of a service user perspective

In their update on supported accommodation for people with severe mental illness, Macpherson and colleagues (2012) stated that there is a need for qualitative studies within SHS research, having relied on conclusions from several international authors (Chesters et al., 2005; Forchuk et al., 2006). The lack of studies employing qualitative methods prompted Kyle and Dunn (2008) to press for their use to understand more fully individuals' lived experiences of different housing arrangements. Indeed, one of the most comprehensive recent studies conducted

within different SHS settings in England was that conducted by Priebe et al. (2009), yet information was provided by managers about service users. Of course, there have been studies in England where qualitative methods have been employed, but these were for the most part conducted at the dawn of the community care reforms (Knapp, et al., 1992; Oliver & Mohamad, 1992) or focused on a specific theme (Fakhoury, et al., 2005).

Lack of information on user preferences

Despite the benefits of enabling choice within SHSs, little is known about service user preferences within SHSs in England. Sylvestre and colleagues (2007) identified a helpful body of literature on choice and control, and their effect on well-being, but this was only within U.S. and Canadian SHS settings, where the service user movement had initially started. Macpherson and colleagues (2012) also referenced accommodation and service user choice, but mostly identified U.S and Canadian studies as well. The only UK-based study cited in this area was that by Fakhoury et al. (2005).

New policies on personalisation and service user choice imply a need for new relationships between professionals and service users, focussing on autonomy and service user priorities, but the uptake of personalised services in the UK has been slow and patchy (Social Care Institute for Excellence, 2009). A better understanding of the reasons of this slow endorsement is needed, especially within SHSs, from the viewpoints of service users and managers alike.

A paucity of research on outcomes

There is little consistent information on what affects outcomes within SHSs in the present policy and practice context, especially in settings with low levels of support (Macpherson, et al., 2004), or what works best and for whom (O'Malley & Croucher, 2005). The review by Fakhoury and colleagues (2002) revealed that there were problems concerning people's social isolation (Goering, et al., 1992; Martin, 1984), and those living in flats felt more socially isolated than people in 24-hour residential care (Friedrich, et al., 1999). With regard to the physical environment, Fakhoury et al. (2002) cited several studies where privacy – or lack of it – was an important concern amongst service users (McCarthy & Nelson, 1993; Nelson, et al., 1995), as well as independence and personal choice (Massey & Wu, 1993). The

issue of privacy was also picked up by Sylvestre and colleagues (2007), citing some of the aforementioned studies as well as others (Forchuk, et al., 2006; Nelson, et al., 1998; Parkinson, et al., 1999; Tsemberis, et al., 2003). Taylor et al. (2009) also discussed privacy within SHSs in relation to Fakhoury and colleagues' (2002) review, as well as Corrigan's (1990) study.

Most of this evidence is international and there has been little research conducted on these issues within English settings. Additional research still needs to be conducted within different forms of SHSs, and information obtained from a variety of service users, not only those leaving large psychiatric hospitals.

The omission of stigma and discrimination in the literature

Another potential reason for the sense of isolation within SHSs may be stigma and discrimination. Not many studies, at least in England, have investigated or focused on social inclusion within SHSs, despite the fact that people with mental health problems represent one of the most excluded groups in society (Social Exclusion Unit, 2004). Sylvestre and colleagues (2007) showed that community integration, dependent primarily on the proximity of residential facilities to community resources (Wong & Solomon, 2002), was an essential factor to well-being, adding that accommodation that is not significantly different in appearance from other houses was found to increase integration (Parkinson, et al., 1999). Another study mentioned in the review was that by Mares et al. (2002) who found that an area's deprivation level had an effect as well: people living in low-income neighbourhoods experienced less social stigma than their counterparts living in high-income ones because their neighbours were more disenfranchised. The only other review of the literature which mentioned stigma and discrimination was that by Kyle and Dunn (2008), in relation to individuals' difficulty in sometimes accessing general housing due to the associated stigma of their illness. Despite many policies that have been drafted in order to tackle stigma and discrimination in England (Department of Health, 1999b; Social Exclusion Unit, 2004), mainly led by the National Institute for Mental Health in England (NIMHE) before it was abolished, together with a considerable awareness campaign (MIND, 2011) not many studies have been conducted within SHSs about the sense of exclusion and discrimination.

A way to evaluate integration, aside from a study of social networks, would be to measure employment as well as community participation. Fakhoury et al. (2002) mentioned that a study by Friedrich and colleagues (1999) found that people with mental health problems living in SHSs in Iowa (U.S.) were less likely to be employed compared to people in independent living. Taylor et al. (2009) noted that work schemes benefitted people with mental health problems, but very few of the studies included people living in SHS settings. No other reviews have mentioned employment within their literature searches, suggesting this gap in the literature. Some UK-based studies (Oliver & Mohamad, 1992; Priebe, et al., 2009) did mention employment rates amongst their samples, but none tackled the barriers to employment. In their discussion, Sylvestre and colleagues (2007) added that more research is needed in this area, since employment is so interwoven within peoples' housing experiences.

The absence of a consistent classification system for SHSs

Studies on SHSs have not employed a common system for defining and classifying SHSs. Fakhoury et al. (2002) reflect that the main problem with defining SHSs lies with the diversity of existing housing models (Budson, 1981; Carling, 1978, 1981; Fairweather, 1980; Goldmeier et al., 1977). Fakhoury et al. (2002) suggested that a way of distinguishing different forms of support was through expected lengths of stay, as put by Bigelow (1998): are the homes transitional or meant as a home for life? Lelliott et al. (1996) used a multi-dimensional approach (discussed in the next chapter). O'Malley and Croucher (2005) note the different typologies of accommodation that have been developed (Clifford, 1993; Pickard et al., 1989), but these studies are nearly two decades old and may not reflect the range of services available today.

Thus, this review has found relatively little research on English SHSs for people with mental health problems. The many small studies and absence of good descriptive data means the evidence base is poor. The current study attempts to address some of these gaps by interviewing service users to elicit their experiences within their respective homes and how they came to be there, as well as managers, to gain a more insightful look into how SHSs are run. Chapter 5 sets out the study

design, but first it is necessary to classify and define the different types of SHS, to offer a more updated view of what is provided within each and to whom.

Table 3-1: Principal selected UK studies of SHSs

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
TAPS: Leff et al. (2000), Leff et al. (1996), Trieman et al. (1998) London	Mixed-methods, longitudinal study	670 patients	Staffed group homes (78%), unstaffed group homes (7%), council flats (11%), family (4%)	Schizophrenia (76%)	Housing, crime, readmission, clinical and social outcomes, costs	Psychiatric symptoms, social networks and social-behavioural problems did not change, skills gained with everyday living tasks.	Large-scale longitudinal study, focussing on various topics, one of the first studies to survey newly discharged patients into the community
Knapp et al. (1992), multi-site	Client records, staff and service user interviews	122	Residential homes, hostels, group homes, foster placement, supported lodgings, independent living	Schizophrenia (82%)	Evaluation of the care in the community programme. Measure while in hospital and after move: community participation, social networks, satisfaction	Compared to when in hospital: no changes in symptoms or behavioural activities, increased participation in activities, increase in social contacts, increased general morale	Several sites sampled from, with urban/rural mix
Oliver and Mohamad (1992), Preston and Chorley	Interviews with service users	61	Staffed hostels, boarding out homes and group homes	Not specified	Well-being and quality of life	A little more than half the sample evaluated their life favourably. Significant differences appeared between accommodation and provider types.	Insight into personal experiences and views of service users
Oliver et al. (1996), North-West England	Interviews with service users	140	Private staffed hostels, boarding out homes and group homes	Not specified	Well-being and quality of life	People living in independent-sector homes scored their subjective well-being relatively higher than the local authority hostel population, and	Comparisons made between independent-sector homes and other provision types.

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
						community social services sample. Also happier about remaining in their homes.	
Shepherd et al. (1996), outer London	Cross-sectional comparison between community residential homes and hospital wards	200 service users but 19 from the hospital and 86 from community homes completed quality of life interview	Hospital wards and community homes	Not specified	Quality of care and quality of life	Compared to people in hospital, those in the community were generally much more satisfied. Differences found between provider types.	Satisfaction sought from a service user perspective
Shepherd (1991, 1995), Cambridge	N/A	20 (12/8)	Ward-in-a-house	Not specified	Psychosocial functioning, costs, community engagement	Compared to people in hospital, psychosocial functioning had improved for residents. They also had more contact with the community, reported greater satisfaction with living situation. Cheaper than acute admission wards.	N/A
Lelliott et al. (1996), English and Welsh districts	Interviews with keyworkers, client records	1951 residents in 368 facilities	Forensic units, acute wards, long-stay wards, hostels, group homes, staffed care homes	Schizophrenia (60%), paranoid psychosis (16%), neurotic disorders (12%), dementia (5%), personality disorders (5%),	Classification of SHSs, characteristics of residents, staffing of facilities	Nearly equal split between genders: males 56% of sample. Women were older. Not many people from BME groups (13%). Low employment rates (4%). Most ill people placed in places with most	First attempt at describing breadth of facilities and classifying them. Large-scale study that is representative of the national picture.

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
				substance misuse (2%)		support.	
Järbrink, et al. (2001), London	Client records, interviews with service users	238 service users	General housing, supported living, group homes, hostels, residential care	Not specified	Resident characteristics, needs, living environment, costs	Supported housing most common living arrangement. Low proportion from BME groups and low employment rates (highest in supported housing). Type of accommodation and support, and frequency of psychiatric contract dependent on age and severity of illness. Group/residential homes scored better in terms of living environment but also had highest weekly costs.	Established instruments employed (CAN, CSRI, Living Units Environment Schedule, Psychosis Screening Questionnaire). Importance of physical environment acknowledged as well as the absence of information on housing pathways
Fakhoury et al. (2005), London and Essex	Semi-structured interviews; mixed methods approach	41 service users and 39 staff	Supported housing settings	Schizophrenia or related psychotic disorder	Goals of new long-stay patients in supported housing, goals of staff, and relative comparisons.	Service users' main goals were to move to independent housing. Cluster analysis of people with no goals revealed higher levels of psychopathology and decreased satisfaction with living situation relative to other group.	Exploratory study with a mixed methods approach, providing much needed information
Priebe et al. (2009), England	Questionnaires	414 service users and 153 managers	Care homes, supported housing	Schizophrenia (60%), affective disorder (20%),	Service user characteristics, accommodation	Large proportion of men (71%), and people from white groups (84%). Only	Established instruments used (CAN, CSRI). Provided

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
(multi-site)			services, floating support services, adult placement schemes	neurotic, substance misuse and personality disorder (4%), organic and learning disability (4%)	characteristics,	3% in open-employment (8% in voluntary or sheltered work). Higher support accommodation relatively more expensive than lower. People in lower support facilities also comparatively saw friends more often.	much needed description on characteristic of different SHSs (staffing, catering arrangements, exclusion criteria) which will aid future classifications. Systematic approach to sampling used, making it a very representative sample
Fakhoury et al. (2002), international studies	Literature review	87 studies met inclusion criteria	Supported housing, sheltered housing	Mentally ill, schizophrenia	Historical background of SHSs, concepts, characteristics of service users, range of research designs and methods used to evaluate SHSs, outcomes of these studies, factors that influence quality of housing care and support	Compared to people living independently, those in 'supported housing' were more likely to be older, less educated, male, with longer hospital stays, and suffering from schizophrenia; also have lower functionality in terms of daily living skills. Lack of privacy an issue. Little research has been conducted on the recruitment, training and management of staff.	Acknowledged the difficulty in classifying different types of supported housing. And also the fact that research has been mainly cross-sectional.
Taylor et al. (2009), international	Systematic review of the literature	110 studies met inclusion criteria	Supported housing, hospital wards,	Mentally ill, schizophrenia	Living conditions, interventions for the treatment of	Service users prefer community settings to hospital ones. Positive	Eleven databases searched. Provided useful quality

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
studies			residential care, board and care homes		schizophrenia, physical health, restraint and seclusion, therapeutic relationship, autonomy and service user involvement, staff training and support, clinical governance.	social climates where independence is encouraged breeds greater satisfaction with living situation. Importance of an enhancing therapeutic alliance between staff and service users as well as privacy. No consensus on ideal number of residents.	assessments of studies. Very rigorous and reliable selection process of studies to be included, domains, assessment of methodological quality.
Chilvers et al. (2010), international studies	Review of the literature	0	Supported housing schemes, outreach support schemes and standard care	Severe mental disorder	Effect of supported housing versus outreach support and standard care through service utilisation, medical or mental state changes, satisfaction, quality of life, and economic measures. Only relevant randomised and quasi-randomised control trials were considered.	No studies met the inclusion criteria	First attempt at reviewing the effectiveness of supported housing versus standard care or outreach support through randomised or quasi-randomised controlled trials.
Sylvestre et al. (2007), international studies	Literature review and content analysis to identify values	40 documents (7 academic articles, 23 grey literature documents, 10 reports)	Not specified	Not specified	Values identified as choice and control, quality, community integration, access and affordability, accountability, housing rights and legal	Choice, control, quality, and community integration, all had an effect on well-being and quality of life	Useful approach; identified values

Author, year, location(s)	Method	Sample size	Housing setting(s)	Main diagnosis	Outcomes	Main findings	Strength(s)
					security of tenure		
Kyle & Dunn (2008)	Systematic review	29 studies met eligibility criteria	Custodial housing, supportive housing, supported housing	SPMI (Severe and Persistent Mental Illness)	Housing and healthcare utilisation, housing and mental status outcomes, housing and quality of life	Housing interventions for homeless people are beneficial, improved outcomes for hospital leavers	Recognised that more research is needed to make correct conclusions about the factors that mediate outcomes
O'Malley & Croucher (2005)	Scoping studies	131 studies	Supported housing	Not specified	Hospitalisation versus community life, accommodation with relatively low levels of staff and support, accommodation with relatively high levels of support, balancing need and service provision	Improved outcomes in community living compared to hospital, high-levels of support still needed, a definite typology needed	Recognised that sometimes people are not able to achieve independent living; organisational websites searched for material as well (a lot of literature on mental health problems appears there)

Chapter 4 Towards a classification of Specialist Housing Services

4.1 Introduction

The aim of this chapter is to review definitions and classifications of SHSs in research literature and official documents, and to seek commonalities, with the aim of establishing a more rigorous taxonomy appropriate for England today, that can inform the research in this thesis.

The review of the literature revealed that researchers were basing their assumptions and conclusions on differing definitions and classifications of SHSs. This can make it difficult to generalise results, compare studies, or make confident conclusions about the effectiveness of a particular type of SHS compared to another (O'Malley & Croucher, 2005).

Indeed, there is much confusion about the meaning of 'community care'. Bulmer (1987) identified four different usages of the term. Originally defined as "*care outside of large institutions*", it encompassed anything other than remote and large asylums. However, it can also denote 'community nursing' or the delivery of various professional services outside of hospital. Third, it could signify care *by* the community (Bayley, 1973), and by voluntary agencies and families. Finally, it could represent provision that is as close to ordinary living as possible. Hence, types of providers, quality and levels of support all vary in all these definitions of community care. Even in more recent studies of SHSs, Macpherson et al. (2004) suggested that staff and support levels varied within each home as well as each type of SHS.

However, these classifications do not adequately reflect the breadth of different support levels. What follows is a detailed description and definition of SHSs of interest here and a potential classification.

4.2 Search strategy

The literature review (chapter 3) provided descriptions of various forms of SHSs. Studies were examined for definitions or descriptions of any form of SHS, but only those that are UK-based were included in order to develop a taxonomy that would be relevant to UK policy. Where studies borrowed definitions from other authors, original authors and definitions were included.

To identify studies that tried to classify UK SHSs, a search was conducted through LSE's Summon electronic database using the following search terms: "classification" AND "definition" AND "supported housing" AND "mental health problems" AND "UK". This query returned 99 hits, of which only two were of any relevance (Fakhoury, et al., 2002; Trieman, 1997). Some 'grey' literature was also searched using the same search terms using Google. This focused on the Mental Health Minimum Dataset for definitions and descriptions, as well as the Supporting People, Housing Corporation and Care Quality Commission websites and policy documents.

4.3 Definition of specialist housing services

Regardless of its components, there is a lack of consistent definition and use of a term that encompasses all accommodation-based services providing support for people with mental health problems in England.

It seems a good time to drop the traditional and most commonly used term for housing options for people with mental health problems, 'supported housing', in favour of the new term 'specialist housing service'. Hence, for purposes of this study, accommodation provided with or without care, specifically dedicated to people with mental health problems, is termed a specialist housing service (SHS).

The new term used by this study, SHSs, covers a range of provision with different antecedent terminology. This new term takes inspiration from previous literature and definitions delineated below, where these focus on '*supported housing*' (Chilvers, et al., 2010; Fakhoury, et al., 2002; Fakhoury, et al., 2005; O'Malley & Croucher, 2005), '*supported accommodation*' (Macpherson, et al., 2004), and '*supported living*' (Järbrink, et al., 2001) and '*supported community placements*' (Knapp, et al., 1992).

Generally, many different definitions of *supported housing* have been offered. Fakhoury and colleagues (2005) note that an early attempt to define supported housing was made by the National Association of State Mental Health Program Directors in the U.S who viewed supported housing as "*an approach that focuses on clients' goals and preferences, uses an individualised and flexible rehabilitation process, and has a strong emphasis on normal housing, work, and*

social networks” (National Association of State Mental Health Program Directors (NASMHPD), 1987).

Not long after, and in the UK, Knapp et al. (1992, pp. 150-151) examined ‘*supported community placements*’, which were basically placements with support outside of hospital. The projects they surveyed met accommodation needs in different ways, with the range of service models reflecting different philosophies of care (for example, in promoting independence), local housing provision and budget limitations.

Drawing from the *Care in the Community* results (Knapp, et al., 1992), as well as the TAPS studies (Lewis & Trieman, 1995), Trieman (1997, p. 67) later went on to define supported housing as a type of facility that comprised relatively small community-based homes (such as residential care homes or nursing homes, hostels, staffed group homes, unstaffed group homes, adult foster homes, and sheltered housing), adjusted to a gradient of support according to service user needs. These houses might have provided support with everyday living (for example, finances, domestic tasks) and facilitated access to community and social activities, with no additional medical cover aside from standard primary care services (GP, CPN).

4.4 Classifying Specialist Housing Services

With this new term, comes a new proposed classification system, drawing heavily on both existing literature and reviews of ‘supported housing’ in the UK.

Shepherd and Murray (2001, p. 309) argued that the range of residential care alternatives available to people with mental health problems was difficult to classify. For instance, one solution, provided by Lelliott et al. (1996), was a multi-dimensional system based on the availability of different kinds of staff cover, number of beds and staff:resident ratio. They described forensic units and acute and long-stay wards, alongside high to low-staffed hostels, group homes and care homes. Shepherd and Murray (2001) propose the need to go beyond this traditional view, suggesting that definitions of residential alternatives should not only include these quantitative aspects (staff availability, number of placements, staff-resident ratios), but also reflect more qualitative information, such as user preferences.

Table 4.2 groups and defines different types of SHS by author and study. The three types of SHS terms appearing in the selected literature that made up the spectrum of SHSs for this study were: care homes, supported housing services, and Shared Lives/Adult Placement schemes. Groups homes were discussed by many authors, however it is particularly difficult to differentiate between them and supported housing services; the focus here will be on the latter. Hostels, sheltered and core and cluster housing, as well as floating support services also appeared at various points in the literature; although as these do not meet this study's definition of an SHS they will be discussed last.

For each of the aforementioned types of SHSs, previous authors had suggested differing definitions and descriptions, which were at times conflicting. The new classification system will build on the literature and attempt to find logical patterns that would make better sense of past definitions, and also take into account the ethos of an SHS.

In the following sections each component of the SHS spectrum will be discussed in detail. Each section will be introduced by this study's definition of that SHS, followed by the differing viewpoints of authors, as well as commonalities. Detailed descriptions extracted from the academic literature as well as grey one will also be presented.

4.4.1 Care homes

Care homes provide intense support, most commonly on a 24-hour basis, with a high staff:resident ratio, and continuous day and night cover (can be waking or sleep-in). Sizes of homes vary. Most residents have their own bedrooms, in order to ensure privacy and autonomy. Although support is intense, the quality of support differed across different homes. For instance some homes were self-catering and some were not. Most commonly, residents had set meal times, and were to have their meals all together.

Most authors of the selected literature (Knapp, et al., 1992; Lelliott, et al., 1996; Macpherson, et al., 2012; Priebe, et al., 2009; Trieman, 1997) agreed with the above definition and description. The only point of contention was the size of homes, with Lelliott and colleagues (1996) estimating care homes to be much

smaller compared to other studies. Still, all agreed that this was the most intensive form of support available within SHSs. Staff were usually responsible for cooking and few services operated self-catering arrangements (Priebe, et al., 2009).

More specifically, under the Care Standards Act 2000, all care homes providing nursing or personal care, as well as their respective managers, are required to register with the CQC (Care Quality Commission, 2011, 2012b).

The Mental Health Minimum Dataset (MHMDS) describes care homes as providing accommodation, together with nursing or personal care. A care home may also include group homes not normally staffed by nurses but providing accommodation and personal care (NHS Data Model and Dictionary Service, 2012).

Lelliott et al. (1996) surveyed 50 staffed care homes and 132 residents, and found that on average fewer than six people lived in each, with constant day cover from staff, and sleep-in night cover. These are highly staffed facilities, with a ratio of staff to residents of 1.01, only 7% of whom had some sort of care qualification. Most (52%) staffed care homes in the study were provided for by the private sector, followed by Local Authority Social Services departments (36%) and the voluntary sector (12%).

Trieman (1997, p. 67) and Knapp et al. (1992, p. 113) agreed with the level of staffing and respective coverage described by Lelliott and colleagues (1996), but differed in their estimation about the sizes of homes: for them, care homes held six or more residents. The basis of staffing, and the care and support provided was similar in all cases.

Macpherson and colleagues (2004) departed from the more traditional aforementioned descriptions of care homes: their version encompassed supported lodgings or adult fostering homes and facilities varying from small family homes (up to three residents) to larger services (where up to 12 residents live in a sort of supported hostel with resident care home staff). In this case, their depiction of larger services in the form of supported hostels could be similar to the typical care homes. However, an updated version of this review (Macpherson, et al., 2012) described nursing/residential care homes in a more conventional sense: 24-hour staffed care provided to individuals in a communal setting, with a greater proportion of qualified nursing staff in the former compared to the latter.

Priebe et al. (2009) gave a detailed account of the 57 care homes sampled, 48% of which had 24-hour staff cover (awake at night): on average there were 16.4 places per service – higher than what was reported in the Lelliott et al. (1996) study. Half of the time (52%) staff were responsible for cooking. Most people were living in single bedrooms (96%). Although it may seem that the proportion of services with 24-hour awake at night staff cover was somewhat low, the study did not provide any further breakdown of facilities with 24-hour asleep or on-call at night staff cover. In terms of the sizes of homes, the notable difference between the other studies (Lelliott, et al., 1996; Priebe, et al., 2009), may be due to sampling errors or differences, or possibly the fact that more managers from larger care homes responded in the Priebe et al. study (2009).

4.4.2 Group homes

Group homes consist of two to five service users living in an ordinary house in the community where staff are not onsite but visit a few times a week. They hence provide relatively less support to service users in comparison to care homes, and are relatively small. These are usually owned and managed by local authorities.

In the past, many authors have attempted to define group homes and some had differentiated between staffed and unstaffed versions (Gibbons, 1988; Knapp, et al., 1992; Trieman, 1997).

Trieman's (1997) and Knapp and colleagues' (1992) group homes hold between two and five residents, and have either continuous or regular day staff, waking, sleeping or on-call night staff – this was the staffed group home, provisions of which resemble slightly Lelliott and colleagues' descriptions of high and mid-staffed hostels. In unstaffed group homes, there was ad hoc or no day staff with on-call or no night cover. On the other hand, Gibbons (1988, pp. 182-183) focussed on unstaffed group homes, where varying numbers of people shared an ordinary house that was supervised weekly by staff, set up by hospitals in partnership with housing associations or voluntary bodies. This definition followed closely that proposed by Capstick (1973) more than a decade earlier, which was that of ordinary residential accommodation in the community for a small number of people, who had been discharged from psychiatric hospital and were able to live as a family unit without

staff supervision. Petch (1992, p. 31) described group homes similarly, as long-term accommodation without resident staff; however added that it was more of a 'home for life' and residents were not really being prepared for a subsequent move.

Lelliott and colleagues proposed a definition of a group home as a house that usually held six or less residents, with on-call or no night cover, and visited day cover from staff (33% of whom had a care qualification) – a description similar to Trieman's (1997) and Knapp and colleagues' (1992) unstaffed group homes.

Similarly, Macpherson et al. (2004) depicted their group homes, which are not staffed, as holding up to five residents in houses owned and managed by local authority social services departments (similarly, in the Lelliott et al. (1996) study, nearly half (42%) of group homes were managed by that body). In their study of 238 individuals living in 'supported housing' in the UK, Järbrink and colleagues (2001) combined group and residential homes into one category, to include group homes, hostels and residential care, with staff based on site. Staff:resident ratios were one to between 5 and 0.75 tenants.

4.4.3 Supported housing services

Supported housing *services* are different from 'supported housing', which seems to encompass nearly all forms of SHSs (Chilvers, et al., 2010; Fakhoury et al., 2002; O'Malley & Croucher, 2005).

In this thesis, supported housing *services* are typically self-contained or shared accommodation on one site. Staff are on site during office hours, or 9am to 5pm, with on-call or no night cover. Support is very much ad-hoc, and available when needed, and not provided on a continuous basis. Service users have tenancies that are for the most part time-limited. Privacy, security and autonomy are very much highlighted amongst service users within this scheme. There were usually no set meal times, and it was very much a departure from being 'institutionalised'.

Supported housing services have been difficult to define as they resemble hostels so much in their staff provision and size; an observation also made by Macpherson and colleagues (2012). The main differing characteristic was that supported housing services had accommodation that was self-contained on one site, where residents could have privacy, and for example meals on their own;

people also have their own tenancies. The site was still shared with other service users with mental health problems with staff on-site during office hours, but with on-call or no night cover (Chilvers, et al., 2010; Järbrink, et al., 2001; Trieman, 1997). Macpherson and colleagues (2004) described what they termed 'core and cluster housing' – also self-contained accommodation overseen by a core staff unit or visiting support staff – and may very well be their version of supported housing services; the same might apply to Trieman's (1997) sheltered housing, however in today's definition sheltered accommodation might be reserved for older people.

The MHMDS uses a very brief description of supported housing services: accommodation supported by staff or resident caretaker (NHS Data Model and Dictionary Service, 2012). As discussed in previous chapters, the largest funders of supported housing services have been Supporting People; they define supported housing as *"support [that] is provided together with accommodation as an integral package. The service may be shared housing, self-contained housing clustered on the same site or dispersed self-contained housing"* (Centre for Housing Research, 2012e). They hold tenancies as per the SP guidelines, and the support provided can either be short-term (less than two years) or long-term (longer than two years or for life) (Supporting People Helpdesk, 2012).

The Housing Corporation (2007) defined supported housing services as both specially-designed facilities intended for vulnerable people as well as accommodation that is designated for use by groups in need of supported housing services. These usually house a number of people with severe mental health problems in self-contained accommodation on one particular site.

Evidence from empirical studies was less consistent. Borrowing their definition from Stein and Test (1980), Chilvers et al. (2010) described these schemes as self-contained accommodation for a number of people with mental health problems on one site. Professional support staff was on-site and available during office hours for either individual or group social support. The definition put forward by Järbrink and colleagues (2001), what they termed supported living, was either a self-contained, or shared living unit where tenants received regular visits from housing officers or community care workers. The shared version in this case might resemble the group home definition by Macpherson et al. (2004).

Priebe and colleagues (2009) originally defined a supported housing service as a Resident Social Landlord tenancy linked with support within their methods section, however the study results later revealed a more detailed description. Of the 61 supported housing services sampled, managers reported a mean of 13.3 people living in each. In 17% of the cases, staff were onsite 24 hours a day and awake at night; 60% of services mainly had self-catering arrangements. With regard to residents, 27% were living in single bedrooms with en-suite facilities; most were living in single bedrooms without en-suite facilities (67%) and a small proportion were in shared bedrooms (6%) – hence one may conclude that most of the supported housing services sampled in this study were not self-contained accommodation on one site. Similarities could be made to shared living units within supported housing (Järbrink, et al., 2001).

Although not actually terming it supported housing, Trieman (1997, p. 67), defined what was meant by assisted/independent accommodation. These were basically independent or supervised flats within facilities that were provided for former patients who were capable of and had the desire to manage their own lives, though still required some occasional practical support or monitoring (ad hoc or no day staff, on-call or no night cover). These types of supervised flats resembled somewhat the shared living units Järbrink and colleagues (2001) described some years later.

4.4.4 Adult Placement/Shared Lives schemes

An adult placement or Shared Lives setting is where a mental health service user here lives in the family home of a Shared Lives carer and shares their life. It is accommodation for up to three service users living within the same household. The Shared Lives carer, an ordinary individual in the community, is screened and trained by a Shared Lives officer, and contractually bound to provide lodging, food and sometimes care to a service user in exchange for remuneration. Shared Lives schemes (Shared Lives, 2012) encompass supported lodgings (Gibbons, 1988; Knapp, et al., 1992; O'Malley & Croucher, 2005), adult foster homes (Trieman, 1997) and adult placement schemes (Priebe, et al., 2009).

There is an emphasis on privacy, and this provides the least institutionalised environment of all, and highlights family living. Shared Lives schemes have now replaced Adult Placement schemes and these terms will be used inter-changeably here (given their usage in the literature).

The National Minimum Standards for adult placement schemes (APSS) document (Department of Health, 2004) describes APSS as offering people alternative and highly flexible accommodation as well as care or support inside or outside the home provided by ordinary individuals or families. Thus, the service user shares in the life and activities of the Adult Placement Carer (APC) and is included as part of the family and, where appropriate, their extended family and network of friends, permitting them to lead independent lives, promoting their health and well-being, and reducing hospital readmissions. Like registered care homes, APSS are also regulated by the CQC under the Care Standards Act 2000, with safety and protection from abuse and neglect in mind (Department of Health, 2004). APSS can be provided in the short-term (e.g. respite care) or long-term and can include accommodation with support where support is funded through Supporting People. APSS fall under the umbrella of 'supported lodgings' as defined by the MHMDS ("*lodgings supported by staff or resident caretaker*") (NHS Data Model and Dictionary Service, 2012).

Gibbons (1988, p. 184) was one of the first to give a detailed account of APSS, or as it was then called 'supported lodgings'. Here, potential landladies, who had been carefully selected by specialised lodgings officers, were contracted to provide a bed, breakfast and an evening meal, with full board at the weekend, services and baths, to a service user with a mental health problem. Specialised lodgings officers occasionally visited the premises and were available for advice and support. Lodgers needed to be relatively stable in their symptoms and competent to care for their own hygiene. Daytime occupation needed to be available, and social workers or community nurses provided on-going support. This description held some resemblance to the small family homes within Macpherson and colleagues' (2004) staffed care homes. Similarly to the latter, Trieman (1997, p. 67) described adult foster homes, where up to three residents lived within an

established household, where support was available by day and on-call night cover. Knapp et al. (1992, p. 113) provided description of supported lodgings.

O'Malley and Croucher (2005) grouped private residential accommodation such as B&Bs and 'family placements' that are organised on either a short or long-term basis, under the category of supported lodgings.

Priebe et al. (2009) described APSs as flexible accommodation and support for up to three adults in the family home of an adult placement carer. Drawing from a small pool of people (five adult placement schemes and 11 respective service users), they reported that staff (or adult placement carers in this case) were on-site 24 hours a day and awake at night in all cases, and no houses were self-catering. The authors also reported that staff were never responsible for cooking, so it was unclear whether surveyed managers were answering on behalf of the adult placement carer, or they did not themselves provide meals on the management site. Otherwise, people living in adult placement schemes were mostly living in bedrooms without en-suite facilities (64%), or otherwise were sharing with someone else (18%). Again, these schemes resembled adult foster homes (Trieman, 1997, p. 67) and some aspects of staffed care homes (Macpherson, et al., 2004).

4.4.5 Hostels

Although Macpherson et al (2012) conclude that the term hostel was now rarely used as it was imprecise and tended to include supported housing services, a definition will be provided next.

Hostels are large facilities with six or more residents with low staff to resident ratios. There is continuous high support during the day and night (sleep-in or waking night cover). This is usually very temporary accommodation with the aim to relocate a homeless service user to an SHS.

Lelliott et al. (1996) provided a useful and detailed account of hostels. The authors further differentiated by staffing level (high, mid and low-staffed), but all had six or more people living in them. High-staffed hostels, mostly provided for by the private sector (70%), provided the most support with constant day cover and waking night cover, the ratio of staff to residents was 0.67; 15% of staff held care qualifications (a higher proportion than in their sampled care homes). Mid-staffed

hostels had similar cover during the day but had sleeping night cover, and a lower staff:resident ratio (0.39) by similarly qualified individuals (14% had a qualification). At the lower end of the scale, low-staffed hostels had regular or visiting day cover and on-call or no night cover. Ratio of staff to residents was also low (0.19) but staff were equally qualified (15%). From the provision side, the private sector was equally prominent in this case (56%) as well as the voluntary (39%). Local Authority and Social Services departments provided less low-staffed hostels (5%) than their more highly staffed counterparts (17% for both).

Similarities can be drawn with Trieman's (1997, p. 67) definition of hostels – yet only in the case of Lelliott and colleagues' (1996) high and mid-staffed hostels. Hence Trieman's (1997) hostels are described as medium support facilities with regular or constant cover by day and on call night staff cover; the same size of home applies (six or more residents).

Knapp and colleagues (1992, p. 113) defined their hostels as accommodation for six or more residents with continuous or intermediate (regular but not continuous) staff cover by day, differing night cover (sleep-in, on-call or none). In Gibbons' (1988, p. 181) selective review of the literature on issues in residential care for mentally ill adults in England, staffed hostels were defined slightly differently compared to other studies with a focus on clients' goals instead: hostels can be differentiated by being rehabilitative (short-stay) or permanent (indefinite). The environments are usually 'permissive' yet one of the conditions of stay was remaining in employment. Similarly to Lelliott and colleagues, Gibbons also mentioned provision, and reported that most hostels were provided by the voluntary sector. In the former study, the voluntary sector was the main provider of group homes and the secondary provider of mid- and low-staffed hostels.

Macpherson et al. (2004) departed from the norm with their definition of staffed hostels. Their definition resembled most closely that of care homes by other authors (Knapp, et al., 1992; Priebe, et al., 2009; Trieman, 1997). According to Macpherson and colleagues (2004), high and medium-staffed hostels are also known as 24-hour nursed-care units, varying in status from NHS-run and funded hostels to residential care homes provided by the voluntary or private sector. These hostels are typically located in residential areas of cities and occupy large, older

detached houses, with high staff: resident ratios: sizes varied from six to 12 residents. Low-staffed hostels usually had day cover only, provided by two or three staff (only a few of whom had formal care qualifications).

4.4.6 Floating support services

Floating support is somewhat a combination of group homes and supported housing services: basically self-contained accommodation on one site, which is not shared by other service users. Staff visit the individual for a specified number of hours per week in their own home, focussing on their independent living skills.

This is probably one of the only categories that most studies have agreed upon its definition, yet floating support services were not included in this particular study, as these services are, in essence, privately owned or rented accommodation, where support 'floats' from one person to another. One of its main discerning features is that support is tied to the individual rather than the property (Chilvers, et al., 2010; Macpherson, et al., 2012; O'Malley & Croucher, 2005).

According to the Centre for Housing Research (2013a), latest figures show that the majority of people with mental health problems funded by Supporting People lived in tenancies with floating support.

More specifically, O'Malley and Croucher (2005) described floating support services as support that is provided that sought to help individuals develop independent living skills.

Similarly, Chilvers and colleagues (2010) described "outreach support schemes", as self-contained accommodation on a site not shared with other mental health service users. An individual was not part of a specialised housing scheme but did receive (at least once every two weeks) home visits by professional outreach workers for individual social support.

Macpherson et al. (2012) combined the terms 'floating' and 'outreach' to describe a service where support is not tied to a specific building but provided with flexible intensity to people with a shared or individual tenancy. These may include core and cluster supported flats, where staff support a cluster of service users living in individual flats within a complex or an area, but where there are core communal facilities.

Priebe and colleagues (2009) described this category as support of a specified number of hours per week in an individual's own home, yet analyses of the study data told a different story. Of the 30 floating support services surveyed, 21% of services mainly had self-catering arrangements. Staff were responsible for cooking in 11% of cases; 26% of people had bedrooms with en-suite facilities (66% without) and 7% were sharing (the highest proportion of people sharing compared to care homes and supported housing services in the study). It is slightly difficult to understand these results and what managers were reporting on, given that the classical definition of floating support was the one provided prior to the results section of the study.

4.4.7 Core and cluster housing

Macpherson and colleagues (2004) described core and cluster services similarly to supported housing schemes (Chilvers, et al., 2010); these also share some aspects of supported living (Järbrink, et al., 2001). Core and cluster housing services were basically individual flats or bedsits that were overseen by a 'core' staffed unit or by visiting support staff, hence the name; this may be similar to floating outreach (Macpherson, et al., 2012). These were most commonly run by mental health charities or housing associations.

4.4.8 Sheltered housing

There were only two instances of sheltered housing in the selected literature and the descriptions were very much analogous. Trieman (1997, p. 67) and Knapp and colleagues (1992, p. 113) described it as individual units within a larger complex or site, with continuous or regular cover by day; night cover can be either waking, sleep-in or on-call. This is not surprising given that both authors were drawing from the same study data (Knapp, et al., 1992).

4.4.9 The final classification

In summary, table 4.1 groups together the final classification that will be used for this study.

Table 4-1: Final classification of SHSs and description

SHS type	Description
Care homes	High support facilities. Highly staffed with a high staff to resident ratio, with continuous day and night cover (can be waking or sleep-in). Sizes of homes vary.
Supported housing services	Self-contained or shared accommodation on one site. Staff on site during office hours, on-call or no night cover. Service users have tenancies.
Shared Lives schemes	Service user lives within the home of the Shared Lives Carer and shares in their life. Accommodation for up to three people, living within the same household in the community.

4.5 Discussion

This chapter brought together material from previous work to describe the various forms of specialist housing services.

Distinguishing between ‘supported housing’, and ‘supported housing services’ is important. The former term has been used in the literature to denote all forms of accommodation designated for people with mental health problems (Chilvers, et al., 2010; Fakhoury, et al., 2002; Trieman, 1997). The latter are a type of self-contained or shared accommodation on one site, where service users have tenancies (Centre for Housing Research, 2012i; Supporting People Helpdesk, 2012). Hence, these placements are for the most part funded through the Supporting People grant; this grant also funds support within many adult placement/Shared Lives placements (Department of Health, 2004), however there were only a few placements recorded through the Centre for Housing Research database. Could it be that most of these schemes are used for respite or day care, or accommodation with care, hence not falling under the remit of Supporting People?

Moreover, SHSs usually varied in terms of staff support provided, staff:resident ratios, staff qualifications and placement numbers. Of the studies sampled and identified as describing SHSs or proposing a classification, only two (Gibbons, 1988; Petch, 1992) mentioned client goals. This should be another factor to be taken into account when classifying SHSs, whilst highlighting their degree of autonomy, freedom and privacy (factors that could have an influence on well-being and quality of life, as discussed in chapter 3). Are service users residents or tenants (who subsequently have contracts)? Are they expected to move on in the future or

remain where they are? Are there restrictions within the home? Do they live in self-contained accommodation or do they have to take meals at set times with other service users? Can they exercise their choices and preferences within their homes? Some of these goals are also put forward by Shepherd and Murray (2001) in their discussion on residential care. The issue of how long a person stays within their accommodation should also be taken into consideration. For example, people in care homes have typically been there for longer compared than their counterparts in supported housing services, and although only marginally significant, supported housing services have higher turnover rates (Priebe, et al., 2009). Of course, length of stay may still depend on an interplay of various elements, including degree of severity of mental health problem, degree of functioning, staff experience and influence, home ethos, availability of other local housing services and Supporting People contract.

It is also essential to obtain information from service users themselves on how they *experience* these different forms of accommodation. This information would certainly supplement usefully the information already amalgamated with regard to different forms of SHSs.

Given the sometimes contradictory definitions, research studies should be encouraged to provide clearer definitions of the form(s) of SHSs that are under scrutiny. This would help the reader compare to other studies, and understand the results. It is still unclear whether a specific terminology (for example a “care home”) within a study is set by the researcher, the study participant, or is locally supplied information.

Table 4-2: Types of SHSs as described in the literature: definitions, consistencies, and differences

Name of service	Author and respective term used	Definition	Similar to	Different to
Care homes	Trieman (1997, p. 67): residential care home	Maximum support facilities where there is continuous staff cover by day and night, and there are six or more residents.	Priebe and colleagues' (2009) definition of care homes, and but differs slightly from Lelliott and others' (1996) in terms of size. Also similar to Macpherson and colleagues' (2004) definitions of high and medium-staffed hostels.	Staffed care homes by Macpherson et al. (2004)
	Priebe et al. (2009): care home	Large residential facilities (on average 16.4 residents per service) where patients live and receive care (staff onsite 24 hours a day and awake at night in nearly half the cases).	Trieman (1997) & Lelliott and colleagues' (1996) definitions of care homes.	Staffed care homes by Macpherson et al. (2004).
	Lelliott et al. (1996): staffed care home	Facilities where less than 6 residents (an average here of 2.6 per facility) live with sleep-in night cover from staff (on average 7% of whom have a care qualification), and have constant day cover. The private sector is the main provider in this case.	Priebe and colleagues' (2009) definition of care homes, but differs slightly from Trieman's (1997) in terms of size.	Staffed care homes by Macpherson et al. (2004).

Name of service	Author and respective term used	Definition	Similar to	Different to
	Macpherson et al. (2004): Staffed care homes	Also known as supported lodgings or adult fostering homes, these have a high proportion of unqualified 'staff' or carers, generally through a care scheme operated by social services departments within the local authority. Units vary from small family homes (up to three residents) to larger services (up to 12 residents in a type of supported hostel, with resident care home staff).	The family home unit definition resembles that of Shared Lives schemes (Gibbons, 1988; Priebe, et al., 2009; Trieman, 1997).	Trieman's (1997), Priebe and colleagues' (2009) and Lelliott and others' (1996) definitions of care homes.
	Knapp et al. (1992): residential home	Continuous staff cover by day, waking staff cover by night, six or more client places.	Priebe and colleagues' (2009) broad definition of care homes, and but differs slightly from Lelliott and others' (1996) in terms of size. Also similar to Macpherson and colleagues' (2004) definitions of high and medium-staffed hostels.	Staffed care homes by Macpherson et al. (2004).
	Macpherson et al. (2012): nursing/residential care	24-hour staffed care provided in communal settings. Nursing care home has a greater proportion of qualified nursing staff compared to residential.	Similar to definitions of care homes put forward by other authors (Knapp, et al., 1992; Priebe, et al., 2009; Trieman, 1997).	Staffed care homes by Macpherson et al. (2004).

Name of service	Author and respective term used	Definition	Similar to	Different to
	Mental Health Minimum Dataset (NHS Data Model and Dictionary Service, 2012): registered care home	Registered with the Care Quality Commission, provides accommodation, together with nursing or personal care. A Care home also includes group homes not normally staffed by nurses but providing accommodation and personal care.	Similar to definitions of care homes put forward by other authors (Knapp, et al., 1992; Macpherson, et al., 2012; Priebe, et al., 2009; Trieman, 1997).	Staffed care homes by Macpherson et al. (2004).
Hostels	Trieman (1997, p. 67): hostels	Medium-support facilities with continuous or regular staff cover by day, on-call night staff cover (six or more residents).	Lelliott and colleagues' (1996) definitions of high and mid-staffed hostels.	All types of hostels by Macpherson et al. (2004).
	Lelliott et al. (1996): high, mid, and low-staffed hostels	All these differently staffed hostels have six or more people living in them supervised by staff, on average 15% of whom have care qualifications. They differ by day and night cover: high-staffed hostels have waking night cover and constant day cover, mid-have sleep-in night cover and constant day cover, and low- have on-call or no night cover and regular day cover. They also differ by ratio of staff per resident places.	High and mid-staffed hostels definitions resemble Trieman's (1997) definition of hostels.	All types of hostels by Macpherson et al. (2004).

Name of service	Author and respective term used	Definition	Similar to	Different to
	Macpherson et al. (2004): high, medium and low staffed hostels	High- and medium-staffed hostels are also known as 24-hour nursed-care unit, varying in status from hostels run and funded by the NHS, to residential care homes provided by the private or voluntary sector. These units often occupy large, older detached houses in the residential areas of cities. Staffing levels vary from 8 to 20 per unit, where 6-12 people typically reside. Night cover may be awake or sleep-in. Low-staffed hostels usually have day cover only, provided by two or three staff, only a few of whom have formal care qualifications.	Some definitions of care homes (Priebe, et al., 2009; Trieman, 1997).	Other authors definitions' of hostels (Gibbons, 1988; Knapp, et al., 1992; Lelliott, et al., 1996; Trieman, 1997).
	Gibbons (1988, p. 181): staffed hostels	Mostly run by voluntary bodies, they can be rehabilitative (short-stay) or permanent (indefinite period of stay). Usually have 'permissive' environments; however a condition of stay in a hostel was remaining in employment (even though most residents had had long hospital stays).	Possibly the Lelliott et al. (1996) definition of low-staffed hostels.	All types of hostels by Macpherson et al. (2004).
	Knapp et al. (1992): hostels	Six or more residents with continuous or intermediate (regular but not continuous) staff cover by day, sleep-in or on call, or no cover by night.	Trieman's (1997) definition of hostels and Lelliott and colleagues' (1996) definitions of high and mid-staffed hostels.	All types of hostels by Macpherson et al. (2004).
Group homes	Trieman (1997, p. 67): staffed and unstaffed group	A staffed group home has continuous or regular staff cover by	Knapp and colleagues' group homes. Staffed	Staffed group homes dissimilar to

	home	day, waking or sleeping or on-call night staff cover, and holds between two and five residents. In contrast, an unstaffed group home provides low levels of support to two to five residents, with ad hoc or no day staff, on-call or no night cover.	group homes similar in staffing cover to Lelliott and colleagues' (1996) descriptions of high and mid-staffed hostels. Unstaffed group homes are similar to the respective definitions by others (Lelliott, et al., 1996; Macpherson, et al., 2004).	all other definitions of group homes (Capstick, 1973; Gibbons, 1988; Lelliott, et al., 1996; Macpherson, et al., 2004).
	Macpherson et al. (2004): group home	Not staffed, are typically houses owned and managed by local authority social services departments with up to five residents. Have regular visits from support workers through the CMHT.	Trieman's (1997) unstaffed group homes.	Trieman's (1997) staffed group homes.
	Lelliott et al. (1996): group home	Usually holds six or less residents with on-call or no night cover and visited day cover from staff (a third of who on average have a care qualification).	Trieman's (1997) unstaffed group homes.	Trieman's (1997) staffed group homes
	Capstick (1973): group home	Ordinary residential accommodation in the community for a small number of residents per home who have been discharged from psychiatric hospital and are able to live as a family unit without supervision.	Trieman's (1997) unstaffed group homes and group homes defined by Macpherson et al. (2004).	Trieman's (1997) staffed group homes
	Gibbons (1988, pp. 182,183): unstaffed group home	Varying numbers of people share an ordinary house, which is set up by hospitals in partnership with housing associations or voluntary bodies. Staff visited weekly.	Definition by Capstick (1973) and possibly Macpherson and others (2004).	Trieman's (1997) staffed group homes.
	Järbrink et al. (2001): group/residential homes	Include group homes, hostels and residential care, with staff based on site. Staffing levels vary.	Too general to find similarities.	N/A
	Petch (1992): group home	Long-term accommodation without	Trieman's (1997) unstaffed group	Trieman's (1997) staffed

		resident staff. No real preparation for a subsequent move.	homes and group homes defined by Macpherson et al. (2004) and Lelliott et al. (1996).	group homes.
	Knapp et al. (1992): staffed and unstaffed group homes	A staffed group home (less than six residents) has continuous or intermediate staff cover by day, waking or sleep-in, on-call or no night cover. The unstaffed version has ad hoc or no staff cover by day, on-call or no staff cover by night. Same size as staffed.	Trieman's definitions of group homes. Staffed group homes similar in staffing cover to Lelliott and colleagues' (1996) descriptions of high and mid-staffed hostels. Unstaffed group homes are similar to the respective definitions by others (Lelliott, et al., 1996; Macpherson, et al., 2004).	Staffed group homes dissimilar to all other definitions of group homes (Capstick, 1973; Gibbons, 1988; Lelliott, et al., 1996; Macpherson, et al., 2004).
Supported housing services	Priebe et al. (2009): supported housing services	Registered Social Landlord tenancy linked with support. Units with on average 13.3 people living in them, mostly self-catering arrangements in place and residents have own bedrooms but have to share a bathroom most of the time.	Possibly shared living units within supported living by Järbrink et al. (2001)	Supported housing by Chilvers et al. (2010)
	Järbrink et al. (2001): supported living	Either self-contained or shared living unit where tenants receive regular visits from housing officers or community care workers.	Trieman's (1997) sheltered housing and assisted/independent accommodation; some provisions of Macpherson and colleagues' (2004) group homes.	Chilvers et al. (2010): supported housing schemes.
	Stein and Test (1980) and Chilvers et al. (2010): supported housing schemes	A number of people in self-contained accommodation on one site. Professional support staff is on-site and available 9-5 at least for either individual or group social support with a minimum aim of maintaining a tenancy.	Supported housing services by Priebe et al. (2009), Trieman's (1997) sheltered housing, Macpherson et al. (2004) core and cluster housing.	Supported living by Järbrink et al. (2001).

	Trieman (1997, p. 67): assisted/independent accommodation	Facilities that are provided for former patients who are capable of and have the desire to manage their basic affairs though occasional practical support or monitoring as needed within independent or supervised flats (ad hoc or no day staff, on-call or no night cover).	Järbrink et al. (2001): shared living units within supported living.	Supported housing services (Priebe, et al., 2009) and supported housing schemes (Chilvers, et al., 2010).
	The Housing Corporation (2007): supported housing	Specially-designed facilities for a number of people with severe mental health problems in self-contained accommodation on one particular site.	Supported housing services by Priebe et al. (2009), Trieman's (1997) sheltered housing, Macpherson et al. (2004) core and cluster housing.	Supported living by Järbrink et al. (2001).
Floating support	Priebe et al. (2009): floating support	Support of a specified number of hours per week in an individual's own home. Staff never on site 24 hours a day (awake at night) but visit people around 3-4 times a week. Mostly not self-catering (79%) and staff responsible for cooking in some places. Some people share a bedroom (7%) but mainly live in single bedrooms without en-suite facilities (67%).	Definitions of floating support (O'Malley & Croucher, 2005), assisted/independent accommodation (Trieman, 1997) and outreach support schemes (Chilvers, et al., 2010)	N/A
	O'Malley & Croucher (2005): floating support	Support that seeks to help individuals develop independent living skills and is tied to the individual rather than the property.	Outreach support schemes (Chilvers, et al., 2010)	N/A
	Chilvers et al. (2010): outreach support schemes	Self-contained accommodation on a site that is not shared with other people with mental health problems. A person is not part of a specialised housing scheme but does receive (at least fortnightly) home visits by professional outreach workers for individual social support with	Floating support by O'Malley and Croucher (2005)	N/A

		minimum aim of maintenance of the tenancy.		
	Macpherson et al. (2012): floating outreach	Support is not tied to a specific building but provided with flexible intensity to people with a shared or individual tenancy.	Floating support (O'Malley & Croucher, 2005)	N/A
Core and cluster housing	Macpherson et al. (2004): core and cluster housing	Individual flats or bedsits that are overseen by a 'core' staffed unit or by visiting support staff. Most commonly run by mental health charities or by housing associations.	Possibly supported housing schemes (Chilvers, et al., 2010) or supported living (Järbrink, et al., 2001); Trieman's (1997) sheltered housing.	N/A
	Macpherson et al. (2012): core and cluster supported flats	Core communal facilities and staff support to a cluster of service users housed in flats in a complex or within an area.	Core and cluster housing (Macpherson, et al., 2004). Possibly supported housing schemes (Chilvers, et al., 2010) or supported living (Järbrink, et al., 2001); Trieman's (1997) sheltered housing.	N/A
Sheltered housing	Trieman (1997, p. 67): sheltered housing	Continuous or regular cover by day, waking or sleep-in or on-call night staff cover within individual units in a larger complex or site.	Sheltered housing by Knapp et al. (1992). Supported housing schemes (Chilvers, et al., 2010) and supported living (Järbrink, et al., 2001); core and cluster housing (Macpherson, et al., 2004).	N/A
	Knapp et al. (1992): sheltered housing	Continuous or intermediate or ad hoc staff cover by day, waking or sleep-in or on-call staff cover by night. Number of client places in the whole facility greater than the number of places in the	Sheltered housing by Trieman. Supported housing schemes (Chilvers, et al., 2010) and supported living (Järbrink, et al., 2001); core and	N/A

		individual living unit.	cluster housing (Macpherson, et al., 2004).	
Shared Lives schemes	Priebe et al. (2009): adult placement scheme	Flexible accommodation and support for up to three adults in the family home of an adult placement carer. Adult placement carer on site 24- hours a day and awake at night, and no services had self-catering arrangements or staff responsible for cooking.	Adult foster homes (Trieman, 1997), supported lodgings (Knapp, et al., 1992) and some provisions of the staffed care homes (Macpherson, et al., 2004).	N/A
	Trieman (1997, p. 67): adult foster home	One to three residents living within an established household, support by day and on-call by night.	Adult placement schemes (Priebe, et al., 2009) and some provisions of the staffed care homes (Macpherson, et al., 2004). Supported lodgings (Trieman, 1997).	N/A
	Gibbons (1988, p. 184): Supported lodgings	Specialised lodgings officers select potential landladies, visit premises and are available for advice and support. Landlady is contractually bound to provide a bed, breakfast and an evening meal with full board at weekend, services and baths. Lodgers need to be relatively stable and competent to care for their own hygiene. Daytime occupation needs to be available, and social workers or community nurses provide continuing support. Costs are met from a mixture of social security and social services payments.	Some similarities with adult placement schemes (Priebe, et al., 2009), adult foster homes (Trieman, 1997) and some aspects of staffed care homes (Macpherson, et al., 2004), supported lodgings (Trieman, 1997).	N/A
	O'Malley & Croucher (2005): supported lodgings	Include private residential accommodation such as Bed and Breakfasts and 'family placements'	Too general to find similarities.	N/A

		organised on an either short-term or long-term basis.		
	Knapp et al. (1992): supported lodgings	Ad hoc or no staff cover by day, on-call staff cover by night. Clients move into pre-existing households.	Trieman's (1997) adult foster homes. Adult placement schemes (Priebe, et al., 2009) and some provisions of the staffed care homes (Macpherson, et al., 2004).	N/A
	Department of health (2004): adult placement schemes	Highly flexible accommodation as well as care or support inside or outside the home provided by ordinary individuals or families currently living in the local community.	Adult placement schemes (Priebe, et al., 2009), adult foster homes (Trieman, 1997), supported lodgings (Knapp, et al., 1992) and some provisions of the staffed care homes (Macpherson, et al., 2004).	N/A
	Mental Health Minimum Dataset (NHS Data Model and Dictionary Service, 2012)	Lodgings supported by staff or resident caretaker.	Too general to find similarities.	N/A

Chapter 5 The study design

5.1 Introduction

Within the literature on specialist housing services described in chapters 3 and 4 there are many approaches to design, sampling strategies and methods of analyses. Yet they all share the common aim of helping to improve practice and the lives of people receiving mental health services. Like those studies, the research in this thesis is ‘real world’ research, engaging with the realities of everyday services and lives.

The design for the study will be a mixed-methods approach. The main emphasis will be quantitative, with an aim to answer the research questions set out in the previous chapter. The secondary emphasis will be qualitative, in order to understand individuals’ perspectives on these topics. Both methods of enquiry combined will help generate a better understanding of peoples’ experiences in SHSs, whether living in them or managing them. The approach selected links directly with the research gaps identified in chapter 3.

The methodological limitations of previous studies will be presented next, such as poor sampling strategies, small samples/sub-samples, limited variability in geographical areas, relatively poor information available on characteristics of SHSs, service users and managers, as well as their experiences. These research limitations helped to drive the design of the study, devised to paint a comprehensive picture of a person’s life and experience within a specialist housing service in England. The study design followed a series of eight steps (figure 5.1), each of which will be discussed in detail in the following sections, and focussing on the choice of research design, the selection of the sample, and the development of study materials.

Figure 5-1: How participants were to be selected for the study, procedure and progression

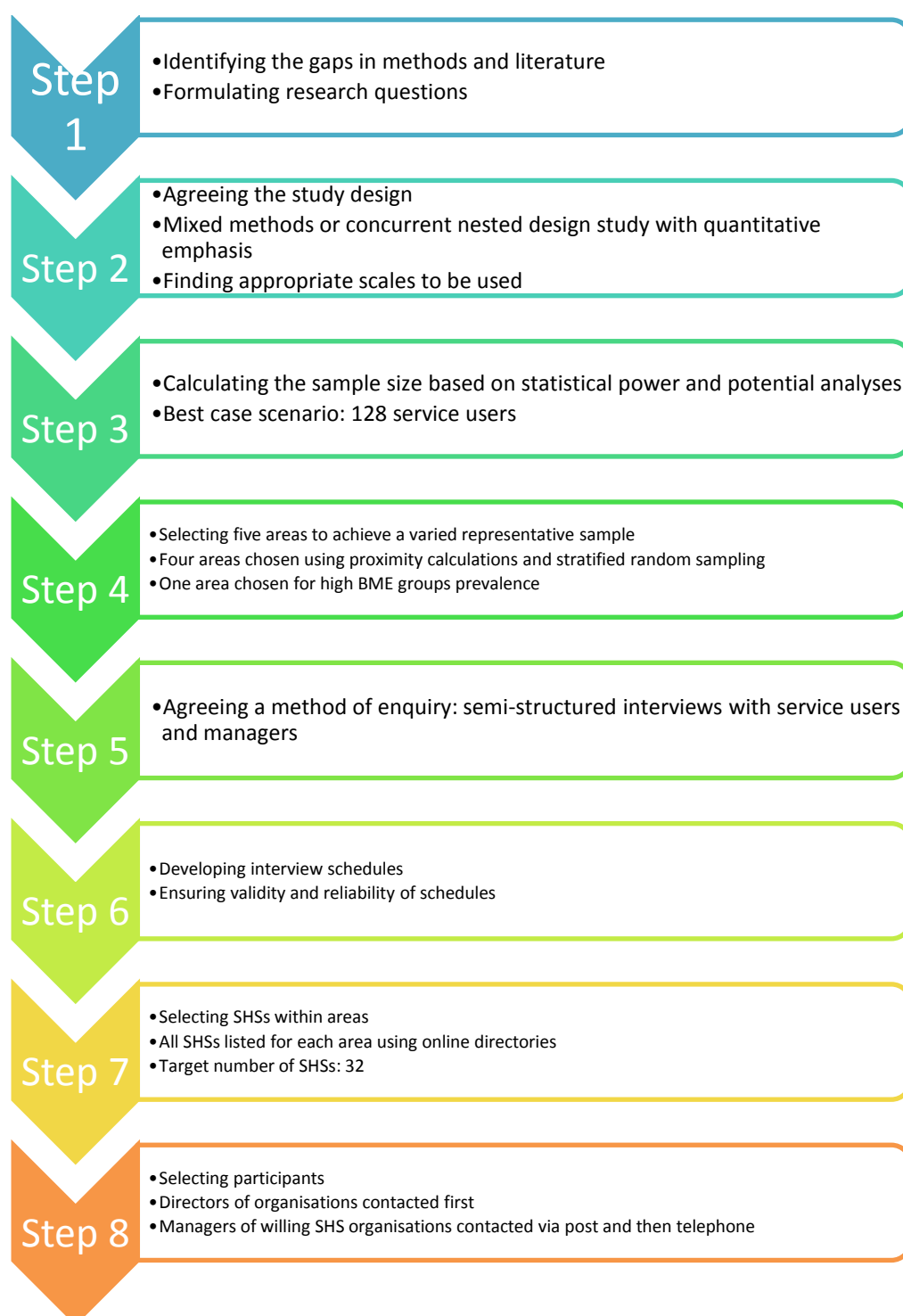


Table 5.1 summarises the research limitations and gaps found from the review of the literature (chapter 3), classified as methodological and substantive.

Table 5-1: Limitations and gaps in the SHS literature

Methodological limitations	<ul style="list-style-type: none"> - Lack of descriptive evidence on SHSs - Small sample sizes - Small sub-sample sizes - Lack of clarity in definitions and classifications of SHSs - Unrepresentative samples - Lack of geographical variability - Most information obtained from secondary sources - No mixed-methods research on SHSs in England
Substantive gaps	<ul style="list-style-type: none"> - Service user characteristics: limited information available - No recent updates on situations of new long-stay patients - Information on manager characteristics lacking - Little research conducted on manager expectations and whether these have an effect on service user experiences - Housing characteristics: little descriptive evidence on aims and structure of different SHSs. Important to capture these from service users as well as managers - Few studies on differences in SHS experiences by types of provision and local population density (urban versus rural) - Information on service user movements and pathways lacking: where they were before, where they are now, if they want to move - Information on delayed discharge due to non-availability of accommodation only reported from practitioner perspectives - Little information on service user choice and preferences in SHSs in England - Personalised services not widespread amongst mental health population: no information on uptake within SHSs - Little known on social networks and community participation within SHSs and potential impact on service user experiences - Employment experiences for people with mental health problems: little information obtained from people living in SHSs - Few studies investigating stigma and discrimination experienced by people living in SHSs

This study aims to address the principal research questions that stem from these limitations and gaps, allowing for a description of peoples' experiences within SHSs:

Main research question:

What are the factors that are associated with the housing satisfaction of service users with mental health problems within specialist housing services?

Subsidiary research questions are:

1) *What are the pathways into and out of SHSs?*

- 2) *How apparent are social exclusion and discrimination within specialist housing services, in terms of, for example accommodation and employment?*
- 3) *Are peoples' choices and preferences taken into account? Does that affect their housing satisfaction?*
- 4) *Do managers promote independence within their services?*
- 5) *Social inclusion: Are service users fully engaged in the social sphere and the community? How is that associated with their housing satisfaction?*

5.2 Research design

The type of study design was chosen carefully, to include a mixed-methods approach and an appropriate sampling methodology.

5.2.1 A mixed-methods approach

One of the goals of mixed methods is to draw from the strengths and minimise the weaknesses of qualitative and quantitative approaches in single-method research studies. Mixed-methods approaches attempt to use more than one approach to answering the research questions, rather than restricting the researcher, making for an expansive, creative, pluralistic and complementary form of research (Johnson & Onwuegbuzie, 2004).

Quantitative methods are supplemented with qualitative techniques in order to check the accuracy, content, validity and meaning of the generated quantitative data (Bowling, 2009, p. 142). Following up a quantitative enquiry with a qualitative one can provide further explanation where more detail or depth about a phenomenon is needed, or can be useful in exploring issues among particular subgroups of participants (Morse, 2003, pp. 192-193; Ritchie et al., 2012, pp. 42-43).

In this study, it was decided that the primary method would be quantitative, and the secondary would be qualitative, using rich data collected from interviews with service users and managers. This design has been called a concurrent nested design, and involves the embedding of a secondary method within a study with one

primary method, which can be qualitative or quantitative (Creswell, 2009; Robson, 2011).

Given the difficulties of access to this particular population (see section below), it was a deliberate aim to extract as much information as possible from these interviews. The main and secondary research questions were therefore to be tested *quantitatively* as well as *qualitatively*. A smaller part of the analysis was to be dedicated to a *qualitative* framework analysis of the different research themes.

Thereafter, the qualitative and quantitative results were to be triangulated, and explored for consistencies as well as irregularities; these were to be reported where appropriate. Some of the secondary hypotheses emerging from the qualitative analysis were to be subsequently tested using quantitative methods. The triangulation section is found in the final chapter of this thesis.

5.2.2 Selecting the sample

As outlined previously, some UK studies of SHS service users have been constrained by small samples - possibly due to difficulties with access - unequal in their sub-categories, and unrepresentative of the population. None appear to have explicitly employed a mixed-methods approach.

In their book on practical social research, Hall and Hall (1996, p. 117) emphasise that it is important to be *realistic* about the sample size that is actually achievable within the time and resources available. That was an important consideration in this case.

5.2.2.1 Sample size calculations

The sample size calculation was to be guided by the quantitative study as well as the choice of study measures (to be discussed later in this chapter). In a widely cited handbook of social science research, Dixon et al. (1987, p. 149) suggest that there are two basic rules that govern sample size calculations, and to choose the one that yields the larger number of participants: 1) a minimum sample size of around 30, and 2) a minimum of five cases in each sub-group. Other authors recommend larger sample sizes and sub-sample sizes (Borg & Gall, 1971), while

recognising that this is sometimes not feasible in student research (Hall & Hall, 1996, p. 116).

There are many online tools that estimate sample sizes, based on calculations of statistical power, defined as how likely the study is to produce a statistically significant result for a difference between groups of a given magnitude (Bowling, 2009, p. 187). The online tool by Soper (2013d) can estimate the minimum sample sizes required for univariate and multivariate analyses, such as independent samples t-tests and regressions, analyses that were to be conducted in this study. This tool can also calculate minimum sample sizes for structural equation models, although no such analyses were to be conducted for this study. In the case of this study, only minimum sample sizes required for independent samples t-tests and multiple regression models will be presented.

This online calculation tool is itself based on manuals by Abramowitz and Stegun (1965) and Cohen (1988). The calculations are based on the significance level, the anticipated effect size, and the desired statistical power level. The power level is the probability that a statistical test will correctly lead to the rejection of the null hypothesis, and hence conclude that the phenomenon exists (Bowling, 2009, p. 187). By convention, these parameters are set at a power level of 0.8 and a significance value of 0.05.

The effect size is the strength of the relationship between the independent and dependent variable (Gliner & Morgan, 2000, p. 177). It is also a means of quantifying the expected difference between the means of two groups of participants. For example, a widely cited RCT of a drug trial on schizophrenia patients expected to find an effect size of five points on their quality of life scale between the control group and treatment group (Jones et al., 2006). After the trial, the authors admitted that their selected effect size may have been overly ambitious.

Effect sizes estimates

Researchers find specifying an effect size the most difficult task in power analysis, partly due to the limited understanding of particular phenomena in psychology (Cohen, 1992) and partly because prior evidence on the effect of an intervention may not be available, particularly using scales planned for a new study.

Effect sizes have largely been reported in real-life experiments of a psychological or medical nature as well as meta-analyses. In the studies discussed in the literature review in chapter 3 of this thesis, very few studies within SHSs had reported effect sizes. Effect sizes can be calculated on the basis of previous research in the area of interest, and estimated from past regression findings (Dunlap et al., 2004). One of the outcomes of interest in this study was whether there were differences in housing satisfaction between different support levels, based on an adapted scale by Schutt et al. (1997). Schutt et al. (1997) reported an R^2 of 0.28 in a multiple regression analysis exploring differences in the satisfaction with housing scale (measured by averaging ratings of eight housing satisfaction concepts: amount of space, the staff, amount of privacy, safety, kinds of people here, number of people here, your freedom, your comfort). Using the Schutt et al. (1997) R^2 value, an effect size of 0.4 was calculated using the online effect size calculator for multiple regression (Soper, 2013a). Calculating a sample size based on an effect size of 0.4 for the housing satisfaction scale, power of 0.80 and a significance level of 0.05, yields a minimum sample size of 52 for a two-tailed independent samples t-test. For a multiple regression model with three predictors (the online calculator can produce minimum sample sizes for regressions with three or more predictors in the model), a sample of 33 was required, given the aforementioned conventions. Another study comparing satisfaction with living situation using a three item-scale (Lehman et al., 1994), between people living in residential care, supportive housing and their own homes, yielded a very large effect size of 1.3 (Nelson et al., 2003b).

Calculating a sample size for this study

An effect size of 0.4 is considered large for multiple regression (Cohen, 1988), and may produce differences that Cohen describes as “*grossly perceptible*”. Cohen (1988) differentiated between small, medium and large effect sizes. For this particular study, and to allow for greater precision and to be able to include a variety of settings within various geographical locations, a *smaller* effect size was taken into consideration, the reasons for which are discussed below.

Semi-structured interviews were to be conducted, and schedules were to include a variety of specially conceived questions as well as some already established instruments. Questions regarding housing satisfaction were to

constitute only one part of the whole schedule. Also, a qualitative study was to be conducted, and the sample size required to generate themes was ambiguous.

In this sense, and taking a large effect size as a minimum threshold, informing a sample size calculation based on a medium effect size could be more suitable and instructive in the case of this study. Medium effect sizes are usually taken into consideration when effect sizes cannot be estimated (Chase & Chase, 1976), much like the situation here where an effect size is difficult to anticipate for the whole interview schedule and where there is no one dominant 'primary outcome' measure. In addition, a larger sample size will more likely be able to detect significant differences, and lead to the true rejection of the null hypothesis.

Table 5.2 presents the results of the sample size calculation for this study using a popular online statistics calculator for an independent samples t-test (Soper, 2013c), given the conventions of power (0.8) and significance (0.05) and a *medium* effect size. The online sample size calculator for independent samples t-test by Soper (2013c) qualifies an effect size of 0.5 to be *medium*.

As this study was mainly concerned with exploring between-group differences, independent samples t-tests were the most frequently used tests. Hence, the respective minimum required total sample size (N=128) for independent samples t-tests will be the target for this study.

Table 5-2: Sample size calculation for a student t-test using a medium effect size

Condition	N
Minimum total sample size (two-tailed hypothesis)	128
Minimum sample size per group (two-tailed hypothesis)	64

(Soper, 2013c)

The online tool can also estimate minimum required sample sizes for regressions (Soper, 2013b), with a minimum of three predictors in the model (Table 5.3). There is not usually an a priori way of knowing how many predictors will be in the equations, but table 5.3 provides illustrations of what this means in the case of this study. Therefore, if running a regression, the minimum required sample size for a model with three predictors would be 76; minimum sample sizes for regression models are presented here in order to better understand the power of the subsequent regression models estimated in this study.

Table 5-3: Sample size calculation for a multiple regression – medium effect size

Number of predictors	Required sample size
3	76
4	84
5	91
6	97

(Soper, 2013b)

A note on power calculations

Power calculations should only ever be approximations as they can at times produce relatively small target sample sizes, but can also estimate large and unachievable ones (Bowling, 2009, p. 188). Gliner and Morgan (2000, p. 157) argue two points when conducting research in applied settings: 1) representativeness is more important than sample size, as an unrepresentative sample can yield misleading results; 2) very large samples will detect differences or relationships that may have little practical or societal importance. They add that, in most social science research, the aim is to identify the key factors that may have an influence on the dependent variable; such research is less interested in finding factors that account for very small percentages of the variance. In addition, samples of more homogenous populations can be smaller than more diverse populations, especially if stratified random sampling is employed (Schutt, 2012, p. 165). The population in question in this study was to be a targeted, somewhat homogenous group of individuals who use SHSs and are diagnosed with a mental health problem. In addition, stratified random sampling was to be employed. Moreover, a key to improving the generalizability of a study is selecting cases in a systematic fashion, i.e. not on a convenience basis only, ensuring that they are typical of the population (Gray, 2004, p. 137).

5.2.2.2 Selecting geographical areas to sample from

As noted above, most UK-based studies of SHSs have had limited generalizability due to the low number of sites sampled or to the fact that most

participants were recruited through convenience sampling, and were located for the most part in a single geographical area.

This study attempted to tackle this issue. It took the set of 166 mental health Local Implementation Teams (LITs) in England as its sampling frame. These are mostly coterminous with administrative authorities. On a purely pragmatic basis, it was decided that at least five (of the 166) areas were to be selected; this would provide some generalisability, while fitting within the resources available for a student project.

To ensure some geographical variability, a method devised by Priebe et al. (2008) – a study in which the author was employed - was borrowed to select *four* of the five LITs (see figure 5.2). This method would enable the selection of a representative sample by taking into consideration six key variables: level of mental health care need in the population, degree of urbanisation, overall level of resources for mental health care locally, extent of community-based mental health services, provision of residential care placements for mentally ill people, and pressure on local housing provision (see Table 5.4). A single numerical score had been produced for each area using these six variables, by converting the latter into standardised scores and then calculating a proximity function. This had produced a score which indicated an area's 'position' on a single axis derived from all the variables. This method was not re-run for this study, but areas were selected using the database created by Priebe et al. (2008). On the other hand, steps 5 to 7 of figure 5.2 were specifically conducted for this study.

Areas were then ranked and *proportional stratified random sampling* was to be employed to select *four* areas for this study: areas were listed in ascending order by rank and the list divided into four strata – the middle of each stratum was found and the corresponding area selected. This is a common method used to avoid obtaining by chance a sample which under- or over-represents certain groups of the population, and improves sample precision (Bowling, 2009, p. 205).

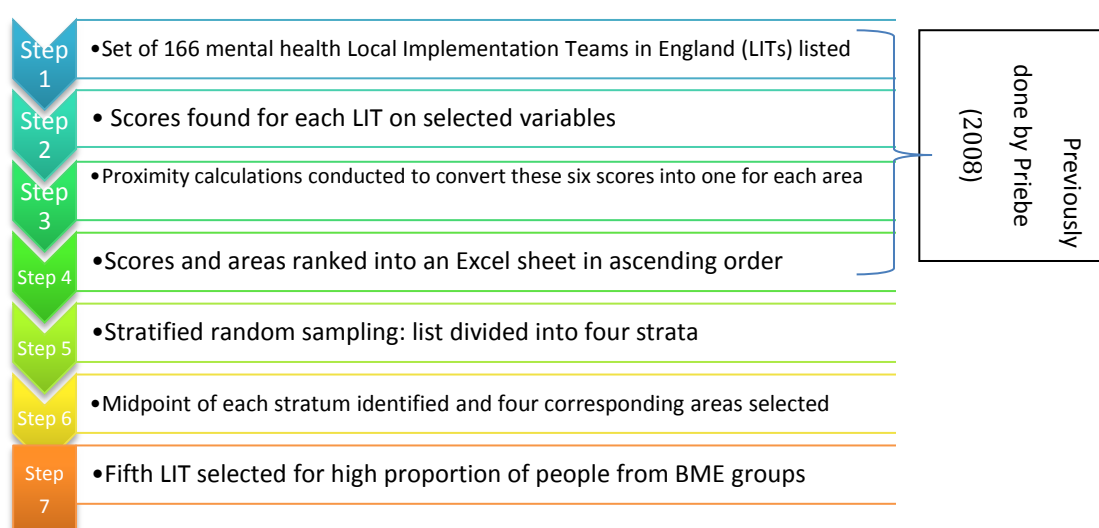
Table 5-4: Selection criteria and corresponding measures for each local area

Criterion	Measure
Likely level of mental health care need in the	The mental illness needs index (G. R. Glover et al., 1998)

population	
Degree of urbanisation	Department for the environment, food and rural affairs definition and local authority classification method (Bibby & Shepherd, 2005). Groupings were simplified to major urban, large or other urban and all others combined and scored 1, 2 and 3 respectively
Overall level of resources for mental health care locally	Total spend on mental health care for working age adults per adult aged 18-64 (Ingham, 2006)
Extent of community-based mental health services	Whole time equivalent professional staff employed in all community based clinical teams per adult aged 18-64. Source: Adult mental health service mapping 2005
Provision of residential care placements for mentally ill people	Total residential placements for working age adults with mental health problems per adult aged 18-64. Source: Adult mental health service mapping 2005 (G. Glover et al., 2005)
Pressure on local housing provision	Proportion of households over-occupied by two rooms or more (Office for National Statistics, 2001)

(Priebe, et al., 2008)

Figure 5-2: Steps to selecting areas for the study



Most samples from previous studies of SHSs in England were made up of participants mainly from a white background. For this study, however, there was a concern to ensure that people from BME groups were over-sampled. So, alongside the stratified random sampling method, a fifth LIT was to be selected on the basis of having the highest proportion of mental health service users from a BME background, identified by data from the Health and Social Care Information Centre (2008). At the time the study started, the Council with Social Services

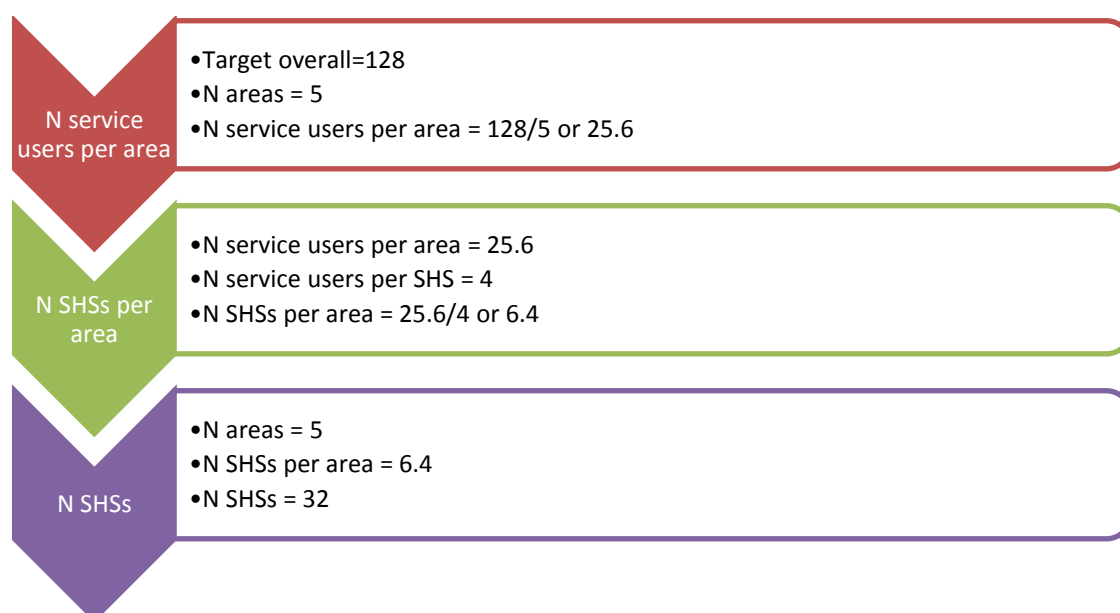
Responsibilities which provided the most support services to people with mental health problems from BME groups was a borough in London.

5.2.2.3 Selecting specialist housing services within the selected areas

On the assumption that the desired sample size of service users was 128, and five areas were to be selected, the aim was to recruit 26 service users in each (see figure 5.3).

To avoid potential cluster effects, the number of service users to be sampled per SHS was limited to four and so around six or seven SHSs were to be sampled per area; a total of 32 SHSs for the study.

Figure 5-3: Number of specialist housing services to be sampled per area and in total



Names and addresses of SHSs for people with mental health problems are freely available to view and download from the internet using the Supporting People (2009), Rethink (2009) and Care Quality Commission (2009) directories; these distinguish between care homes, adult placement or Shared Lives schemes, group homes and supported housing services.

For each selected area, and using all the information available from the aforementioned sites, all SHSs were listed and given an identifier code. There was a greater proportion of care homes than other types of SHSs, especially in some

areas. For the sample of SHSs to be representative of services available, it was decided that at least two care homes per area would be sampled.

Care homes were selected separately and at random, using a random number generator. All other types of SHSs in an area were listed and also chosen using the same method.

5.2.3 Selection of the data collection method

It is common practice for face-to-face interviews to be employed when conducting research about people with mental health problems (Robson, 2011, p. 279). These can involve structured or unstructured methods, or a combination of the two (semi-structured): a structured, pre-coded questionnaire but with open-ended questions that allow the interviewee to respond in their own words. This can be supplemented by measurement instruments (self-completion or self-administration scales) that participants can complete themselves, with the aim of reducing any social desirability bias during the interviews (Bowling, 2009, pp. 285-286).

Semi-structured interview schedules were designed (see sections 5.2.4 and 5.2.5), and through a repeated consultation process with supervisors, as well as a pilot study, their content modified seven times.

5.2.4 Development of service users' interview schedules

The development of the service users' interview schedules followed a rigorous process (full interview schedules can be found in Appendices F and G).

The ordering of questions was seen to be highly important, as noted, for example, by Bowling (2009, p. 322). Easy and basic questions should be asked first, to obtain rapport and goodwill. In this case, the opening question was *"Tell me what a typical day for you is like. What did you do today for example?"*. Questions relating to socio-demographic information were asked last (to avoid any difficulties in asking about issues that might be more sensitive such as ethnicity, derailing the start of the interview). The core questions for the research were prioritised, in case the interview could not be completed, for whatever reason. Questions about behaviours (e.g.: *"do you want to move somewhere else after this?"*) were asked

before questions about attitudes (e.g.: “*how satisfied are you with your social situation?*”) to prevent socially undesirable behaviour from being left unreported (Bowling, 2009, p. 322), such as saying they wanted to move because they were unhappy.

The interview schedule, of course, contained questions especially formulated to address the research questions and to reflect the pathways into SHSs and subsequent experiences (for example: “Is this your first time in an SHS?” or “Did you have a choice of where to live?”), as well as questions on social inclusion (“do you have a job?” or “if you don’t have a job, would you like to have one?”). These questions were a mixture of open-ended and closed questions. Already established instruments were also included and are discussed next.

5.2.4.1 Measuring housing satisfaction

The review of the literature (Chapter 3) found that satisfaction within SHSs was associated with several factors, such as the amount of privacy, the size of home, social cohesion, and (importantly) the extent of choice and meeting of preferences. In England, several studies have examined satisfaction with services amongst the mental health population (Lester et al., 2003; Parkman et al., 1997; Ruggeri et al., 2000) using well-known scales like the Verona Service Satisfaction Scale (Ruggeri & Dall'Agnola, 1993); as the name suggests, the VSSS measures aspects that are linked to satisfaction with mental health services, such as access and information. The MANSA (Manchester Short Assessment of Quality of Life) is more concerned with quality of life, and focuses on satisfaction with life as a whole and with specific life domains (job, financial situation and accommodation for example). The MANSA also poses questions about whether the participant has ever been accused of a crime or been a victim of physical violence (Priebe, et al., 1999).

Although these scales measure satisfaction, they may not necessarily tap well into peoples’ experiences within SHSs or measure housing satisfaction due to living within the SHS environment. Indeed, these scales were not specifically designed for people living in SHSs: the MANSA was originally developed and tested on participants who were on the CPA and receiving services under the Community and Mental Health Act (Priebe, et al., 1999).

A study that did evaluate satisfaction within SHSs – although not in the UK - was conducted by Schutt et al. (1997). They suggested that the body of research on housing as well as service satisfaction had “*failed to establish that satisfaction varies in direct response to experience*”. The authors hypothesised that experiences will be evaluated as satisfactory when these are not too inconsistent with a person’s expectations and, more central to this thesis, their *preferences*. To test their hypothesis, they conducted a randomised-controlled trial for severely mentally ill homeless people who were living in shelters in the United States. Participants were randomly assigned to two types of housing – independent apartments or group homes. Subjects were interviewed at baseline (before housing was assigned to them) and after being allocated accommodation, and a scale used that evaluated three aspects of satisfaction (satisfaction with housing and shelter features, overall residential satisfaction, satisfaction with life in general), the properties of which are summarised in table 5.5.

A modified version of the Schutt et al. (1997) housing satisfaction scale was used for the present study. All questions on housing satisfaction were converted into a Visual Analogue Scale (VAS) format, and displayed as lines of a defined length and anchored at each end by a descriptive word or phrase that would represent the two extremes: in this case “very satisfied” and “very dissatisfied”. The respondent was asked to place a mark on the lines, which had numbers displayed at regular intervals, to indicate how satisfied they were. The VASs for all housing satisfaction items were displayed vertically next to each other on a single sheet of paper, to allow participants to compare their answers for different items.

In the Schutt et al. (1997) study, both satisfaction with residential features and overall residential satisfaction were presented on a four-point Likert scale, with higher scores indicating greater satisfaction and vice-versa. For this study however, this was re-scaled to 100 points (more like a ‘thermometer’), to allow for more variation, and the direction retained.

Rescaling the questionnaire in this fashion may raise some concerns about the reliability and validity of this ‘new’ scale. Dawes (2008) investigated whether the number of data points on a Likert scale had an effect on data: by rescaling scales from five and seven points into 10, no changes occurred to the skewness or kurtosis

of either format; yet the study found that if a scale had more response options, respondents in turn used more response options. Other studies have demonstrated increased validity with increasing numbers of response categories or scale points (Andrews, 1984; Chang, 1994; Hancock & Klockars, 1991; Preston & Colman, 2000).

The question in the Schutt et al. (1997) instrument that asked about satisfaction “with the number of people here” was not asked in the present study, as a question was already included about satisfaction with fellow residents. In hindsight, it might have been more useful to ask that particular question. Instead, questions 11 and 12 (section 3) from the MANSA (Priebe, et al., 1999) were added and rescaled to 100, to reflect this study’s interest in social inclusion whilst attempting to make this new scale all-encompassing of peoples’ experiences:

- “How satisfied are you with your job?”
- “How satisfied are you with your financial situation?”

In sum, this study aimed to measure overall housing satisfaction, by including questions on satisfaction with: housing situation, staff, fellow tenants, income, job, social situation, amount of comfort, amount of freedom, amount of space and amount of privacy. One question in this scale asks about satisfaction with housing situation specifically, offering a more focused indicator linked to features of the home itself.

5.2.4.2 Social cohesion, networks and participation

Another aspect of interest to this study was the level of social participation as well as cohesion experienced by people with mental health problems living in SHSs. These factors might be thought to have an influence on how people experience life within their homes. Most UK studies exploring this issue have compared peoples’ lives when first in hospital and then later in the community in order to evaluate whether their move out of hospital was beneficial. The TAPS study, for example, developed a Social Network Schedule (SNS), which was an exhaustive measure of the quality of the relationship between a participant and contacts who they see monthly (Dunn et al., 1990). Although it produces a useful measure of network size, it also generates categories of what were called social behaviours, concepts that were not assessed in this study.

For this study, it was decided to explore individuals' social networks and how these are associated with living in SHSs, as well as the quality of these relationships. The scale for social cohesion, networks and participation was built on work conducted by Araya and colleagues (2006) who set out to investigate the relationship between the built and social environments and mental health. Not many researchers have investigated the mental health aspect, preferring to focus more on the interaction between social capital and health (Lochner et al., 1999).

The Araya et al. (2006) scale was hence adapted for this study, although only the social cohesion and participation sub-scales were included, as these were of particular interest, rather than an aggregate measure of social capital. It would have been of some interest to have included all of the dimensions by Araya et al. (2006), but it was important not to over-burden interviewees with long questionnaires.

The full Housing And Neighbourhood And Health (HANAH) scale was obtained through private correspondence with Ricardo Araya and relevant questions were extracted. Pre-set categories were provided (for example: relative or friend), but for this study, the semi-structured interview format allowed open-ended questions, which would extract the largest amount of information possible. For example: "Who have you seen to chat to, or do something with, in the past two weeks?" was an open question, inviting a longer, more discursive response.

Social participation questions asked about how often, for example, participants went to the library or on a social outing. Categories of answers on the HANAH were: often (at least once a month), sometimes (at least once a year) and never. Again for this study, participants were allowed to answer as they wanted. Service users also asked whether they were actively involved in any clubs or associations, like a hobby or interest group for instance. Answers to these questions were binary (yes/no).

After the pilot was conducted, several questions (for example neighbourhood watch scheme) were removed from the final version of the interview schedule as they were not applicable to the user group; in addition, tenants' group and residents' group were merged into one category.

5.2.4.3 Health and ethnic group information

A limitation of this study was the lack of a formal measure of psychological disability. There are many available scales that measure this characteristic, such as the SF-36. However, its use can require clinical experience in order to administer, and might incur fees. These requirements would have been impractical and, in the case of fees, impossible to fulfil given the available resources of this student study. Instead, psychiatric diagnosis was obtained from participants, as well as more functional measures of health outcomes, such as activities of daily living and the EQ-5D-3L, which tap in to aspects of more relevance to this study. The EQ-5D-3L also contains a measure of psychological *distress* and is discussed below.

EQ-5D-3L

To measure health-related quality of life, the EQ-5D-3L was utilised. A standardised and widely used measure of health status, it is applicable to a wide range of health conditions and treatments, and is used in the clinical and economic evaluation of health care (Rabin et al., 2011).

However, evidence is mixed with regard to using generic measures such as the SF-36 or EQ-5D in mental health population research and the evidence base is limited in this respect (Papaioannou et al., 2011). That said, there seems to be no gold standard for measures of self-reported health-related quality of life (Brazier, 2010). The EQ-5D has been successfully used in studies of people with psychosis, and detected significantly lower scores compared to the general population (Saarni et al., 2010), as well as significant differences post-intervention (Barton et al., 2009).

The EQ-5D-3L comprises five dimensions: mobility, self-care, usual activities (work, study, housework, family or leisure activities), pain/discomfort and anxiety/depression. Each dimension has three levels: no problems, some problems, extreme problems, later coded as 1, 2, and 3 respectively. Participants were asked to indicate which statements best described their own health state today. The anxiety/depression dimension was used in this study as a proxy for participants' psychological functioning.

There are various ways of presenting the data generated from this scale. It is possible to illustrate it using a table with the frequency or proportion of reported

problems for each level for each dimension; these can then be broken down by subgroup (for example age or gender). It is often simpler to dichotomise the levels into no problems vs. 'problems' (i.e. levels two and three), and has proven useful in some cases (Rabin, et al., 2011). Given the nature of this study, and its sample population (working age adults with mental health problems), it was hypothesised that not many participants would be reporting extreme levels of a given problem. Also, the study was more interested in uncovering the existence or not of a problem, not the variation in its levels.

The second and final part of the EQ-5D-3L is the VAS where respondents self-rate their health on a visual analog scale (0-100). The endpoints are labelled 'best imaginable health state' and 'worst imaginable health state' (Rabin, et al., 2011). The rating will be used as a quantitative self-rated measure of health status.

Activities of daily living

The scale for activities of daily living (ADLs) was borrowed from the Evaluation of the Individual Budgets Pilot Programme, the IBSEN study (Glenndinning et al., 2008), which piloted IBs on various client groups, including people with mental health problems. There were nine categories of ADLs investigated, each asking the participant whether they usually managed to, for example, "*Get up and down stairs or steps*".

Participants were asked to rate these as: "on own without help", "on own with difficulty", "only with someone else" or "not at all". Like Rabin et al. (2011), for simplicity Glenndinning and colleagues (2008) also dichotomised ADL abilities into problems and non-problems. A scale for self-perceived health was also used, which would complement the EQ-5D-3L VAS. Glenndinning et al. (2008) suggest that "*a person's perception of his/her own health has been found to be a reliable predictor of objective health*" and used a scale devised by Robine (2003). Participants were therefore asked to rate their health in general on a five-point scale: very good, good, fair, bad and very bad.

Ethnicity

Participants were also asked to state their ethnicity based on categories used in the 2001 Population Census (Office for National Statistics, 2001). The 2011 Census categories did not differ radically from their 10-year predecessor, although a

category for 'Arab' was added. For this study, this was coded under 'other' when participants were asked to indicate their ethnic group.

5.2.4.4 Health service use and personal finances

To measure health service use, one of the most comprehensive and well-known scales is the Client Service Receipt Inventory (CSRI). First developed in the mid-1980s by Beecham and Knapp (1992), the CSRI has been used in over 500 studies in various forms. It was originally developed to describe service use patterns and to calculate community care costs for people with mental health problems moving from long-stay psychiatric care (the *TAPS* study), as well as to evaluate the *Care in the Community* programme (Knapp, et al., 1992). The CSRI collects retrospective information on service utilisation, service-related issues and income; it can also be tailored for the purposes of the study (Patel et al., 2005). For this study, the CSRI was completed during interviews with service users, and a three-month retrospective period was applied. Chisholm et al. (2000) suggest that this period is sufficiently long to pick up the wide range of services that individuals might take up, but without stretching their powers of recall, as these may be hindered the more time has elapsed (Jobe et al., 1990).

Although the CSRI takes into account accommodation use as well, for the purpose of this study, only services and support that were provided outside of the SHS in the last three months needed to be asked about.

In terms of personal finance, participants were asked about receipt of social security benefits, categories of which were also taken from the CSRI (Chisholm, et al., 2000): income support, jobseeker's allowance, disability living allowance, and housing benefit.

Table 5-5: Description of the measures used in this study

Scale name and author	Items in scale	Scale type	Outcome measures	Number in sample if applicable	Psychometric properties
ADLs and health (Glennndinning, et al., 2008; Robine, 2003)	2	Ordinal	Abilities in activities of daily living: get up and down stairs or steps; go outdoors and walk down the road; get around indoors (except steps); get in and out of bed (or chair); use WC/toilet; wash face and hands; bath, shower or wash all over; get dressed and undressed; feed yourself and health outcomes (5-point Likert scale)	959	n/a
CSSRI-EU (Chisholm, et al., 2000)	5	Mix of nominal and ordinal	Socio-demographic information, usual living situation, employment and income, service receipt and medication profile	n/a	n/a
EQ-5D VAS (EuroQol Group, 1992; Rabin, et al., 2011)	1	Interval	Health state today (100-point Likert scale)	n/a	n/a
EQ-5D-3L (EuroQol Group, 1992; Rabin, et al., 2011)	5	Ordinal	Mobility, self-care, usual activities, pain/discomfort, and anxiety/depression Three possible answers for each: no problems, some problems and extreme problems.	n/a	Good construct validity and reliability demonstrated, for example in patients with anxiety disorders (König et al., 2010)
Ethnic group (Office for National Statistics, 2001)	1	Nominal	Ethnic group (16 possible answers)	n/a	n/a
Housing And Neighbourhood And Health (Araya, 2009)	6	Mix of nominal and ordinal	The area where you live, the people you know, things you do, your home, your feelings, how has your health been in the last two weeks, questions about you	1058	n/a

Scale name and author	Items in scale	Scale type	Outcome measures	Number in sample if applicable	Psychometric properties
Manchester Short Assessment of Quality of Life (Priebe, et al., 1999)	16	Mix of nominal and ordinal	Satisfaction with various life measures	55	Cronbach's alpha=0.74; significant negative correlations with BPRS sub-score of anxiety/depression
Satisfaction with housing (and shelter) features; satisfaction with housing (Schutt, et al., 1997); satisfaction with life in general (Lehman, 1984)	10	Interval	Amount of space, staff, amount of privacy, safety, kinds of people here, number of people here, amount of freedom, amount of comfort; housing; life (100-point Likert scale)	RCT N=118	Cronbach's alpha (baseline) =0.79

5.2.5 Development of managers' questionnaires

The managers' schedules (appendix F) were also redrafted many times for content, layout and order of questions. Managers' schedules were less structured than service users', including only one self-completion scale (a modified version of the housing satisfaction scale); the rest were mostly open-ended questions, compiled especially for this study.

5.2.5.1 Housing structure

Information on the structure and features of each SHS was needed to allow categorisation of establishments in a structured manner, facilitating the analysis. These data also allow SHSs in this study to be compared against already established information (chapter 4).

The opening question was "What type of housing service is this?", with follow-up questions such as "are staff on premises 24-hours a day?" and "are staff awake at night?". There were questions concerning how many people lived in the SHS, and their turnover rate. Managers were also asked what the typical referral routes were, where people usually moved on to, if they excluded anyone from the service, what the SHS offered and if service users had any responsibilities around the house.

5.2.5.2 Manager characteristics

Questions on the characteristics of managers were comprehensive, including the manager's title within the SHS, how long they had been in that role for and what their qualifications were.

It was previously emphasised how managers' or staff experiences and personalities could be associated with service users' housing satisfaction and inclusion within housing. Managers were therefore asked about what challenges, in their opinion, service users faced, giving some examples, such as employment and relationships. They were also asked what they aimed to achieve within their service, and if they pushed their service users towards independent living.

5.2.5.3 Managers' accounts versus service users' accounts

Massey and Wu (1993) have found that managers and service users differ on the values placed on different aspects of service users' lives. In this thesis, service user housing satisfaction was measured (Schutt, et al., 1997); managers' interview schedules included the same housing satisfaction items using a VAS, but managers were asked to rate these as "How *important* do you feel these aspects are to service users?". This measured what they thought service users valued, and how much importance they placed on each was complemented by their answers on what challenges they thought service users faced, and what they aimed to achieve. Their answers can therefore be directly compared with users' housing satisfaction.

Social networks, community links and activities were also investigated from a manager's perspective. This allowed for a clearer depiction of different SHSs, as well as enabling a comparison between managers' and service users' accounts. Many studies have investigated these issues solely from a manager's perspective.

5.2.5.4 Policy-relevant issues

The interviews with managers were also used to explore relevant housing policies as well as managers' attitudes to recent policy changes. Hence, managers were asked if they thought service users found it hard to find suitable accommodation and also if, in their opinion, people faced any sort of discrimination. These topics had not been previously discussed in the UK SHS literature.

The topic of personalised services was also broached, and managers were asked about their experiences with direct payments, personal budgets and choice based lettings.

Finally, because the data collection occurred in the midst of changes to the social security system, managers were asked how people were going to be affected should their DLA entitlement (largest sum awarded) be reduced, and how that would contribute to people's social inclusion.

5.3 Methods of analysis

5.3.1 Quantitative analysis: coding and cleaning the data

For closed questions in interviews, where there are only a set number of options to choose from, analysis consisted of counting and summarising replies, and comparing results for different groups of people. For open-ended questions, a form of content analysis was employed (Hall & Hall, 1996, p. 133): various responses were to be grouped into a logical set of discrete categories. As suggested by Hall and Hall (1996, pp. 133-134), a provisional set of categories for open-ended questions can be achieved after 20 responses. The data are thus transformed, and *quantitised*: collected qualitative data are converted into numerical codes that can be statistically analysed (Teddlie & Tashakkori, 2003, p. 9).

Hence, after about 35 service user interviews, a list of the frequent answers by question was compiled, and then entered into a bespoke database in the Statistical Package for the Social Sciences (SPSS Inc, 2010). Some answers were entered as string variables for reference purposes, and then coded into binary or continuous variables thereafter. Answers from the EQ-5D-3L VAS and housing satisfaction scales were single-transfer coded, as responses were already computer-readable format (Robson, 2011, p. 416)

The same process was applied for the interviews with managers (database created after 15 interviews); this database was kept separate from the database of service users' responses.

Of course, as the study progressed, new variables were added, and participants' answers were coded accordingly.

Once all participant data was entered into both databases, all entries were examined, and checked for inconsistencies. Simple frequency analyses were conducted to check for highly unlikely or 'illegal' codes (Robson, 2011, p. 418).

5.3.1.1 Quantitative analysis: statistical tests

All analyses were to be conducted using SPSS version 18.

Measures of central tendency

For issues where there is relatively little previous research, such as employment barriers or movements, the first step was to explore the data, in terms of frequency distributions and descriptive statistics (Rabin, et al., 2011, p. 421). Descriptive statistics were used throughout the thesis and include frequencies, means (M) and standard deviations (SD). The first two are measures of central tendency and aid in the understanding of data that have been collected (Huck, 2000, p. 35). SDs describe the dispersion of the data in more detail, by showing the difference of values from the mean (Bowling, 2009, p. 197).

Preparing the data

Keeping with the concept of central tendency, it is good practice to test whether a continuous variable (for example housing satisfaction ratings in the case of this study) is normally distributed. Normally distributed data follows a bell shape and has one 'hump', where the mean is centred, with cases tapering off symmetrically from each side. If a variable is normally distributed, 95% of cases will lie between plus and minus 1.96 standard deviations from the mean (Schutt, 2012, p. 468).

It is important to test the distribution of a continuous variable in order to subsequently report the correct statistical test(s) (Fife-Schaw, 2000, p. 364). Conducting statistical tests on a normally distributed variable allows for the researcher to better understand 'where they stand' and be confident about their conclusions. For this study, it may be the case that housing satisfaction ratings are skewed to the right of the curve, as more people tend to give higher ratings; so it is important to test for normality in this case.

A more formal technique of testing for normality, compared to producing probability plots or histograms, is to employ the Shapiro-Wilks test. This test has now become the preferred test due to its power properties; it basically measures the departure from normality due to either skewness or kurtosis (Razali & Wah, 2011).

Besides having normal data, another assumption to fulfil before interpreting the results of some statistical tests used here, namely analyses of variance and t-tests, is homogeneity of variances, and specifically that the variances of the two groups being tested are similar or homogenous.

SPSS tests for homogeneity of variances using Levene's test. Variances are said to be homogenous when the Levene test was not violated ($p > 0.05$). In this case, the t-test for homogeneity of variances assumed, and the F test for the ANOVA are reported. In the case of heterogeneous variances, the t-test for homogeneity of variances not assumed and the robust test for equality of means (Welch test) will be reported (Laerd Statistics, 2012).

Measuring relationships between normally-distributed variables

More specifically, an ANOVA tests for "*an overall difference between the means under different conditions*" (Rabin, et al., 2011, p. 453). The most frequently used test statistic is the F-test; and a p-value of 0.05 was taken as the threshold of statistical significance. This test was employed when there were two or more levels to the independent variable.

When a significant overall difference is found between groups, post-hoc tests will be used to pinpoint which of the differences between particular pairs of means are contributing to this overall difference (Robson, 2011, p. 454). Post-hoc tests use stringent criteria to correct for the chance of falsely rejecting a true null hypothesis and to identify significant differences (Healey, 2002, p. 254). The most conservative test will be used in this case, the Scheffé post-hoc test (Gliner & Morgan, 2000, p. 225), which has also been the preferred test for unequal sub-sample sizes (Wilcox, 1987, p. 36).

Where there are only two levels to the independent variable, and the dependent variable is on a continuous scale, an independent samples t-test will be used. The most commonly used is the two-tailed t-test; it assumes no strong a priori reason for expecting a particular direction to the relationship (Robson, 2011, p. 450). Like the ANOVA, a significance value of 0.05 would be taken as the threshold for statistical significance. For non-normally distributed independent variables, the Mann-Whitney test for non-parametric data will be reported alongside the t-test for robustness. The t-test compares means while the Mann-Whitney test compares distributions.

T-tests (and Mann-Whitney tests, where appropriate) and ANOVAs were to be reported for categorical independent variables, for example to check whether

people in care homes were more satisfied than in other accommodation types. Scheffé post-hoc tests would then be performed following ANOVAs only.

To compare differences between two binary variables, chi-square statistics will be calculated and cross-tabulations produced. The Pearson's chi-square statistic will be taken into consideration when there are five or more cases in each cell of the 2x2 table. If that condition is not met, Fisher's exact test (two-tailed) will be reported. The threshold for statistical significance is also 0.05.

Pearson's correlations

Pearson's correlation coefficients were to be computed to check for bivariate relationships between interval variables (Huck, 2000). Only significant correlations would be reported.

Linear regressions

Linear regression was employed to explain relationships between a continuous dependent variable and independent variable(s) of interest.

An assumption for linear regression is that there should be a linear relationship between the dependent and independent variable(s). This can be checked by producing normal probability plots. Histograms will also be produced to ensure that the errors (residuals) are normally distributed. Homoscedasticity, where the variances along the line of best fit remain constant as you move along the line will also be tested for using scatterplots. Tolerance tests will be produced to test for multicollinearity, which occurs when two or more independent variables in the regression model are highly correlated – this can produce inflated results, making it more difficult to ascertain the effect the independent variable has on the dependent one; these will be subsequently reported.

The first results table produced in SPSS is the overall model fit, which produces the R, R^2 , adjusted R^2 , and standard error of the estimate. Only the R and R^2 will be reported in this thesis. R corresponds to the correlation between the observed and predicted values of the dependent variable, and its square, the R^2 , can be interpreted as giving an indication of the proportion of the variance in the dependent variable which can be associated with the independent variable(s) in the model.

The next table is the ANOVA table, and will be reported accordingly. The last table produced contains the parameter estimates for each independent variable in the equation. Variables of interest here are B, which produce the values for the equation for predicting the dependent variable from the independent. A t-test is also produced, alongside its significance level.

Otherwise, backward linear regression models were fitted when exploring the data, for instance when exploring the factors that might affect housing satisfaction. Variables tested were reported first, alongside their frequency statistics. Thereafter, the final model is produced, containing the significant variables that the backwards removal regression had kept in. The variable for psychological disability was always added in to the final model.

Binary logistic regressions

Binary logistic regression does not require all the conditions of linear regressions. A Hosmer-Lemeshow statistic will be produced and reported, as a measure of how well the model fits the data.

The omnibus tests of model coefficients tests whether the model is significant: since the dependent variable is categorical, the chi-square χ^2 will be reported and its significance level. The next table produces pseudo R^2 , in the case of binary logistic regression Cox and Snell R^2 and Nagelkerke R^2 . The next table is somewhat similar to linear regression, as variables of interest are B (same as above) and a modified version of the t-test which is the Wald chi-square and its significance levels.

Regressions are mainly used to explore the associated dependent variables of moving out of an SHS, and being more or less satisfied with different aspects of their lives. Binary logistic regression is used at times to explore employment rates.

Accounting for psychological disability

Depending on the nature of the dependent variable, and whether it was linear or categorical, regression models were estimated after every between- and within-group analysis to ascertain whether the independent variable was still significantly associated to the dependent variable in this case, after controlling for the measure of problems with anxiety/depression on the EQ-5D-3L. For simplicity, only in the case where this condition was violated is this mentioned; it may then be

a confounder in the analysis. For all other analyses reported in this thesis, the analyses were not confounded by the psychological functioning measure.

All other regression analyses will control for psychological disability in their models.

5.3.2 Qualitative analysis

Several methods exist for analysing qualitative data, and the approach adopted here was *framework analysis*. Originally developed by researchers at the National Centre for Social Research (NatCen), it enables researchers to “*work systematically through the analysis of raw data into concepts that explain and enhance the understanding of social behaviour*” (Furber, 2010). Furber (2010) explains that the features of applied social policy research have been integral to the development of some aspects of framework analysis, because it frequently aims to find out answers to problems in a short space of time (Ritchie & Spencer, 1994). More importantly, in this field of policy research, framework analysis can be conducted with linkages to statistical inquiry, so as to, for example, illuminate, explain or qualify empirical research (Ritchie & Spencer, 2002, p. 175). The use of semi-structured interviews, as well as the mixed-methods approach adopted for this study would call for a deductive qualitative method.

Given that this particular study was mostly quantitative, it was decided that interviews were not transcribed in full due to the large number of interviews to be conducted. There are several instances in the mental health literature where for various reasons (time, money, lower level of detail required), interviews have not been transcribed in full (Taylor & Lewis, 2008; Velderman et al., 2006). Krueger (1995) suggests that, following his work with focus groups, the use of transcripts in some situations may be impractical and overrated, especially when there are time constraints or less in-depth analysis is required. Transcribing a typical single interview requires at least several hours of work and generates dozens of pages of single-spaced text (Pope et al., 2000). This study was not particularly concerned with semantic analyses, but rather with eliciting new and interesting themes and sub-themes from the interviews, and getting deeper insights into topics explored

through quantitative methods. During the coding phase (section 5.3.1), answers to open-ended questions were to be written in full on the interview schedules.

Further expert advice and recommendations on the type of method to use were obtained from specialist qualitative researchers at King's College London, Ms Jo Moriarty and Dr Kritika Samsi, both of whom had extensive knowledge in framework analysis. Their advice was to start with the first stage of framework analysis, the *familiarisation* stage: immersion in the raw data by listening to audio-recordings. Unlike many qualitative studies, the majority of interviews in this study were conducted by the author, so familiarity with the data was already high.

As the qualitative analysis would come after the quantitative analysis, the recommendation from Moriarty and Samsi was to put empirical impressions aside while listening to the interviews a second time, allowing new issues to emerge and thereby produce richer findings. Thereafter, strong impressions and themes were to be noted down (including any sub-themes). At this stage, interview questions could be referred to, in order to help identify key themes. These are the *identification* and *indexing* stages (Pope, et al., 2000). Themes could then be labelled, and specific interviews, participants, and quotes found that typify these themes.

Naturally, a decision had to be made about how much material was selected, as it was not feasible in this case to transcribe, and apply a framework to all of the text. Ritchie and Spencer (2002, p. 179) suggest that this decision is mediated by the range of methods used in a study, the number of researchers involved, the diversity of people and circumstances studied, the time period of data collection, and the degree to which the research agenda evolved or was modified during that time.

The *charting* stage follows, and using an Excel spread sheet, each theme and subtheme should form a heading. Each relevant participant is added in (along with a quote, if appropriate). This spread sheet helps to identify between-group and within-group differences. The final stage of framework analysis is *synthesizing*, which involves the mapping and interpretation of data, and possibly checking chart summaries or comparing themes and sub-themes. The descriptive summaries in the charts become incorporated into explanatory accounts, clarifying the data (Furber, 2010).

5.4 Discussion

The choice of research design for this study was based on the available literature on SHSs, the research gaps identified, a clear understanding of available methods as described in a range of sources, and sample size calculations. Taken together, the sources suggested that the best way to address the research questions would be to design semi-structured interview schedules that included some established scales, as well as especially formulated items. These would be administered to service users as well as to managers, using a concurrent nested design study with a mixed methods approach.

Like any research design, the chosen approach had its advantages, but it also suffered from some disadvantages, explored below.

Is mixed methods the right approach?

As noted, there are many advantages to conducting interviews. Information on people living in SHSs is relatively scarce and at most times obtained from secondary sources. Converting the interview data into a format suitable for quantitative analysis, as well as conducting a separate and additional qualitative analysis, would potentially generate a more complete picture, as many avenues of investigation could be explored. Together, these were likely to provide a more comprehensive picture than either would alone (Morse, 2003, p. 205).

Newman et al. (2003) suggest that selecting a primary method of inquiry must be dictated by what is to be investigated.

The decision to make the quantitative analysis the primary research method in this study was based on the fact that a key aim was to collect information on a fairly large number of people across a number of localities, which would thus generate a large amount of data. The nature of the research questions, including some linked to housing satisfaction and factors affecting it meant that a quantitative analysis would be helpful. Indeed, some questions required a relatively large sample, such as questions on housing satisfaction. The secondary qualitative analysis could then be more exploratory.

Interviewing people within specialist housing services

An advantage of face-to-face semi-structured interviews are that they allow the interviewer to probe fully for responses and clarify ambiguities, as well as to obtain a greater depth of information from participants (Bowling, 2009, p. 286). This approach also minimises the chances of having missing data. Given that this study was concerned with exploring peoples' personal experiences of living in or managing SHSs, this was considered to be an appropriate approach. Issues such as stigma and discrimination, choice and control, as well as whether people have had positive or negative experiences whilst in SHSs could be explored more easily through face-to-face conversations, as opposed to written questionnaires. Shepherd and colleagues (1996) suggested that future research be focussed on investigating satisfaction (especially in terms of choice, privacy and freedom), specifically via semi-structured interviews. In his review, Corrigan (1990) stressed the importance of obtaining information from service users in order for them to voice their opinions, yet it has been stressed that there are sometimes validity issues (LeVois et al., 1981).

Participant bias, where a participant acts and responds in a way that they think the experimenter expects, may also be an issue. Other biases to acknowledge are (Kumar, 2005, pp. 131-132):

- 1) The quality of the data relies heavily upon the quality of the interaction, and may cause responses to differ significantly from one type of interaction to another.
- 2) The quality of the data also depends on the interviewer's skills, experience and commitment.
- 3) The framing of the questions may bias the participant's answers.
- 4) The interviewer may be biased.

The repeated consultation process with supervisors and other colleagues, which shaped and improved the validity of the interview questions, as well as the conducting of a pilot study before the main data collection began (to be discussed in the next chapter), was a process aimed at eradicating any leading questions and making them understandable to all participants.

Generalisability of results

Choosing the scales for the interview schedules followed a rigorous process. These were scrutinised for content and original reliability in order to ensure relevance and suitability for the present study. In a few cases, items were added or removed, or the scaling was changed. Possibly, using already established instruments without subsequent modification would have ensured that the original reliability of the scale remains unchanged. However, the aim of this study was to explore peoples' individual experiences within SHSs, a world where not many researchers have ventured, which called for a bespoke interview schedule.

As discussed previously, adding response categories to Likert-type scales increases the scale's resolution and reliability (Andrews, 1984; Chang, 1994; Hancock & Klockars, 1991; Preston & Colman, 2000). Yet transforming the scaling or adding/removing items renders the originally reported scale reliability redundant (Bowling, 2009, p. 314).

A comprehensive measure of psychological disability was not included in the service user interview schedules, for practical as well as contextual reasons, and may thus represent a limitation of the study. A more practical scale that evaluates individual functioning with everyday tasks (ADLs and EQ-5D-3L) was incorporated instead. Glenndinning et al. (2008) reported significant associations between carrying out ADLs and psychological well-being; a measure of the former could be used as a proxy for the latter in this study. A proxy measure for psychological disability (problems with anxiety/depression on the EQ-5D-3L) was hence controlled for in all the analyses in this study.

Sample size calculations yielded a target number of around 128, based on medium effect sizes, whilst ensuring at least five cases in each sub-sample. This may seem modest, but considering the method of enquiry (semi-structured interviews) and the limited resources of a student project, it may also have been slightly ambitious. The sample size of 128 nevertheless exceeds the previously calculated sample size using large effect sizes.

Considerable steps were taken to ensure that the sample would be representative: the selection of areas, SHSs and participants followed a rigorous process, employing stratified random sampling and other methods.

In sum, the design of this study was planned carefully, and scrutinised closely, in order to ensure that the data obtained in this under-researched area would be useful, relevant and valid, and could be explored fully. Research questions were formulated following the literature review and the exposing of the research gaps.

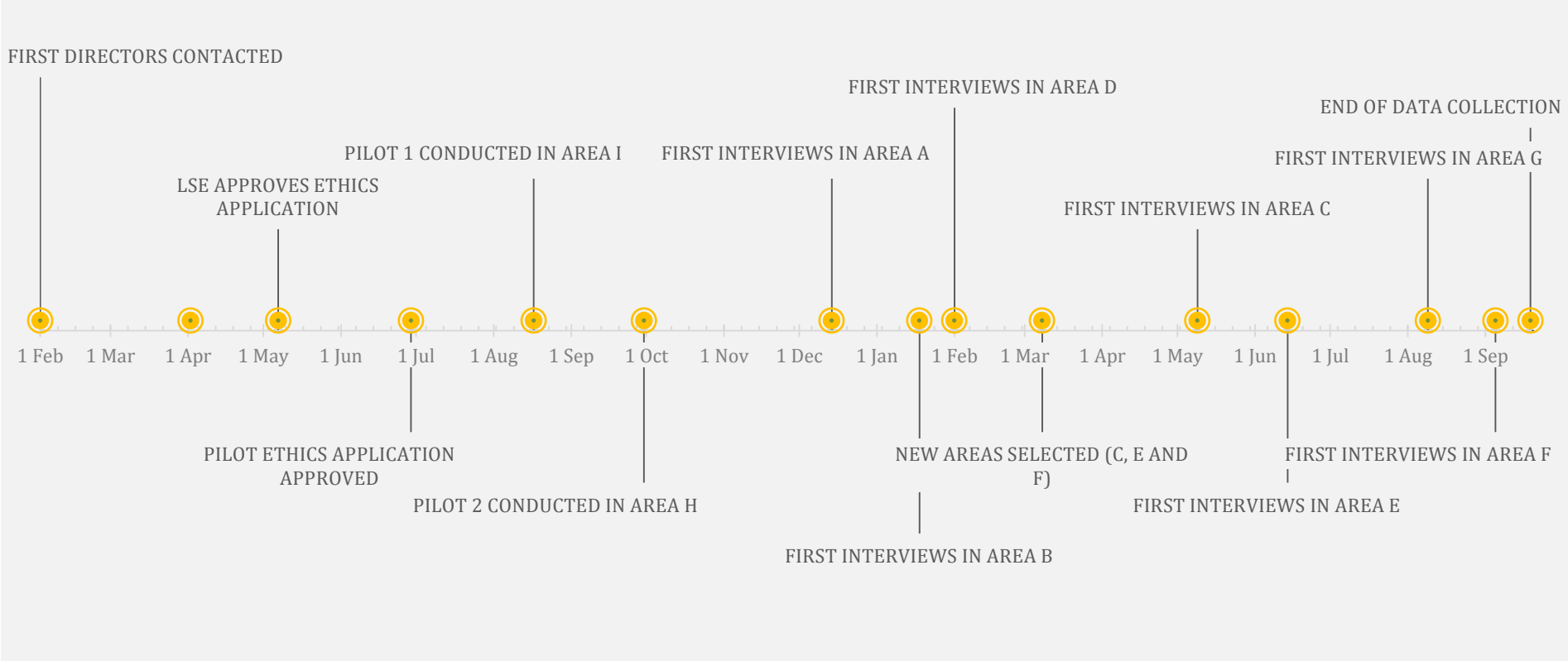
Chapter 6 Implementing the study and describing the sample

6.1 Introduction

This chapter describes how the study was conducted in practice. Figure 6.1 summarises the timeline of the data collection, starting from when directors of SHS organisations were first contacted up to the date of the last interview.

Although some directors were first contacted in early February 2010 (before ethical approval had been granted, as was explained in the letters to them), the study did not officially start for nearly another year, due to the time taken both on the pilot studies and securing ethical approval. The data collection itself spanned nine months in total. The final parts of this chapter describe the samples of service users, managers and SHSs.

Figure 6-1: Timeline of data collection



6.2 Implementing the research design

The next sections will discuss the implementation of the research design for this study.

6.2.1 Ethical considerations

An important consideration when planning any ‘real-world’ research is ethics, particularly in a study that involves participants with mental health problems (Robson, 2011, p. 211).

Initially, a query was made to the National Research Ethics Committee, who deemed it to be the remit of the Social Care Research Ethics Committee (SCREC) as NHS service users would not be sampled. An application, along with study materials, was submitted to the SCREC, and reviewed on 7 May 2010. Following the Committee’s suggestions regarding safety, breaking confidentiality, intrusiveness of questions, data protection and anonymity, some of the research processes were altered. Changes were made to the information letters, consent forms and interview schedules. All study materials were reviewed and redrafted as per the Committee’s recommendations. For example, the study consent form was replaced with a modified version of the SCREC template for managers and service users (see Appendices D and E); the wording of all study materials was standardised and simplified.

The Committee subsequently decided to refer the submission to the LSE Research Ethics Committee, and via correspondence explained that since *“issues relating to the Mental Capacity Act no longer apply, it is not necessary to resubmit to the Social Care Research Ethics Committee”*, concluding that service users would be able to consent for themselves. Whilst they would welcome a resubmission, it was felt that the LSE Research Ethics Committee could equally well review it.

An application was then made to that Committee. Following submission of the form and additional materials on 29 June 2010, the LSE’s Research Ethics Committee concluded that the appropriate ethical safeguards were in place for this project, and that the School was willing to accept responsibility for the conduct of the research.

6.2.2 The pilot studies

In exploratory research, it is usually recommended to conduct a pilot, particularly when new and specific study materials have been produced: not only will it test the validity of the questions, but it also increases interviewer confidence (Hall & Hall, 1996, p. 165).

A pilot study was carried out at two SHSs run by a well-known mental health charity. Two managers and five service users were interviewed. Before contacting the relevant SHS managers, approval was obtained from the charity's own research ethics board.

The first pilot interviews took place at the end of September 2010 in a registered care home. A colleague from PSSRU, skilled in conducting interviews with people with mental health problems, was also present. She was able to provide constructive criticism about interview technique, structure and content. A manager was interviewed first for about 40 minutes, longer than expected. Thereafter, interviews with service users lasted about 20 minutes on average. Seven service users lived in the SHS, of which two agreed to take part in the study. Some valuable feedback was obtained and the following questions were added to the service user interview schedule:

- Do you think it's been a good thing for you to come here?
- What do you think your next step will be – independent living?
- What is your primary diagnosis?
- Would you like to see your family and friends more often?
- Where were you living before?
- Did you see other places before picking this one and moving in?
- What responsibilities do you have around the house?
- How easy was it for you to move in?

In addition, and as discussed previously (sections 5.2.4.1 and 5.2.5.1), the scaling of housing satisfaction questions for both managers and service users was changed, to generate more detailed responses.

The second pilot study, in a supported housing service, yielded three service user interviews, as well as one manager interview.

The pilot was a success and proved an important starting point for undertaking the full research study. Some parts of the interview schedule were modified after the first pilot, and tested in the second pilot, yielding satisfactory results. Data collected in the pilot interviews were included in the main study analyses as far as possible.

6.3 Contacting directors and managers of consenting organisations

The first step towards actual data collection was establishing contact with directors, informing them about the study and inviting them to participate. Although *five* areas were to be selected on the initial plan, due to difficulties in recruiting sufficient numbers, this was subsequently revised to *nine*.

The organisations managing SHSs in the *five original* areas started being contacted in early February 2010. Directories of organisations had been populated for each area, and a code assigned to each organisation in each area (to allow for a random selection). As ethical approval had not yet been obtained, the start date of data collection was unknown. A total of 67 directors were contacted via post concerning the study. They represented a mix of providers (voluntary, local authority and private-sector SHSs) who managed or owned different types of SHSs.

These letters (Appendix A) asked for a reply within two weeks of receipt (via postage-paid envelope) as to whether or not they would let one or more of their SHSs participate in the study. Non-respondents were assumed to be in agreement, as stated in the original letters to directors. Should a director reply negatively, then another SHS of the same type was selected in that area.

In some cases, only a few directors were contacted, as they were in charge of a large number of SHSs within those areas.

Of those contacted at this stage (where only five areas were under consideration), some directors replied with negative responses, some with positive, but most did not reply at all and were assumed to be in agreement (see Table 6.1).

Table 6-1: Responses from the first batch of letters to directors

Area	Positive responses	Negative responses	Non-replies	Total number of letters sent
A	0	2	4	6
B	0	1	2	3
D	0	2	7	9
G	2	4	6	12
J	0	1	8	9

For organisations which had agreed to participate (or that had not replied within two weeks), letters were sent to managers of SHSs, inviting them to participate (Appendix B). The letter also detailed that should they agree to participate in the study, they should select up to four service users whose birth dates fell closest to the date they received this letter. This approach guards against the selection of only the most able service users or their selection on some other non-random criterion. Finally, they were also informed that a few days later the researcher would call them to arrange a date and time for the interview.

6.4 A guide to how interviews were secured

In reality, as has been shown, several steps were added to achieve a large enough sample, and this would be more representative, as a larger number of areas and SHSs were selected in the end (figure 6.3). Steps five to eight were taken for two reasons: 1) at times a specific area did not have any consenting SHSs left to select; and 2) at times responses from directors, managers and service users were poor. These steps will be described in more detail in section 6.4.2. The next section will be focussing in more detail on the original areas, A, B, D, G and J; then on how the new areas were selected, and how the data were collected (sections 6.4 and 6.5).

Figure 6-2: How interviews should be secured in principle

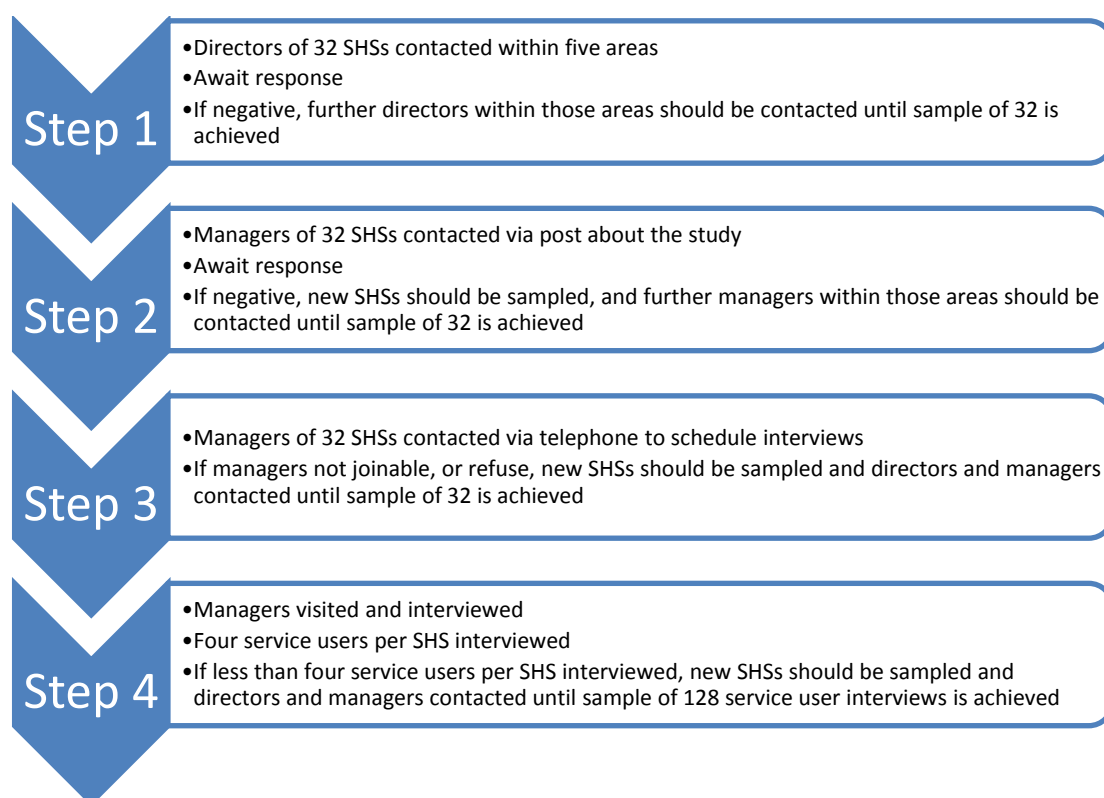


Figure 6-3: How interviews were secured in practice



6.4.1 The original five areas (A, B, D, G and J)

This next section will describe steps two to four of figure 6.3.

Following ethical approval, in late July 2010, the process of sending letters to those managers in the consenting organisations started. Areas A and B were sampled first, due to their proximity to London. Nine managers were sent letters in area A and seven in area B, informing them that they would be contacted in a few weeks to schedule an interview, should they wish to participate. These letters were sent out before the pilot had taken place, to prepare managers and gauge their responses. When they were called a few weeks later, it was to introduce the researcher, and ensure that they had in fact received the letter – indeed two managers had not, as the previous managers to whom the letters were addressed had left. New letters with the correct addressees were subsequently sent out.

It was not until early 2011 that managers of approving organisations started being contacted via telephone. In the meantime, a new batch of letters to directors was sent out to all of the organisations in the directories set up for each area, in the interest of gaining time.

Only five managers in area A were *successfully* contacted via telephone and interviews scheduled, despite efforts to contact 17. It became clear that such a low response rate (both non-responses and refusals) meant that new SHSs would need to be sampled. It was decided that eleven new SHSs (more than the required; see figure 5.3) in area A should be randomly selected; this was undertaken at the end of January using a random number selector. Figure 6.4 illustrates the detailed process by which new services were selected in area A. This process was repeated for each area that had a poor response rate; for areas where the number of SHSs was exhausted, new areas were sought.

In general, it was not refusals that decreased the overall response rate (table 6.2), but rather ‘other’ issues, mainly non-contacts. Often, managers were never reached by telephone, either because they no longer worked in the organisation and the position was waiting to be filled, or they were never available to speak on the telephone. On average, a manager was telephoned four to five times before a decision was obtained as to whether they would agree to participate.

Figure 6-4: Selecting SHSs in area A (step three of figure 6.3)

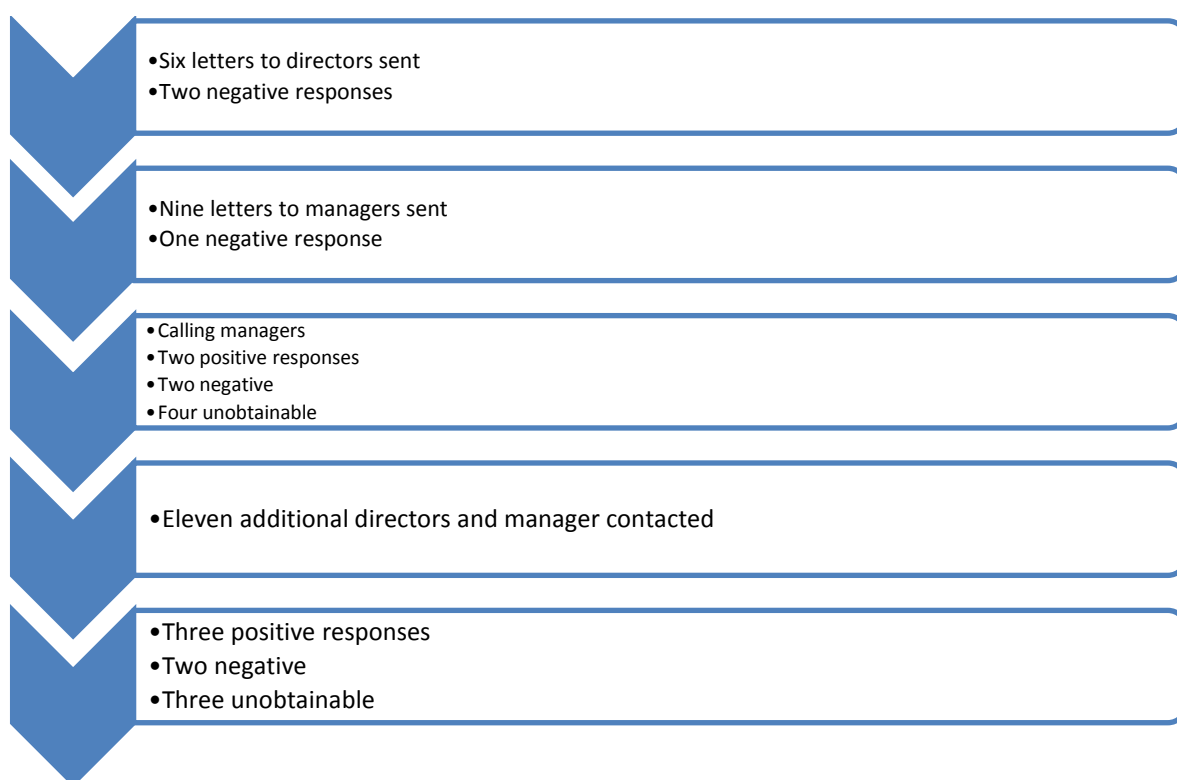


Table 6-2: SHSs contacted and response rates of managers

Area	Total number of managers contacted via telephone	Refused	Accepted	Other	Response rate (%)	Refusal rate (%)	Other rate (%)
A	17	5	5	7	29	29	41
B	5	0	3	2	60	0	40
C	5	0	2	3	40	0	60
D	9	2	7	0	78	22	0
E	12	1	10	1	83	8	8
F	7	0	4	3	57	0	43
G	18	2	7	9	39	11	50
H (pilot)	1	0	1	0	100	0	0
I (pilot)	1	0	1	0	100	0	0
Totals	75	10	40	25	53	13	33

Contacting managers in area B was relatively more successful: three out of the five managers agreed to be interviewed. Only five SHSs had been selected in

area B: it had a high concentration of non-accommodation-based support (i.e. floating support, table 4.2).

Area D managers were contacted from mid-February 2011 (figure 6.1). Seven of the nine managers contacted agreed to participate.

In August 2011, managers in area G started being telephoned. However, many were unobtainable, so additional SHSs had to be selected, bringing the total number of SHSs contacted (successfully or not) to 18. In sum, 50% of managers in area G were never reached by telephone. However, seven SHSs were visited and interviews conducted by an experienced researcher (section 6.5.1).

Area J had been selected for the original five. However, time and resource constraints made it impracticable to interview people there as the area was over 200 miles away.

This reduced the number of *original* areas selected to four.

6.4.2 The 'new' areas (C, E, F)

As illustrated in figure 6.3, four additional steps (5 to 8) were added to the sampling procedure.

By the end of March 2011, 18 months from the thesis submission deadline, three of the five originally planned areas had been visited (as described above, interviews in area G did not take place until August 2011 as a local interviewer was yet to be secured), and only 17 service users and 15 managers had been interviewed (see table 6.5). These disappointingly low numbers (especially with regard to service users) had a major impact on the original sampling plan (figure 6.3). It was decided that:

- New areas would need to be sampled as the pool of SHSs within areas A, B and D had been exhausted.
- An average of 1.1 service users had been interviewed per SHS (areas A, B and D), lower than anticipated (managers had been told to select up to four). To balance this effect, more than the initial 6.4 SHSs per area (see figure 5.3) would need to be selected.

The new areas were sampled in the same representative way as the original areas. The database that produced a single score for each area, taking into account

six different variables (see section 5.4.2.2), was used again: hence, new areas C, E and F were chosen by selecting the next area closest to each mid-point of each stratum. Thereafter, the procedure used for the original areas was applied: directories of SHSs were populated for each area, randomised, directors and then managers contacted, and interviews scheduled. While the fact that more areas and SHSs being sampled could bring increased representativeness, it also meant more resources and time were spent traveling and interviewing. Where possible, more than six managers were contacted per area, due to the fact that the rate of service users interviewed per SHS was so low.

Two other managers were selected in area E who had been recommended as potential participants by two other SHS managers. In general, response rates for areas C, E and F were relatively good (table 6.2).

6.4.3 The final sample of areas

In total, seven areas and 38 SHSs were visited for the main study.

The *final* nine areas A, B, C, D, E, F, G, H, and I were classified according to their rural or urban status (Department for Environment Food and Rural Affairs, 2009). The SHSs in question were located in major urban (MU), large urban (LU), part rural (PR), very rural (VR) and mostly rural (MR) areas (defined in table 6.3).

In later analyses, this variable (termed population density) will be dichotomised into urban (includes MU and LU) and rural (includes PR, VR, and MR) areas to make for larger sub-sample sizes.

Table 6-3: Urban/rural classifications and definitions

Area type	Description
Very rural (VR)	80% or more of the population live in either rural settlements or market towns, where a 'rural settlement' is any settlement of less than 10,000 people and a 'market town' is a settlement of between 10,000 and 30,000 people which provides certain functions and services to its wider rural hinterland
Mostly rural (MR)	between 50% and 80% of their population live in rural settlements or market towns
Part rural (PR)	if between 26% and 50% of their population live in rural settlements or market towns
Major urban (MU)	if not VR nor MR nor PR but <u>either</u> at least 50% <u>or</u> at least 100,000 of their population live in an urban area with a total population of 750,000 or more
Large urban (LU)	if not any of the above but <u>either</u> at least 50% <u>or</u> at least 50,000 of their population live in an urban area with a total population of 250,000 or more

(Palmer, 2009)

6.5 Interviews with service users

Managers had been requested to choose up to four service users within their SHS to be interviewed. In practice, an average of 2.2 service users per SHS was interviewed (see Table 6.4).

The interviews were all conducted at the SHS, with only the interviewer and one participant present.

Three managers in total did not allow their service users to be interviewed at all, mainly citing confidentiality issues. One manager said that they would need to check with service users' social workers first and then later refused. A manager in area F reported that service users were not interested in participating.

Table 6-4: Service users' response rates by area and per SHS

Area	Number of SHSs visited	Number of service users interviewed	N per SHS
A	5	8	1.6
B	3	5	1.7
C	2	4	2
D	7	12	1.7
E	10	24	2.4

Area	Number of SHSs visited	Number of service users interviewed	N per SHS
F	4	9	2.2
G	7	19	2.7
H	1	3	3
I	1	2	2
Totals	40	86	2.2

Visiting more areas and SHSs than had initially been planned meant that more time and resources were spent traveling. Travel was primarily by car, as some SHSs were in remote places, with impractical transport links from London. In most cases, interviews were audio-recorded (unless the participant refused). The audio-recordings were all transferred to a drive on the server at the London School of Economics and securely stored. Some responses were written down on the interview schedule itself, verbatim occasionally.

6.5.1 Interview assistance

From London, area G was a 440 mile return drive. Therefore, for resource purposes, a local interviewer, with experience in mental health and social work, was used. To ensure that she was fully familiar with the purpose of the study and what to expect, many meetings were held with her, to go through the interview schedules and provide some training.

All interviews by this assistant were set up by the author; details of locations, dates, and the names of managers were sent subsequently. Only after having assessed the quality of her initial interviews, and established that similar quality was being obtained from participants, were the rest of the interviews (7 SHSs in total) scheduled in area G. The local interviewer conducted seven manager interviews, as well as 19 service user ones.

To help ensure consistency across interviewers, all participants were read an identical paragraph detailing the study's aims as well as their individual rights (see Appendices F and G). All interviews were audio-recorded where applicable.

6.5.2 Challenges to sample acquisition

It must be noted again how important it is to be realistic about sample sizes (Hall & Hall, 1996, p. 117) and that statistical power calculations with this kind of study design are not straightforward (Bowling, 2009, p. 188). As described in chapter 5, the target sample size of service users was 128 (see section 5.4.2.1). In fact, the final sample size was 86 service users and 40 managers within nine areas. This was, of course, disappointing, but perhaps not surprising given the difficulties encountered. The sample size obtained nevertheless exceeded that required for instances where large effect sizes are expected.

In fact, ethical approval took nearly a year to obtain, longer than anticipated, and two pilot studies were conducted to test the study materials. Once the main study started, the researcher was faced with two types of gatekeepers: directors and managers. When they did not agree to participate in the study, further SHSs or areas had to be sampled, and the first steps repeated again (see figure 6.3).

In spite of all these challenges, a considerable sample of interviews was conducted by 19 October 2011, allowing for a little less than a year for analyses and write-up. The many steps that had to be undertaken to ensure the representativeness of the sample, as well as problems with access and gatekeeping meant that the data collection took longer than expected.

6.6 Characteristics of the sample

There is not much evidence on the characteristics of English SHSs, their service users or their managers. Previous studies (table 5.1) tended to have some methodological limitations, such as weak sampling strategies, small and/or unrepresentative samples, and a lack of geographical variability.

6.6.1 Description of service users

Table 6.5 sets out the types of SHS in which service users lived; it can be seen that many lived in care homes, which were heavily sampled and had a good response rate amongst users. There were two service users in the sample who fell under the 'independent living' umbrella and were introduced to the author via their former supported housing manager whilst visiting that home. Care homes were

nearly evenly split between rural and urban areas. People in supported housing services in this sample were mainly living in rural areas, as were all Shared Lives schemes service users, and people in independent flats.

Table 6-5: Number of service users interviewed by SHS type and area

Area	Population density	Care home	Supported housing scheme	Shared lives	Independent living
A	MU/urban	8	0	0	0
B	MU/urban	5	0	0	0
C	MU/urban	3	1	0	0
D	PR/rural	8	3	1	0
E	VR/rural	12	7	3	2
F	LU/urban	9	0	0	0
G	MR/rural	17	1	1	0
H	MR/rural	0	3	0	0
I	MU/urban	2	0	0	0
Totals		64	15	5	2

Table 6.6 presents demographic characteristics of service users categorised by type of SHS. Statistical analyses in this thesis will mainly compare people in care homes to people in supported housing services. People in Shared Lives (5) and independent living were receiving less structured support. Care home and supported housing service users are more easily comparable in this regard.

There were no statistically significant differences in health status or other characteristics by SHS type.

The youngest participant was 24 years and oldest was 90; mean age was 51.7 years (SD = 15.22). There were more men than women (57 versus 29); indeed, a few of the SHSs accommodated men only.

The majority of the sample was white British (N=71); disappointingly given one of the aims of this study, only six people were from a BME group. Most people (74) were born in the UK, were single (59) or separated (17) and did not have any children (62). Most people had completed secondary school (N=64) and ten people had gone to university.

Table 6-6: Main demographic characteristics of service user sample by SHS type

Characteristic	Care homes (64)	Supported housing service (15)	Shared lives scheme (5)	Independent living (2)	Totals
Mean age (SD)	53 (±15.1)	42.5 (±13.7)	62.4 (±11.9)	51.5 (±3.5)	51.7 (±15.2)
Males (N)	41	12	3	1	57
White/BME (N)	59/5	14/1	5/0	2/0	80/6
<i>Psychiatric diagnosis</i>					
Schizophrenia (N)	35	8	3	1	47
Personality disorder	5	0	0	1	6
Organic disorder	5	0	0	0	5
Unipolar depression	2	3	2	0	7
Learning disability	3	1	0	0	4
Bipolar affective disorder	2	2	0	0	4
Brain injury	3	0	0	0	3
Dual diagnosis: schizophrenia and learning disability	3	0	0	0	3
Neurotic, stress-related and somatoform disorders	1	1	0	0	2
Disorder of psychological development	2	0	0	0	2
<i>Marital status</i>					
Single	43	13	2	1	59
Separated	12	2	2	1	17
Widowed	3	0	1	0	4
Married	3	0	0	0	3
<i>Education level attained</i>					
Secondary school or equivalent	33	4	3	0	40
Less than secondary school	17	4	2	1	24
University/ polytechnic	7	2	0	1	10
Further education college	3	5	0	0	8
Higher degree	1	0	0	0	1

Characteristic	Care homes (64)	Supported housing service (15)	Shared lives scheme (5)	Independent living (2)	Totals
<i>Health ratings</i>					
EQ-5D-3L VAS (M/SD)	73.2 (±22.1)	70.1 (±19.7)	72 (±8.4)	60 (±14.1)	72.4 (±20.8)
<i>Problems with:</i>					
Mobility	29	4	0	0	33
Usual activities	25	5	1	0	31
Pain	23	7	1	0	31
Anxiety	20	5	2	2	29
Self-care	21	2	0	0	23

The most frequently reported diagnosis was schizophrenia or schizoaffective disorder (N=47). Five people had organic disorders such as dementia, seven had some form of depression, and six had a personality disorder (among other illnesses).

For the remaining services users, specific diagnoses were less common and included depression, and neurotic and stress-related somatoform disorders. Care homes housed a very high number of people with personality disorder. People with bipolar disorder were mainly living in supported housing services. Three people with schizophrenia were living in Shared Lives schemes (see Table 6.7). A little less than half the sample of people in care homes reported at least one problem on the dimensions of the EQ-5D-3L.

Health status

There are various ways of displaying the results from the EQ-5D-3L (Rabin, et al., 2011). Here, the results from the visual analogue scale (VAS) are discussed first, then the ratings on the five health domains.

EQ-5D-3L VAS

People in SHSs reported being relatively healthy, and scored a mean of 72.4 (SD=20.8; Min=20, Max=100) on the VAS.

The older the men were, the lower their EQ-5D-3L self-reported scores (see Figure 6.5), but the situation was reversed for women (Figure 6.6).

Figure 6-5: Men's EQ-5D as a self-rated index by age

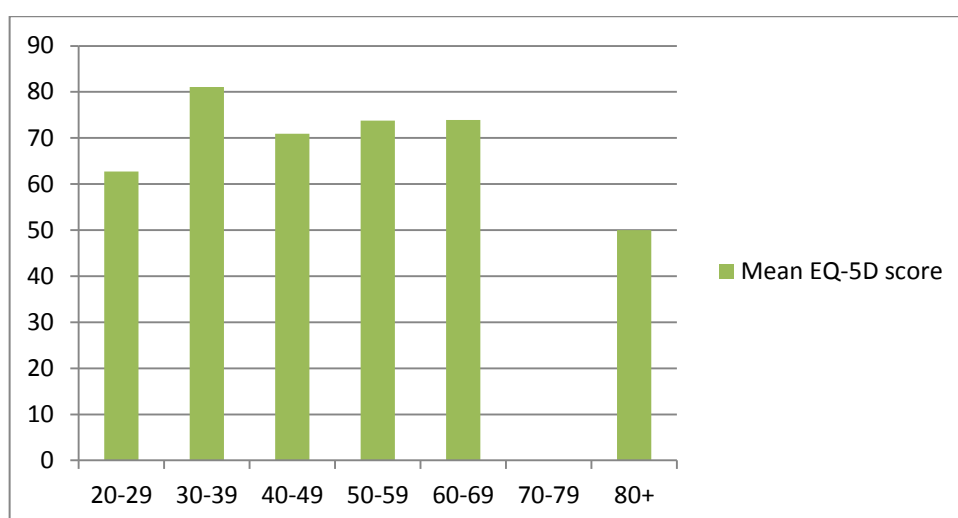
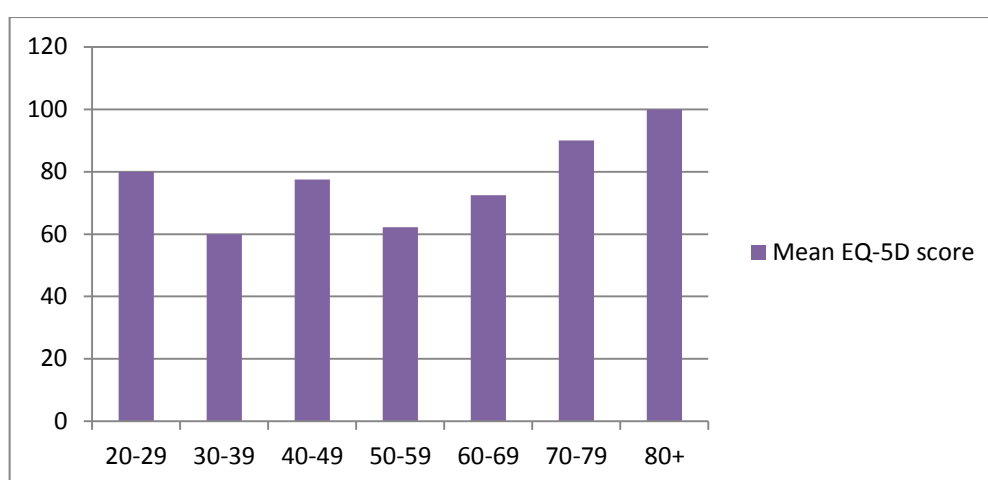


Figure 6-6: Women's EQ-5D as a self-rated index by age



EQ-5D-3L dimensions

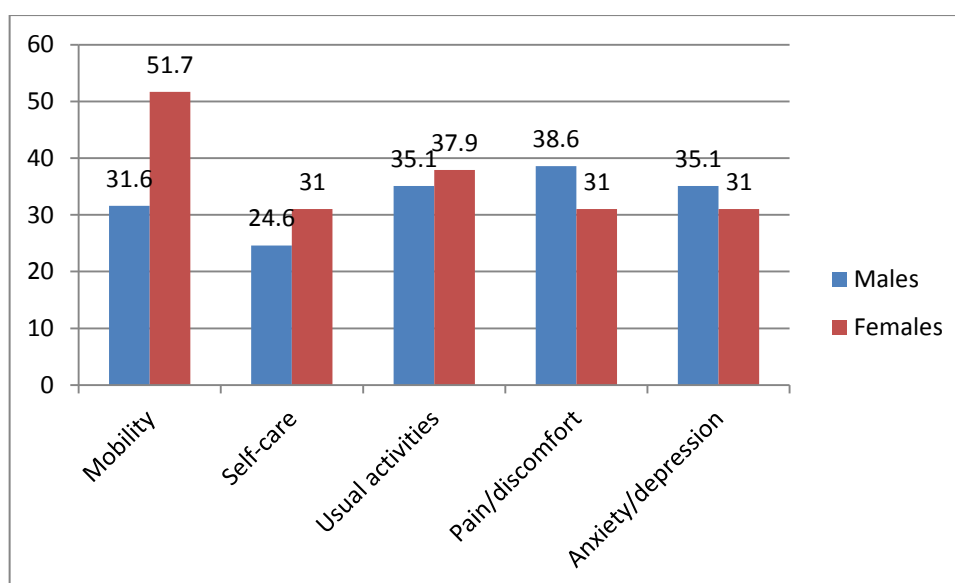
As table 6.7 shows, 58 of the 86 respondents (67.4%) reported having at least one problem in one of the EQ-5D-3L dimensions: mobility 33%, self-care 23%, usual activities 31%, pain/discomfort 31%, and, a similar proportion with anxiety/depression 29%. Only in the case of anxiety or depression did service users report extremely high levels (four people).

Figure 6.7 shows the proportion reporting at least some problems on each of the individual EQ-5D-3L dimensions by gender. More women than men reported having difficulties with mobility (51.7% and 31.6% respectively).

Table 6-7: EQ-5D-3L ratings by ability: agreement with statements (frequencies)

Statement	Frequency (N)	Percent (%)
<i>Mobility</i>		
I have no problem in walking about	52	60.5
I have some problems walking about	33	38.4
I am confined to bed	0	0
<i>Self-care</i>		
I have no problems with self-care	62	72.1
I have some problems performing my usual activities	23	26.7
I am unable to perform my usual activities	0	0
<i>Usual activities</i>		
I have no problems with self-care	54	62.8
I have some problems performing my usual activities	31	36
I am unable to perform my usual activities	0	0
<i>Pain and/or discomfort</i>		
I have no pain or discomfort	54	62.8
I have moderate pain or discomfort	31	36
I have extreme pain or discomfort	0	0
<i>Anxiety and/or depression</i>		
I am not anxious or depressed	54	62.8
I am moderately anxious or depressed	25	29.1
I am extremely anxious or depressed	4	4.7

Figure 6-7: EQ-5D-3L ‘problem areas’ by gender



As recommended by Rabin (2011), the presence of problems on the EQ-5D-3L was explored by age (Table 6.8). Most problems with usual activities, mobility and self-care were concentrated within the 50-69 age, but issues with anxiety were most prominent among those aged 30 to 59 (n=21).

Table 6-8: EQ-5D-3L problems by age

Problems with	Age category (N)						
	20-29 (11)	30-39 (10)	40-49 (15)	50-59 (23)	60-69 (20)	70-79 (3)	80+ (4)
Mobility	1	1	4	11	12	0	4
Self-care	1	2	4	7	7	0	2
Usual activities	3	1	6	7	12	0	2
Pain	2	3	5	11	8	1	1
Anxiety	3	5	6	10	4	1	0

Future analyses will compare service users living within different population densities. It is useful here to present EQ-5D-3L scores accordingly (table 6.9).

Table 6-9: EQ-5D-3L ratings by area

	Major urban (18)	Large urban (8)	Part rural (12)	Major rural (20)	Very rural (24)	Urban (28)	Rural (58)
VAS	68.2 (±20.5)	79.4 (±21.4)	67.6 (±25.7)	75.2 (±21.1)	73.2 (±18.4)	48.7 (±13.2)	53.1(±15.9)
<i>Reported problems with</i>							
Mobility	9	3	8	5	8	12	21
Self-care	6	2	4	3	8	8	15
Usual activities	7	3	5	6	10	10	21
Pain	5	3	9	5	9	8	23
Anxiety	6	2	8	5	8	8	21

Activities of daily living

As with the EQ-5D-3L, data obtained using the Glenndinning et al. (2008) scale on activities of daily living showed that at least two-thirds of people could undertake all activities with no help (table 6.10). However mobility was a problem

for some, such as getting up and down stairs or steps (N=30) and going outdoors and walking down the road (N=29). Only one person could not get in and out of bed, use the toilet, bathe, or get dressed without the help of someone else. There was missing information on one person.

Service users were also asked to categorise their health (very bad, bad, fair, good, very good): 44 gave a rating of very good or good, and 30 said it was fair.

Table 6-10: Ratings of Activities of Daily Living (N)

Activity	Ability			
	On own without help	On own with difficulty	Only with someone else	Not at all
Get up and down stairs/steps	54	30	0	1
Go outdoors and walk down the road	54	29	1	1
Get around indoors	63	21	0	1
Get in and out of bed	64	20	1	0
Use the toilet	65	19	1	0
Wash face and hands	68	17	0	0
Bathe, shower or wash all over	66	18	1	0
Get dressed and undressed	66	18	1	0
Feed yourself	67	17	1	0

6.6.2 The manager sample

A total of 40 managers were interviewed; 16 male and 24 female. Their ages ranged from 23 to 77, with a mean of 47 years (SD=10.72). They generally described themselves as “service manager” or “registered manager”, and had been in that role for a mean of 6.7 years (SD=6.43).

Managers mainly described themselves as white British (26); a few were black or black British Caribbean (4) and black or black British African (7). Most were born in the UK (29) and four in the Caribbean Islands. The majority had attained formal qualifications such as NVQs (N=12) or attended university or a polytechnic (N=22). All had attended secondary school or its equivalent.

6.6.3 Description of the specialist housing services sampled

Because of the difficulties of classifying and describing SHSs, discussed in chapter 3, a new classification system was developed for the purpose of this study.

A total of 40 SHSs participated in the study, containing a mixture of housing services providing differing levels of support. Table 6.11 presents the SHSs within the sample, broken down by type in three ways: first, according to their 'official classification' (how they were described in the directories); second, by how their manager described them; and third by the new classification system presented in chapter 4. It may be useful to note that information provided by managers with regard to the size of homes, hours, type of support provided and overall setup (for example self-contained units, meals taken at the same time) guided the new classification. This classification is used throughout the study.

Table 6-11: Number of SHSs in sample by support type classifications and area

Area	Supported housing services			Care homes			Shared Lives schemes		
	Official	Manager	Study	Official	Manager	Study	Official	Manager	Study
A (MU)	1	1	0	4	4	5	0	0	0
B (MU)	0	0	0	3	3	3	0	0	0
C (MU)	1	1	1	1	1	1	0	0	0
D (PR)	1	1	1	6	5	5	0	1	1
E (VR)	3	4	3	5	4	5	2	2	2
F (LU)	0	0	0	4	4	4	0	0	0
G (MR)	0	0	0	6	6	6	1	1	1
H (MR)	1	1	1	0	0	0	0	0	0
I (MU)	0	0	0	1	1	1	0	0	0
Totals	7	8	6	30	28	30	3	4	4

There were more care homes within the study, than supported housing or Shared Lives schemes (the three main types of SHSs included) in this study. Although group homes had originally been sampled (see table 4.2) and letters sent, the managers were either unobtainable or declined to participate.

It should be added that there were some differences in the ways that the three sources (official, manager and study) classified the SHSs. In area D, an SHS that had been officially listed as a care home was described by the manager as a

Shared Lives scheme, and this is how it was classified according to the system set out in Chapter 4: the home had been de-registered due to the large amount of paperwork generated, and according to the manager, the new 'label' made service users more independent, and gave them more money to spend. That particular SHS was the manager's own home and residence.

In areas A and E, although managers had introduced the homes as 'supported living', the vast amount of support provided as well as the layout, would suggest that they were actually care homes. Although self-contained flats are generally regarded as a distinguishing feature of supported housing services, in this sample, many care homes offered self-contained units within a large house, where residents had their own cooking facilities and lounges; these care homes were also staffed 24-hours a day. The difference between care homes and supported housing services was clearly explained by one manager:

The difference between here and a care home is that we have tenancies; each client here is a tenant. So they have a small studio or self-contained flat and pay rent or the service charge.

Manager, supported housing service

6.6.3.1 Size of homes

Size was not a very good indicator of housing type in this study, as it was in chapter 4. For instance, care homes were relatively small but with more people living in them ($M=11.8.5$; $SD=9.4$) compared to supported housing services ($M=9$; $SD=2.2$) (see Table 4.2).

Shared Lives organisations were considerably larger than the other types of SHSs and had many service users on their 'books' ($M = 82.2$; $SD = 68.9$); this rather large standard deviation may be due to the fact that three managers of Shared Lives *organisations* were interviewed in addition to one Shared Lives *carer* who housed and fostered three individuals within their own home. In general, and according to Shared Lives organisation managers, one or two service users lived within each home at most.

6.6.3.2 Support provided

Care homes provided a high level of support, with staff on site 24 hours a day and waking-night cover in 16 of the 29 services (13 of the 29 care homes had sleeping night cover). In supported housing schemes, in contrast, staff were usually onsite from 9am to 5pm only and service users lived in self-contained flats.

These differing levels of support are in line with the literature. For Shared Lives schemes, the support from the carer was continuous. Quotes from managers of supported housing services and care homes illustrate the differences in support:

"We're supported living and staff is here, Monday to Friday, 9am to 5pm. We also have an after-hours on-call system which is a phone service and only to be used in case of emergencies like fire or flood. Each person lives in an individual flat."

Manager, supported housing service

"This is a residential care home for adults with a variety of mental health problems or challenging behaviour. So we run a care home on the premises where 21 residents live and have 24-hour support. We also own a supported living scheme across the road where people are more independent. There's an on-call system, and night support. We're basically getting them ready for independent living."

Manager, care home

Managers were asked open-ended questions about services users' responsibilities around the house. Around 70% of managers of both care homes and Shared Lives schemes mentioned that service users often did the housekeeping and cleaning, as did all managers of supported housing services. Half the managers of Shared Lives and supported housing schemes stated that service users were responsible for their own shopping; eight managers of care homes cited this, too. More managers of care homes than those of supported housing services reported mentioned service users' cooking responsibilities.

6.6.3.3 Providers

Most care homes in this study were privately owned and run (Table 6.12). Nearly all supported housing schemes were provided by a voluntary-sector organisation; this is in line with Supporting People data (Centre for Housing Research, 2012b):

*“We’re a supported housing scheme and we’re funded by Supporting People. They fund us to provide support for the tenants to live here and the building is provided by a housing association. Basically *name of charity* rents it from the housing association.”*

Manager, voluntary-sector supported housing service

Most Shared Lives schemes were local authority provided, with the exception of the private care home that had de-registered and now provided foster care for service users.

Although this study had aimed to compare differences by provider types, this was not deemed possible due to the majority of private sector care homes, and one private sector supported housing service in the sample (table 6.12). Contrasting people in private sector to voluntary sector homes may be very similar to comparing care homes and supported housing services.

Table 6-12: Number of SHSs by support and providers

Provider type	Care home	Supported housing scheme	Shared Lives scheme	Totals
Private	23	1	1	25
Voluntary	7	5	0	12
Local authority	0	0	3	3

6.6.3.4 Restrictions and rules within the home

Ten managers said that there were rules within their home, nine of them care homes and one supported housing scheme. For instance, when asked, only eight managers of care homes said that they allowed visitors at any time, as opposed to two supported housing schemes. Nearly half of care home and supported housing scheme managers allowed their service users to spend the night outside the home, but very few accepted strangers to spend the night in the SHS. Shared Lives schemes were more relaxed in this regard, and insisted that service users had no rules within their homes.

6.6.3.5 Other home characteristics

Most care homes (24) had achieved a two-star CQC rating, deeming it to be a ‘good’ service, whilst two services received one star (‘adequate’), and three were rated as excellent.

Most homes operated some sort of exclusion criteria (N=31). Four SHSs reported that they did not accept paedophiles, 13 excluded people with current violence issues. Other exclusions were: not being male (2) and having learning disabilities or dementia (9).

6.7 Discussion

“Even in the most carefully managed research project, things do not always go quite as planned” (Blaxter et al., 2010, p. 149).

Chapter 5 presented the research gaps and questions, and the design chosen to address these. Selecting an appropriate sample was seen as fundamental, given the relatively weak sampling procedures within previous studies of SHSs. This was an identified methodological gap, alongside the more substantive ones (table 5.1), some of which are addressed in this chapter.

Sampling participants

The timescale for this study necessarily shifted, with the main data collection starting later than expected, due to the delays in obtaining ethical approval, as well as conducting the pilot study. This meant that less time was available for the data collection, given the time constraints of PhD registration (and LSE regulations about thesis submission). In fact, this stage also took longer than expected, given the difficulties in obtaining the consent of managers and the eventual need to select and visit additional areas and SHSs. Nevertheless, 40 SHSs were visited, and 40 managers and 86 service users were interviewed within nine geographical areas, with differing population densities.

Although the target sample number was not met (section 5.4.2.1), the study collected rich information from a considerable number of participants. The additional areas and SHSs visited, although time- and resource-consuming, generated a more representative sample. This also entailed a departure from previous studies, some of which had sampled only a small number of areas or accommodation services, and did not capture much variability within different types of SHSs or geographical locations (as well as urban/rural variations). This also made for richer descriptions of SHSs in England, managers, and service users.

Describing service users and managers

Care home managers were not only more willing to participate in the study compared to managers of other types of SHS, but as gatekeepers, they were also more willing for their service users to take part as well. This meant that care home service users were necessarily a considerable majority of the sample (table 6.9). This made comparisons across groups of people within different SHSs possible (Dixon, et al., 1987), but difficult, and such comparisons should be treated with caution in later chapters. It was decided that for the planned quantitative analyses, comparisons would only be made between care home service users and those in supported housing services. Descriptive statistics will still be provided for the whole of the sample. Unequal or small sub-samples by different accommodation types were also apparent within previous UK-based SHS studies (Järbrink, et al., 2001; Oliver & Mohamad, 1992; Priebe, et al., 2009; Shepherd, et al., 1996), however statistical analyses were still possible.

In terms of demographic characteristics, a typical service user in this study was male, single, white, with schizophrenia, had attained secondary school level of education and rated their health on average (on the VAS) as 72 (out of 100). A diagnosis of schizophrenia is common amongst people living in SHSs (Fakhoury, et al., 2002; Friedrich, et al., 1999; Middelboe, et al., 1998; Priebe, et al., 2009). Male versus female ratios as well as the proportion of unmarried (single, separated and widowed) individuals were similar to those reported in a recent large-scale survey of SHSs in England (Priebe, et al., 2009). Although the sample in the Priebe et al. (2009) study was younger compared to this study, they also had more difficulties with activities of daily living; this finding should perhaps be treated with a little caution, however, as this was reported by managers, not by service users.

In terms of EQ-5D-3L health ratings, a UK study by Barton et al. (2009) found that most patients with psychosis scored 67.6 on the VAS (95% CI [60.4 - 74.8]); lower than in this study. Across the five dimensions, the proportion of people reporting problems with self-care, usual activities and pain and discomfort were similar to this study; the only discrepancies were with mobility and the prevalence rates of problems with anxiety and depression (higher in this study). High frequencies of problems with the latter domain were also reported amongst patients with schizophrenia in a study by McCrone et al. (2009).

Although this study had purposely aimed to sample people from BME groups, only six such service users were actually interviewed (7%). In terms of ethnicity, this sample is perhaps not representative of people with mental health problems; although it is typical with regard to all other demographic characteristics. Proportions from BME groups in this sample are lower than that found in the Priebe et al. (2009) study, which did not seek out a purposeful BME sample. Yet, in that study, fewer people were born in the UK. In general, low proportions of people from BME groups were found in some previous studies of SHSs (Järbrink, et al., 2001; P Lelliott, et al., 1996). In the Lelliott et al. (1996) survey, 87% of residents were white, despite the fact that this included patients within inpatient wards; according to the 2010 census, 13% of psychiatric patients were from a BME background (Care Quality Commission and National Mental Health Development Unit, 2011).

This study had set out to describe the experiences of people from BME backgrounds, which was identified as a research gap, yet the final sub-sample was too small to do so. Future studies will either have to sample more people in general or to choose some targeted sampling design, in order to obtain a large enough BME sub-sample size, considering problems with access, sampling and gatekeeping within SHSs.

No significant differences were found in terms of individuals' characteristics between different SHS types (table 6.7); a finding also reported by Priebe et al. (2009). Lelliott et al. (1996) did find significant associations, but their sample included a wider range of SHS and support types, as well as psychiatric wards – distinctions that may not be as apparent in the sample in this study.

Another gap in the evidence base is the description of service managers. Managers were relatively young, and there were more women in charge than men. There was also a relatively high proportion of people from BME groups.

Defining and describing SHSs

A valuable contribution of this study is that a new classification of housing types was developed on the basis of both official documents and discussions with managers. The views of the latter contrasted with this study's taxonomy, particularly as two managers labelled care homes as supported housing. Yet as the

terms are used in the existing literature, in the latter people usually live in self-contained units or flats (Chilvers, et al., 2010; Järbrink, et al., 2001; Trieman, 1997), and have *tenancies*, which enable them to personalise their homes, and provides some form of security of tenure (Macpherson, et al., 2012). It has been noted by Macpherson et al. (2012) that many residential care homes have been changing their registration status to supported housing schemes, to ensure that service users get their full entitlement to benefits. This is also what a manager had in mind when de-registering a home, making it a foster scheme.

Size was not a very good indicator of housing type in this study, as it was in chapter 4. Care homes were not much larger than supported housing services; however, both were much smaller than similar services within the Priebe et al. study (2009). The cut-off point between smaller and larger homes as first used by Knapp et al. (1992, p. 113) and by Lelliott et al. (1996) was six people (large is six or more individuals). All the supported housing services in this study were deemed large under this classification, and nine of the 30 care homes small. However, there seems to be no clear consensus on the ideal number of service users per SHS, but a lower density is recommended (Taylor, et al., 2009). Sizes of Shared Lives schemes were more consistent with previous literature (Priebe, et al., 2009; Trieman, 1997).

McDaid et al. (2007) commented about the prominence of the private sector in residential care; indeed most care homes in this study were private sector provided. Macpherson et al. (2012) noted that the range of services within an area depended on the activity of local private providers, as well as the focus of each local Council. Indeed, in this study, charities and voluntary organisations mainly provided residential care within areas B and D; no private sector homes were sampled within those areas.

Although an attempt was made in this study to capture the full spectrum of SHSs in England (table 4.2), only three types of SHSs were represented, due to the comparatively greater responses from care home managers and the lower sampling of supported housing and Shared Lives schemes. The depth of information provided by managers regarding the structure of their services allows for rich descriptions.

Chapter 7 Movements, Experiences and Referrals

7.1 Introduction

This chapter addresses a gap in the SHS literature, namely pathways into and out of housing services. Although there is some data on the former locations of some people in supported housing services funded by the Supporting People grant (and for some individuals, their subsequent ones), this is for the most part raw data collected from service staff. Such information is not at all illustrative of service users' perspectives during a crucial moment in their lives – moving into a new home or leaving it.

For this study, data was collected directly from service users about where they had been living previously, how they viewed their moving experience, and whether they aimed to move anywhere else in the future. Much of the English literature on housing pathways has focussed on the outcomes for service users as they move from long-stay psychiatric hospitals. Yet with community care initiatives in full swing, people move from one place to another by a range of routes.

In addition, information was obtained from a range of people living in different support services, not only those in supported housing schemes (as with the CHR data), but also people in accommodation with intense support (care homes), variable support (Shared Lives) and ad-hoc support (independent living). Information on their movements was extracted from five questions (2-6) in the service user interview schedule (appendix G), namely: "What is the reason you're living here?", "Why did you move into this accommodation?", "How long have you been staying here?", "How were you referred to this housing service?" and "Where would you live if you could choose?". The answers were scaled either on a binary scale (where a score of 1 on that variable represents the presence of a condition) or a nominal one and are analysed in detail in this chapter.

The data is presented first on the whole sample, then in more detail according to the different support types. It was hypothesised that SHS type would be associated with differing housing pathways. In addition, previous experiences, such as having lived in hospital at some point or having had problems with their move to an SHS, might be associated with their housing experiences. Hence, much

emphasis was placed on service users' future housing prospects, and the factors that would be related to their wish to move on from their existing housing situation. As few studies have focussed on these issues, the analyses here are necessarily exploratory, seeking to identify significant associations in the data. Naturally, an attempt was made to include a measure of psychological disability (problems with anxiety/depression on the EQ-5D-3L) in the analyses.

A useful perspective was also obtained from managers of SHSs concerning similar issues (see "Section B: Tenants' movements" of the manager interview schedule, appendix F), including whether they encouraged service users towards independent living. This information provided a useful contrast to that provided by service users. Again, it was hypothesised that managers' responses would be correlated to the SHS they were affiliated to.

An additional section of this chapter is dedicated to users' experiences in a psychiatric hospital. A common pathway into an SHS is from hospital, and it was felt that obtaining a clearer understanding of peoples' previous experiences within hospital might provide insight into their present situation. Relevant questions from the interview schedule (section F) were analysed, and the issue of delayed discharge was explored, where it related to housing, and a lack of possible move-on accommodation from hospital. As with housing pathways, the issue of delayed discharge has been discussed in the literature primarily with respect to the views of practitioners or members of staff.

The final section of this chapter describes in detail the experiences of people who had moved from 'asylums' or who had been long-stay psychiatric patients, as this has been an important focus of past research.

In each case, the analysis starts with descriptive statistics, including independent samples t-tests and chi-square tests where appropriate. Binary logistic regressions are also produced to examine factors that may be associated with service users' reported desire to move. Missing data are reported where applicable. Statistical analyses will consider the sample of service users in care homes and supported housing services only. However, some descriptive statistics are presented for service users in Shared Lives schemes and independent living.

Binary logistic regression models were also run (in the case of binary dependent variables) in order to rule out the potential confounding effect of psychological disability on service users. Similarly, linear regression models were run in the case of a continuous dependent variable. Unless otherwise stated, in the following analyses, the following independent variables – SHS type, population density, wanting to move or not, length of stay in psychiatric hospital, experiencing problems in psychiatric care, and gender – were statistically significant in relation to the dependent variable when controlling for problems with anxiety or depression as measured by the EQ-5D-3L (binary scale); the direction of the relationship did not change.

7.2 Service users' pathways into and out of SHSs

In this section, housing pathways are presented for the sample as a whole, with later analyses exploring the information in more detail by SHS type. The mean length of stay for the sample in SHSs was 4.6 years (SD=5.5).

First, moves were not generally undertaken by default. Less than half of the sample (40) felt that they had moved to their current home because they had nowhere else to go; data was missing for one person. On further probing, although 59 people disclosed that they had wanted to come to their current location, 23 felt that they had been forced to move to this location by someone else. Some quotes can be seen as illustrative:

"I was sectioned. The doctor said I should go to "high support", which I didn't really agree with because it's too restrictive. This place is fine; I just wanted to get out of hospital. If I hadn't come here I would still be in hospital."

Kenneth, Supported Living service user, Major urban area

The most commonly cited reason for their current residential status or living in an SHS ("What is the reason you're living here?") was having a mental health problem (63). Some were also seeking more support (39) or just did not want to be in hospital anymore (21). Referrals were mainly conducted by social workers (39) or hospitals (18).

Finally, there were individuals who had moved because they had been placed in the wrong kind of support beforehand (7); usually in a care home for people with learning disabilities:

"I used to live in X house before and I had to share a bathroom. It was horrible, I didn't fit in with people. They needed much more support than me. I felt like an outcast. I fit in really well here."

Mary, Supported Housing service user, Very rural area

Twenty-one people had experienced difficulties in being able to move into their SHS, mainly due to the lack of available placements (9).

Service users were nearly evenly split between whether they wanted to move out of their SHS (37) or stay (42). People most frequently mentioned wanting to move to an independent flat (23) or supported housing services (9).

Chi-square tests and independent samples t-tests were conducted to compare the differences in health outcomes and ADL ratings between people in care homes and supported housing services who wanted to move out and those who wished to remain. This would allow for clearer analyses as to the reasons associated with a person's reported desire to want to move. This is in addition to the binary logistic regression models that were run. No statistically significant differences were found with regard to health ratings on the EQ-5D-3L.

Differences by SHS type are discussed below in more detail. Service users' journeys are also considered, differentiated by current SHS type as well as a detailed three-stage process: getting there, being there and moving on. For each, service users' accounts will be presented first, followed by managers'.

7.3 The movements of care home clients

7.3.1 Getting to the current home

For many of the 64 care home clients, this was their first experience in an SHS (35). Roughly half (34) were out of area placements and these service users had not lived in the new area for most of their lives. Most (19) had moved in straight from hospital, or from another care home or nursing home (12); Table 7.1 presents places of origin. Only in a few instances had individuals moved from a lower-level support SHSs, such as supported housing (3) or a Shared Lives scheme (2).

Table 7-1: Care homes service users' places of origin (total n=64)

Place of origin	Frequency	Percent
Hospital	19	29.7
Other care home	12	18.7
Independent flat	7	10.9
Hostel	5	7.8
Care home for people with learning disabilities	5	7.8
Home with family/other	5	7.8
Asylum	4	6.3
Supported housing	3	4.7
Shared Lives	2	3.1
Homeless	2	3.1

It was most commonly a social worker (31) who had been in charge of processing applications and referrals into the care home, followed by hospital staff (13); Table 7.2 lists all other care home service users' reported referral routes.

Table 7-2: Care home service users' referral routes: frequencies (total n=55)

Referral route	Frequency	Percent
Social worker	31	53.4
Hospital staff	13	22.4
Keyworker	4	6.3
Manager	2	3.1
Family/self-referral	2	3.1
GP	1	1.6
Psychiatrist	1	1.6
Care co-ordinator	1	1.6
Missing	8	12.5

Reports from managers with regard to referral routes into care homes were similar: most of their referrals came from the Community Mental Health Teams (28)

and hospital staff (11). Seven care homes took self-referrals. Their accounts provide some insight into the processes by which a service user moves into a care home:

"There's a new referral system now. The council has a panel that gives us referrals. The care co-ordinator refers to the panel and the panel is aware of local housing services, and they match individuals to the services. It's much more efficient now."

Care home manager, Major urban area

"A single-referral system will send out calls every other week asking for vacancies. We send them the number and they send that back to the joint assessment team. Committee will read the referral and send client to appropriate place."

Care home manager, Major urban area

"A person can only get in here via the council. So they have to apply to the CMHT, the CMHT refers to the council. A housing officer will then decide whether that person can go to that housing service and then we in turn decide whether to accept them or not. The turnover is slow but the process is quick."

Care home manager, Part rural area

Most service users who recounted their experiences of moving into their care home (43) reported having had no problems. Yet 12 people experienced some difficulty, such as having to wait a certain time to obtain a placement, due to lack of availability or funding issues.

The most frequently cited reason for living in their current home was simply because they had a mental health problem (47). Many also mentioned problems around support, such as having been in need of more support or not being able to cope on their own (31). A few said they had had too much support (5), or had had support that was not suited to their mental health needs (6).

The majority of those interviewed said that they had wanted to come to their present housing (40), but further questioning uncovered this to be a negative choice: 30 said they had nowhere else to go or no other option, including not wanting to be in hospital any longer or their institution had closed down. Some people stated that they had moved because they had had negative experiences in their previous care home (3) or Shared Lives scheme (1). But positive reported choices included that they had chosen to come to this care home to help regain skills and reintegrate into the community (10):

"I was in a care home before with [charity]. And I was homeless before that. I stayed there for 15 months then moved here. Moving here was a good thing and it was quick and easy. At the end of the day, I'm happy because now I have a roof over my head."

Roberta, Care Home service user, Major urban area

"I was living in a house like this before, but this one is closer to my family. I believe it was a good thing for me to come here. When moving out of hospital they gave me a place quite far away, and I didn't really like that. So I moved in there first, until they found me somewhere closer."

Samantha, Care home service user, Major urban area

"I was living in a care home for learning disabilities before here. I moved out because I didn't like the people and the staff. I get looked after properly here. The resources, support, and quality of life are good. Some places are cheap and nasty."

David, Care home service user, Part rural area

Given these 'negative' choices, it was interesting to explore whether the wish to come to their present housing was less frequently expressed by people living in a care home, compared to supported housing services, and a statistically significant difference was found using a chi-square test: $p=.029$, Fisher's exact test, two-tailed (see table 7.3). These results suggest that individuals in care homes were significantly less likely to report to have chosen to move to their home compared to those who had moved to supported housing services.

Table 7-3: Cross-tabulation: having wanted to move to a SHS (care home versus supported housing)

			Having wanted to move		Total
			No	Yes	
SHS type	Supported housing	N	1	14	22
		%	13.6	86.4	
	Care home	N	23	40	63
			36.5	63.5	

"I'm living here because I was sectioned, and I'm on antidepressants at the moment. I was in another home before this one for 3 years."

Safa, Care home service user, Mostly rural area

"I was living on my own before. And then I failed to take my medication. So they sent me to hospital and detained me for 2 years. I really had nowhere to live. Then the hospital said they would move me to a care home for alcohol dependents. But I had to wait 8 months for them to place me, and when they

did, it was the wrong kind of support. So I did 3 care homes in 3 years. But now I'm happy here, and settled."

Diane, Care home service user, Major urban area

7.3.2 Being in the current home

At the time of interview, care home service users' mean length of stay was 5.2 years (SD = 5.9), ranging from two months to 28 years. When managers were asked how long their clients usually stayed within the service, they could not generally identify an exact length of time, but rather suggested it was dependent on the person and their capabilities. However, when pressed, 16 of 30 care home managers gave a response, with a mean duration of 3.4 years (Min = 1; Max = 8; SD = 2.22):

"It really depends on peoples' needs. We get people who move on after 6 months, some move on after 2 or 3 years."

Care home manager, Major urban area

Care home managers as a whole reported that 1.9 residents had moved in in the last year (SD = 2.1), but ten care home managers reported no new clients had moved in in the last 12 months.

7.3.3 Moving on

When asked if they would like to move anywhere else, 31 care home service users said they would not, three people did not know and there were four missing cases.

Most people who said they did not wish to move anywhere had previously been living in a structured environment, such as another care home or nursing home (10), psychiatric hospital (8), or psychiatric institution (4); for other previous locations see table 7.4. Indeed, for most it was not their first time in an SHS (18), and they may have had to move around frequently.

Table 7-4: Prior locations of care home residents who did not want to move (total n=31)

Prior location	Frequency	Percent
Care home	10	32.2
Psychiatric hospital	8	25.8
Psychiatric institution	4	12.9
Independent flat	4	12.9
Home with family/other	2	6.5
Supported housing	2	6.5
Hostel	1	3.2

Controlling for anxiety and depression problems, it was hypothesised that a care home service user who had lived in an equally or more supported setting beforehand and had been in the care home for longer would be associated with a less strong reported desire to move out.

For reference purposes, a cross-tabulation of these variables is presented in table 7.5.

Table 7-5: Cross-tabulation: wanting to move from a care home (total n=26) or want to remain (total n=31)

		Want to move		Total
		No	Yes	
Living with equal or more support beforehand	No	8	12	20
	Yes	23	14	37
Mean current length of stay (years)		7.4	3.2	5.2
Reported problems with anxiety on the EQ-5D-3L	No	22	14	36
	Yes	8	10	18

A chi-square test did not show any statistically significant associations between wanting to move out and problems with anxiety nor previous location (living with equal or more support). However, an independent samples t-test between current LOS and wanting to move out or not achieved statistical significance: $t(45)=2.682$; $p=.010$. Hence, care home residents who wanted to move

had been there for 3.2 years (SD=4.2), a shorter time period compared to people who wanted to remain. People who expressed no desire to move out of their care home had been there for a mean of 7.4 years (SD=6.9).

Combining these variables into a single model and controlling for anxiety or depression problems on the EQ-5D-3L, a binary logistic regression model was generated and was significant (Table 7.6). The model accounted for approximately 41% of the variance of wanting to move out of a care home (Cox & Snell $R^2=.310$; Nagelkerke $R^2=.410$). The Hosmer and Lemeshow goodness of fit test was not significant, indicating that the model fit the data well.

Controlling for anxiety and depression problems as measured by the EQ-5D-3L scale, care home residents expression of wanting to move was associated with not having lived somewhere with more support (such as hospital) directly before and with shorter lengths of stay.

Table 7-6: Wanting to move out of a care home: binary logistic regression

Variable	B	S.E.	Wald χ^2/χ^2	Df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Constant	2.068	.862	5.753	1	.016	7.910		
Previously living in equivalent/ more support	-1.970	.796	6.118	1	.013	.140	.029	.664
Current LOS (years)	-.251	.115	4.731	1	.030	.778	.621	.976
Anxiety/depression problems	.690	.748	.851	1	.356	1.993	.460	8.626
Omnibus tests of model coefficients			18.523	3	<.001			
Hosmer and Lemeshow goodness of fit test			4.881	7	.675			

On the other hand, people who did want to move aspired to move into an independent flat (13), or to less supported arrangements such as a supported housing service (8).

Of the 26 service users who wanted to move from their care home, 17 had not been in an SHS before.

The thirteen people who were thinking of moving straight from their care home into their own flat had been relatively independent prior to moving to the care home: they had been living in a hostel (3), a supported housing service, at

home with their family (1) or had been homeless (3). Three people, however, had been in hospital beforehand.

In contrast, the eight service users who had moved in straight from hospital were more conservative about their potential future trajectories, with only three reporting wanting to move to an independent flat, and the rest preferring to move to supported housing services.

"I'm scared of living on my own. Seen so many people go into that spiral and moving out when they were not ready and get back on the ward. I'd never want that. Then it's difficult to come back here. I would never put my placement in jeopardy. I think that independent living is of poor quality."

George, Care home service user, Large urban area

Contrasting care home residents' reported housing satisfaction scores by whether they wanted to remain in their home or move may provide an indication with regard to the aspects that mediate that desire. Significant associations were found with regard to housing satisfaction ratings and the reported desire to move or not, as identified by independent sample t-tests alongside Mann-Whitney (U) tests where appropriate (Table 7.7). The largest reported differences concerned the amounts of freedom, comfort and space, fellow tenants, as well as social situation. Satisfaction with privacy did not differ as markedly between people who wanted to move from and those who wanted to remain in their care home. Hence, a desire to move was generally associated with lower reported scores on selected aspects of housing satisfaction, compared to people who were happy to remain in their current accommodation. Further analyses, not reported here, did not find a significant association of length of stay when inserted into a linear regression model, and desire to move was still statistically significant across all satisfaction variables. Hence people who wanted to remain in their current home reported significantly higher housing satisfaction rates than their counterparts, regardless of current length of stay. The issue of housing satisfaction ratings is explored in greater depth in the next chapter.

Table 7-7: Housing satisfaction and wanting to move from a care home: significant differences and means

Variable	Mean of people who want to move (SD/N) (total n=26)	Mean of people who want to stay (SD/N) (total n=31)	U	Sig.	t(n)	Sig.
Social situation	64.5 (±19.7/26)	81.4 (±20.3/29)	n/a	n/a	3.072 (53)	.003
Housing service*	77.7 (±21.5/27)	92.1 (±11.2/26)	411.5	.001	3.058 (37)	.004
Community activities	61 (±27.2/23)	90.2 (±11.1/22)	n/a	n/a	4.746 (43)	<.001
Amount of space*	74.1 (±21.6/26)	92.3 (±8.8/25)	457.5	.008	2.592 (36)	<.001
Staff	79.7 (±20.6/26)	94.3 (±9.1/25)	n/a	n/a	3.340 (50)	.002
Amount of privacy	81.4 (±18.3/26)	91.3 (±10.5/25)	n/a	n/a	2.434 (51)	.018
Fellow tenants	64.7 (±22.4/25)	83 (±16.2/26)	n/a	n/a	3.352 (49)	.002
Amount of freedom*	72.1 (±29/25)	89.7 (±16.9/24)	450	.021	2.592 (31)	.014
Amount of comfort	72.6 (±19.6/26)	92.2 (±11.2/21)	n/a	n/a	4.375 (46)	<.001

*These ratings of housing satisfaction were non-normally distributed, so Mann-Whitney (U) tests are also presented. Further discussion on non-normal distributions with regard to housing satisfaction ratings can be found in chapter 8.

As mentioned in the introduction to this chapter, linear regression equations were estimated after analysing differences between groups, to test whether the variable for psychological disability (anxiety/depression problems on the EQ-5D-3L) was related to the independent variable in relation to the dependent one under scrutiny. Here, linear regressions were estimated, and the introduction of the psychological disability variable had no effect on the significance of the desire to move related to most ratings of housing satisfaction. However, for the dependent variables amount of freedom and social situation, the psychological disability and the desire to move variables were significant in the model, indicating that satisfaction in these cases was mediated by an interplay between wanting to move and reported problems with anxiety/depression. For reasons linked to thesis length, these will not be reported.

Care home managers' records indicated that 1.8 service users had left (SD = 2.44) in the previous year. Eleven managers said no service users had left during the past 12 months.

Managers were asked where their residents usually moved to and why they did so; their responses are summarised in table 7.8. Thus, according to care home managers, service users usually moved out because they required less support, and most commonly relocated to supported housing.

Table 7-8: Care home managers' thoughts on why people moved on and where to (total n=29)

Reasons to move/location	Frequency	Percent
Want less support	27	90
Relocate to supported housing	26	86.7
Person wants to move on	11	36.7
Relocate to independent flat	14	46.7
Want more support	8	26.7
Health or mental health deterioration, needs not met	7	23.3
Relocate to hospital	5	16.7
No longer want to live in care	4	13.3
Relocate to their own home	4	13.3
Tenancy breaks down	3	10
Relocate to rehabilitation unit	2	6.7

"I suppose they relocate from here to more independent living. Or maybe another period of rehabilitation elsewhere. The general aim would be for people to move into somewhere less supported. Maybe somewhere with staff 9 to 5."

Care home manager, Major urban area

"I guess they move because they don't want to live in a care home anymore. People who have moved into the community seem to be doing well. Others who have gone back to rehab seem to be bouncing from one rehabilitation centre to another."

Care home manager, Part rural area

The majority of care home managers (20) said that they encouraged their service users towards independent living. However, nine managers were opposed to the idea of people with mental health problems living alone in the community, because they believed they were incapable of doing so. The quotes below illustrate some of the standpoints of care home managers' vis-à-vis independent living:

"I suppose they all want to live in a flat on their own, and they aspire to have one, but it's different to what they really want. They need company. They might get caught up in a cycle of their accommodation breaking down because of social isolation, they end up back in hospital and eventually lose the flat."

Care home manager, Major Urban area

"We don't really put pressure on people. I mean, we actively promote independence through reviews and talking to people, teaching them to budget their money and enhancing their day to day skills. Everything is individualised and personalised. Basically, one of the most important tasks is teaching them to self-medicate and maintaining their own bank account. It's quite nice, often when people leave, they come back to visit us all. It's home."

Care home manager, Mostly rural area

"We do help encourage and support independent living. Some people won't be able to survive in independent settings. We tend to leave the door open as to what they want to do. If someone wants a step down from this, that's fine too. But there's always the danger of it becoming a vicious cycle...and the whole revolving door thing."

Care home manager, Mostly rural area

7.4 Supported housing service users' movements

7.4.1 Getting to the current home

Of the 15 people interviewed in supported housing services, less than half (N=6) had been living in a care home beforehand, and only two had been living in hospital; other common previous locations are presented in table 7.9. For seven people it was their first time in an SHS.

Table 7-9: Supported housing service users' place of origin (total n=15)

Place of origin	Frequency	Percent
Care home	6	40
Hospital	2	13.3
Independent flat	2	13.3
At home with family/other	2	13.3
Supported housing	1	6.7
Hostel	1	6.7
Homeless	1	6.7

Service users most commonly reported being referred through a social worker (5). Three people said they had been referred by the hospital (possibly following a short stay there), and two through a CPN. Other referral routes included their GP (1), self-referral (2), and psychiatrist (1).

All but one service user (14) conveyed having wanted to come to their current SHS. Many (12) justified being there because of a mental health problem; less than half said it was because they had no other place to go to. Five people were seeking less support and four just wanted to get out of hospital.

Again, many of these service users were living away from their places of origin (9), yet nearly all felt that the move had been a good decision. Moving into a supported housing scheme had been relatively easy, and very few mentioned experiencing any difficulty: two people said they had to wait a certain amount of time to find a placement, but none mentioned difficulties in obtaining funding:

"I used to have a council flat, but then I moved to hospital because I couldn't cope on my own. I really think it was a good thing to have moved here, I needed that little bit of extra support. It was a bit difficult to move at first because I was used to being in hospital for a long time."

Nasser, Supported housing service user, Very rural area

"I wanted more support because things got on top of me, and I've moved somewhere with less support...so it was a step back in order to move forward. I want to try to be as independent as possible."

William, Supported housing service user, Mostly Rural area

People were not usually shown anywhere else before moving in (12); but 11 supported housing service users expressed having the choice of where to live:

"Social worker [referred me]. Had to wait quite a long time, a couple of years. Just looked at this place. Don't like living in care...it's good for the people that like it, but it doesn't suit everyone."

Mary, Supported Housing service user, Very Rural area

"I was referred straight from hospital, because of the problems I had. I was referred to this house because it was time to move on from the care home that I had been in before hospital. I did have the choice of saying no, I'm not ready, but when you're ready, you're ready. And in that care home I felt I wanted more independence. And I guess I moved here because I've come this far and couldn't go any further there."

Tarek, Supported Housing service user, Mostly rural area

Managers most commonly said that their referrals were from: CMHTs (6), hospitals (4), self-referrals (3), early intervention teams (3), outreach teams (2), and other housing services (2). Hence, both managers and service users agreed that referral routes into supported housing were usually through the CMHT, and as more specifically noted by the latter, through social workers:

"It really depends on your Supporting People contract. Some services are not allowed to take self-referrals, we can. We take referrals from CMHTs, hospitals, early intervention teams. We just send a void to all of those and ask them if there's anyone in hospital or elsewhere that would like to move out."

Supported housing manager, Mostly rural area

"We usually take referrals from the CMHT, but also from individuals, families, GPs. But everything has to be done through an approved social worker. And based on their needs assessment it's decided what care they need. People don't bid for places here. They're put on a waiting list."

Supported housing manager, Major urban area

"We get referrals from everywhere. Assessment is made through a single-referrer system. They tell us what the needs of the service user are, the risk and suitability and where they'd like to be placed. The referral co-ordinator writes back to the individual."

Supported housing manager, Very rural area

7.4.2 Being in the current home

In terms of length of stay, service users had been living in their respective supported housing schemes for an average mean of 2.4 years (SD = 3.1), a shorter period compared to care home residents.

Managers (N=4) said that their clients stayed an average of 2.4 years (SD=.65) and they had had on average three (SD = 1.14) new clients register in the last 12 months. Compared to care home managers, supported housing managers were less reluctant to give a specific typical length of stay – understandable given that most service users were contracted with Supporting People for two years.

7.4.3 Moving on

The majority of service users in supported housing services were aiming to live on their own in the future (11). They were all seeking less support and wished to move on and reintegrate into the community. One wanted to move to another supported housing scheme, but the majority aspired to reside in independent flats. Four people did not plan to move out at all; they had all come from another supported housing scheme, care home or hostel.

A chi-square test was found to be statistically significant when testing for differences in reporting a desire to move out amongst people living in supported housing services compared to those living in a care home: $p=.042$, Fisher's exact

test, two-tailed. Frequency distributions reported in table 7.10 suggests that living in a supported housing scheme was associated with reporting a desire to move, and more specifically, that individuals in supported housing services were more likely to report a higher desire to move compared to people in care homes:

Table 7-10: Cross-tabulation: want to move out of a supported housing service versus care home

			Want to move		Total
			No	Yes	
SHS type	Care home	N	31	26	57
		%	54.4	49.1	
	Supported housing service	N	4	11	15
			26.7	73.3	

A binary logistic regression model (table 7.11) was produced to test whether this still held true after inserting the variable ‘current length of stay’. This model accounted for approximately 27% of the variance of wanting to move out of a supported housing service (Cox & Snell $R^2=.203$; Nagelkerke $R^2=.271$). The Hosmer and Lemeshow goodness of fit test was not significant, indicating that the model fit the data well.

Adding the variable ‘current length of stay’ to the model did not render the variable for supported housing service non-significant. Hence, controlling for anxiety and depression problems as measured by the EQ-5D-3L scale, service users in supported housing services expressed a higher desire to move compared to their counterparts. People who had been there for shorter periods of stay were also more likely to want to move.

Table 7-11: Wanting to move out of a supported housing service: binary logistic regression

Variable	B	S.E.	Wald χ^2/χ^2	Df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Constant	.461	.447	1.065	1	.302	1.586		
Living in a supported housing service (no=0; yes=1)	1.417	.738	3.683	1	.055	4.124	.970	17.527
Current LOS (years)	-.189	.078	5.916	1	.015	.827	.710	.964
Anxiety/depression problems (no=0; yes=1)	-.096	.551	.030	1	.862	.909	.309	2.673
Omnibus tests of model coefficients			16.150	1	.001			
Hosmer and Lemeshow goodness of fit test			7.030	8	.533			

"I plan to go to my own flat after this, somewhere near here. I'm looking forward to it. I'm a little bit nervous about being on my own and being lonely but I think it will be ok."

Robin, Supported housing service user, Very rural area

"I'm not really sure yet, whether I want to move out or not. It has come to a stage now where I have to move on, where I have to move back into the community. I would want to live a normal life and have my own flat, and I'm looking forward to that."

Tarek, Supported housing service user, Mostly rural area

According to managers, around 2.8 (SD = 2.05) service users had left in the last year, suggesting a high turnover rate compared to care homes.

Managers also said that service users usually left supported housing services seeking less support and because they wanted to move on (six manager accounts). One manager admitted that in some instances service users' needs had not been met: some had moved out of their service seeking additional support because their mental health had deteriorated.

Six managers reported that service users most commonly moved to flats of their own or to another supported housing service (2). Most managers hence reported positive move-ons, yet one manager had seen people move to hospitals and rehabilitation units:

"I guess they leave when they're ready to go. The person has identified different areas like finance, budgeting, shopping, and built skills towards them. They also need to have a structure to their day that they're comfortable with and most importantly have an understanding that their medication is making them stable and well."

Supported housing manager, Major urban area

"I suppose they move because they want to build relationships and of course move on with their lives. Their self-esteem should also be higher. We have nomination rights so we can nominate people to move on."

Supported housing manager, Part rural area

All supported housing scheme managers supported the idea of independence and reportedly promoted it amongst service users. One manager still expressed some reservations about people with mental health problems living alone in the community and possibly receiving inappropriate support. Managers felt that they achieved independence for their clients in part by giving them hope and encouragement (3) but mainly (five managers) by focussing on their skills and teaching them new ones, for instance with regard to cooking, self-care and looking after their home, in preparation for an independent life in the community; for other responses, see Table 7.12.

Table 7-12: Supported housing managers' answers on how they promoted independence amongst service users (total n=6)

Independence promotion	Frequency	Percent
Skills training	5	83.3
Give hope and encouragement	3	50
Give responsibilities	3	50
Promote choice	3	50
Teach self-medication	2	33.3

"Yes, I guess we do promote independence. We look at everyone as an individual, though. Some people can't move on within 2 years, so we work with them. We manage their expectations. And it's good because commissioners accept the fact that not everyone can move on in 2 years. We work towards recovery and service user engagement and encourage social networks. It's not all about negative things and being stuck in here. There's a lot of focus on prevention, more specifically hospital prevention as well and building up their self-esteem."

Supported Housing Manager, Very rural area

"Independence is definitely not for everyone. Some people are absolutely terrified of living on their own and having no one to rely on. And plus there's

the risk of getting into the whole revolving door cycle. We teach them how to manage their housing and tenancies. And also how to manage their potential landlords. It's all about empowering service users and getting them involved in their own tenancies."

Supported housing Manager, Very rural area

7.5 Shared Lives schemes clients' and people in independent living movements

Both the people in Shared Lives schemes and those in independent living were comparable, as they were not essentially receiving any structured support, and can be presented together

7.5.1 Getting to their current homes

Of the five people living in Shared Lives schemes, two had come straight from hospital and one from a similar scheme. One person had been living at home with family, and another in a care home. Two people had never lived in an SHS previously. Two people were living out of area.

None reported having seen any other placement before moving in to their current one. All expressed having had a choice of where to live, but two people said that they had initially not wanted to come to their current place. Two people moved because they did not want to remain in hospital; the rest justified their move because they wanted more support.

Three of the five had experienced problems moving in, due to the length it took to secure the placement. Indeed, it was common for them to feel depressed when they first moved because it took them a while to feel at home:

"They told me I needed to see a psychiatrist, because I was struggling a bit. I was here on respite at the start and then it dragged. The idea was attractive because I couldn't be in a flat on my own and they said that residential homes wouldn't suit me. I was living with my parents before this and have had treatments since the age of 13 and have partial learning disabilities as well as a mental health problem. And there weren't any difficulties with the whole moving process. They helped me move out from my family home. It took me a bit of time to get used to this place and feel at home."

Talal, Shared Lives service user, Mostly rural area

"I was living in another area before, but close to here. I went through a list of all available spaces and this placement was the only one available. I suppose it was hard to move here at first because I was living in my own home before, and it was just hard to adjust to being part of a new one."

Mandy, Shared Lives service user, Very rural area

"The Adult Placement Scheme Officer interviewed me in hospital about my housing prospects. I didn't really know what to expect. They asked me if I wanted to come with them to see the house. And things started looking up. I really felt relieved. And now I'm part of the family, it's my home."

John, Shared Lives service user, Very rural area

Two people had been referred via the hospital (and one, more specifically, via a psychiatrist) and the rest through the CMHT, either by a social worker or a care co-ordinator.

The second interviews with Shared Lives scheme managers differed slightly from the first, as additional questions were posed about how the schemes worked and recruitment procedures for Shared Lives carers, in order to gain a better understanding of how this distinct SHS operated. One Shared Lives *carer* was also interviewed.

Shared lives scheme managers were usually regional managers who were in charge of matching service users to families, training potential carers, and managing funding streams. Referrals typically came from the CMHTs, although one manager accepted self-referrals as well as referrals from hospitals:

"We usually get most of our referrals from the CMHTs. Some people are better than others at referring. Some know us better than others. The social worker, community psychiatric nurse or care manager really needs to know who we are and what we do, because usually service users don't know us."

Shared Lives social worker, Very rural area

"Referrals are usually made through social workers or care co-ordinators. We are in the process of accepting self-referrals. We work with them to put together a support plan identifying a possible match for carers, and also facilitate introductions, as well as visits to the carer's home."

Shared Lives unit manager, Very rural area

Two service users were living in independent flats and were receiving ad-hoc support. Both said they had been presented with a choice of where to live, and had exercised that choice – both had wanted to live in their present flats. Both individuals had moved from supported housing schemes as they were now ready to live on their own, and with no support. Neither reported any moving difficulties and both were living within the same area. They had been referred by the CMHT:

"I was living in a supported housing scheme for 2.5 years, then I went to move on flat for 6 months, just to see how I'd cope. It was time for me to

move on, I think. I like living on my own but still like to be involved with [charity] because I like to do it."

Christina, Independent living service user, Very rural area

7.5.2 Being in the current home

Shared Lives services users had been in their current homes for a mean of 5.2 years (SD=5.40).

Managers of Shared Lives schemes estimated that 10 new mental health clients registered every year (SD = 8.66). They were generally unable to give a specific timeframe, but one manager said service users typically stayed 4.5 years.

The Shared Lives carer could not give a response as to a typical length of stay; there were three services users with mental health problems living in their (family) home and all had moved in more than 12 months ago.

Otherwise, people who were living independently had only recently moved in to their flats (M=1.5; SD=0.7).

7.5.3 Moving out

Shared Lives service users had no desire to move anywhere else; all conveyed being happy where they were. Interestingly, they described their scheme as 'home'.

No service user had moved out of the carer's home in the last year. The carer rejected the promotion of independent living, adding that *"the guys here [we]re never going to get better or become independent"*:

"I suppose 'push' is a really emotive word. We encourage them to realise their potential. With certain people they need prompting and encouraging to maintain independence. We build on their skills. Obviously, some people will be in these schemes for life. However it's important for them to make their own choices, and we promote that, and take responsibility. We are basically family-based accommodation offering support in a natural home environment. People have as much support as they need, and it's very individualised and personalised and person-centred."

Shared lives co-ordinator, Mostly rural area

"It really depends. There are some examples of people who have gone on to live on their own. Some people had moved here from hospital and stayed for a long time and now live independently. And I suppose there are varying degrees of independence. And of course, wherever possible we would support people to move into less supported accommodation."

Shared lives unit manager, Very rural area

According to managers, two service users had left in the past year ($SD=1.73$), a minuscule number given the size of Shared Lives schemes (section 6.3.3.1). Two managers confirmed that Shared Lives supported the idea of service user independence, yet all agreed that service user capabilities were an important factor to consider. According to managers, carers promoted independence by giving service users responsibilities around the home (1), allowing them to make their own choices (3) and teaching them new skills and helping them regain old ones (1). Similarly to supported housing managers, Shared Lives managers thought that most of the moves out had been positive. All managers agreed that clients usually moved because they required less support (3) and wanted to move on (1); but on occasion their tenancy broke down, or the fit with the family proved dysfunctional (1). Three managers had clients who moved on to their own independent flat:

"There is no specific pattern, and not many have left Shared Lives. It's usually because of a breakdown in tenancy as not enough information was supplied about the severity of their mental health problem. Some, I guess, would move because it's the wrong place. Others because they've acquired the skills and are ready for independent living."

Shared lives co-ordinator, Mostly rural area

Individuals living in independent flats reported being happy with their current situation, with no desire to move anywhere else.

7.6 Experiences in psychiatric hospital and delayed discharge

Most sample participants (62) had reportedly stayed in a psychiatric hospital at some point within their lifetimes. Four could not recall how long they had stayed for, and data were missing for eleven people.

Although subject to possible recall bias, the mean reported length of stay of people who recollected their last stay in hospital was 21.6 months ($SD = 44.47$). This ranged from a week to 20 years; the median was seven months. People usually cited mental health problems as their reason for being admitted to psychiatric hospital (44) or indicated that they were sectioned (19). Substance misuse (3) was also mentioned, as well as one case of brain injury.

When asked to recount their experiences in hospital, 13 people in this sample reported that they had been delayed unnecessarily, arguing that they could

have been discharged earlier, mainly due to no placement being available for them to move into (9), or no place would take them (3). One person had been delayed in hospital awaiting a decision from the Ministry of Justice. The majority of people experiencing delayed discharge had a diagnosis of schizophrenia or schizo-affective disorder (the most common psychiatric diagnosis in this study sample).

"I definitely stayed longer than I should have. I was ready to leave but had to stay for 2 extra months because they couldn't find me somewhere to go."

Samantha, Care home service user, Major urban area

7.6.1 Delayed discharge: factors and outcomes

Delayed discharge varied in length; most people were held back for up to six months (6), others up to a year (3) and one person for more than that (six people were uncertain about how long it was for). Many service users (26) qualified their hospital experience as 'difficult', including 10 who reported having been delayed in hospital.

"It was a difficult transition from hospital to residential care. I had to wait a year in hospital for them to find me somewhere to move to. And when I finally did move, it was really difficult to do everything on my own, like cooking and cleaning...when I wasn't used to it and wasn't ready to take on those kinds of responsibilities."

June, Care home service user, Major urban area

Independent samples t-tests were conducted to compare experiences in psychiatric hospital by individual characteristics and support settings (care home versus supported housing). Significant differences were reported according to SHS type.

People in care homes in this study experienced much longer psychiatric hospital stays, expressed here in months ($M=28.2$; $SD=53.5$) than people in supported housing services ($M=6.6$; $SD=9.1$); $t(40)=-2.303$, $p=0.026$. However, controlling for problems with anxiety or depression on the EQ-5D-3L, the independent variable 'housing type' was rendered statistically insignificant with regard to the length of psychiatric hospital stay, indicating that reporting current problems on this scale may explain longer stays.

Chi-square tests were also conducted to explore whether having been delayed, or reporting difficulties in hospital had any association with subsequent

experiences in an SHS. Significant differences were found between having experienced difficulties in hospital and reporting having a choice of where to live.

Care home and supported housing service users who reported facing difficulties in psychiatric care were more likely to say that they did not have a choice of where to live compared to the latter, and the relationship approached statistical significance: Pearson's $\chi^2(1)=3.303$, $p=.069$ (table 7.13).

Table 7-13: Cross-tabulation: experiencing problems in hospital

			Problems in hospital		Total
			No	Yes	
Had a choice of where to live	No	N	15	13	28
		%	53.5	46.4	
	Yes	N	25	8	33
		%	75.7	24.2	

7.6.2 Comparisons with national data

The Mental Health Minimum Dataset (MHMDS) keeps a record of average length of stay in hospital per record by year for patients with psychiatric problems (Health and Social Care Information Centre, 2011b). Compared to data from this study, there are some differences (Table 7.14), including a much larger proportion of the whole population spending up to a month in psychiatric hospital, compared to the sample currently in an SHS. The latter were most likely to have spent three months to a year, or over one year in hospital. The most comparable lengths of stay between this study and MHMDS data were in the case of stays lasting between two and three months.

Possibly, people currently in an SHS are more disabled by their condition, compared to the general population of mental health service users.

Table 7-14: Length of stay in psychiatric hospital: a comparison between study data (total n=58) and MHMDS data

Type of study	Length of stay categories									
	Up to 30 days		31-60 days		61-90 days		91 days to one year		Over one year	
	N	%	N	%	N	%	N	%	N	%
Thesis data	2	3.4	4	6.9	4	6.9	25	43.1	23	39.7
MHMDS data (2010-11)	57,992	53.5	19,260	17.7	9,851	9.1	16,332	15.1	4,911	4.5

7.7 Long-stay psychiatric patients

As mentioned, there were four people who had been living in a long-stay psychiatric hospital (or ‘asylum’) before moving to their respective SHS. All were now living in care homes and some of their characteristics are presented in table 7.15. All had wanted to leave their ‘institutions’, and had been relocated to their respective care homes without having the chance to visit other settings to compare. None felt they had been presented with a choice. All wanted to remain in their current SHS; their current mean length of stay was 10 years (SD=7.8), ranging from two to 20 years. One person was living out of area.

Table 7-15: Long-stay psychiatric patients (total n=4) descriptive statistics: means, standard deviations and frequencies (where applicable)

Variable	Frequency [*mean /(SD)]
Age*	55 (±7.1)
Have a job	1
Male	2
Single	2
Less than secondary school education	2
Secondary school or equivalent	1
Master’s degree	1
White British	4
Psychiatric diagnosis: schizophrenia	2
Psychiatric diagnosis: learning disability	1

Variable	Frequency [<i>*mean /(SD)</i>]
Psychiatric diagnosis: bipolar affective disorder	1
Average number of months spent in psychiatric hospital*	12.5 (± 7.8)
EQ-5D-3L VAS rating*	75.8 (± 20.8)
Mobility problems (EQ-5D-3L)	1
Self-care problems (EQ-5D-3L)	2
Usual activities problems (EQ-5D-3L)	2
Pain problems (EQ-5D-3L)	1
Anxiety problems (EQ-5D-3L)	1

7.8 Further studies and analyses

Although employment is discussed in detail in chapter 9, three service users had mentioned in their interview that a barrier to their employment was their current housing status, and that a change in their current circumstances was necessary in order to obtain a job:

“At the moment I don't think I can cope with a full-time job. Maybe in the future, when I move into my new flat. And anyway, there will come a time when I won't have a choice but to get a job.”

Robin, Supported Housing service user, Very rural area

Here, a person's desire to obtain a job is tested against their wish to move out of their SHS. Working-age service users in care homes and supported housing services who wanted to move were more likely to report wanting a job in the future, compared to people who did not want move (see table 7.16), as identified by a significant Fisher's exact two-tailed test, $p=.007$. A possible explanation is that people may feel somewhat restricted in care, or in their SHS, and would only be able to work once they have reintegrated fully into the community (this is discussed further in chapter 9).

Table 7-16: Cross-tabulations: Wanting to move from a SHS and wanting to work in the future

		Want to move		Total
		No	Yes	
Would like to be employed	No	18	3	21
	Yes	14	16	30

7.9 Discussion

This chapter has explored the experiences of individuals as they move into and possibly out of an SHS, their points of origin and their potential trajectories from their perspectives, as well as those of managers’.

Evaluating the sample of service users

Comparisons to a recent study conducted in the UK which collected similar data (Priebe, et al., 2009), showed that care home service users in this study had shorter stays (at the point of interview/survey) and were more likely to be experiencing an SHS for the first time. The pattern in terms of length of stay is reversed for people in supported housing – clients in the Priebe al. study had been there for a longer time. However, people in supported housing services in this study were more likely to have had no previous experiences in an SHS compared to the other study. Although these results can be directly compared, it must be noted that data for the Priebe et al. study was supplied by managers using client records, whereas the information in this study may suffer from recall biases.

The journey into an SHS

Pathways into housing seemed to follow a somewhat downward linear progression with respect to support.

Although conducted nearly two decades ago, the *Housing Pathway Pilot Programme* (Watson, 1996) was designed to assess housing need amongst the ‘community care’ population including people with mental health problems; comparisons can be tentatively made to this study. In the Watson study, among the sample of 52 people with mental health problems living in residential homes or shared housing, almost half had moved in directly from long-stay hospitals, and 13 were previously in another residential home. In the Watson study, only one person had moved in from being at home with family, and overall no people were out of area. One care home service user expressed the desire to move. As previously discussed, care home service users in this study had moved in most frequently from hospital or other care homes, similarly to the Watson study. The differences lie with

regard to out-of-area placements, and people's desire to want to move (more vocalised in this study).

Within supported housing schemes, there was also a high proportion of out of area placements, contrasting with data collected by the CHR (2012d), where 94% of referrals were host ones, or local. CHR data (Centre for Housing Research, 2012a) comparisons also revealed that a larger proportion of people in this study had come from other care homes, and fewer from local authorities or private tenancies. However, referral routes into supported housing were similar, the CHR (2012c) also ranked CMHTs the highest in terms of referring bodies.

Psychiatric hospital experiences

Experiences in hospital were also explored, as hospital is a major gateway to SHSs. Some service users found their experiences difficult, with some reporting that their discharge had been delayed.

Similar to the findings of this study, the reasons given by mental health patients for delayed discharge in the previous literature revolved around a lack of suitable accommodation (Fulop & Koffman, 1992; Fulop et al., 1996; P. Lelliott & Wing, 1994; McDonagh et al., 2000; Sainsbury Centre for Mental Health, 1998; Shepherd, et al., 1997).

The rates reported in the literature of delayed discharge varied widely, most likely due to the subjective assessment of inappropriate placement – in most studies, it was psychiatrists or nurses who were asked to judge whether a certain placement was appropriate, and whether a patient should have been discharged earlier. These assessments also differed by staff characteristics. In a one-day census of all patients occupying psychiatric beds in an inner-London District Health Authority (Fulop & Koffman, 1992), medical, nursing and social work staff were independently asked to enumerate inappropriate placements within their wards and responses varied extensively. Reported rates of delayed discharge also varied due to a lack of standard definitions and guidelines for what constitute all or part of a psychiatric in-patient stay in the UK (Bartlett et al., 1999). A strength of this study was that it obtained accounts of delayed discharge directly from the perspectives of service users, but like psychiatric hospital stays, these are subject to recall biases.

Although not age-standardised (and including service users over the age of 65) data from the Hospital Episode Statistics (Health and Social Care Information Centre, 2012a) show an average length of stay in England for patients with schizophrenia (the most common diagnosis in this thesis study) of 101.8 days, shorter than this study.

Significant differences found by support types

In general, service users seemed to be evenly split between wanting to move out and wanting to remain where they were. Further analyses revealed that SHS type was significant in this case: people in supported housing services were more likely to report wanting to switch homes or move into less supported environments, compared to the people in care homes. There might be several factors mediating this: the expectations of supported housing managers, who in turn were more enthusiastic about 'independence', their Supporting People contracts, and their possible relative dissatisfaction with their surroundings or their homes. Within care homes, there were more people who wanted to stay compared to individuals who wanted to move; people who wanted to move were less satisfied with certain aspects of their lives.

The majority of people in supported housing schemes in this study wanting to move out mirrors research by Fakhoury et al. (2005), although a definition of what supported housing is was not provided in their study. Their aspirations, in terms of accommodation, may reflect the reality of others' experiences: the majority of people in SP-funded supported housing schemes went on to live in local authority general needs tenancies, or other supported housing services, according to the CHR (2012f).

Indeed, managers provided useful information with regard to SHS pathways. An interesting finding was that all the supported housing managers said that they promoted independence for their service users, and aspired for them to move on; yet many care home managers did not share this view. The Fakhoury et al. (2005) study found little agreement between clients' stated goal and those of staff. However, in this study could supported housing managers be influencing their service users to express a greater desire for independence?

In an early study of the aftermath of deinstitutionalisation, Oliver and Mohammad (1992) found that service users in private-sector boarding-out homes (sort of a fostering scheme) enjoyed the least amount of independence, less than their peers in voluntary-sector group homes, even though the latter were older. Analyses from this study show that, similarly, people in voluntary sector supported housing schemes were more likely to express a desire to move, and may have been more autonomous. Although results by Oliver and Mohammad (1992) focussed on provider types, actual differences between them may actually be due to the different support levels offered by the homes within each sector, where voluntary-sector group homes may have been more 'permissive' than private-sector boarding out homes.

These results possibly suggest, since psychological disability was not an apparent confounder in this case, that 'a desire to move out' may be a feature of the home and the rules that 'govern' it, rather than a characteristic of the resident.

Exploring choice and independence

All the people interviewed in Shared Lives schemes wanted to remain there, saying that this was their 'home'. With regard to moving in, none had visited other placements, two had said that they had originally not wanted to come, yet all expressed having a choice of where to live.

Compared to people in supported housing services, some service users seemed to have been less willing to have moved to their care home. Yet one would have assumed that moving out of hospital (their most common previous location) would seem desirable. Further investigation of the 23 people living in care homes who had not wanted to move in revealed that they had for the most part (13) been living in less supported surroundings, such as with family (5) or in flats of their own (3). Only four people had been in hospital immediately beforehand; the rest had been living in other care homes. Hence, a possible reason for their not wanting to move in this case may be because they had been forced out of environments where they had been happy, and into sometimes more supported environments. Indeed, as table 7.6 suggests, wanting to move out of a care home was associated with lower reported housing satisfaction ratings.

It would seem that the mechanisms for gaining independence and the expression of *choice* were not completely straightforward, and there were possibly more factors at play here, perhaps directly tied to a person's SHS type as well as expressed housing satisfaction. The biggest differences between reported housing satisfaction scores between care home residents who wanted to move and those who wanted to stay were found with ratings of freedom, comfort, space and social situation. Could these be important precursors for people to want to move? All of these issues warrant deeper exploration and could be analysed further in the qualitative analysis.

Otherwise, wanting to move was positively associated with wanting to obtain a job, controlling for age. This may indicate that people aspired to fulfilled, autonomous lives, a prospect that may be hindered by their current residential situation.

Generally, it would seem that the sample of service users in care homes and supported housing services in this study are comparable to those seen in the previous literature (Fakhoury, et al., 2005; Watson, 1996) and current CHR data in terms of pathways and movements. Yet they differed in terms of lengths of stay in SHSs (Priebe, et al., 2009) and hospital (Health and Social Care Information Centre, 2012a).

Another apparent strength of this study was that a proxy measure of psychological disability was included in all analyses, either directly, as a control in binary logistic regressions, or indirectly as a robustness check after independent samples t-tests.

In all analyses in this chapter, reporting problems with anxiety or depression on the EQ-5D-3L produced no change in the significance of an independent variable in relation to a dependent one. However, in two instances, it was found that these problems may have played a part in the lower reported satisfaction scores of freedom and social situation felt by care home residents expressing a desire to move out.

Nevertheless, one needs to be aware of other factors that may not have been apparent in this study, or not measured, that mediated a person's desire to wanting to move out or not.

Chapter 8 Experiences within Specialist Housing Services

8.1 Introduction

Most UK policies have population well-being at the heart of their respective agendas (see chapter 2). From 2000, the importance of a decent home for positive well-being was promoted for service users with mental health problems (Department of the Environment Transport and the Regions, 2000), with a particular focus on independence as conducive to better well-being (Department of Health, 2005b). More recently, the *Healthy Lives Healthy People* White Paper underlined the significance of endorsing the mental health and well-being of the whole community, with a special focus on prevention and support for people with mental health problems (Department of Health, 2010).

Little research has been conducted on the housing satisfaction of people with mental health problems living within SHSs in England, with most previous studies focusing on outcomes post-deinstitutionalisation. Most studies of satisfaction, originating from the United States, have tended to focus on the homeless population (Schutt, et al., 1997; Tsai et al., 2012; Yanos et al., 2004).

This chapter explores the housing satisfaction of study participants with respect to their experiences of living in an SHS, including the reports of managers concerning their service users. One section is also dedicated to the challenges faced by service users, according to managers, as this relates to their housing experience.

The review of the literature (chapter 3) uncovered several factors were associated with reported satisfaction: environment cohesiveness, independence and autonomy promotion, perceived choice, housing appropriateness, SHS type and restrictiveness within it, as well as the role, expectations and experience of managers. Past housing histories may have an influence as well (Shepherd, et al., 1996). Each of these factors is explored here in relation to SHS residents.

8.2 Preparing the data and variables used

8.2.1 Service users' answers

Housing satisfaction variables were obtained from the modified Schutt et al. (1997) questionnaire (section 5.4.2.1); this corresponds to section C of the service user interview schedule used in this study. These variables were on a continuous scale, and some statistical tests (such as independent samples t-tests and ANOVAs) assume the data to be normally distributed. So, before embarking on specific group comparisons, the data distribution was explored. Analyses of normality using Shapiro-Wilk tests found that the following aspects of satisfaction were non-normally distributed: housing situation, amount of space, income, and amount of freedom. All other variables achieved significance levels beyond that of 0.05 and were assumed to be normally distributed.

8.2.2 Managers' answers

Like service users, managers were asked to rate the same aspects of housing satisfaction (staff, social situation, privacy, etc.; see section E of manager interview schedule). However, managers were instructed to evaluate these aspects as how important they believed they were to service users, for example: "How important do you think service users' social situation is to them?". Managers were asked to provide an answer on a scale from 0 to 100 (0 being very unimportant and 100 very important). Analyses of normality using Shapiro-Wilk tests found that all variables, except community experience and employment, to be non-normally distributed.

8.2.3 Accounting for non-normal distributions

For the non-normally distributed variables, and to calculate differences between two groups, the Mann-Whitney test for non-parametric data will be presented alongside independent samples t-tests for robustness. Homogeneity of variances was always tested for using Levene's test, and the corresponding t-test reported accordingly.

8.2.4 Considering psychological functioning

Linear regression models were estimated after every independent sample t-test or chi-square test to ascertain whether the independent variable was still significantly associated with the dependent variable in this case, after controlling for problems with anxiety/depression on the EQ-5D-3L. For simplicity, only in the cases where this condition was violated, was this mentioned as it may be a confounder to the results of the analysis. All other analyses must be assumed to be non-confounded by psychological functioning.

8.3 Housing satisfaction of service users

Although most service users were able to complete the housing satisfaction scale, there were some missing data, as people sometimes struggled to score their level of satisfaction in a particular domain. For example, only 14 of the 21 employed people answered the job satisfaction question and it was not applicable to those who were unemployed. On average, 78 of the 86 service users answered the rest of the housing satisfaction questions. This relatively high response rate varied according to specific questions and different SHSs. Aside from the job satisfaction aspect, less people in supported housing and care homes answered the community satisfaction question, compared to other answers. The two individuals in independent flats answered all questions (except the one relating to other tenants, since they were living alone).

Service users in general felt most satisfied with the staff ($M=86.5$; $SD=16.59$), their housing situation (Median=90; $M=84.8$; $SD=16.71$), and their degree of privacy ($M=83.9$; $SD=17.33$). Satisfaction levels were lower in questions relating to their social situation ($M=73.9$; $SD=19.91$), community activities ($M=74.4$; $SD=22.29$) and fellow tenants ($M=74.3$; $SD=20.59$).

Table 8-1: Service users' housing satisfaction levels by SHS type

	Care Home					Supported Housing					Shared Lives					Independent living					Total samples				
	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD
Social situation	61	10	100	72.6	20.9	15	50	100	77	18.4	5	70	90	78	8.4	2	65	100	82.5	24.7	83	10	100	73.9	19.91
Housing situation	59	25	100	83.9	18.2	15	60	100	86	11.9	5	80	100	92	8.4	2	70	100	85	21.2	81	25	100	84.8	16.71
Community activities	49	0	100	75.8	24.5	12	40	100	68.3	15.3	5	60	90	80	12.2	2	50	70	40	14.1	68	0	100	74.4	22.29
Job	5	70	100	86	13.41	7	50	100	80.7	20.5	0	-	-	-	-	2	20	60	40	28.3	14	20	100	76.8	23.66
Income	57	0	100	86	13.4	15	50	100	77.3	19.4	4	45	100	73.7	22.8	2	50	90	70	28.3	78	0	100	74.1	26.33
Amount of space	59	20	100	83.3	18.3	15	20	100	82.3	21.5	5	70	100	86	11.4	2	50	80	65	21.2	81	20	100	82.8	18.54
Staff	57	20	100	86.3	17.4	15	50	100	85.3	15.1	4	80	100	93.7	9.5	2	50	80	65	21.2	76	20	100	86.5	16.58
Amount of privacy	59	30	100	86.8	15.2	15	50	100	74.7	21.9	5	70	100	85	6.7	2	50	80	65	21.2	81	30	100	83.9	17.33
Fellow tenants	57	0	100	73	20.8	15	40	100	79.7	21.7	3	70	80	73.3	5.8	-	-	-	-	-	75	0	100	74.3	20.59
Amount of freedom	57	0	100	81.2	23.9	15	40	100	79.7	21.7	5	70	100	90	12.2	2	60	90	75	21.2	78	0	100	82.7	22.06
Amount of comfort	54	35	100	82.8	17.9	15	50	100	82	16.1	5	70	100	86	15.2	2	80	100	90	14.1	76	35	100	83	17.06

8.3.1 Housing satisfaction by specialist housing service types

Table 8.1 shows the mean housing satisfaction levels in each domain by SHS type. As noted, the number of residents in Shared Lives schemes and independent living are very small, so comparisons are made only between people in care homes and people in supported housing services.

Independent samples t-tests tests were conducted on all responses. The only significant difference found was with reported satisfaction with privacy. People in care homes reported much higher scores for their satisfaction with privacy (M=86.8; SD=15.2) compared to people living in supported housing services (M=74.7; SD=21.9); $t(72)=-2.513$, $p=0.014$.

Even when controlling for home size, current length of stay, psychological disability, care home residents reported significantly higher satisfaction scores in terms of privacy than their counterparts in supported housing settings (see table 8.2). The regression model for satisfaction with privacy was statistically significant (total $n=68$), and accounted for approximately 14% of the variance of satisfaction with privacy. The Durbin-Watson statistic was computed to evaluate independence of errors and was at 1.574, which is considered acceptable, and suggests that the assumption of independent errors has been met. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a relatively normal distributional shape. Homogeneity of variance was also met.

Table 8-2: Multiple linear regression: satisfaction with privacy

Variable	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	73.275	5.865	12.493	<.001	61.558	84.992
Lives in a care home	14.017	5.237	2.676	.009	3.555	24.478
Number of people living in SHS	.106	.277	.383	.703	-.448	.660
Current LOS	.130	.389	.333	.740	-.648	.907
Problems with anxiety	-5.850	4.314	-1.356	.180	-14.468	2.767
ANOVA			2.579	.046		
Model fit			$R^2=0.139$; Adjusted $R^2=0.085$			

Although statistically significant differences were not tested, the data suggests that people living in Shared Lives rated their homes, carers, and their amount of freedom extremely highly (table 8.1). However, the two persons living in flats on their own rated their satisfaction lowest for their community activities, income and amount of space. They also did not rate the ad-hoc support (labelled as staff in table 8.1) they received very highly either.

Interestingly, people living in care homes gave the widest range of answers with regard to community activities, income, fellow tenants and amount of freedom, possibly indicating that they harboured strong feelings towards these aspects, as these ranged from 'extremely dissatisfied' to 'extremely satisfied'. Consequently, two of these variables (income and amount of freedom) had been found to be non-normally distributed. The sample of care home residents was also the largest, possibly allowing for a greater diversity of answers. With regard to amount of privacy, the range was also wide, wider than that given by people in supported housing schemes.

8.3.2 Housing satisfaction by population density

The type of area (see table 6.2) care home and supported housing service users lived in was strongly associated with housing satisfaction levels. Table 8.3 shows that independent samples t-tests identified four statistically significant relationships between population density (binary variable) and housing satisfaction: social situation ($t(74) = -2.246$, $p=.028$), staff ($t(70) = -2.574$, $p=.007$), housing situation ($t(42)=-1.977$, $p=.050$; $U=553.5$, $p=.054$) and amount of comfort ($t(67)=-2.482$, $p=.016$).

Table 8-3: Means and significant associations between population density and housing satisfaction ratings

Variable	Population density	N	Mean	Standard deviation
Social situation	Urban	28	66.7	20.9
	Rural	48	77.4	19.3
Staff	Urban	26	78.9	20.5
	Rural	46	87.7	13.9
Housing situation	Urban	28	79.1	21.4
	Rural	46	87.9	13.9
Amount of comfort	Urban	25	75.9	20.9
	Rural	44	86.4	13.9

Overall, people living in urban areas were much less satisfied in terms of their social and housing situations, the staff and their amount of comfort compared to people living in rural areas. However, it must be noted that most people in urban areas were for the most part care home residents, and this may have contributed to the variance in housing satisfaction ratings.

For all aforementioned relationships except satisfaction with other residents or tenants and housing situation, the independent variables psychological disability (as measured by the EQ-5D-3L) and population density were significant in linear relationships. This indicates that while population density is significant in contributing to variances in satisfaction ratings, psychological disability may have also had an effect; all later regressions in this chapter control for psychological disability in the model. For satisfaction with fellow residents/tenants and housing situation, and controlling for psychological disability (not significant), population density was significant (using linear regression).

Taking into consideration the nominal variable for population density, the differences mainly lie between major rural and major urban areas, as identified by the Scheffé post-hoc criterion for significance. More specifically, people in MR areas were more satisfied with their social situation ($p=.039$), staff ($p=.033$), and comfort ($p=.042$) than people in MU areas. With regard to housing situation, the difference between MR and MU areas approached significance ($p=.060$).

8.3.3 Other factors affecting specific aspects of housing satisfaction

As relatively little research has been conducted with regard to specific aspects of housing satisfaction (for example social situation and freedom), the following analyses are exploratory in nature. The following analyses will only consider people in supported housing and care homes.

A Pearson's correlation was computed to assess the relationship between the number of people living in an SHS (as reported by managers) and ratings of housing satisfaction. An association with satisfaction with social situation was the only significant correlation found: $r(76)=0.256$, $p=0.026$. Taking into consideration only care homes and supported housing schemes, homes with more residents were associated with higher ratings of satisfaction with social situation, probably because the greater diversity of people on-site led to more opportunities to form relationships. Older age was positively correlated with specific aspects of satisfaction, such as housing situation ($r(74)=.253$, $p=.030$), community activities ($r(61)=.262$, $p=.041$), staff ($r(72)=.286$, $p=.015$), and comfort ($r(69)=.413$, $p<.001$). For the satisfaction variables staff and comfort, age and problems with anxiety were statistically significant in linear regression models, indicating that whilst older age was associated with higher satisfaction ratings, experiencing problems with anxiety was associated with decreases in specific aspects of housing satisfaction.

To identify which variables were associated with ratings of social satisfaction within an SHS, it was hypothesized that engagement in various activities, as well as being part of a home with a higher number of residents would be associated with higher reported social satisfaction, as it would create more opportunities to meet people. The most frequent types of activities service users engaged in were tested, extracted from the first question, as well as questions 34 to 41 of the service user interview schedule (activities are discussed in detail in chapter 9).

The backward linear regression model for social satisfaction contained two of the 'activities' variables, in addition to the size of home variable and was obtained in 12 steps (keeping problems with anxiety/depression on the EQ-5D-3L in). The frequency statistics of these variables are presented first (table 8.4).

Table 8-4: Frequency statistics: satisfaction with social situation

Variable of interest	Total n
Engages in religious activities	21
Engages in outdoor sports	19
Enjoys activities such as reading and writing	22
Participates in hobbies	31
Goes to the pub	15
Goes to the library	15
Goes out for a meal	17
Goes to the day centre	13
Number of people in home*	79
Stay in and watches television	45
Engages in educational activities	8
Goes shopping/into town	20
Problems with anxiety/depression	25

(*: N valid cases)

The final linear regression model for satisfaction with social situation within care homes and supported housing services (table 8.5) contained three variables and was statistically significant (total n=71), and accounted for approximately 34% of the variance of satisfaction with social situation. The Durbin-Watson statistic was computed to evaluate independence of errors and was at 1.833, which is considered acceptable, and suggests that the assumption of independent errors has been met. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a relatively normal distributional shape. Homogeneity of variance was also met.

Hence, satisfaction with social situation was associated with lower levels of anxiety problems on the EQ-5D-3L, engaging in activities such as reading and writing as well as outdoor sports, and to a lesser extent with living in a bigger SHS.

Table 8-5: Multiple linear regression: satisfaction with social situation

Variable	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	62.078	5.816	10.673	<.001	50.472	73.685
Enjoys activities such as reading and writing	14.553	4.493	3.239	.002	5.588	23.518
Engages in outdoor sports	13.012	4.639	2.805	.007	3.755	22.268
Size of home	.514	.264	1.949	.055	-.012	1.041
Problems with anxiety	-14.818	4.304	-3.443	.001	-23.407	-6.229
ANOVA			8.775	<.001		
Model fit			R ² =0.340; Adjusted R ² =0.302			

A backward linear regression was fitted to check whether social cohesion, perceived choice, being active within the home and outside, population density and possible proximity to services, specifically living in a major urban area, the existence of rules within the home (home restrictiveness), age and a need for greater independence were associated with satisfaction with housing situation within care homes and supported housing services. Keeping the variable for problems with anxiety/depression in, the final model contained three of the 11 original variables and was obtained in seven steps (see table 8.6 for frequency statistics).

Table 8-6. Satisfaction with housing situation: frequency statistics

Variable of interest	Total n
Lives in major urban area	19
Age	68
Reports move as being a good decision	68
Reports rules within the service	3
Outsiders cannot stay overnight	4
Involved in any activity outside the home	73
Wants to move out of SHS	27
Had a choice of where to live	42
Saw other SHSs before deciding to move in	18
Problems with anxiety/depression	25

The model (table 8.7) was statistically significant (total n=65) and accounted for approximately 25% of the variance of satisfaction with housing situation. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a relatively normal distributional shape. Homogeneity of variance was also met.

Having adjusted for psychological functioning on the EQ-5D-3L, satisfaction with housing situation was primarily associated with the service user not wanting to move out of their SHS, and not living in a major urban area (only marginally significant).

Table 8-7: Linear regression: satisfaction with housing situation

Variable	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	94.842	3.117	30.425	<.001	88.611	101.074
Wants to move out of SHS	-10.463	4.014	-2.607	.011	-18.486	-2.440
Lives in major urban area	-8.789	4.663	-1.885	.060	-18.109	.532
Problems with anxiety	-5.218	4.121	-1.266	.210	-13.454	3.019
ANOVA			5.383	.002		
Model fit			R ² =.255 Adjusted R ² =.226			

In some instances, community activities had received a low score from study participants. As these were mostly exploratory analyses, a backward linear regression was fitted to check whether population density, types of activities, age, being in receipt of benefits and being in a more supported environment prior to moving to the current SHS were associated with satisfaction with community activities within care homes and supported housing services. Three variables were retained after seven steps (keeping problems with anxiety/depression on the EQ-5D-3L in), and the model was statistically significant (see table 8.8 for frequency statistics).

Table 8-8: Satisfaction with community activities: frequency statistics

Variable of interest	Frequency of answer
Involved in religious activities	21
Receives DLA	57
Attends day centre	13
Living previously in more supported environment	39
Age*	68
Lives in major urban area	19
Engages in religious activities	21
Engages in outdoor sports	19
Participates in hobbies	31
Goes to the pub	15
Problems with anxiety/depression	25
Goes to the library	15

(*: N valid cases)

The linear regression model (total $n=44$; table 8.9) accounted for approximately 22% of the variance of satisfaction with community activities. The Durbin-Watson statistic was computed to evaluate independence of errors and was at 2.077, which is considered acceptable, and suggests that the assumption of independent errors has been met. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a relatively normal distributional shape. Homogeneity of variance was also met.

Controlling for psychological functioning, satisfaction in this instance was primarily associated with taking part in religious activities and going to the day centre, and to a lesser degree with receiving DLA. DLA is the largest amount of benefits awarded. Its receipt enables people to participate in community activities, such as going to church, the gym or attending a day centre, activities that would not be possible if money were not available for transport. Both attending a religious centre and going to a day centre regularly might also provide a heightened sense of community belonging.

Table 8-9: Linear regression: satisfaction with community activities

Variable	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	48.818	9.522	5.127	<.001	29.628	68.008
Involved in religious activities	14.732	6.969	2.114	.040	.687	28.776
Receives DLA	18.602	9.538	1.950	.058	-.620	37.823
Attends day centre	15.802	9.538	1.950	.037	.980	30.624
Problems with anxiety	-4.086	6.322	-.646	.521	-16.828	8.656
ANOVA			3.011	.028		
Model fit			R ² =.215; Adjusted R ² =.144			

Direct quotes from care home and supported housing service users illustrate care home and supported housing service users' particular experiences with people in their homes:

"It's been such a positive experience, and I've really enjoyed the socialising. On top of that, I've been learning skills to keep my own flat. I've met so many people."

Kate, Care Home service user, Large Urban area

"I've really enjoyed my time here and it will be sad to leave. But it's a step in the right direction. Culturally, it will offer me more options and I will be closer to friends and family. Still I won't forget this place, I'll come and visit frequently to see everyone here and go to the day centre."

Raoul, Care home service user, Part rural area

"The house is really nice, and I'm very well looked after. The people living here and staff are all very nice. Things are really good here. I have no problems."

Robin, Supported Housing service user, Very rural area

When asked, most people in care homes and supported housing schemes said they had 'some' friends (N=24), but 19 people said they had no friends at all, and 20 replied that the only people they would call friends were the people living in the same accommodation (more discussion of users' social networks can be found in Chapter 9).

A backward linear regression model was produced (table 8.9) to ascertain whether population density, types of activities, SHS type, size of home and being in hospital prior to moving to a care home or supported housing service was associated with satisfaction with fellow residents or tenants (frequency statistics are presented in table 8.10).

Table 8-10: Satisfaction with fellow residents/tenants: frequency statistics

Variable of interest	Frequency of answer
Lives in a care home	57
Home size*	76
Involved in religious activities	21
Receives DLA	57
Attends day centre	13
Living in hospital beforehand	21
Lives in major urban area	19
Engages in outdoor sports	22
Participates in hobbies	31
Goes to the pub	15
Wants to move	37
Problems with anxiety/depression	25

(*: N valid cases)

Three variables were retained within seven steps, and the model was statistically significant (total n=63). It accounted for approximately 26% of the variance of satisfaction with fellow residents or tenants. The Durbin-Watson statistic was computed to evaluate independence of errors and was at 2.325, which is considered acceptable, and suggests that the assumption of independent errors has been met. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a normal distributional shape. Homogeneity of variance was also met.

Controlling for psychological functioning on the EQ-5D-3L, satisfaction with fellow residents was positively associated with not wanting to move and having lived in hospital beforehand, and to a lesser extent with living in a supported housing scheme (table 8.11).

Table 8-11: Linear regression: Satisfaction with fellow tenants or residents

Variable (n)	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	89.775	6.423	13.978	<.001	76.924	102.627
Lives in a care home	-12.940	5.954	-2.173	.034	-28.854	-1.025
Living in hospital beforehand	16.142	5.626	2.869	.006	4.884	27.400
Want to move out	-16.826	5.022	-3.350	.001	-26.875	-6.776
Problems with anxiety	.234	5.246	.045	.965	-10.263	10.732
ANOVA			5.123	<.001		
Model fit			R ² =.258; Adjusted R ² =.207			

A linear regression model was computed to identify associations between past housing situation, SHS type, rules within the home, present experiences and activities, and satisfaction with freedom among people living in care homes and supported housing services. The binary variable ‘satisfied with benefits’ was also tested, as this may be linked to service users’ opportunities and *freedom* to purchase goods and services:

“I’m satisfied with my benefits because I don’t have to spend anything if I don’t want to. Everything is provided for me at the home. That’s why the funding for the place is so expensive.”

Raoul, Care home service user, Part Rural area

“I’m not happy at all with my benefits. I only get £100 per week as an allowance, and that’s really not enough because I have to buy cigarettes.”

Diane, Care home service user, Major Urban area

The statistically significant model (see table 8.12), accounted for approximately 52% of the variance of satisfaction with freedom (total n=42). The Durbin-Watson statistic was computed to evaluate independence of errors and was at 2.222, which is considered acceptable, and suggests that the assumption of independent errors has been met. Tolerance for all variables was greater than 0.1, suggesting that multicollinearity was not an issue. Residuals followed a relatively normal distributional shape. Homogeneity of variance was also met.

Controlling for problems with anxiety and depression, satisfaction with freedom was associated with wanting to remain in their SHS, and being satisfied with benefits, and with the home not being located in a major urban area. Being satisfied with benefits was positively correlated with feelings about perceived amount of freedom, possibly due to the range of options they offer in terms of purchasable activities, and decreased restrictions. Variables that were negatively associated in this respect were living in a major urban area and wanting to move out. It may be that there were more restrictions placed on people living in a major urban area or in a city, or that people chose not to leave the home themselves. People who wanted to move were more likely to report decreased feelings of satisfaction with freedom, but these analyses do not identify the direct causality.

Table 8-12: Linear regression: Satisfaction with freedom

Variable (n)	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	67.183	10.030	6.698	<.001	46.861	87.505
Lives in a major urban area (19)	-20.114	7.783	-2.584	.014	-35.423	-4.922
Wants to move (37)	-15.905	6.125	-2.597	.013	-28.304	-3.506
Satisfied with benefits (33)	23.313	6.907	3.375	.002	9.331	36.299
Problems with anxiety (25)	-6.293	6.731	-.935	.356	-19.919	7.3332
ANOVA			10.498	<.001		
Model fit			R ² =.525, Adjusted R ² =.475			

8.3.4 Service users' general satisfaction with their housing experience

A new variable was computed and labelled 'general satisfaction'. This calculated the mean for service users' individual scores by taking into account all housing satisfaction variables and producing a single score for their general satisfaction with their housing experience. The mean for general satisfaction was 80.5 (SD=14.7; Min=34; Max=100). The distribution was normal, as identified by the Shapiro-Wilk test.

Independent samples t-tests were thereafter computed to identify associations between all binary variables of interest, such as SHS type, employment, receipt of different benefit types, demographic characteristics, and general housing satisfaction.

Several variables produced statistically significant differences associated with positive ratings of general housing satisfaction. Notable are: wanting to remain in their SHS, living in a rural area, having moved straight from hospital, not wanting to work, being satisfied with one's benefits, and not reporting any anxiety or depression problems on the EQ-5D-3L. Table 8.13 presents all corresponding independent samples t-tests, as well as group statistics, between group 1 (who replied "no" to the question) and group 2 (who replied "yes" to the question). Very large differences were found between people who wanted to work and those who did not: interestingly, people who wanted to remain unemployed were much more satisfied in general. A possible precursor to wanting to work may be general dissatisfaction; this could also apply to people who want to move out of their SHS. Another important contributor to increased general housing satisfaction was being satisfied with benefits, and hence in sufficient amounts. Living in a rural area was also associated with higher reported general housing satisfaction. For the dependent variable general satisfaction, the psychological disability variable and all aforementioned variables except 'satisfied with benefits' were both significant in the model, indicating that reported satisfaction in these cases was mediated by an interplay between these variables and reported problems with anxiety/depression.

Table 8-13: Independent samples t-tests: significant associations between variables and general housing satisfaction

Variable	Mean general satisfaction of group 1 (SD/N)	Mean general satisfaction of group 2 (SD/N)	t(n)	Sig
Does the service user want to move somewhere else?	88.2 (±9.7/34)	74.1 (±15.7/37)	4.577 (60)	<.001
Is the SHS in a rural area?	75.2 (±15.8/28)	83.5 (±13/49)	-2.496 (75)	.015
Did the service user move straight from hospital to the SHS?	78.5 (±15.3/57)	86.2 (±10.5/20)	-2.093 (75)	.040
Does the service user want to work?	83.9 (±12/45)	72.3 (±17.7/20)	3.097 (63)	.003

Is the service users satisfied with their benefits?	67.2 ($\pm 19.1/14$)	85.4 ($\pm 12.3/33$)	-3.897 (45)	<.001
Does the service user report problems with anxiety/depression on the EQ-5D-3L?	83.1 ($\pm 12.2/49$)	75.1 ($\pm 17.4/25$)	2.291 (72)	.025

Continuous variables were tested with Pearson's correlations in order to identify relationships with general housing satisfaction. There was a modest positive relationship between general housing satisfaction and age ($r=.332$, $n=77$, $p=.003$), and a smaller but positive one with EQ-5D-3L VAS health ratings ($r=.268$, $n=73$, $p=.022$). Hence, increases in age, and higher ratings on the VAS were associated with higher scores of general housing satisfaction.

An analysis of variance showed that population density (nominal variable) was significant in this case ($F(4,72)= 3.438$, $p=.013$); the Levene test was not violated. In general, people living in mostly rural (MR) areas were the most satisfied overall, and those living in major urban areas the least. Post hoc analyses using the Scheffé post hoc criterion for significance indicated that general satisfaction was significantly lower in major urban areas than in major rural ones (mean difference=-14.5, $p=.034$).

Taking into account all the aforementioned variables significantly associated with general housing satisfaction, a backward linear regression was computed. The final model contained five variables (keeping problems with anxiety/depression on the EQ-5D-3L in) and was achieved in four steps. The model (table 8.14) was statistically significant (total $n=44$), and accounted for approximately 68% of the variance of general housing satisfaction. Controlling for problems with anxiety and depression, general housing satisfaction was associated with wanting to remain within the SHS, and being satisfied with benefits. It was also associated with not living in a major urban area, and having moved directly from hospital.

Table 8-14: Linear regression: General housing satisfaction

Variable (n)	B	Standard error	t/F	Sig.	95% CI for B	
					Lower bound	Upper bound
Constant	78.002	3.931	19.841	<.001	70.051	85.954
Lives in a major urban area (19)	-11.486	4.349	-2.641	.012	-20.283	-2.690
Wants to move (37)	-12.704	3.208	-3.961	<.001	-19.192	-6.216
Satisfied with benefits (33)	14.777	3.627	4.074	<.001	7.441	22.113
Living in hospital beforehand (21)	7.891	3.677	2.146	.038	.454	15.328
Problems with anxiety (25)	-5.803	3.416	-1.698	.097	-12.713	1.108
ANOVA			16.510	<.001		
Model fit			R ² =.679, Adjusted R ² =.638			

8.4 Concerns of managers

According to the managers interviewed, aspects such as housing situation, income, and staff were particularly important to service users (see Table 8.15). Less important issues for service users were thought to be community activities and employment (seeking or maintaining it). Table 8.15 also identifies managers' perceptions of users' concerns by housing type.

Regardless of housing type, managers (39) thought housing was very important to users. Care home managers thought staff (29) and income (29) were very important, but job (29) and community activities (28) less so, possibly because many services and activities are delivered within the home. Managers of supported housing (6) placed a great value on privacy, freedom, and income. Supported housing services usually have staff present at specific hours; most of the time service users could come and go as they please. This might explain the relatively low scores managers ascribed to staff and the great importance they thought service users placed on freedom.

Shared Lives managers (3) also gave a very high rating to staff (or to Shared Lives carers in this case): service users are meant to share in the life of their Shared Lives carer, and so users' quality of life would depend greatly on the users' judgement of the quality of the carer. Shared Lives managers and carers (4) also

rated the amount of comfort and social situation highly, aspects that are linked to the Shared Lives carer and the environment created.

Table 8-15: Importance or non-importance of service users' concerns (as judged by managers)

	Care Home					Supported Housing					Shared Lives					Totals samples				
	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD
Social situation	29	35	100	79.8	20.5	6	50	90	76.7	16	4	70	95	88.7	13.1	39	35	100	80.2	19.1
Housing service	29	20	100	86.7	17.3	6	80	100	86.7	8.2	4	60	100	90	20	39	20	100	87.1	16.17
Community activities	28	20	100	68.7	20.3	6	50	95	69.2	17.4	4	70	100	83.7	12.5	38	20	100	70.4	19.43
Job	29	10	90	42.9	24.6	6	50	80	68.3	11.7	4	10	80	51.3	34.7	39	10	90	47.7	25.41
Income	29	30	100	87.2	17	6	80	100	91.7	9.8	4	40	100	70	24.5	39	30	100	86.2	17.52
Amount of space	29	30	100	77.9	22.22	6	60	80	73.3	10.3	4	60	90	75	12.9	39	20	100	76.9	19.86
Staff	29	50	100	88.4	14	6	60	100	76.7	13.6	3	90	100	96.7	5.7	38	50	100	87.2	14.22
Amount of privacy	29	10	100	83.2	21.1	6	80	100	95	8.4	4	70	100	83.7	7.63	39	10	100	85.1	19.21
Fellow tenants	28	40	100	77.5	17.7	6	60	95	83.3	12.5	4	70	95	86.2	11.1	38	40	100	79.3	16.45
Amount of freedom	28	10	100	83.1	23.3	6	85	100	94.2	6.6	4	70	100	85	12.9	38	10	100	85	20.8
Amount of comfort	29	20	100	82.2	22.9	6	65	100	88.3	13.7	4	80	100	95	10	39	20	100	84.5	20.92

Independent sample t-tests (as well as Mann-Whitney tests where appropriate) were presented when comparing whether the managers of care homes and those of supported housing services rated aspects of service users' lives differently. The only significant differences found were in how important they thought employment and staff to be to service users.

Care home managers thought that employment was less important to service users ($M=42.9$; $SD=24.6$), compared to managers of supported housing ($M=68.3$; $SD=11.7$); $t(33)=2.078$, $p=0.020$, although employment rates were relatively low across SHS types (discussed in the next chapter). This may suggest that care home managers placed relatively less significance on autonomy and its development amongst service users; as discussed in section 7.2.3, there were many care home managers who did not promote the concept of 'independence' in their home. Furthermore, care home managers thought that their service users placed greater importance on staff ($M=88.5$; $SD=14$) than did supported housing managers ($M=76.7$; $SD=13.7$); $t(33)=-1.881$, $p=.059$; $U(34)=43.5$, $p=.050$.

To test whether the characteristics of care home and supported housing managers (such as gender, education level, age, place of birth, years of service and ethnicity) were associated with their perceptions of users' concerns, independent samples t-tests (and Mann-Whitney tests where appropriate) and correlations were generated, identifying some statistically significant relationships with regard to their concerns.

Managers from BME backgrounds ($M=96.4$; $SD=6.7$; $n=11$) ranked users' perceptions of income much higher compared to their white counterparts ($M=84.1$; $SD=17.7$; $n=24$); $t(32)=2.953$, $p=.006$; $U(33)=76.5$, $p=.011$. The 21 female managers scored community activities ($M=74.5$; $SD=15.5$) much higher than the 13 male ones ($M=60$; $SD=22.8$); $t(36)=2.177$, $p=.037$.

Manager birthplace (born in the UK versus abroad) bore significant associations with their ratings of concerns, as identified by independent samples t-tests (see table 8.16). Managers born in the UK ranked service users' concerns with space and freedom lower than did people who were born abroad. Managers born

abroad were mainly from the Caribbean Islands, Africa or Eastern Europe, and may have had substantially different experiences, including education and training.

Table 8-16: Descriptive statistics and significant relationships between concerns of managers of born in the UK and abroad

Concern	Mean of manager born in the UK (SD/N)	Mean of manager born abroad (SD/N)	U	Sig.	t(n)	Sig.
Amount of space	72.8 (±21.5/25)	88 (±13.8/10)	66.5	.010	2.062 (37)	.047
Amount of freedom	80.2 (±24.2/24)	96.5 (±4.7/10)	67	.012	3.150 (26)	.004

8.5 Main challenges service users face according to managers

Managers were also asked what they thought were the main challenges for service users. The question was open-ended, although respondents could be prompted with examples such as “social situation”, “employment”, “mental or physical health”. The most frequent responses were employment (20), health issues (19), discrimination (18), and social exclusion and community integration (22); other responses are reported in Table 8.17:

“I suppose the main challenge would be engaging with other people and maintaining relationships. They don't have a real social network. From an employment perspective, they lack confidence and feel unable to maintain and seek a job. The fact that some have been on benefits for a long time does not help either.”

Care home Manager, Major urban area

“Main challenges? Employment. There is still a lot of stigma attached to people with mental health problems, and it is difficult to find employers who are ready to take on service users. Employers don't really know what to expect. And it's true that some of our service users are very unpredictable.”

Care home Manager, Major urban area

Table 8-17: Challenges service users face: a manager's perspective

Challenge	Frequency (N)	Percent (%)
Relationships with friends	15	37.5
Relationships with family	13	32.5
Maintaining relationships and social networks	7	17.5
Poor ADL skills including budgeting	6	15
Lack of confidence and communication skills	5	12.5
Having choices and voicing their opinions	4	10
Having been institutionalised for a long period of time	3	7.5
Loneliness and social isolation	3	7.5

"Relationships with friends and family are an issue. We are trying to bridge those relationships as most have lost contact with their respective loved-ones. Employment and daytime activities are another problem, seeing that day services have been cut from the budget. Another key aspect is keeping them motivated and encouraging community-based activities given all those factors."

Care Home Manager, Large urban area

"Acceptance in the community. And also being told what to do by people sometimes younger than you. People socialise during the day but they have absolutely nothing to do at night. It's different to you and I – we work during the day and see our friends in the evening; they don't have that routine. So I guess sometimes they get lonely and bored. And their medication doesn't help - it makes them feel lethargic or low."

Supported Housing Manager, Major urban area

A chi-square test identified a statistically significant difference in the aims expressed by supported housing managers compared to care home managers. Three supported housing managers were concerned about rehospitalisation amongst service users following their departure from an SHS, and worked towards mitigating that risk. No care home managers mentioned this point; $p=.003$, Fisher's exact test, two-tailed. Managers' demographic characteristics were also significant in this respect, as demonstrated by a chi-square test, using Fisher's exact test (2-tailed).

Approximately three quarters of male managers recognised that employment was a major challenge for service users; a third of women mentioned this ($p=.048$, Fisher's exact test, two-tailed). Also, many men reported that their

goal was to move people on to less support; very few women mentioned this ($p=.030$, Fisher's exact test, two-tailed):

"I really want to help people change their lives around, by providing good quality of life. One needs to understand their situation and where they fit in society so they can go on to have successful lives and good quality of life in the future. Some people have moved on from here and very few have gone back to hospital, which is fantastic."

Male supported Housing Manager, Major urban area

8.6 Discussion

Shepherd and Murray (2001, p. 315) suggest that several factors have been shown to be associated with self-reported satisfaction or quality of life in residential care: quality of the physical environment, size and degree of individualisation of care, choice (with regard to people sharing the home, meals, etc.), privacy, rules and restrictions, levels of disturbance among peers, and attractiveness of the local neighbourhood. This chapter has explored the housing satisfaction of service users with various aspects of their lives, related to the SHS they are living in. Although service users might be reluctant to criticise certain aspects of their housing for fear that this might adversely affect their care or future security (Shepherd, et al., 1995), participants were assured that all the information would be kept strictly confidential and what they say would in no way affect their rights or care. McEvoy and colleagues (1981) have in the past questioned the validity of research on satisfaction amongst the mental health population; yet the consensus is that these opinions are necessary and are an accurate description of reality (Corrigan, 1990; Distefano et al., 1981; Goldstein et al., 1972; Kalman, 1983; Plutchik et al., 1978; Weinstein, 1979). LeVois et al. (1981), however, suggested that interviews may inflate satisfaction scores by 10%. Nevertheless, this study's findings do enrich the relatively limited evidence base on satisfaction within English SHS settings.

The international evidence is mixed with regard to ratings of satisfaction, with some studies reporting marked dissatisfaction with housing (Hatfield, et al., 1992) and others reporting moderate to high levels (Elliott, et al., 1990; Middelboe, et al., 1998), more similar to levels reported in this study.

Several factors that mediate satisfaction are mentioned in the literature, some of which have been explored here. As discussed in chapter 3, previous studies

have found satisfaction to be associated with the environment as well as features within it, such as privacy, autonomy, social cohesion, staff, provider and support types, comfort, and choice. As mentioned previously, differences by provider type were not tested in this study, due to the similarities with differences by SHS types.

SHS type did not produce many statistically significant associations with housing satisfaction, although it was hypothesised that the different environments offered and differing restrictiveness levels would produce significant results.

In this study, satisfaction with privacy was generally rated highly by service users. Privacy as a dependent variable was also found to be statistically significantly associated with SHS type. People in care homes, who in this sample were likely to experience the highest levels of on-site staff support, were reportedly more satisfied with the amount of privacy they had than people in supported housing services even after controlling for home size and length of stay. This result is counter-intuitive, and contradicts findings by Tsemberis et al. (2003) and Tsai et al. (2010), where the amount of support received was negatively associated with satisfaction ratings of privacy. More specifically, Corrigan (1990) highlighted the importance of service users having space of their own, suggesting that an SHS should have a low density of residents. In this study, all care home service users had their own rooms, and the number of people living in the SHS was not significantly associated with satisfaction ratings for amount of privacy. It could be that the privacy afforded by single rooms was associated with higher levels of reported satisfaction, and that residents benefited from the staff support without it reducing these scores. Otherwise, Nelson et al. (1997) had reported higher (general) satisfaction scores amongst people in care homes compared to people in lesser supported settings, and commented that this was possibly due to longer lengths of stay; LOS was not statistically significant in the model for satisfaction with privacy in this study.

No other statistically significant differences by SHS type were found. However, residents' individual descriptions give some insight into what was associated with the reported housing satisfaction of service users in particular support types. People in Shared Lives were particularly satisfied with the support

delivered within the home by their carer, and were also very satisfied with their privacy and the home itself.

However, people living in independent flats expressed a low level of satisfaction with their community activities, income, amount of space and support. Some of these aspects, such as income, support received and community activities, may be key to the successful transition of service users into the community. In a study by Elliott et al. (1990), some significant differences were found with regard to SHS type and satisfaction. The highest level of housing satisfaction was expressed by people living in individual flats with good levels of staff support and in residential homes where there was good outside contacts; it must be added that people in individual flats reported that they relied heavily on having good workers, because they lacked outside social contacts.

The finding in this study that service users living independently are not satisfied with certain aspects is important. Although managers reported many 'success' stories of service users moving out into the community (see chapter 7), this result, although constrained by a small sample size, indicates that this was not the case here. Further exploration of this area is offered in chapter 10.

An aspect that home size did affect was service users' ratings of social situation, and this relationship was positive, as it may be correlated with more frequent contact. This is in line with findings by Mares et al. (2002).

This study aimed to explore restrictiveness within the home and housing satisfaction (see chapter 3). Variables alluding to restrictions and autonomy (for example for service users: "Are there rules within the home?" or for managers "do you promote independence within the home?") did not produce any statistically significant associations with housing satisfaction. However, a strong positive correlation between satisfaction with freedom and general satisfaction was found.

Population density was a statistically significant independent variable in many respects. Generally, people living in urban areas reported being less satisfied with certain aspects of their lives compared to their counterparts in rural ones. Wong and Solomon (2002) suggest that service users who live in proximity to community resources are more integrated than their counterparts. In this study, however, people in rural areas, hence not necessarily close to such facilities, scored

their community activities higher than people living in more urban places. They also rated their social situation as higher. Could living in an urban area and a densely populated city be associated with more restrictiveness? Mares et al. (2002) found that people living in high-income areas experienced more social stigma. Stillman (2007) reported that service users who reported higher neighbourhood quality participated in more community activities. Although measures and populations were different in this study, people who were involved in religious activities and attended a day centre reported increased community satisfaction. Naturally, rural areas may be deprived as well; however it might be that the quality of the outside environment afforded by rural areas (Nicholson, 2008) – most of the rural areas visited for this study were in rural countryside – was positively correlated with the housing satisfaction of service users. Relatively to urban areas, rural areas may also provide aesthetically pleasing local neighbourhoods. The importance of the quality and attractiveness of the neighbourhood in relation to well-being was also raised by Shepherd and Murray (2001, p. 315).

Recurring and important variables in the exploration of housing satisfaction were prior location prior to being in this SHS, as well as the expression by a service user of a desire to move out of their SHS in the future: people who wanted to move were less happy with certain aspect of their lives, even after controlling for problems with anxiety and depression on the EQ-5D-3L. Previous location also had an important bearing in this case, specifically when the service user had moved from hospital, or from a location with more or equivalent support. This may represent a significant and positive change in service users' circumstances. Improved outcomes in the community following hospital stays were also reported in the TAPS studies, as well as others (Shepherd, 1991; Shepherd, et al., 1995). Moreover, Shepherd et al. (1996) also found that when comparing ward inpatients and community residents, the former rated their lives less favourably. In a qualitative study, McCourt (2000) conducted semi-structured interviews with 26 former psychiatric hospital patients now living in supported housing projects. Although most were happy with their current housing situation and had no desire to move, few had been able to exercise any particular choice in the move from

hospital; nevertheless they still compared their current housing situation favourably with the hospital or other SHSs in which they had lived.

Although an aim of this study was to explore choice and its impact on housing satisfaction, no statistically significant associations were found. Possibly questions posed regarding preferences and choices such as “did you have a choice of where to live?”, did not capture the concept of choice in this case and a more finely tuned instrument might have been more successful, such as that employed by Srebnik (1995). The Schutt et al. (1997) study also did not find a significant association of choice with housing satisfaction, yet their sample consisted of homeless people, and possibly any option would have been better than their present situation of not having a home (hence the non-significance of having a choice). This study still aimed to test their hypothesis using their scale, although with people already having been allocated housing. A possibility would be to explore the choice concept further using qualitative analysis.

Some service user socio-demographic characteristics were significantly associated with ratings of housing satisfaction. Positive associations were found with age, and EQ-5D-3L VAS ratings; the strongest association appeared between age and amount of comfort. A study by Mares et al. (2005) on the subjective ratings of housing quality by people with mental health problems living in the community did not find any statistically significant associations with regard to socio-demographic characteristics.

Significant relationships were found with regard to the importance managers’ placed on certain aspects of peoples’ lives, and the SHS they were attached to. Managers of supported housing schemes were more likely to recognise that service users may prioritise employment, possibly indicating that they spent more resources improving this aspect of peoples’ lives. Care home managers thought that their service users valued staff much more than supported housing scheme managers did. This is expected, as care home service users had staff on-site 24 hours a day, and possibly played a greater part in their daily lives.

Managers’ opinions were sought on what they thought were important challenges and concerns for service users. Generally, service users reported being

very satisfied with staff; and managers believed that people valued this aspect very highly as well. It might be that this belief is translated into the quality of care that they try to provide, and is hence reflected in the positive ratings that service users gave. Interestingly, in terms of privacy, people in care homes were much more satisfied compared to people in supported housing schemes, although managers of the latter type valued it extremely highly.

Although sub-sample sizes were relatively small and corresponding results should be treated with caution, statistically significant associations were found with regard to managers' responses and independent variables such as SHS type. For example, supported housing managers were comparatively more concerned about hospital readmissions than managers of other types of homes. It was discussed in chapter 7 that service users had mostly travelled downwardly through SHS pathways; people from care homes generally moved to supported housing services, and people from supported housing services moved to independent flats. It might be the case that the aforementioned result is an indication that supported housing services managers were more concerned than care home managers about the risk of moving people on into the community because of the potential 'revolving door' effect due to inappropriate support received in the community.

Shepherd et al. (1996) found that staff characteristics such as number of years within their role had an impact on the housing environment. Although age or number of years as a manager were not significant, in this study, managers' birthplace and ethnicity had significant bearings, for example on the importance they thought service users placed on income, amount of space, privacy, freedom and comfort. This could indicate that people born outside the UK or from BME groups had different values, linked to their culture. Male managers were also more likely than their female counterparts to recognise employment as a challenge to service users, as well as maintain that one of their goals was to move people to less support. Further exploration of staff characteristics will be offered in chapter 10.

Chapter 9 Chapter 9 Social inclusion within specialist housing services

9.1 Introduction

People with mental health problems are among the most socially excluded in society (Social Exclusion Unit, 2004) and several policies have been launched to tackle the issue of social exclusion and promote social inclusion (Department of Health, 1999b, 2009, 2011).

This chapter investigates some aspects of participation and social inclusion: participation in economically or socially valuable activities, the capacity to purchase goods and services, and social interaction (Boardman, 2010b, p. 25).

Taking employment first, previous research has reported relatively low rates of employment among people with poor mental health living in an SHSs, as well as variations between different levels of support. Much of the literature has focussed on the barriers to employment for this population, with particular interest in stigma and discrimination (Boardman, et al., 2003). Other studies (Secker et al., 2001) have found, however, that service users with mental health problems generally want to work. The question arises of whether the nature of the barriers to work, as well as the desire to work, varies according to SHS type and population density of the areas in which service users live. Section D of the service user interview schedule included questions on their employment, their wish to be employed and any barriers to employment. Managers were also asked about their views on the employment of service users, as well as barriers to achieving this (questions 20 and 21).

Secondly, service users' involvement in community activities was explored with them using some questions (34-41 of the interview schedule) taken from the HANAH questionnaire (Araya, et al., 2006). Answers to the very first question of the interview schedule (*"Tell me what a typical day for you would be like. What did you do yesterday for example?"*) were also examined. Again, managers' opinions were also sought with regard to community involvement, and about the activities that service users reportedly engaged in.

Finally, to investigate the social networks of service users, items of interest were extracted from the HANAH questionnaire (Araya, et al., 2006): these are

questions 42 to 51 of the service user interview schedule. These questions were open-ended, with frequency responses then classified into distinct categories.

The number of categories of people in a person's social network will be presented first. Chi-square tests were employed to identify whether individuals' social behaviour differed by SHS type and population density. Any associations between the nature of users' social networks and their reported ratings of housing satisfaction were also explored.

A major driver of peoples' sense of social inclusion could be their income, which – for this sample – is primarily their social security benefits. Knapp and Beecham (1990) found that service users believed that more generous social security benefits (or the availability of 'real' employment) would extend the range of their choices, and bring these closer to those of the general public. Not many UK studies have investigated the impact of benefits for people living in an SHS and whether the amount received was associated with their range of choices and activities. In this study, service users were asked what social security benefits they received (question 19): these were subsequently quantified and classified by type. A particular focus was placed on Disability Living Allowance (DLA) as this is the most common benefit received by a person with mental health problems. Attempts were made to find if there were significant associations between the number of benefits received and several variables: SHS type, population density, aspects of housing satisfaction, and involvement in activities.

This chapter also explores the uptake of 'personalised' services among people living in an SHS. Service users were asked whether they were receiving either direct payments or a personal budget; managers were also asked if they had individuals in their homes who were receiving these services.

Another aspect of 'personalisation' is choice-based lettings, and there was an interest in understanding how this has been implemented in the SHSs sampled for this study. Much of what is known of choice-based lettings is drawn from routinely collected statistical data, so here it is helpful to gain both managers' and service users' perspectives.

In this study, no direct questions were posed to service users about whether they felt discriminated against. However, managers were asked for their views on

whether people with mental health problems faced any sort of discrimination, whether from housing providers or from the wider community (question 36).

The analyses of aspects of social inclusion, aided by chi-square tests, independent sample t-tests, Pearson's correlations, and binary logistic regressions (to find simplified models of associated factors with occupational activities as well as a desire to be employed), were used to explore a service user's level of social inclusion, and investigate the mediating factors. Statistical analyses will consider the sample of service users in care homes and supported housing services only. However, some descriptive statistics, for example on the frequency of engaging in certain activities, will also include people living in Shared Lives schemes or independent living.

The chapter concludes with an emphasis on relocation policies, as there has been increased pressure on local social services to provide accommodation within the community since the advent of deinstitutionalisation, with demand for community places exceeding supply, one consequence of which has been a greater role for the private sector. Unfortunately, private-sector facilities are often provided at a distance from the preferred location of their purchasers - service users - not taking into consideration their long-term interests (Poole et al., 2002). People placed in out-of-area-treatments (OATs) are disadvantaged by dislocation from their family and community and loss of continuity of services from their areas of origin (Killaspy et al., 2009). Hence, as part of the questions posed to service users about how they had moved in to their SHS, they were also asked whether "[...] the housing service [they] were living in at the moment was in the same area [they] had been living in most of [their lives]". Their responses were analysed to explore whether the change of area was associated with their social inclusion, community involvement or housing experience.

9.2 Employment and occupational activities

Of the 79 service users interviewed in care homes and supported housing services, 67 were of (conventionally defined) working age (between 18 and 65 years). Nineteen were in some form of occupational activity at the time of the interview: one person was employed full-time, two part-time, and 16 were in

voluntary work. Six people were attending college, taking classes in languages, computers and graphic design. Service users most commonly worked in charity shops, such as Age Concern or the British Heart Foundation, but also engaged in some gardening work. The two people in independent living were engaged in occupational activity (part-time and voluntary work). One Shared Lives scheme service user was in voluntary work. As most people were not in remunerated work, this will be termed an occupational activity, rather than conventionally defined employment.

Chi-square tests, specifically Fisher's exact tests (2-tailed), were conducted to explore the associations between engaging in occupational activities and demographic characteristics, as well as ratings of health. The only significant associations were with regard to ratings of mobility, self-care and usual activities on the EQ-5D-3L: people in care homes and supported housing services who were engaged in an occupational activity, were much less likely to report problems in those areas (Table 9.1). No statistically significant differences were found between people who were engaged or not in such an activity in terms of ratings of anxiety/depression.

Table 9-1: Fisher's exact test statistics and cross-tabulations between being engaged in an occupational activity or not and ratings of health (EQ-5D-3L)

Problems with	N Employed (%)	N Unemployed (%)	Sig
Mobility	1 (5.2)	23 (52)	.001
Self-care	1 (5.2)	16 (34)	.015
Usual activities	2 (9.1)	20 (42.5)	.019

Of those who were not currently in any form occupational activity, more people did not want a job (35) compared to those who did (20). Even those who wanted to work expressed some doubts about their abilities and their capacity to maintain a job (see figure 9.1), with some noting more than one reason.

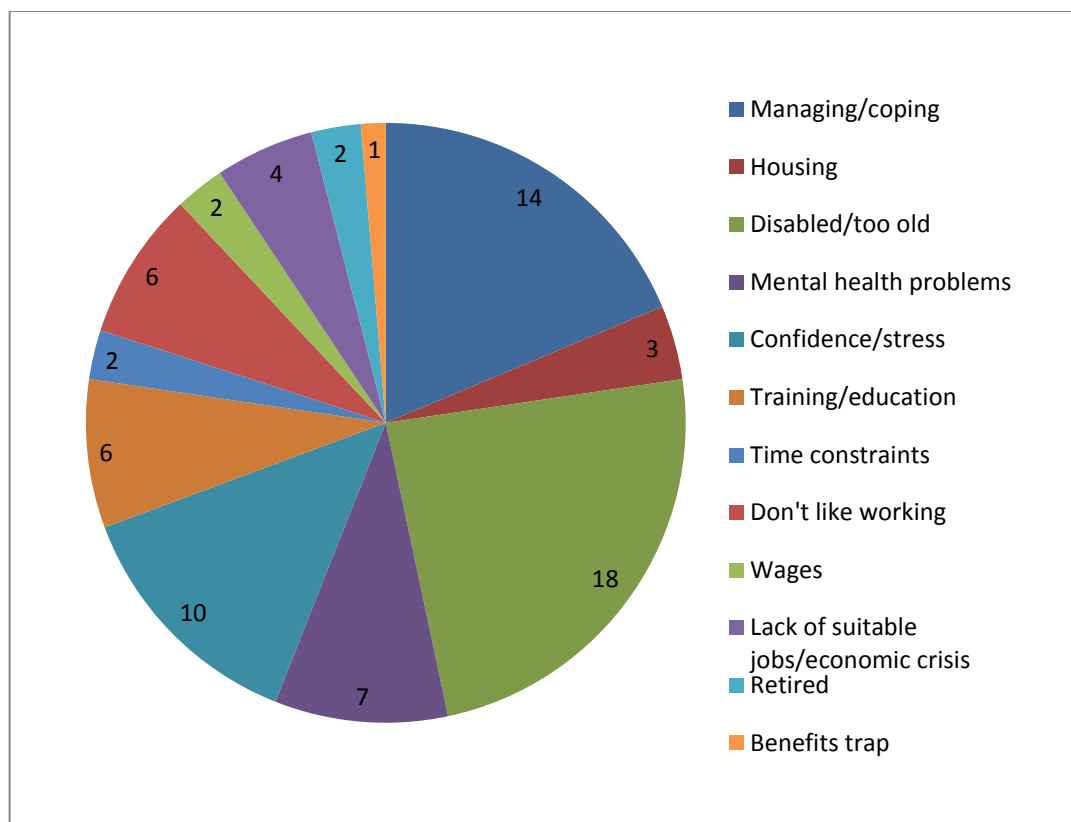
Nearly a quarter of working-age participants in this sample reported feeling too disabled or old to get a job. These were all living in care homes and nearly all expressed having problems performing their usual activities, or with mobility or self-care. Seven reported having anxiety/depression issues as measured by the EQ-

5D-3L. Many service users were otherwise concerned that they would find it difficult to manage (N=14) and were not ready or confident enough (N=10):

"I used to work at a charity shop with normal people, but I'm not sure if full-time employment is for me yet. I still don't feel ready and I'm not confident enough to do it yet."

Jeni, Supported Housing service user, Very rural area

Figure 9-1: Barriers to seeking and maintaining employment: service users



9.2.1 Occupational activities and future employment by support types

A Pearson's chi-square test was conducted to compare differences in occupational activity rates in people in care homes compared to those in supported housing services. Not many people in care homes were engaged in such activities (N=11; 21%), whilst half those sampled in supported housing services were (N=8; 53.3%); ($\chi^2(1)=5.394$, $p=.015$).

Reported barriers to future employment were also different for people living in care homes as opposed to supported housing. Statistically significant associations, as identified by chi-square tests, specifically Fisher's exact two-tailed test (table 9.2), showed that people in care homes were more likely to feel that it was their

intellectual or physical capabilities that were to blame for their inactivity, whilst people in supported housing were uncertain about their management and coping mechanisms, and also exhibited a comparative lack of confidence.

Table 9-2: Cross-tabulation statistics between housing type (care homes/other SHSs) and employment barriers

Employment barriers	N Care homes (%)	N Supported housing services (%)	$\chi^2(n)$	Sig
Disabled/too old**	15 (35.7)	0	n/a	.046
Lack of confidence**	4 (9.5)	5 (50)	n/a	.008
Cannot cope/manage*	6 (13.9)	5 (41.6)	4.503(1)	.034

(*: Pearson's chi-square; **: Fisher's exact two-tailed test)

9.2.2 Occupational activities and future employment by population density

Population density was also an important independent variable with regard to occupational activities (table 9.3). A simple binary variable was used to classify population density: urban versus rural areas. Although people in rural areas were more likely to be employed, those who were unemployed were less likely to want a job, compared to those living in urban locations. This was linked, in their view, to the fact that it would be difficult for them to cope in employment, either full or part-time.

Table 9-3: Fisher's exact test statistics and cross-tabulations between population density and employment and its barriers

Employment variable	N Urban homes (%)	N Rural homes (%)	$\chi^2(n)$	Sig
Employed**	3 (11.5)	16 (39)	n/a	.025
Want to work*	14 (58.3)	6 (19.3)	8.882(1)	.003
Difficult to manage**	2 (8.3)	9 (29)	n/a	.050

(*:Pearson's chi-square; **: Fisher's exact two-tailed test)

A binary logistic regression model sought to identify any significant associations between occupational activities, SHS type (care home versus supported housing service), population density, as well the aforementioned aspects of the EQ-5D-3L. For reference, a cross-tabulation of these variables is presented in table 9.4.

Table 9-4: Cross-tabulation: engagement in occupational activities

		Employed		Total
		No	Yes	
Reported problems with mobility on the EQ-5D-3L	No	26	20	46
	Yes	23	1	24
Lives in an urban area	No	27	18	45
	Yes	23	3	26
Reported problems with anxiety on the EQ-5D-3L	No	31	12	43
	Yes	18	9	27
Lives in a care home	No	9	10	19
	Yes	41	11	52
Reported problems with usual activities on the EQ-5D-3L	No	28	19	47
	Yes	21	2	23
Reported problems with self-care on the EQ-5D-3L	No	31	12	33
	Yes	18	9	27

The overall regression model (table 9.5) was statistically significant and the included variables accounted for approximately 45% of the variance in occupational activity status. The Hosmer and Lemeshow goodness of fit test was not significant, indicating that the model fitted the data well.

Controlling for problems with anxiety and depression, being engaged in an occupational activity (amongst the working age population) was associated with not reporting problems with mobility and living in a rural area. The variables living in a care home, and problems with self-care, usual activities (as measured by the items on the EQ-5D-3L) were not statistically significant in the model.

Table 9-5: Binary logistic regression odds ratios: engaged in an occupational activity or not

Variable	B	Standard error	Wald χ^2/χ^2	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Constant	-.580	.987	.345	1	.557	.560		
Problems with mobility	-2.655	1.206	4.845	1	.028	.070	.007	.748
Lives in rural area	1.652	.801	4.253	1	.029	5.217	1.085	25.078
Problems with anxiety/depression	.503	.727	.478	1	.489	1.653	.397	6.880
Problems with self-care	-1.335	1.434	.867	1	.352	.263	.016	4.374
Lives in a care home	-1.069	.795	1.807	1	.179	.343	.072	1.632
ANOVA			25.017	6	<.001			
Hosmer and Lemeshow goodness of fit test			4.553	7	.714			
R ² =.315; Nagelkerke R ² =.451								

A binary logistic regression model also sought to identify any significant associations between desire to be employed, SHS type (as many service users in urban areas were care home residents, and most supported housing service users were in rural areas), population density, as well as some aspects of the EQ-5D-3L. For reference, a cross-tabulation of these variables is presented in table 9.6.

Table 9-6: Cross-tabulation: desire to be employed

		Wants to be employed		Total
		No	Yes	
Lives in a care home	No	9	6	15
	Yes	27	15	42
Lives in	Urban	10	14	24
	Rural	26	7	33
Reported problems with anxiety on the EQ-5D-3L	No	22	13	35
	Yes	13	8	21
Reported problems with mobility on the EQ-5D-3L	No	20	12	32
	Yes	15	9	24
Reported problems with self-care on the EQ-5D-3L	No	22	17	39
	Yes	13	4	17
Reported problems with usual activities on the EQ-5D-3L	No	20	14	34
	Yes	15	7	22

The overall regression model (table 9.7) was statistically significant, and the included variables accounted for approximately 33% of inter-individual variance in wanting employment. The Hosmer and Lemeshow goodness of fit test was not significant, indicating that the model fitted the data well.

Controlling for living in a care home and problems with anxiety/depression, wanting to be employed (amongst the working age population) was associated with living in an urban area. Problems with self-care, mobility, usual activities (as measured by the EQ-5D-3L) were not significant in the model.

Table 9-7: Binary logistic regression odds ratios: desire to work (no/yes)

Variable	B	Standard error	Wald χ^2/χ^2	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Constant	1.764	1.071	2.712	1	.100	5.838		
Lives in a care home	- 1.461	1.002	2.124	1	.145	.232	.033	1.655
Lives in a rural area	- 2.613	.878	8.857	1	.003	.073	.013	.410
Problems with anxiety/depression	.226	.699	.104	1	.747	1.253	.318	4.935
Problems with mobility	.654	.880	.552	1	.457	1.924	.343	10.803
Problems with self-care	- 1.173	1.166	1.012	1	.314	.309	.031	3.042
Problems with usual activities	.160	1.132	.020	1	.888	1.174	.128	10.793
ANOVA			14.883	6	.021			
Hosmer and Lemeshow goodness of fit test			4.415	6	.818			
Cox & Snell R^2 =.241; Nagelkerke R^2 =.329								

9.2.3 Employment and occupational activities: the manager's point of view

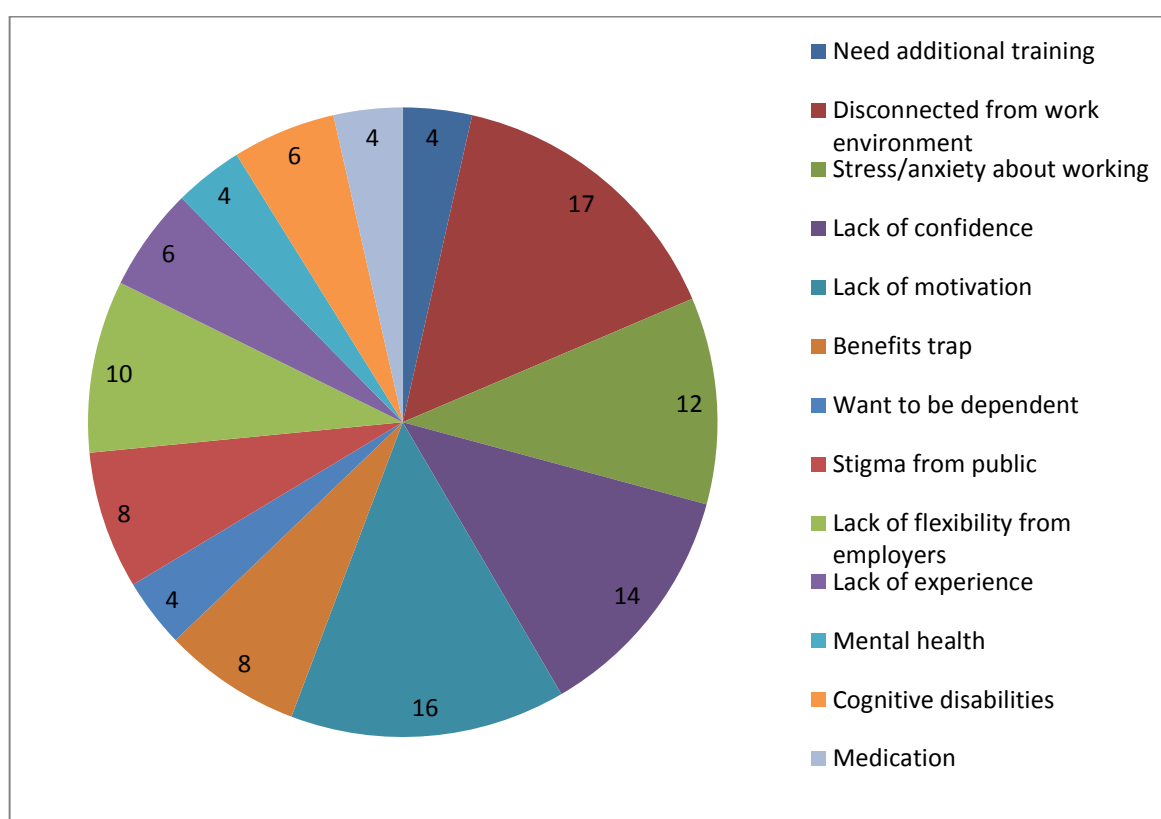
Information about service user occupational activities' was also obtained from managers in the sample. Across 39 of the 40 SHSs (one manager declined to answer), 13 managers reported having one or more service user engaged in an occupational activity. This rate of engagement was a little less than one service user per home ($M = 0.8$; $SD = 1.81$); the mode was 0. However, taking into account house size or total number of people living in each, a more useful figure to consider might be the proportion of people engaged in an occupational activity in each SHS; that mean was .057 ($SD = .122$). Engagement rates and these proportions across different housing types are reported in Table 9.8 (differences between SHS types did not achieve statistical significance). Here, Shared Lives managers estimated how many service users were engaged in occupational activities across all of their schemes, and given their large sizes, this might offer an explanation as to the low ratios within them.

Table 9-8: Means and relationships between housing type and occupational activities

	Care home (SD/N)	Supported housing	Shared Lives
Employment rate	.45 (\pm .78/29)	2 (\pm 3.69/7)	1.33 (\pm 2.31/3)
Proportion employed	.053 (\pm .11/29)	.09 (\pm .18/7)	.01 (\pm .01/3)

A large number of barriers to service user employment were reported by managers (see Figure 9.2), and some corresponded to the opinions voiced by service users. Some managers cited more than one barrier.

Figure 9-2: Barriers to service users seeking and maintaining employment: managers' perspectives



Managers commented that the biggest problem faced by service users was a feeling of being 'disconnected' from the work environment (N=17), a fear that they would not be able to fit in, alongside a lack of motivation (N=16), and low confidence (N=14):

"I suppose a lot of our clients are in voluntary work. But some are scared. And also they're lazy. And we must not forget, it's stressful, going to an interview."

It's a whole different world. They lack confidence and some of them are very anxious. It helps to encourage them to do voluntary work and get up in the day."

Manager, Supported Housing, Mostly rural area

This last factor was also an important concern voiced by service users, when they reported that they felt concerned that they would not be able to cope with a job, and that they were not confident enough to seek or maintain one.

Another important factor was the perceived lack of flexibility from potential employers (N=10) regarding working conditions and hours:

"There's still a lot of stigma surrounding mental health. And I'm guessing an employer wouldn't be able to deal with that, or their chaotic lifestyles. Plus their personal hygiene isn't too great. Their medication doesn't help either. I'm not sure an employer in the current climate would go that extra mile with service users. At the end of the day, it all comes down to tolerance and patience."

Supported housing Manager, Major urban area

This point had not been mentioned by service users in their interviews, but is reflected in several studies (Manning & White, 1995; Roberts et al., 2004).

Roughly one-fifth of the managers mentioned that the benefits trap constituted a major disincentive towards service users seeking employment and four added that some service users had a wish to be 'dependent' on the system:

"The main problem is the benefits trap and the fact that they're not going to be paid much anyway. Motivation is also a problem. If they did get a job they'd need a lot of support. I know one person who wouldn't take up a job because they live for their benefits."

Supported housing Manager, Very rural area

"Some do voluntary work. But there is still the disincentive of not getting paid or not getting paid enough. Lack of motivation is also an issue as well as their mental health. Some of them just desire to be dependent. People don't want to do everything, all the time - they actually like people taking care of them."

Care home Manager, Part rural area

In contrast, only one service user had mentioned the benefits trap during the interviews.

9.3 Community involvement

9.3.1 Community activities: service users' accounts

In this section responses to some of the questions borrowed from the HANAH (Housing and Neighbourhood and Health) questionnaire are analysed, including service users' participation in religious activities, a political party, and social activities such as going to the pub or library (table 9.9). Here, participation is considered for the whole of the sample where appropriate.

Most care homes and supported housing services had a tenants' or residents' group that people attended. Many service users had hobbies, such as playing pool or bingo.

Table 9-9: Service users' involvement in activities in the community and other (frequencies)

Activity	N	Percent
Tenant or residents group*	47	59.5
Hobby or interest group	36	41.9
Shopping and going into town	23	26.7
Working out and walking	23	26.7
Restaurant	22	25.6
Religious (church, temple, etc.)	21	24.4
Sports or supporter club	20	23.3
Library	18	20.9
Day centre	17	19.8
Pub	15	17.4
Gym	14	16.3
Political party	9	10.5
Café	8	9.3
Other local group	7	8.1

(*: represents proportion of service users in care homes and supported housing services only)

As summarised in table 9.9, more than half of service users in care homes or supported housing services regularly attended a residents/tenants meeting organised by their SHS – the highest frequency of participation in any activity – perhaps because it was held within the home.

Around 25% of service users in the sample reported eating out at restaurants regularly, and 17.4% said that they went to the pub frequently. Both these activities require people to spend money. Given their low disposable income, it is possible that many decided that such outings were too expensive. Nearly one-quarter (24.4%) of the service users participated in regular religious activities, such as going to church or mosque.

The first question of the interview schedule asked service users to describe the activities undertaken on a typical day and. Their responses are summarised in table 9.10.

Table 9-10: Service users' typical days (frequencies)

Typical day activity	N	Percent
Stay in/watch television	49	57
Running errands (e.g. going to bank, shopping, going into town)	35	40.7
Outdoor sports (e.g. walking, running, field sports)	22	25.6
Meal (e.g. restaurant, pub, takeaway)	20	23.3
Housework	19	22.1
Day centre	13	15.1
Work (paid or voluntary)	13	15.1
Trip (e.g. daytrip, bus/car trip, visit to family/other)	12	14
Reading	11	12.8
Listening to music	10	11.6
Hobbies within group setting (e.g. bingo, pool, cards)	10	11.6
Drawing	9	10.5
Solitary hobbies (e.g. gardening, playing video games, cooking)	9	10.5
Educational activities (e.g. school, college, library)	9	10.5
Writing	6	7
Gym	6	7
Health-related activity (e.g. GP/hospital visit, blood test)	5	5.8

Quite a significant number of people reported spending a lot of time indoors, watching television or reading. A small proportion were engaged in some kind of physical activity, like going to the gym or walking around. Many liked going into town for shopping or a meal.

Chi-square tests were performed to compare differences in the nature of activities of people living in care homes as opposed to those living in supported

housing services. The statistically significant associations (table 9.11) demonstrate that people in care homes were more likely to engage in sedentary and solitary activities, such as staying in and watching television, whilst people living in supported housing services were more gregarious, typically engaging in some form of vocational work, or going out for a meal or a coffee. These relationships were still statistically significant even after controlling for problems with mobility and anxiety (measured by the EQ-5D-3L) in binary logistic regression models.

Table 9-11: Pearson's chi-square tests and Fisher's exact test statistics and cross-tabulations: engagement in activities and SHS type

Variable	Living in a care home (%)	Living in supported housing service (%)	$\chi^2(n)$	Sig.
Typical day: stayed in and watched television**	41 (64)	4 (26)	n/a	.010
Typical day: vocational activity**	4 (6.2)	6 (40)	n/a	.002
Typical day: go out for a meal*	11 (17.2)	6 (40)	5.162(1)	.023

(*: Pearson's chi-square; **: Fisher's exact two-tailed test)

"In this place you have to do things to entertain yourself. I really wish there were more things to do."

Kate, Care Home service user

"If there wasn't the café, I'd be really bored. I like it there, they call me by my name, everyone knows me."

Helen, Care Home service user

9.3.2 Day centre attendance

Previous research has looked at the effect of attendance at day centres, finding mixed evidence (Catty et al., 2006); some authors have argued that "*day centres cater for a variety of needs, providing a sense of purpose and belonging for their clients*" (Catty & Burns, 2001), and that day activity settings commonly enable users to establish and maintain relationships, and help them spend their days in a way that is worthwhile to them (Beecham et al., 1999b). There are fewer day centre places currently, due to funding cuts (Cole et al., 2007).

Although not asked, some managers mentioned the closure of day centres for mental health service users, and their concerns about this. With these closures, many SHSs had been forced to provide day care themselves within the homes:

*“They’ve cut all the day centres. So we’re supposed to provide all the day-care as well. They started cutting day centres back in London in 2004. Day centres are a place where people can be themselves. There’s one in *name of area* but it’s about £60 a day. So if you think of a service user living on benefits, they can’t really afford that. So if the care managers want to pay it, then that’s great. But they expect us to provide the day-care within the fees that they pay. So it’s a bit of an eye-opener really. [...] It’s all about money unfortunately.”*

Manager, very rural care home

Marginally significant yet positive associations were found between attending a day centre regularly and satisfaction with community activities (table 8.7). Here, independent sample t-tests alongside Mann-Whitney tests, where appropriate (table 9.12), were conducted to identify differences in certain aspects of housing satisfaction amongst people who attended a day centre and those who did not amongst people living in care homes and supported housing services. The results suggest that among the additional benefits that day centres may bring, attending one makes people much more satisfied with their sense of freedom, fellow tenants and housing situations.

Table 9-12: Descriptive statistics and significant relationships: going to a day centre on a typical day

Satisfaction	Go to day centre (SD/N)	Do not go to day centre (SD/N)	U	Sig.	t(n)	Sig.
Fellow tenants	87 (±10.9/9)	72.4 (±21.1/63)	n/a	n/a	-2.092 (72)	.040
Amount of freedom	96 (±8.4/10)	80.1 (±23.5/61)	229	.008	-3.935(40)	<.001
Housing service	93 (±12.5/10)	83 (±17.4/66)	283	.035	-1.740(72)	.043

9.3.3 Community activities: managers’ accounts

Interviews with managers painted a somewhat more positive picture with regard to community activities (Table 9.13); people within their services were described as being very engaged in community activities, especially of the religious type or day centres.

Table 9-13: Service users' activities: managers' responses (frequencies)

Type of activity people engage in	N	Percent (%)
Religious	25	62.5
Day centre	24	60
Gym	18	45
Pub	14	35

However, managers did stress the importance of individual personalities and motivations, relating to the amount of their involvement in the community:

"I guess they are marginally involved in the community. It all depends on people's personalities. They do have acquaintances in the community, but not people they can call friends. They lack social skills, like for example the ability to empathise, to be able to maintain relationships."

Care home Manager, Part rural area

Much like those of service users, managers' responses differed by the type of setting they were attached to. It is useful to examine one significant activity, going to the pub, because pubs provide a space for socialising with people who are not necessarily service users. Chi-square tests showed that service users living in supported housing were more than three times more likely to go to the pub, according to their managers (N=5; 83%) than those living in care homes (according to their managers) (N=7; 23%); and the relationship was statistically significant using Fisher's exact test (two-tailed): $p=.010$.

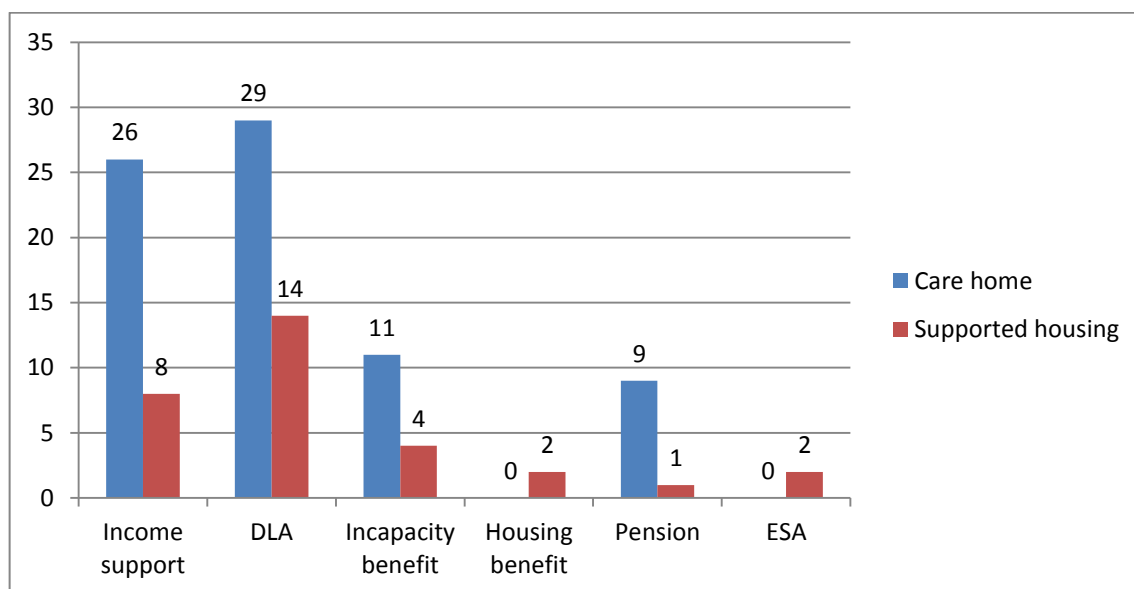
Accounts from service users revealed that 15 (out of 86) actually went to the pub regularly.

9.4 Social security benefits

A key driver of a service user's sense of social inclusion is likely to be their income, generally derived from benefits (Boardman, 2010a; Knapp & Beecham, 1990; Leff & Warner, 2006). The most relevant benefit in the case of people with mental health problems is DLA (Rethink, 2010). Approximately 40% of all DLA claims in the UK are made on the basis of mental illness, as well as 34% of incapacity benefit claims (Department for Work and Pensions, 2002).

Nearly all the people (80) in this sample reported receiving social security benefits: four said that they did not, and two were not sure if they did or not. Most people were in receipt of DLA. Figure 9.3 presents the types of benefits received by service users in care homes and supported housing services.

Figure 9-3: Receipt of social security benefits by type (frequencies)



Other social security benefits were less commonly mentioned: pension credit (11), severe disablement allowance (2), and council tax benefit (1). The mean number of benefits received was two ($SD=0.7$).

Chi-square tests, specifically here Fisher's exact tests (two-tailed), as well as independent samples t-tests, were conducted to explore whether SHS type (care home versus supported housing settings), was associated with variance in the type and number of benefits received. The statistically significant relationships demonstrated that not only were people in care homes receiving a lower number of social security benefits, but they were also less likely to be in receipt of DLA (table 9.14). These results may be expected, as typically a care home resident would receive meals and support as part of their care package, and possible people in supported housing schemes may have more recourse to benefits as they had to pay for some services themselves.

Table 9-14: Descriptive statistics and significant relationships between number and types of benefits by SHS type

Variable	Living in a care home	Living supported housing	t(N)	Sig.
Receives DLA*	69%	93%	n/a	.045
Number of benefits received	1.6 (\pm .63/46)	2.3 (\pm .8/15)	3.042 (59)	.003

(*: Fisher's exact two-tailed test)

It was interesting to explore here whether the number of benefits a person received had any relation to the type of activities they engaged in and housing satisfaction ratings. Pearson's correlations, significant at the .05 and .01 levels of significance are presented in table 9.15.

In terms of activities, the number of benefits was positively associated with going to the day centre, shopping, and hobbies such as pottery, hinting at more disposable income being available to service users. Indeed, a lower number of benefits was associated with service users describing their typical day as "staying in and watching television". Receipt of a larger number of benefits also had a negative correlation with number of days spent in hospital. The number of benefits received had no impact on service users' perceived housing satisfaction, yet did have an effect on their everyday experiences and participation in activities. It should be noted that these results may be very similar to care home residents' involvement in activities, as they were receiving a significantly lower amount of benefits compared to their counterparts.

Table 9-15: Number of benefits received: significant Pearson's correlations

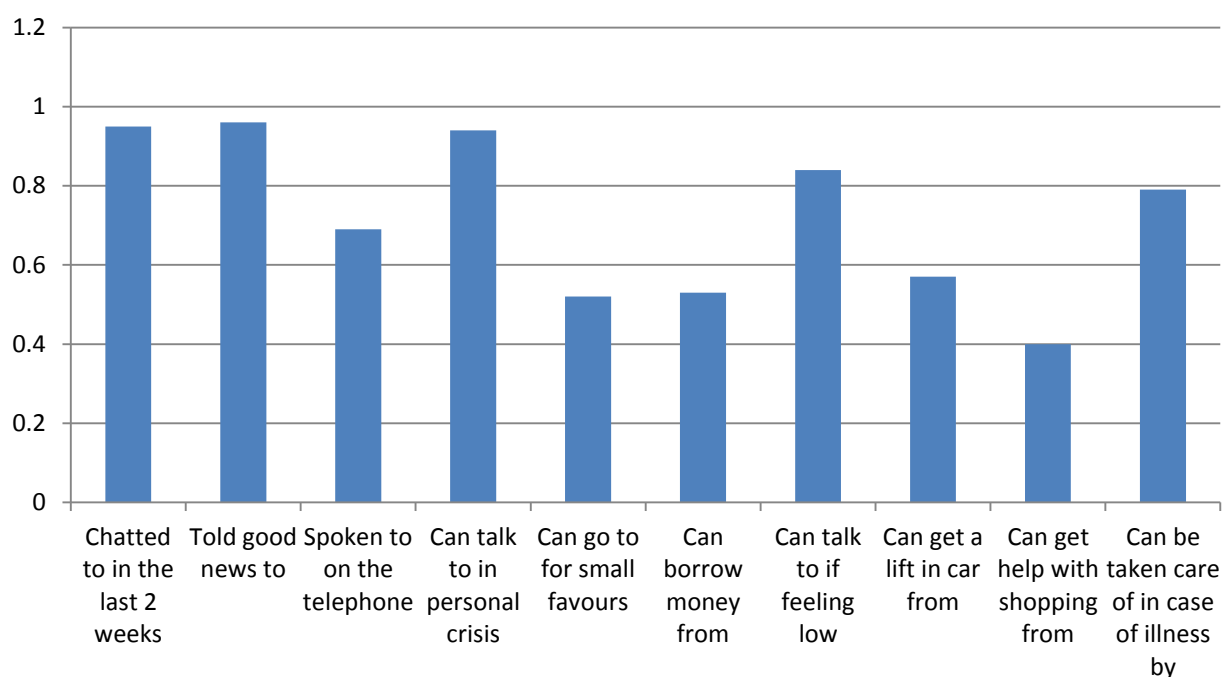
Variable	Pearson's correlation	Sig	N
Times attended day centre in the last three months (CSRI)	.344**	.005	64
Number of days spent in hospital in the last three months (CSRI)	-.256*	.041	64
Most of the day spent within the SHS watching television	-.308*	.012	65
Go shopping and into town frequently	.262*	.035	65
Involved in activities	.326**	.008	65

(**: correlation significant at the 0.01 level (2-tailed); *: correlation significant at the 0.05 level (2-tailed))

9.5 Social networks

To evaluate social networks, ten questions were borrowed from the HANAH questionnaire and included in the instrumentation for this study. No predetermined categories were provided, but the responses were aggregated into six groups: staff, other residents, partner, family, friends or no one.

The mean number of 'categories' of people across all 10 questions that individuals would turn to or rely on was 0.75 (SD=0.32). Individuals expressed having a wider range of people to talk to when they had good news, when they had a personal crisis, or to chat to; and lower numbers when they needed small favours, or to borrow money (figure 9.4).

Figure 9-4: Average number of categories of people across all questions

9.5.1 Describing social networks

For each question, frequencies of answers for each category are shown in table 9.16. People in this sample relied most heavily on staff at times of illness, personal crises and when feeling low, but were more likely to chat with other residents/tenants, family or friends. Service users were most likely to telephone family members, and this was the group with which they shared good news. Family were also there when service users were in a personal crisis. A lack of social networks was most likely to be felt when service users sought people to talk to on the telephone, to borrow money from, to give them a lift in their car, or to ask for small favours.

Table 9-16: Social networks: frequencies of answers by category of person

	No one	Family	Friend	Resident	Staff	Partner
Chatted to	15	27	18	15	16	1
Spoke on the telephone to	34	37	14	1	5	1
Tell really good news to	12	39	13	4	22	1
Turn to in a serious crisis	12	28	6	1	37	2
Ask for a small favour	28	11	5	6	31	2
Borrow money from	33	15	2	8	10	1
Talk to when low	14	16	10	2	35	1
Get a lift in their car	33	10	3	1	30	1
Get help with shopping from	15	4	2	6	26	0
Be looked after when ill from	17	5	1	0	56	1

9.5.2 Social networks by support types

Chi-square tests identified statistically significant differences between people living in a care home or a supported housing setting (see table 9.17). The former tended to rely more on staff to look after them when ill, or when they needed a car ride, but were generally more socially isolated than their counterparts in supported housing services; for example, they were less likely to have chatted to friends in the last two weeks. Also, more people living in care homes said they had no one to telephone.

Table 9-17: Chi-square tests: cross-tabulations of social network differences by SHS type (care home versus other setting)

Variable	N Care home (%)	N supported housing (%)	χ^2 (df)	Sig.
Get a car lift from staff**	27 (50)	1 (6)	n/a	.002
Chatted to friends*	9 (15.2)	6 (40)	4.531(1)	.033
Spoken to no one on the telephone**	30 (50)	2 (13)	n/a	.017
Ask staff to look after them when ill*	44 (80)	7 (46.7)	6.622(1)	.010

(*: Pearson's chi-square; **: Fisher's exact test)

9.5.3 Social networks by population density

Who people would turn to in certain situations, or the availability of support in some cases, differed by population density (table 9.18), as demonstrated by chi-square tests. Using a simple urban/rural binary variable, care home or supported housing service users in urban areas were seemingly more isolated. In comparison, people in rural areas were more likely to turn to staff for support in certain situations. It must be noted again here that most people in urban areas were also care home residents, and may produce similar findings to social network analyses by SHS type.

Table 9-18: Chi-square tests: cross-tabulations of social network differences by population density (urban versus rural areas)

Variable	Urban area (%)	Rural area (%)	χ^2 (n)	Sig
Tell good news to staff**	3 (11.5)	16 (32.6)	n/a	.050
Get a car lift from staff*	5 (19.2)	23 (53.5)	7.886(1)	.005
Chatted to no one**	10 (40)	4 (8.2)	n/a	.003
Chatted to family**	4 (16)	20 (41)	n/a	.038
Spoke to no one on the telephone*	15 (60)	17 (34)	4.606(1)	.032
No one to ask for favour*	15 (57.7)	11 (22.9)	8.949(1)	.003
No one to get lift in car from*	18 (69)	13 (30.2)	9.959(1)	.002

(*: Pearson's chi-square; **: Fisher's exact test)

9.5.4 Social networks and housing satisfaction

Having someone as part of their social network in the following situations was associated with higher housing satisfaction for people in care homes or supported housing services, compared to people who did not have anyone to rely on. People who were dependent on staff in cases of personal crises reported greater satisfaction with privacy, as well as generally (table 9.19). For the dependent variables amount of freedom, housing and general housing satisfaction, the psychological disability and 'having chatted to someone' variable were both significant in the model, indicating that higher reported housing satisfaction in these cases was mediated by an interplay between having chatted to someone and not reporting problems with anxiety/depression.

Table 9-19: Social networks and housing satisfaction ratings: descriptive statistics and statistically significant differences

Housing satisfaction measure	Social network measure	Mean (SD/N)	U	Sig.	t(n)	Sig
Housing situation	Chatted to someone	87.5 (±14.6/56)	288	.019	2.428 (68)	.018
	Chatted to no one	75.8 (±21/14)				
Amount of freedom	Chatted to someone	86.6 (±17.8/53)	278.5	.023	2.878 (25)	.018
	Chatted to no one	67.7 (±32.8/15)				
Social situation	Chatted to someone	76.8 (±18.4/57)	n/a	n/a	3.171 (69)	.002
	Chatted to no one	58.2 (±24.4/14)				
General satisfaction	Chatted to someone	82.9 (±12.9/58)	n/a	n/a	2.739 (70)	.008
	Chatted to no one	71.4 (±16.7/14)				
Amount of privacy	Personal crisis: went to staff	88.7 (±13.6/33)	n/a	n/a	-2.188 (66)	.033
	Personal crisis: did not go to staff	79.7 (±20.1/35)				
General satisfaction	Personal crisis: went to staff	83.5 (±12.5/33)	n/a	n/a	-1.847 (68)	.048
	Personal crisis: did not go to staff	77.1 (±16.1/37)				

9.6 Discrimination: managers' perspectives

It is important to consider managers' views on the question of discrimination against people with mental health problems. Their responses concerning its frequency and circumstances varied widely (see Table 9.20). According to SHS managers, service users were most likely to have limited housing options and choices of who to live with and where. Some managers reported that service users who had just moved from hospital struggled as some were not receiving proper after care.

Table 9-20: Manager responses: discrimination towards people with mental health problems (frequencies and percentages)

Area of discrimination	N	Percent (%)
Limited choice about who they live with	25	62.5
Limited places where clients can live	24	60
No hospital after care and support	13	32.5
No gradation in support	12	30
Discrimination from private landlords	11	27.5
Poor quality housing services	8	20
Public lack understanding and awareness of mental health	8	20
Quotas from social services on number of placements for people with mental health problems	2	5

Discrimination and social exclusion are explored more closely in chapter 10.

Nevertheless, in managers' eyes, it was mostly social services or a client's care manager who would make the decision for them with regard to accommodation. As discussed in Chapter 7, only 18 service users (20.9% of the sample) had actually visited other accommodation services before deciding on their current residence. Nonetheless, almost half (48.8%) said that they had a choice of where to live.

Service users also offered other interesting insights into their situation. Here, quotes extracted from an open-ended question about whether they would like to add anything about their experience of living in an SHS were telling:

"The standards here are good. And if I move out, because of my situation, I'm going to get the lower end of the market. And it's not like I can get a mortgage or anything."

Daniel, Supported housing service user, Very rural area

"I suppose what's provided here is sufficient. It's not really safe to move to independent living because what's provided is of very poor quality. I know lots of people who have moved into supported housing services and ended up back on section or in wards. They can't cope on their own."

George, Care home service user, Large urban area

As illustrated in Table 9.20, 20 managers spoke expressly about discrimination from private landlords and eight mentioned issues concerning the public and their misconceptions. Those figures may be slightly conservative, however, because when asked if they would like to add anything at the end of the interview, 16 raised the subject of public discrimination and stigma:

"The media plays a big role in discrimination and the stigmatisation of people with mental health problems. They are very badly portrayed. They're depicted as murderers. There's a complete lack of awareness of what mental health really is."

Care home Manager, Part rural area

"I'm very aggravated by the media because they're crucifying care homes that are bad. [...] So elderly people read about the state of care homes, which is a very small minority of the population, and feel terrified about where they're going, and whether it's going to be really bad. And then they don't want to go anywhere. And they're advertising all this stay in your own home till you die and we'll look after you there. [...] And they didn't come before because they were frightened by the press. You never read an article about a good care home. To be honest, most care homes are pretty good. They never talk about those, the ones where they're well looked after, where they're well-fed, dressed and happy."

Care home Manager, Mostly rural area

Many managers expressed a general dissatisfaction with the range of support services available to people with mental health problems, limited housing opportunities and the inadequacy of after-care. The quotes below illustrate their concerns:

"There's no gradation between residential care and independent living. The quality of home support is poor. I know someone who moved out from here and into community living and unfortunately died shortly after due to inadequate care."

Care home Manager, Part rural area

*"Yes, lots of them face discrimination. Some people who moved from *asylum* when it closed down couldn't find any suitable accommodation. Their problems were too severe and there weren't any care homes or supported housing services in the borough. They had to be moved to hospital, stay there for three years, until this place was built. And it's a shame that supported living gets more funding because there still is a great need for care homes and this type of setting."*

Care home Manager, Major urban area

"There's a massive shortage of suitable accommodation for people who want to live on their own and have the opportunity to be supported. There's a real lack of one and two-bed properties. There's a need for something like extra-care housing but for adults not older people. And someplace where people can socialise as well."

Shared lives unit manager, Very rural area

"Another problem service users face is that a lot of the accommodation is shared; but at the same time people can get very isolated and supported housing suits them more. They want to live in a shared house, maybe something like student accommodation."

Supported housing Manager, Very Rural area

Such issues, particularly the scarcity of supported housing, and the tendency for too little preparation for independent living, especially for people who had had prolonged hospital stays, were also voiced by managers interviewed in a study by Johnson (2008).

Managers expressed many concerns about the lack of available placements, and - with poor availability of funding - their general outlook was pessimistic. Differences could be seen in the accounts of care home managers versus those of supported housing services or Shared Lives schemes. A chi-square test identified a statistically significant association between these two groups of managers in reporting a lack of gradation in housing. More than half of the supported housing or Shared Lives schemes managers believed that more diversified and progressive options should be available to people as they move on from their SHS, while only a few care home managers did, as identified by a statistically significant Fisher's exact test (two-tailed): $p=.045$.

In addition, managers of supported housing schemes tended to argue that an increasing number of people with mental health problems, as well as complex support needs, were being moved directly from hospital into services such as theirs without any adequate preparation or after-care. In contrast, service users typically

moved from care homes to supported housing services where they still received support (see chapter 7).

9.7 Personalised services

9.7.1 Direct payments and personal budgets

When asked, only one of the 86 study participants mentioned being on a direct payment (DP); none were on personal budgets. Five managers, however, said that some of their clients were on DPs. In considering the uses to which such payments were put, they mentioned a support worker (1), a holiday (1) and gym memberships (2):

"We had a direct payment for a tenant to have a holiday once. I don't understand it all to be honest, and councils are bringing them in at different times."

Supported housing Manager

"One person has a DP to have a support worker come in because of their needs. The person's relative is dealing with it. I think they're happy and it's working reasonably well. But this is a one-off, because I know people in residential care shouldn't be on DPs in any case."

Care home Manager

Three managers confessed to not understanding how DPs worked at all:

"None of the clients here are on direct payments. We've been going on training, and I find that it's very complicated. We just had 2 days of training, and I still can't get my head around it! We don't know if mental health service users are going to be affected."

Care home manager

Three mentioned that some of their residents liked the way the benefits system currently worked, and two said that their residents had indicated that they would not want someone else to manage their money for them.

Three managers reported that some service users were on personal budgets, but negative views were expressed:

"I know that there is a lot of dissatisfaction with personal budgets but I really can't give details."

Shared lives Co-ordinator

"They have seriously started talking about personal budgets now. People who have been moving out from here get a personal budget. Personally, I think it's a bad idea. People won't be able to deal with it and all the stress that comes with managing money."

Care home Manager

9.7.2 Choice-based lettings

Another aspect of 'personalisation' is choice-based lettings (CBLs). Six supported housing scheme managers and two care home managers reported that some service users had moved out using the CBL system. Care home service users would be more likely to move to another SHS, whilst people in supported housing would be more likely to move to their own tenancies within a local authority or other property:

"Choice-based lettings is what we do. People move in here and we do the housing form for them and they go onto a silver band. And when they're ready to leave I write a letter and they go onto platinum band if I feel they're ready to move on. Then they can bid easily, go online and do so. You can definitely get a house when you're on a platinum band. They can get flats of their own but there isn't much shared accommodation available these days. Basically, we don't accept referrals through choice based lettings."

Supported housing manager

"People in here move out using choice based lettings. We have to put them on a register as soon as they move in. And they have to move out within 2 years. CBLs are also limited though. It's all about the money now. It's a shame that people can't have tenancies for life anymore."

Supported housing manager

9.8 Recent policy initiatives

9.8.1 The funding situation

At the time of the fieldwork there was a lot of coverage in the national media of the looming and actual funding cuts to health and social care, and changes to the benefits system. As previously discussed, benefits are a very important source of income for people with mental health problems, and full receipt of their entitlement helps to facilitate social inclusion.

Managers were asked about the current funding situation, and to evaluate how cuts to funding might affect their clients. Some believed that it would create a very difficult situation for service users, especially those living in supported living

arrangements, because they relied heavily on DLA to do 'normal' everyday things. More specifically, 14 managers were of the opinion that cuts to DLA would mean they would lose links with the community and 20 said that it will stop people from doing little things, such as going out for a meal, buying gifts and other activities:

"I really think that people could easily be living here instead of in hospital. Serious inefficiencies are happening. DLA cuts will gravely affect them. And they will be even more socially excluded. And this will impact greatly on their mental health. They are already dealing with a lot of anxiety."

Care home Manager, Part rural area

"People are going to be very badly affected by DLA cuts and it causes great concern. Of course the system has been abused by people in the past. But at the same time, people are not exactly able to go out and get a job. And there aren't any part-time jobs like there were in the past. People have lost their skills. Now with the new assessment system for the Employment Support Allowance, people have been called up for interviews, and when asked have said "I can do this" because maybe that day they feel that they can, but the next day they may not be able to. There's no one there to advocate for them."

Care home Manager, Mostly rural area

Although not specifically asked, a few service users also mentioned the funding situation in their interviews, and their anxieties surrounding it:

"I'm really anxious about DLA cuts and funding cuts to housing. People are going to end up in hospital. There isn't enough sheltered housing available and certainly not enough effort put into housing."

Carol, Supported housing service user, Part rural area

"I'm really distressed and I'm afraid of cuts to funding. They're raising the tax on cigarettes and I already find them too expensive and I can't afford them. They're also closing a lot of care homes and that makes me scared."

Diane, Care home service user, Major urban area

Without prior prompting, managers raised an important point about imbalances occurring within the current benefits system, specifically around people who were discharged from hospital under section 117 and subsequently entitled to free aftercare and, in this case, free residential care (Rethink, 2011), and see also Jones (2011, pp. 477-478). This reportedly created discrepancies between service users living under the same roof: a person subject to section 117 conditions would have their whole benefits' entitlement as disposable income, whilst others would be required to pay their rent with it – a situation managers described as clearly

unfair. Three service users in care homes were accommodated under section 117, and they were mostly very satisfied with different aspects of their lives, especially with regard to income, housing and staff (Table 9.21).

Table 9-21: Residents' on section 117 after-care mean housing satisfaction ratings

	Mean	SD
Social situation	76.7	25.2
Housing situation	93.3	11.5
Community activities	76.7	5.8
Income	90	17.3
Amount of space	80	28.3
Staff	93.3	11.5
Amount of privacy	95	7.1
Fellow tenants	80	10
Amount of freedom	100	0
Amount of comfort	100	0

"The benefits system is flawed....All the guys here are living in a residential home and everything is provided for them, so they need X amount of money for a week. And obviously it frustrates them, because they talk about money and they'll be like 'why are you on £500 a month when I'm on £100?'....If someone has ever been sectioned on a 123 then they get a 117 aftercare you don't have to contribute. But if you haven't been, then you have to contribute. So the tip is, get sectioned!"

Care home manager, Mostly rural area

"DLA cuts won't affect people living in residential care so much because all they're getting is the low mobility. It will affect people living in the community much more. And I know they couldn't do what they're doing without their DLA. And at the same time there are people who don't need it and it's being abused. There are people here with tremendous amounts of money. Because they're on section 117 they probably have more than £50,000 in their accounts.. There's someone they want to move from here and he just doesn't want to go. The county council said that we need to move him or they won't fund him anymore. They're quite patronising sometimes."

Care home Manager, Mostly rural area

9.8.2 Placing people out of area

Of the 79 people in care homes and supported housing services, 37 said that their current location was not where they had spent most of their lives. There were

no statistically significant differences between SHS type or population density in this respect, nor with regard to individual-level independent variables, such as gender, psychiatric diagnosis, or marital status.

However, a statistically significant difference was found between reporting problems with self-care on the EQ-5D-3L and living out of area (Pearson's $\chi^2(1)=6.511$, $p=.011$).

People who lived out of area did, however, recount different moving experiences. Notably, people who were living in their home area ($N=29$) were significantly less likely to report problems with the move to their respective SHS ($N=24$; 82.7%) compared to those who were not ($N=13$; 48%); Pearson's $\chi^2(1)=5.617$, $p=.018$. People whose first time it was in an SHS were more likely to be living within area ($\chi^2(1)=4.619$, $p=.032$).

The literature suggests (Killaspy, et al., 2009) that placing someone out of area may sever their ties with their community, as well as with their family and friends. Chi-square tests were run to explore whether living out of their area of origin had any association with how service users interacted with members of their social network or community. Service users who had been displaced were more likely than their counterparts to report that distance was the main barrier to seeing their families and friends (66% versus 21% of service users), as identified by a statistically significant Fisher's exact (two-tailed) test: $p=.015$. People living out of area were also more likely to report that they had no one to borrow money from compared to people living in their hometowns; $\chi^2(1)=3.838$, $p=.050$.

Although tested for in a binary logistic regression model, SHS type and population density were not significantly associated with being placed out of area. Variables that were significant included housing experiences prior to moving in to the SHS, as well as reporting problems with self-care on the EQ-5D-3L; cross-tabulations of these variables are presented in table 9.22.

Table 9-22: Cross-tabulation: living within area or not

		Living within area		Total
		No	Yes	
First time in an SHS	No	22	14	36
	Yes	15	26	41
Experienced problems with moving into this SHS	No	15	24	39
	Yes	13	5	15
Reported problems with anxiety on the EQ-5D-3L	No	20	33	53
	Yes	16	7	23
Reported problems with self-care on the EQ-5D-3L	No	26	25	51
	Yes	10	13	23

The binary logistic regression model (table 9.23) was statistically significant, and accounted for approximately 35% of the variance of a person living within area or not. The Hosmer and Lemeshow goodness of fit test was not significant, indicating that the model fitted the data well. Controlling for anxiety and depression problems as measured by the EQ-5D-3L, living within area was associated with it being a person's first time in an SHS, and not having experienced problems with the move nor with self-care.

Table 9-23: Binary logistic regression odds ratios: living within area or not

Variable	B	Standard error	Wald χ^2/χ^2	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Constant	-.106	.525	.041	1	.840	.899		
First time in an SHS	1.566	.691	5.136	1	.023	4.788	1.236	18.548
Experiencing problems with the move	-1.389	.740	3.526	1	.060	.249	.059	.1.063
Problems with anxiety/depression (EQ-5D-3L)	.811	.720	1.268	1	.260	2.251	.548	9.237
Problems with self-care (EQ-5D-3L)	-1.842	.787	5.477	1	.019	.159	.034	.741
Omnibus tests of model coefficients			16.620	4	.002			
Goodness of fit test			2.480	6	.871			
Model fit		Cox & Snell R^2 =.261; Nagelkerke R^2 =.348						

9.9 Discussion

Service users are often disadvantaged when it comes to community participation (Huxley & Thornicroft, 2003), especially in terms of employment (Boardman, et al., 2003; Warr, 1987). This chapter has explored this issue by looking at how service users participate in activities as well as employment, and attitudes to and perceptions of discrimination against people with mental health problems.

Employment and occupational activities

For both this study and the Priebe et al. (2009) study, voluntary work prevailed as the most frequently reported option; not many people were in remunerated or full-time work. Priebe and colleagues (2009) found that only 3% of their total sample were in open employment, 8% were in sheltered or voluntary work, and 2% were studying. Statistically significant differences were found in both studies by housing type, producing similar results: people in supported housing were more likely than people in care homes to be in open-employment, sheltered or voluntary work or even studying. Possibly, people in 24-hour support had fewer opportunities to engage in employment, due to the restrictiveness of the setting.

Furthermore, perhaps service users in supported housing services were offered more opportunities for engaging in occupational activities in preparation for their possible transition to an independent flat in the community. There was no statistically significant association with level of education attained and other variables of interest here.

Even when controlling for problems on the EQ-5D-3L and SHS type, rates of engagement in occupational activities were found to be higher in rural than urban areas. This is counter-intuitive, as people in rural areas might have poorer access to transport links, and this subsequently might affect their access to physical places of work. At the same time, it was found that rates of casual, part-time and seasonal work tend to be higher in rural areas (Nicholson, 2008). Indeed, people in rural areas in this sample were mostly engaged in voluntary employment, mirroring research by Drake et al. (1998) in the USA. Furthermore, competition for employment could be higher in urban areas.

Could SHSs otherwise be located in deprived urban areas where employment opportunities were scarce? Deprived areas are characterised by higher unemployment rates amongst people with mental health problems (Boardman, 2010a; Boardman & Killaspy, 2010, p. 77).

Binary logistic regressions illustrated the interplay between setting, location and employment and desire to be employed, although these associations should be treated with some caution due to the relatively low number of cases in some cells.

Barriers to employment

Among the group of service users who were unemployed, people in rural areas were less likely to want to work compared to people in urban areas; this may have been a post hoc rationalisation because they did not think it likely they would find work. People in rural areas were significantly more likely to report that it would be difficult to manage a job than people in urban areas. Could transport links be an issue in this case (Nicholson, 2008)? Further investigation is required.

According to Marwaha and Johnson (2004), the desire for a job is one of the best predictors of future employment. In this study, only a few people possessed such a desire. Proportions of people wanting to work in this study are in line with results reported by Secker et al. (2001).

An important barrier to employment frequently mentioned in this study by managers and service users (especially in care homes) was poor mental health, and disability more generally.

Marwaha and Johnson (2004) in their review of studies on mental health and employment, concluded that the main barriers to employment for people with serious mental illness were not only the stigma they faced, but also their low self-esteem, economic disincentives, and the response of mental health services to their needs for support in obtaining and maintaining employment. Although a general lack of confidence was noted in service users' responses in this study (and was significantly more pronounced in people living in less than 24-hour support), the other barriers mentioned by Marwaha and Johnson were not. Managers had recognised these barriers, in particular employer attitudes and stigma, yet (and perhaps surprisingly), these did not emerge in service users' accounts, possibly because they were not specifically asked. Marwaha and Johnson (2004) had based their conclusion about stigma being the main barrier to employment of people with mental health problems on a focus group study of people with schizophrenia investigating stigma (Schulze & Angermeyer, 2003), and surveys with predetermined answers to choose from (Rinaldi & Hill, 2000; Secker, et al., 2001). A possible conclusion, taking into account this study's data, is that service users may not be aware of stigma and discrimination within the realm of employment. Another possibility, perhaps because they were not directly asked about discrimination, is that they did not feel the need or desire to divulge such information.

No previous studies were found that evaluated how barriers to employment differed between support types. In this study, people in care homes tended to blame their own incapacities for not being able to seek or obtain work, whilst people in supported housing services were more likely to attribute it to a lack of confidence. Given that psychological disability was controlled for, these barriers may be linked to the home environment the person is living in. Possibly, care homes did not instil a belief among service users with regard to their capabilities, and similarly supported housing services did not build up peoples' confidence with regard to employment, perhaps focusing instead on building their skills for

maintaining a tenancy. Supported housing schemes had higher rates of engagement in occupational activities amongst their service users compared to care homes. In the previous chapter, managers of supported housing services also thought their service users placed a higher value on employment, compared to their counterparts in care homes; could managers be influencing this?

The importance of benefits

The type and number of benefits service users received were unequal across settings (table 9.14), and this was related to the activities service users were involved in. In another study it was found that receipt of less than their full entitlement of benefits makes people with mental health problems more socially excluded, because they are unable to share in the costs of social and leisure activities (Cattell, 2001).

In retrospect, despite the possible problem of recall bias, it would have been interesting to have included a question on the cash amount of the benefits received, as it is the *total income* received, rather than the number of benefits, that is important here. The question was not asked because it was thought that it might be hard to get accurate information, and because questions about financial matters can sometimes prove sensitive when interviewing people.

There was much concern among service users over DLA cuts, and their subsequent (negative) impact on their lives, especially in terms of losing links with their communities through a reduction in their income. Managers were also very concerned about unequal funding situations, specifically where people had been in hospital under section 117. This created unfairness among residents in the same SHS.

Social networks

Social networks, in terms of their size and frequency of contact, can have a major impact on peoples' lives. Network sizes were relatively small (also shown by Forrester-Jones et al. (2012)), but people in the present study relied a lot on staff, similar to findings reported in that study. Participants reported a larger available social network, or a more varied one, when they wanted to pass on good news to or chat to someone, as well as when needing a person to talk to when feeling low or during a personal crisis. Networks were smaller and less diverse in comparison

when a 'service' was required by the service user; for example when needing help with shopping, asking for a favour, or borrowing money. Although emotional support seemed to be available to service users when needed (as this may have later repercussions on their mental health), practical support - not related to their mental health needs - seemed to be less so.

People in care homes got relatively more support from staff compared to people in less supported settings, possibly due to the fact that staff were on site most of the time, mirroring findings by Goering et al. (1992), where support received from staff was positively correlated with the number of staff in residents' networks. On the other hand, people in care homes were more isolated in terms of friends, and were more likely to have not telephoned anyone in the two weeks prior to the interview. Similarly, Meltzer et al. (1996) reported that people in care homes were most likely to say that they had no friends outside of the household that they felt close to, in comparison to people in group homes.

Interesting findings also emerged when contrasting different types of area, with people in urban areas being seemingly more socially isolated. McKenzie (2008, p. 364) describes this phenomena as typical of cities, where social networks may be undermined and more difficult to maintain and access. People in urban areas were also mainly care home residents so this may explain part of the variance.

The quality of a person's social network was again associated with self-reported ratings of housing satisfaction; Goering et al. (1992) in their study of supported housing residents in Canada also found that overall satisfaction was greater when residents had more friends in their social circles.

Day centres and community activities

The frequency of day centre attendance was comparable to that reported in the survey by Priebe et al. (2009); although unlike the latter, there were no statistically significant associations by SHS type. Significant associations were found for housing satisfaction in this sample, with reported higher housing satisfaction scores amongst people who attended a day centre compared to those who did not. Although evidence is mixed regarding day centres and social inclusion, going to a day centre may bring the additional benefit of providing a place to go to, to get out

from 'under the roof' of an SHS. Indeed, people who went to the day centre reported very high satisfaction ratings with their amount of freedom in particular.

The most commonly reported activities were shopping and going into town. In addition, nearly a quarter of the sample participated in a religious activity regularly; similar numbers were reported by Oliver et al. (1996, p. 119). These two studies differed, however, in the frequency of shopping; much higher rates were reported in the Oliver et al. study, despite the fact that most of the people in their sample were employed, including 20-hour weeks, possibly hinting at differences in terms of abilities or, perhaps, income.

Significant differences also appeared here by SHS type, with care home residents being seemingly more sedentary than their counterparts (table 9.12). This may be linked to their lower relative incomes, since they were receiving a smaller number benefits. Managers of supported housing services in turn reported that their service users went to the pub frequently.

Personalised services and choices available to service users

Managers reported no real uptake of direct payments or personal budgets amongst service users, with some managers blaming their complicated delivery arrangements, as well as a lack of motivation to switch to a new system. The NHS Information Centre reported that only a very small proportion (5.9%) of social care clients receiving personal budgets and/or direct payments in 2009-10, were people with mental health problems (Health and Social Care Information Centre, 2011c).

With regard to choice-based lettings (CBLs), managers admitted that this promoted choice for service users, but that some groups of people may find the system difficult to access, or even possibly appreciate. In this sample, the use of CBLs was perhaps not widespread due to the high number of care homes in the sample – it was mainly supported housing services which offered CBLs for their service users who were moving on to independent flats in the community. As discussed in chapter 7, service users typically followed a step-down approach to support. Results of the CBLs pilots as reported in a National Social Inclusion Programme briefing (NSIP, 2006) were also mixed. They suggested that CBLs led to a better understanding of allocations and lettings from an applicant's point of view, and a greater perceived fairness compared to the old points-based system.

Challenges included a concern that some people with mental health problems may be unaware that the system is in operation, and may possibly find it difficult to navigate the system and bid for properties. Appleton and Molyneux (2009) concluded that, ultimately, finding a proper balance between choice and need is imperative.

The low uptake rates meant that any meaningful statistical analyses were not possible, and any enhancing effect on choice and housing satisfaction, as well as variations by individual characteristics, or by population density or area (Samuel, 2011) could not be explored. However, some aspects of personalisation could possibly be explored in the qualitative chapter.

Managers' perspectives on social inclusion

Managers were generally more optimistic than service users with regard to their community involvement and social participation. They were also more vocal with regard to stigma and discrimination, although they had been specifically asked about these issues. According to managers, mental health service users in SHSs faced difficulties in terms of both employment and housing due to discrimination, as well as stigma from the public and the media. These topics will be explored further in the qualitative analysis.

Managers also spoke about current housing options, with supported housing managers particularly highlighting the need for more gradation in support. Care home managers may have been less concerned about this, seeing that there was typically a linear step-down approach to support, yet for service users leaving supported housing services the slope may be steeper. It is possible that those leaving supported housing receive inadequate support in the community, thus perpetuating concerns of their managers.

Managers' accounts, perhaps somewhat unrealistic at times in terms of community involvement, highlight and cement the need for a service user perspective in mental health. Perspectives from people in SHSs and those managing them provide useful contrasts and information.

Out of area placements

This study found that a large number of people were living away from their original areas of residence, and some managers mentioned that current policies

meant social services were trying to relocate people back to their original areas of residence. The literature suggests that placing someone out of area does have an impact on their sense of community and tends to break social ties. Indeed, people who classified themselves as out of area found that the main barrier to their seeing their families and friends was not living nearby. They are also more likely to have no one to borrow money from, and report problems with having moved into their SHS.

All of these results provide further evidence with regard to the lack of choice faced by service users, and in some cases the negative impact this may have on their social inclusion.

It is not easy to confirm whether service users in an SHS are socially included or not. Yet several factors, such as benefits receipt, specific geographical areas or support types, were revealed to be mediating that process.

Chapter 10 Exploring the experiences of people living in and managing specialist housing services in England

10.1 Introduction

This chapter presents the qualitative study, designed to explore in greater depth the experiences of SHSs from the perspectives of individual service users and managers. It addresses two main issues: how living in an SHS is experienced and managed, and the potential associations between perceptions of service users and managers. Within-group differences are also explored. Such information is intended to complement the data gathered in the quantitative study.

The principles of framework analysis form the foundation of this qualitative study (Furber, 2010; Pope, et al., 2000; Ritchie & Spencer, 1994, 2002). Compared to other methods, such as grounded theory which is much more *inductive* (Glaser & Strauss, 1967), framework analysis is a *deductive* approach, yet themes are extracted through an interpretive manner (Robson, 2011, p. 479). The main principles of framework analysis were broadly described in Chapter 5, but more detail is added here.

Qualitative interviews can involve four different *types* of questions and this study incorporated all four. Table 10.1 sets out the characteristics of each type of question and presents examples from both managers' and service users' interview schedules. Most questions included in the qualitative study were evaluative.

Table 10-1: Types of questions and examples from interview schedule used in qualitative study

Type of question	Description	Example from interview schedule
Descriptive	Prompts interviewees to provide factual and general accounts of what happened or what is the case as well as biographical information.	Service user: Tell me what a typical day for you is like. What did you do yesterday for example? Manager: Are there rules in place that limit the times outsiders can visit service users?
Structural	Prompts interviewees to identify the categories and frameworks of meaning that they use to make sense of the world.	Service user: What's stopping you from getting a job? Manager: What are you trying to achieve within this housing service?

Type of question	Description	Example from interview schedule
Contrast	Allows participants to make comparisons between events and experiences.	Service user: Did you look at other places before deciding on this one? Manager: How do you feel choice-based lettings compare to the old waiting list system?
Evaluative	Asks about participants' feelings towards someone or something.	Service user: Do you think it's been a good thing for you to come here? Manager: How do you feel people are going to be affected by the Disability Living Allowance cuts?

Adapted from Willig (2001, p. 24)

10.2 Analytical process

Because some of the participants declined to be recorded, it was not possible to include them in the framework analysis. In total, the accounts of 70 service users and 36 managers form the basis of the analysis.

Framework analysis involves a five-stage process (Pope, et al., 2000; Ritchie & Spencer, 2002; Samsi et al., 2010), as shown in table 10.2.

Table 10-2: Steps undertaken in this study for the framework analysis

Stage 1: Familiarisation	
Step 1 Immersion in the data	The researcher immersed herself in the audio files and interview diaries. All interviews were repeatedly listened to. This was done by order of interview date.
Step 2 Strong impressions noted	The researcher took down notes on her impressions of each interview.
Stage 2: Identifying a thematic framework	
Step 3 Aims and research questions recalled	The researcher reminded herself of the research questions and aims of the overall study.
Step 4 Identifying themes	All the previous steps permitted the researcher to identify four master themes recurrent in the data. The interview schedule questions helped to delineate these themes as well. Themes were 'data-driven' as well as 'theory-driven' (Robson, 2011, p. 479).

Stages 3 and 4: Indexing and charting	
Step 5 Starting an Excel spread sheet	An Excel workbook was created, with master themes on each sheet. A supplemental sheet with participant demographic information was added. Every participant had a unique identifier code representing whether that person was a manager or service user, and what type of home (care home, supported housing services, independent living or Shared Lives) they belonged to, their age group, and area they were living in (or population density, urban versus rural). This was done to identify potential between- and within-group differences.
Step 6 Transcribing participants' answers	Interviews were listened to again, and answers to open-ended questions transcribed where they pertained to a particular master theme. Each row represented a participant.
Step 7 Adding sub-themes to each sheet	Gradually themes and sub-themes were added using an iterative process and were populated for each master theme. Quotes were rearranged under different sub-theme headings. Where quotes pertained to more than one theme or sub-theme, this was noted.
Step 8 Identifying key quotes	Key quotes from participants were identified where they typified a particular theme or sub-theme.
Step 9 Thematic charting	An extra column was added to each sheet where each quote was interpreted in the researcher's own words. These represented useful <i>summaries</i> of what each participant said.
Step 10 Starting a reflexive diary	Emerging ideas and thoughts were noted down using a reflexive diary. Notes were taken with regard to data impressions, as well as interpretations, and contrasts between participants' accounts. The author also wrote down any questions that she might want to test once the charting was over; a useful practice during the first stages of the framework analysis.
Step 11 Discussions with expert qualitative researchers	The completed framework analysis chart was discussed with Kritika Samsi and Jo Moriarty, in order to ensure that the interpretations and charts were sound and objective.
Step 12 Refinement	Some refinement was conducted to the initial framework chart, where themes and sub-themes were collapsed, and some simplified.
Stage 5: Mapping and interpretation	
Step 13 Reviewing the charts	Charts were reviewed to make sense of the entire data set. Summaries were re-read and themes and sub-themes compared.
Step 14 Chapter 12 created	A new document was created to include the analysis of the qualitative data.
Step 15 Interpreting the data	The descriptive summaries in the charts became incorporated into explanatory accounts that clarified the data (Spencer et al., 2003, p. 210). These interpretations were conducted for each theme and sub-theme.
Step 16 Identifying between-group differences	Managers' accounts are presented and explained first, followed by service users'.
Step 17 Adding quotes	A quote that typifies a sub-theme was added after the explanatory account in the word document. The service users' quotes were preceded by a pseudonym.

Step 18 Identifying within-group differences	Focussing on age, population density, and SHS type, participants were identified according to these characteristics. Any significant differences by sub-theme and aforementioned variables were highlighted.
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10.2.1 Methods to establish methodological rigour

A personal interview diary was maintained throughout the data collection phase. First, general impressions of each SHS were noted, like cleanliness of the home environment, as well as other factors, such as whether the home was located on a main road, or in a rural setting with poor public transport links. Notes were also made on the home dynamics; some homes had people milling about, whilst in others people all sat on armchairs in a large room, watching television and smoking. The researcher's impressions on the individual interview interactions were also noted, such as whether an interview was particularly difficult, or whether the flow was natural. Other visible characteristics of participants were also mentioned, where they appeared anxious or distressed for instance. Keeping a diary also proved useful when participants gave off-the-record remarks or expressed anxiety over being recorded. This diary served as a basis for reference and comparison when re-listening to interviews.

In qualitative analysis, it is important to highlight reflexivity⁴, which is the "awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research" (Willig, 2001, p. 10). Maintaining an awareness of reflexivity throughout the research process is an attempt to add rigour to the study, as well as to help the reader obtain a complete picture of how data was elicited, obtained and analysed. Reflexivity questions to what extent different approaches could have given rise to a different understanding of the phenomenon under investigation.

There is evidence that interviewer characteristics may have an effect on participants' responses (Lyons & Chrysoschoou, 2000, p. 143). For example, discrepancies in age, cultural background or gender between interviewer and

⁴ Much of the discussion on reflexivity is extracted from Willig, C. (2001). *Introducing qualitative research in psychology : adventures in theory and method*. Buckingham: Open University Press.

interviewee may affect both the level of disclosure and the nature of the response given. Personal reflexivity hence involves reflecting upon the ways in which *“our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research”* (Willig, 2001, p. 10). This section expands on the author’s characteristics, starting with presentation at the time of interviews, pre-existing knowledge and experience in the field and personal attributes.

The researcher is a British Lebanese woman, 28 years old at the time of the interviews. Her prior research experience provided awareness as to the importance of presentation when interviewing people. She always dressed smartly, but not in a suit. She had her university ID badge to hand so that service users did not see her as a social worker or psychiatrist, a mistake that could have biased results, especially since the research was interested in issues of where people might subsequently move. At the start of each interview, she emphasised that the time being accorded to her was greatly appreciated, as it was providing valuable data for her PhD thesis. Many service users said they were happy to participate, as it was nice to have someone to talk to besides the other people in the SHS. Some were keen to know why she had chosen this particular topic (housing) and why she was interested in mental health. A few managers displayed some uneasiness when she first met them, with a couple carefully reading through the ethical approval letter, and checking her credentials. They seemed to relax during the interviews; especially after data protection processes were reasserted. Yet, on the whole, they expressed a genuine desire to help and felt that this was a very under-researched area, with none of their (service users and staff) views ever being taken into account or sought. The majority of participants wanted to receive a summary of the results of the study once the PhD was obtained. Following the interview, one service user sent the researcher a letter, and another sent a booklet of their own poems as a thank you.

The author’s background is in Psychology, and she had sufficient pre-existing theoretical knowledge. In terms of experience, she had worked as an assistant psychiatrist in Lebanon, but was unfamiliar with UK care settings. She had conducted prior research work on SHSs for people with mental health problems in

England, using a postal questionnaire completed by managers (Priebe, et al., 2009). The author was therefore curious to find out more and gain a perspective from the users of these services.

On a personal level, the author is generally a calm and empathetic person, and people seemed to feel comfortable conveying personal, and sometimes negative stories and experiences. In many instances, the author was alone in a closed room with a participant; her prior knowledge and experience of mental health contributed to her confidence.

As mentioned in section 6.5.1, interview assistance was provided by another researcher. The second interviewer was older than the author, female, British, and possessed a similar background in terms of experience of working with people with mental health problems.

10.3 Characteristics of the qualitative study sample

Audio recordings of interviews were obtained for 70 service users and 36 managers in this study. All 36 managers' narratives were used in the charting phase of the framework analysis, but not all service users could be included at that stage. For instance, where they were unable to be informative or strayed off the point, their full responses were not transcribed or inputted into the spread sheet for later analysis. In total, 53 service users and 36 managers were included in the final framework analysis. Of these, eight service users and seven managers had been interviewed by the other researcher.

10.3.1 Service user characteristics

Service users were on average 52 years old ($SD=12.1$). Thirty-five participants were male, and white British (there were three people from a BME background). Service users reported a mean score of 70 on the EQ-5D-3L VAS; 19 (out of 53) people said they had problems with anxiety and/or depression. The most common primary diagnosis was schizophrenia (34), followed by unipolar depression (6) and personality disorder (4).

Most people were living in care homes (34) and supported housing services (12). Five people were living in a Shared Lives scheme, and two people were living independently. There were more people living in rural areas (35) than urban.

Compared to the sample for the whole study (see section 6.6.1), the sample for the qualitative study scored their health slightly lower (although the ages were similar), and there were more people reporting problems with anxiety or depression.

10.3.2 Manager characteristics

Managers' mean age was 46 (SD=9.8) years, and they were managing care homes (27), supported housing schemes (5) and Shared Lives schemes (4). The majority were women (22), and white (25). As with service users, they were mainly located in rural areas (19). In general, manager characteristics were comparable to the full study sample (see section 6.6.2).

10.4 Introduction to qualitative findings

Four broad themes were identified from the initial analysis. These included (1) independence and autonomy, (2) the housing experience, (3) choice and control, (4) social exclusion. The full framework analysis chart can be found in appendix H.

These master themes were chosen as they were recurring categories in the data (Ritchie, et al., 2012, p. 228).

The first stage of analysis is *descriptive*, and involves the 'unpacking' of the content and nature of a particular phenomenon or theme (Ritchie, et al., 2012, p. 237). This is done for all master themes and respective sub-themes. What follows is the *interpretive* section, with a comparison between managers' and service users' accounts. These are presented separately but consecutively, so to facilitate comparison.

10.4.1 Master theme 1: Independence and autonomy

The first master theme concerns the descriptions that service users and managers use about their perceptions of independence related to moving in and out of SHSs. A number of elements were discussed by both groups, comprising (1)

interpretations of independence, (2) concerns and fears, and (3) success stories. Each group tended to focus on different specifics, and differed in the way they expressed their views. Managers tended to view independence as a functional process, somewhat mediated by powers beyond that of the service user, whilst the latter took a more subjective view on how it might affect them.

10.1.1.1. Interpretations of independence

For some managers, independence was very much seen as a concept that was relative to a service user with a mental health problem, and that ascribing a generic definition of independence to them would be false:

"I suppose the main goal for everyone here is independence, but independence for Joe Bloggs could be getting married, working 9 to 5. Whereas independence for some of our guys could be making a slice of toast safely or doing their own laundry, due to their mental illness or brain injury, or institutionalisation which we try and get out of them. Some guys have been in care for 30 or 40 years, so all of their adult life."

Manager, rural care home

Indeed, some managers referred to an engrained 'institutionalisation' inherent in some service users, due to their long period of time within care, as a barrier to becoming more independent.

However, many managers viewed independence as a process concerning service users' changing relationship to staff, with a particular focus on issues of autonomy. Once a service user learnt to detach from staff and rely less on a care team, be it to go out 'unsupervised', to self-medicate or to attend doctors' appointments without prompting, then they were deemed 'independent':

"Moving on is not something you wake up and say you're moving this person on, it's a gradual process. You have to identify that these persons' needs are progressing towards independence. So when a person becomes independent, they get to a point where they don't require 24-hour care, so that's what we try to do. So when their needs are satisfied, they're ready to move on."

Manager, urban care home

Not many service users (only five) spoke of independence as a concept, but of those who did, they were mainly referring to a similar sense of autonomy, for instance to be able to cook for themselves, do their own washing and laundry, have a full-time job, and basically *"be [their] own boss"* (Chloe, rural care home):

"I'm a very intelligent and capable person. And I wanted to get out of there. And I wanted to do more things for myself, and I wanted to be independent."

Mary, rural supported housing service

10.1.1.2. Concerns and fears

Managers were divided as to whether they sought to promote independence amongst their service users.

Some managers believed that too much independence was, in general, 'bad' for service users. They felt that service users could become socially isolated, and independence was not 'natural' because it was based on a false ideal, for instance that *"culture dictates to us that making it is 'having a flat'"* (Manager, urban care home). Indeed, they were concerned that service users could be prone to abuse and exploitation, leading to an eventual deterioration of their mental health condition:

"We've gone too far the other way really. It's a human need to be in a social environment. An acute problem is social isolation in this case. People who are more disabled socially won't be able to move. Social isolation is far more of a threat, though, than somebody's well-being. That's a real big issue. And there's a sort of philosophy that independence is good. Which is not true. And it's not normal for the majority of people to live by themselves. I mean, some people do. But they are the exception. To expect someone to move on when they're so disabled by their personalities is completely unreasonable and it puts pressure on them."

Manager, rural care home

Many of these fears were the result of bad experiences they had witnessed when seeing people move on from their homes. These failures did not stem primarily from service users' increased social isolation, as some had envisaged, but from the receipt of poor support in the community:

"Someone was living here and he wanted to move independently. But the quality of support he got was so terribly inadequate. He died a couple of months later. He used to tell the social worker to go away, but he didn't really want them to. It was a cry for help. He fell down the stairs while drunk and died. That's the peril of moving out in the community, the quality of care isn't good and not reliable. Some people who provide domiciliary care aren't properly trained or qualified. It's really hard to regulate people in domiciliary care, and what happens behind closed doors. You're employing people at the bottom of the wage scale and some of them are really good, but some are not adequate. If that was addressed, then people could live better in the community."

Manager, rural care home

Moreover, managers reported that the personalised support people had been receiving tended to disappear, because social workers had too many people on their lists and not enough time to offer. The health and hygiene of service users deteriorated, as they stopped self-medicating, and kept poor food habits:

"We see them from time to time, but their lives are not the same after we sent them off. They've deteriorated, they're not taking their medication. When they leave we have no formal contact. But informally they still come round and visit. One fellow left and I saw him two weeks ago and he's not taking his medicine, speaking like a machine gun, he's lost weight. They're not giving him enough support there. I went to a person who was living here's flat...the social worker was trying to help but the person shut him out. He was eating at random, opening a tin of sausages and would eat that from the tin. There were mice and rats all over because it was so unhygienic."

Manager, rural care home

Service users' own responses to moving somewhere more independent in the future was mixed. Of those who did not want to move, many expressed anxieties about being on their own and the loneliness that would ensue. Yet the term 'loneliness' seemed to be used in a different sense than expressed by managers; it was more about being alone, without supervision, without staff. Indeed, they were deeply concerned about the lack of security they would experience without staff support in the community. For many service users, staff represent security and safety:

"I used to live in the main house. But then I got the opportunity to get that flat and moved out [of the main house]. I feel like I'm becoming more and more independent, and sometimes I feel like I need the staff. But sometimes I feel they think I'm ok, but quite a lot of the time, I'm not. If they left me altogether, I don't know what I'd do. And it worries me if they suddenly said to me, go on and live on your own, I wouldn't be able to do it. It worries me...because they take less and less notice of me. If I needed help I could ask them. I don't want to leave. It's nice for me in my flat because I've got support and security as well. I wouldn't know what to do if I lived on my own. I have the best of both worlds here."

Catherine, rural care home

They also expressed a lack of confidence in their ability to do things on their own such as cooking, as *"things might blow up, burn"* (Kylie, rural Shared Lives scheme). Service users who had been in their accommodation a long time were reluctant to leave the comfort of their surroundings, the personal care they were receiving from having staff that did not change; *continuity* provided security:

"I couldn't cope on my own. The best place for me is residential care because of my mental health, and my physical health. So we're getting the full support here. They've known me a long time, they know how to look after me, they know what I like to eat. I know the rules. I like being here, it's really good here, it's home. I don't think it's safe to live in independent living, and what you get in terms of support is poor. And I've known a lot of people who've gone out and are back to square one and ended up on sections or in acute wards. I wouldn't take that chance, no way. I've come such a long way, if I moved out of here into somewhere completely different and I wasn't coping then maybe I couldn't get back into here. And I'm going to regret it. And I'd lose everything."

George, urban care home

A concern was also expressed by some service users over money management, and how they would manage to pay bills, especially for some who had lost their tenancies at one point because they could not keep up their rent:

"Plan to leave next year to get my own flat. But a lot of the things revolve around money, like how much money I've got to spend, or if I want to go into town or whatever...I will get more money when I move out, but I will have to pay for food, electric, gas, council tax, water, television licence. I'm not really sure how it will work out."

Olivia, urban care home

10.4.1.1 Success stories

Some managers reported positive outcomes from seeing service users move into the community and some service users also had positive stories.

Managers reported on service users reintegrating successfully into the community, obtaining jobs, managing their own money and budget, and self-medicating. The issue of managing a tenancy was also broached, and managers reported providing service users with information on advocacy as well as their rights as tenants. Many managers recounted that they achieved higher degrees of independence amongst their tenants by improving their ADL skills, focussing on their strengths rather than their weaknesses, and empowering them as individuals. The focus here was on *recovery* and instilling that idea in service users:

"We focus on what people can and can't do. Reinforce what they can do. So it's not all negative. So it's not all about 'I have a mental health problem and I'm stuck here'. In reality, there are a lot of people who have mental health problems who hold down jobs and have families. It's about their recovery. And the belief that they can believe in themselves. And it's also about self-awareness, and the early triggers of what they can do."

Manager, rural supported housing service

Service users who had moved to less supported settings, and were now in supported housing services or independent flats, reported positive experiences, improved well-being, as well as a sense of achievement: they were now able to do things for themselves, although admitting being slightly ambivalent about the move at first:

“Try to keep myself active. If I'm busy, it's good for my health and well-being. Something to do. I don't really like staying indoors for any length of time. Because if you're on your own, it can be very isolating and lonely at times. So I do make a point to get out and about and be around people and the community. And it's good for your well-being. We are gregarious animals. I was a bit anxious at first, about living on my own. In case I had another breakdown. But once I moved in, it was all plain sailing. And I was quite relieved that I could cope. And was pleased. And my confidence and morale grew as a result. It's been a good thing for me. I feel safe and secure and I'm coping all right.”

Ally, rural supported housing service

Service users who were thinking about moving to their own flats all mentioned that they wanted to maintain links with their previous SHS, by going to visit sporadically, in part to maintain *continuity*.

One person living in a flat on his own reported being happy, yet missed the support he had previously received from the CMHT:

“The move was a good decision. I certainly am more independent now than I was before in the more dependent [housing service]...the only downside is that I don't have a worker now, I don't have a CPN, I don't have a social worker, I don't have a housing worker. Between 2005 and last year I had a housing worker, now I don't have anyone. All I have are a GP and a consultant. (“Do you find it...?”) It's not a problem, I just have a few on-going problems with the council. But I'm quite happy where I'm living. I mean, I'm quite independent, but I could do with having a housing worker of some sort. A lot of people I know, people who are more unwell than myself even, don't get proper workers. They don't get CPNs, they don't get social workers. I'm just saying there's not a lot of support at the moment, whereas before there was support. I guess it's just different. I had some good times when I was with [charity].”

Tom, rural independent flat

10.4.2 Master theme 2: Choice and control

Choice and control emerged as an important theme that ran through several aspects of peoples' lives, from accommodation to the services received. Four broad sub-themes emerged: (1) the adoption of policy changes; (2) choice of where to live; (3) choice-based lettings and (4) personalisation.

10.4.2.1 Policy changes

Policy changes have had a profound effect on life within SHSs. These had been felt in three ways: (1) the departure from 'homes for life', (2) the pressure imposed by social services on managers (and subsequently on service users) to move people out into the community, and (3) relocation policies. These policy changes were imposed on service users and managers of SHSs: choice of where a person lived, how long they were allowed to stay, and what support they received, were mediated by social policies beyond their – or managers' – control.

The departure from 'homes for life'

Supporting People, a funder and provider of supported housing, normally assess their tenants every two years for an indication as to whether they can move on to less support (see chapter 2). As indicated in previous chapters, relatively little information exists on the pathways of people into residential care or on the nature of care provided, and more specifically whether these services were intended as homes for life or more transitory accommodation.

The only type of SHS in this sample seemingly affected by this change in policy stance was care homes. The consensus from managers of care homes, when asked about service users' average lengths of stay, was that there seemed to have been a policy shift in the last 10 years, with more of a focus being placed on recovery and gradual independence:

"A lot of the current clients, when they came here, in a sense this was going to be their home for life. But all the policies have changed now, and the idea is that people don't spend time in residential care. I mean who wants to be in residential care? So that is changing. But at the same time I haven't had a vacancy in three years. If I did get someone new in now, it would be short-term."

Manager, urban care home

They reported that this shift has led to relative confusion and subsequent anxiety amongst the original community care clients who had expected to be housed and taken care of all their lives within the same setting:

"Some guys have been in care for 30 or 40 years, so all of their adult life. Times are changing now, there's a lot more focus on recovery and independence. But 10 years ago, that wasn't the case, so people have been caught up in the system for a long time. It's extremely difficult and it's extremely scary for them, the prospect of being alone or not being looked after as such."

Manager, rural care home

More specifically, managers related to feeling powerless in the face of these changes. They had no choice but to follow through with these national changes, so that service users who had had all their needs formerly met by staff were suddenly being expected to do much for themselves. Several managers reported mental health relapses right before a person was supposed to move, due to the fear of this unknown:

"We've set them up, basically, so let's look after them, let's do everything for them, and now that the government has run out of all the funding, let's move them on. While they've encouraged us to cook for them, clean, laundry, everything for them. And now they want to change it. I think that's really hard for someone to change the way they live, especially you know, at their age as well."

Manager, urban care home

There was a general consensus amongst managers that the experience of having an insecure placement that could be revoked at any time breeds insecurity amongst service users, especially those with a mental health problem, and lends itself to decreased well-being:

"I think it's a shame that people don't get tenancies for life anymore, because when you have mental health problems, and you have basic needs and your secure housing is met, even if you go into hospital, your landlord won't take your housing away and you'll have something to come back to. And that, in itself, gives you more security and probably you're less likely to have a relapse, because you have less to worry about."

Manager, rural supported housing service

Pressure from social services

Many managers reported feeling pressured by social services to move people on, sometimes before service users were ready to do so, due to financial pressures. This created, in some instances, false expectations for service users, who were thereby expected to get better and to require less (and in turn cheaper) support. In some ways, managers felt that users' capacity was taken advantage of,

because service users were presented with choices that were not necessarily advantageous to them:

"We don't push people, but I've got a feeling that social services do. Because obviously they try to make people move to supported living, because they think the fees are less expensive. If they see a chance that somebody wants to move, then they say that this person is healthy, and they can do everything and they don't consider much their mental condition. They tried to push a person out, and this person is very polite and he says yes to everything, and he said yes to them and he confirmed indirectly that he wanted to move. But in truth he couldn't because of his mental condition. We had to stop this process because it was absolutely nonsense."

Manager, rural care home

Funding pressures created impossible situations that were out of managers' control, as they were faced with making decisions between what would make sense for them as a business compared to what was in the best interests of service users. Most managers admitted that at the end of the day, it was the service user's choice as to whether they ultimately wanted to leave:

"It is a fine balance. There is a lady here who has absolutely all the skills and when I asked her if she'd come and talk to you said "Is this about me moving? Is this about me leaving? I don't want to leave!". Which is kind of a bit frustrating because she could be moving on, and again it's a difficult balance between my business head and my social one. At the same time I don't want my business to stagnate with a bunch of people that I can't move anywhere, and the only reason people would leave was if they die. This is their home. We've come to this stage where they say this is my home, I don't want to move to an older person's home."

Manager, rural care home

Some service users, in turn, felt helpless in the face of such pressures and indicated that they were not being accorded their rights. Most felt that they had no control over how long they could stay within their home and no choice as to where they were going to be placed afterwards. Most exhibited confidence in their capacities to make decisions, yet felt that they were never presented with an opportunity to exercise that choice. This was a great source of anxiety for them:

"They're trying to move me on. They're cutting down on the mental health services. Apparently it's about putting prices in different corners. I don't really understand it all. They came to me before Christmas and told me your funding is going to stop. I actually need my room. It's a terrible insult to me as a mental health patient."

Joanna, rural care home

Relocation policies

Five managers spoke of general relocation policies, or selected local authorities' new policy stances to move people back to their original county or borough. People had originally been moved because of substance misuse issues, or judicial ones; presumably out of no choice of their own. Now, people were being moved back to where they came from, and away from their current residencies, also due to funding constraints.

These managers all held negative views of this policy, as they felt that it would not benefit service users on any front. It would disrupt the social ties that they had forged with their local communities and also place them back into the negative environments they had been moved from. Managers were powerless in the face of this situation, and also indicated that the service user had no say in the matter, even if they expressed a reluctance to go. Managers who had seen people being relocated reported it is as being detrimental to service users' well-being and social situations:

"Most people here are out of county, and they're here for a reason. Like one person is on the sex offender's register. And they thought it would be easier to move them out of county in those days. But now, they're bringing people back in to county...our people don't have any connections or family back in their county, so there will be no point. We have challenged it, but it's been very difficult. A couple of years ago it was all about personalisation and person centred care, now it's all about financing and funding."

Manager, rural care home

No service user spoke of their experiences or concerns in terms of relocation policies, although as described in chapter 9, many people were living out of area, and reported worse outcomes compared to their counterparts.

10.4.2.2 Choice of where to live

Managers gave a wide range of explanations as to why someone with a mental health problem would find it hard to find suitable accommodation in the community or elsewhere. It was said that there were limited housing options available. There were not many self-contained units available on the market, so sometimes people had to share communal areas with people they did not know,

and who they had not chosen to live with. The only grouping characteristic between people was often the fact that they had a mental health problem:

"My theory is that when you choose to marry someone and live with them, that can be quite hard at times. But when these people are all thrown together, they haven't asked to be put with that person there, so it's difficult for them. It's hard to put 30-odd people together when they haven't chosen to live together."

Manager, rural care home

When service users were faced with a so-called 'choice', it was more about what was available, rather than what they really wanted, according to managers. This choice was additionally constrained by the fact that they were on benefits. Managers reported that people at times did want to move to less supported arrangements, yet were forced to remain in their current situation, either because there were no other options available, or because their care team did not agree. Again, service users' preferences were reportedly not taken into account:

"Sometimes they're kind of dictated by what the care co-ordinators say. They might sometimes not want to move in here, but it's what's available. And quite often they would think that they can move on to independent living but the care team disagrees."

Manager, urban care home

Managers said that they provided prospective service users with the option to visit the SHS to decide whether they liked it or not; managers considered that, in their opinion, by doing this, they were offering a service user a choice.

Service users, when asked if they felt they had a choice of where they lived, reported several factors that had restricted their choices. One issue was funding, that their choice was limited to whether they could obtain funding for a place. Sometimes service users had to move somewhere because there was no other alternative:

"I looked at [name of place] but I couldn't get the funding for it, and [name of place] and [name of place]. And this was the first place that offered me a place."

Robin, rural supported housing service

Not only were their choices limited, but service users felt that their needs were not taken into account. For instance, they might be forced into accommodation with intense support after their stay in hospitals, when they in fact

felt they required less. This hints that there may be a specific pathway that service users had to follow, one that was mentioned by several managers in this study:

"The expectation is that when people leave here they just follow a certain pathway, and it seems quite dictated to them...They go from hospital, to residential care to supported living...if you do well here, you'll get to here."

Manager, rural care home

Some service users reported taking up an offer of a placement just because it was preferable to remaining in hospital:

"If I didn't come here I'd still be in hospital. And the doctor was very one-sided about it, and said I should move to high support. If I had a change of consultant, I would have had more of my views allowed and more leniency. I probably wouldn't be in high support, I'd probably be in my own flat. But the doctor just treated me like some kind of juvenile delinquent. I'm 32 years old. And she treated me like a retarded child. And I've got a university degree myself, and I've worked, with normal people. In normal environments. I had no choice in anything. Well I had a choice to come here, I could say yes or no, but there was no other choice available. I came to see it, but it was just a quick way out of hospital."

Kenneth, urban care home

A few service users, who were ready to move to housing with less support, felt that what was on offer in the community was not actually what they wanted or needed, and that the quality of housing was poor:

"Housing seems to be such an issue, it's so difficult to get anywhere to rent. There's a bidding system, I'm reluctant to bid for those massive huge boxes, but if you have to, you have to. They're just so impersonal. I know I'll get something eventually. I thought there would be more sheltered stuff available rather than family placements."

Paul, rural supported housing service

Choice was conveyed when (some) service users reported having seen other placements before deciding, and having the choice to refuse a housing placement, should they want to:

"I was brought here...but I did have the choice to say no."

Sylvia, rural care home

10.4.2.3 Choice-based lettings

Despite policies that have curbed peoples' choice of where to live, a relatively new policy, choice-based lettings (CBLs), planned to promote choice and control amongst service users. This was discussed by a few participants in this study. CBLs seemed to be a policy exclusively reserved for people living in supported housing services, and many managers described putting people on the CBL register as soon as they moved in, as they had two-year contracts.

Most supported housing services managers agreed that CBLs offered more choice to service users, as they could see what they were bidding for, and exert their preferences. It also gave them something to look forward to:

"I think it's quite a good system for people in supported housing who get help in using it, they can see what they're bidding for, they can look at the property, they can go and have a look around where it is. They can see where they're going to finish. It gives them a bit of hope. If you're on a waiting list you haven't got a clue what's out there, what you're likely to get. And there are a lot of people here who enjoy bidding, they really do. There's one service user who really studied the property for quite a while, the bus route, will I be able to get to services."

Manager, rural supported housing service

However, CBLs supposedly also brought negative externalities. In practice, some managers were concerned that service users experienced disappointment due to the excess demand and could become anxious as to where they were going to live. People sometimes just gave up and took what was available, rather than what they wanted, be it an independent flat or another SHS. It was seen as important to manage expectations in this case:

"I think it's quite complicated and frustrating because they're bidding against everybody else. The guy who was doing it, he was bidding on quite a few properties, and we sort of did a lot of work around why he didn't get it and I think for others it put them off. One guy here, he's not doing it anymore, he's kind of given up the ghost."

Manager, urban supported housing service

One manager commented that giving choices to service users would place additional pressure on them, and was associated with anxiety:

"People are entitled to choices, and they should have choices, but they need to be realistic. If you sometimes give somebody too much choice, they might not

know what to do...and often this client group should have these closed boundaries of you can have option A or B and they're happy with that because it's a choice, and it's a choice they've been helped with."

Manager, rural care home

Not many of the service users in this study had used CBLs; only a handful of people in independent accommodation were sampled. The one person who recounted their experience was positive and satisfied about it, particularly welcoming the transparency and simplicity of CBLs. They were happy with having exercised their choice, yet still sought advice from their care team:

"I was bidding for a while and I never thought I'd get a place. And the place that I really wanted was the place that I ended up getting. You go online and you bid, and I was third in line. And then they phoned me up and they said, look we want to offer you this house. So I spoke to my housing worker and he said, well you better take it. So I did."

Tom, rural independent flat

Another service user who was currently bidding commented that there were not many options available to choose from and that it was *"slim pickings out there"* (Dimitri, rural supported housing).

10.4.2.4 Personalisation

The theme of personalisation was translated in two ways here: with the services that people were offered and with the processes in place.

Person-centred care and one-to-one funding were processes by which managers aspired to offer people more personalised care. Some discussed their decision of not having set meal times, and providing a range of choices of meals, for example. They aimed to avoid routine in peoples' lives, allowing for some spontaneity. However, in some cases, this would require additional funding: for example, if a person wanted to go into town on a whim, and had to be accompanied by a member of staff, they would require one-to-one care. Some managers tried to provide personalised care within the limits of their funding, innovating where possible. This proved even more difficult with premises housing a large number of people, where not every need could be catered to:

"Group living is a challenge. It's difficult for people who live here and it's difficult for people providing the service. We work very hard to not routine peoples' lives,

to be completely flexible. Doing that for 15 people is difficult. In order to respond to their individual, likes, dislikes, needs, requirements, and enabling people to just off the cuff say, "oh can I go and do this tonight?". Obviously I can't staff the accommodation on a one-to-one basis. I mean our funding is around one to 4, so we're having to juggle lots of wars all the time. We do encourage people if they want choice to be involved in making that."

Manager, rural care home

Service users did not talk about this aspect of personalisation much, and not many conveyed a feeling of restriction in return. On the other hand, not many communicated being involved in the running of the house, although some managers had reportedly tried to enable that. Possibly some service users did not want to be involved in making those types of choices and preferred to be taken care of instead. In general, some service users reported they were involved in menu planning, and gave their preferences on what activities they should be doing as a group.

Although a few managers believed that direct payments (DPs) or personal budgets (PBs) provided service users with choices of services they would not have been able to access otherwise (for example gym membership) and increased control over their care, the majority of them held negative views on these payment systems due to their complexity. Most did not understand how these personalised services worked, adding that service users would not have the capacity to manage their own money (although most managers admitted to teaching people how to budget) and make those choices on their own. Some believed service users were at risk of abusing the DP system, by possibly buying services they did not need, or harmful substances such as alcohol and drugs. Some added that DPs and PBs were not a service that people necessarily want:

"I've heard a lot about personal budgets in the last couple of months. I personally think it's a dreadful idea. I think there are a lot of people that will be given personal budgets that don't have the ability to budget daily, let alone look at a yearly budget and work out where they're going to get their services from. Sometimes it would be a matter of looking at what services they will be able to find, and they don't have the ability to do that, let alone being able to purchase it and work out how many. So I think when you've got somebody who has mental health issues, it's an area of their life where they don't really need the extra hassle and anxiety."

Manager, rural care home

Not many participants in this sample were on DPs as the majority of them were in care homes where DPs were largely unavailable (at the time of interview). One service user who had been offered DPs expressed anxiety over not wanting to switch providers:

"I know direct payments go direct to the person. I'm not interested in changing provider. I'm quite happy with [charity]."

Ally, rural supported housing service

10.4.3 Master theme 3: Housing experience

A key aspect of this study is how housing is *experienced*. Several factors within the homes contributed to making this experience positive or negative for service users and managers. The most vivid ones that came out of the interviews were (1) freedom and safety; (2) staff; (3) environment quality and (4) money issues.

10.4.3.1 Freedom and safety

Most managers' first reaction to questions about their users' freedom was to say that there were no rules within the housing service, and that service users could come and go as they pleased. However, further probing uncovered some sets of intricate rules.

Managers differed in the reasons as to why they had imposed these rules. Some said that they restricted services users' current freedoms in order to enable them to become more autonomous in the future. For instance, it could be necessary to restrict a person's freedoms to go out in order to free up staff time to work with them on their ADL skills. Another reason concerned their responsibility to protect service users from their own 'vulnerability' in the outside world. Yet, managers felt it was still important to take risks:

"They can go out any time, no restrictions. We look at the risk side of things. Come back when it's dark because it's not safe, when it's meal time, when it's medicine time. But they do comply with that. And of course occasionally someone will be late, so it does happen. But the downside that we try to emphasise is that it's not very safe for them out there."

Manager, rural care home

Most homes locked their front doors after a certain time of night, typically at 22:00, to keep people in (and thus service users did not have a key). Most managers insisted that this was done in service users' best interests, and justified that they were not depriving them of their liberty, although such deprivation of liberty was never raised by the interviewer. Several managers added that, in their opinion, this was what service users wanted, as they preferred these boundaries because it made them feel more confident, secure and safe:

"Safety and boundaries and freedom, it's all a bit of a mix. Sometimes you have to limit freedom to provide a safe boundary to come up against. But then on the other hand, there is total freedom to go outside and get out from under the roof."

Manager, rural care home

Other rules included named visitor policies, and no visitors after a certain time; some services did not permit non-residents to stay over or people of the other sex in their rooms at any time. Most of the time, people had to be back for meals, and to take their medication. This was all done in the name of protecting service users, and to respect the other people living in the house, as well as staff. There were guidelines to abide by. But it could be said that such rules somewhat lessened the feeling of it being a home, and the possibility for people to have meaningful relationships:

"They're never going to be able to come and go as they want to. I'm not saying they all want to do that, because there are some that are able to go out independently, but most residents have to have somebody with them. They're restricted, they can't eat at any time of the day. Wherever you go, however homely it is, it's still an institution because there are rules and boundaries set within the home. It's not an infringement on their rights because obviously we have all this legislation out and all these guidelines, to make sure that people are you know, looked after. And also if you have the mental capacity act, the deprivation of liberty, so these are all things we have to answer to, to make that people are living an independent life as possible within a care setting. You can't be worrying that someone is out at 9-10 at night."

Manager, rural care home

The concept of freedom was very subjective, depending on service users' personalities. As mentioned above, all homes operated rules and restrictions to a varying degree, and service users did not seem to have absolute freedom in the

conventional sense of the word, yet they derived enjoyment from the simple activities accorded to them:

"I'm not allowed to go on a bus and the reason for that is not social offensiveness, because I always behave when I go out. It's difficult to explain. They tell me it's dangerous. I wouldn't say I don't have freedom, I've been out to buy books with my social worker. If I wanted to call my family, I would have to go through staff because I don't have access to the telephone."

Dominic, rural care home

For some service users, restrictions had a negative bearing on their sense of freedom, as well as their relationships with people, and some complained that their friends could not spend the night with them. They still had to report back to base, inform the care team where they were going and what they were doing; much like a child would have to do vis-à-vis their family. Yet the majority of service users still *felt* they had freedom, despite all these constraints. Some were afraid of their own vulnerabilities and these rules represented a safe and secure base from which to go out and explore the world; they always knew they had something to come back to:

"Need to tell staff where I go and come but there's no pressure. There's no one to tell you why did you do this and that."

Jimmy, urban care home

10.4.3.2 Staff

A sense of security was essential to service users, and staff seemed to be the principal medium by which this was conveyed. For both managers and service users then, individual staff were important focal points to the running of the home. These were also important in allowing people to prosper and, in some cases, move on. Managers believed that mental health training was crucial and that staff should be sensitive about people with a mental illness, and treat them as individuals, forgoing stereotypes and stigma. The importance of personality was mentioned by many managers, as each member of the staff team brought something new to the mix:

"It's a diverse group of people, with a diverse group of skills. So we've got a mums-y lady, who nurtures people, and does home cooking from scratch. Then we've got the youngsters who are quite hip and trendy, and come in with their trendy clothes. So we've got quite a diverse group of people, and it's quite lovely."

Manager, rural care home

It was not all about being authoritarian, as many managers expressed that not only was it their job and responsibility to care for people, but they also *cared about* service users. Many people did not have families or had lost contact with them, so that staff now also represented family.

"Some want to be looked after. Most of them don't have family. Or their families have had a rough time before their diagnosis. The relationships have been fractured. So we are their family. People see it as a sign that we care, that we look after them."

Manager, rural care home

However, some managers had received remarks from social services about making the house too 'homely', but they insisted that this was the service users' home, and it was their duty to make it a comfortable experience for them:

"It's one of those things, sometimes you get told off for making the place too homely...because you're supposed to be running a move-on service and they'll moan that it's too homely. But in my opinion it's their home and I won't have them living in a dump."

Manager, rural care home

Another consideration by managers for successful outcomes was to have continuity of staff, and in some cases a small number of full-time members. The importance for service users to receive personalised care, by someone who knows them well, was highlighted. Yet this might affect the range of choices available to them:

"I like to keep my staff team very small, it's to an advantage and a disadvantage. The advantage is that we have good consistency, people work full-time so they know the clients very well, and things get done. If you have part-timers then clearly people aren't in so often. So the keyworker system works well, because you have a staff member attached to one person. But actually then covering 24/7 can get a bit stressful. People get sick, take days off, but that's about me being the owner of a business and being passionate about what I do and caring for people that are here, and I would rather give up my own time."

Manager, rural care home

Service users also gave their thoughts on staff. Unlike managers, they spoke mostly about their individual personalities, and not their jobs, roles or proficiencies. One person commented that the staff were not cultured enough. Yet most commented that what they appreciated most was staff kindness, patience,

attention and the fact that they took care of, as well as cared about, them. What seemed to be important was for them to be seen not as patients, or people with mental health problems, but as individuals who required help with some aspects of their lives, but were still able and rational adults:

"Staff are very good and very amenable and always available to talk to, and not just about things about the house, but about general things like art and things like that. The world situation, the crisis in the Middle East."

Chloe, rural care home

Continuity of care was also highlighted by service users as important, and seen to provide security:

"Staff always there to support and guide me and advise me which is good. So I'm quite happy."

Eva, rural care home

10.4.3.3 Quality of the environment

Several factors contributed to why staff believed their home to be a good environment for service users. This mainly centred on comfort, by providing a nurturing setting for people. It was important that people had their own rooms, to emphasise privacy, and possibly to differentiate from hospital:

"If you help make people comfortable, they will feel more nurtured. And you're increasing the feeling of well-being. And if you put people into a Spartan environment, they're not going to respond as well as when you put them into a comfortable, friendly, family type environment."

Manager, rural care home

Like staff, service users were most likely to say that they appreciated the environment they were in because they were taken care of and were comfortable. An appreciation of a sense of security was conveyed, and many mentioned that they liked the routine they had, and that they got good, warm, consistent meals cooked for them.

They also liked the structure of the homes, and the fact that they had communal areas that they shared, and where they could interact with people, but could withdraw to the privacy of their own bedrooms when they wanted, much like living with family:

"I like it a lot. Best house I've ever been in. You have friends. There's no locks on the doors, but people knock, so they don't come in unless they're invited. Nothing gets pinched. You've got a nice garden, you can smoke in the bedroom, there's nice staff. Go to bed when I want, go out when I want. Go out alone. I got my books, and a TV for myself. Clothes and stuff. Wardrobe of my own. Stereo and everything."

Safa, rural care home

The fact that they had learnt new skills, and had improved their potential outcomes did not go unnoticed amongst service users, and some felt very indebted and grateful for organisations such as SHSs:

"Over the years I've learnt a lot about myself and how I cope in different situations. And it's been a learning experience, a positive experience. And I'm grateful to [charity] for providing me with supported housing in the first place. It's been great, I've enjoyed it."

Ally, rural supported housing service

The main complaints people had about their SHS was not feeling integrated enough in the home or in the community. Some people said they were bored most of the day, and they did not have much to do. They did not grasp why sometimes staff ignored them, and at times felt that staff attention was mainly directed to people who needed more assistance. They did not appreciate very crowded settings where they were just lost in the numbers, and lost their sense of identity:

"There's not always a member of staff to interact with, they seem to be very busy with domestic things. So we don't really get the chance to chat or anything. It's ok, I don't mind, I tend to be down the list, because I'm quite capable of doing things for myself. Whereas further up the list, there's more people that need assistance. So I tend to get put on the back burner."

Olivia, urban care home

10.4.3.4 Money issues

Personal income was a central talking point for both managers and service users, as receipt of social security benefits had an impact on housing satisfaction as well as future prospects (chapter 9).

All managers recognised that income was extremely important for service users. Two major issues were apparent in managers' narratives: the cuts to DLA and the imbalances in the amounts awarded to people.

Cuts to Disability Living Allowance (DLA)

There seemed to be some confusion amongst managers as to what DLA was for and how it should be used, as well as to the consequences of its reduction. Many believed that DLA was service users' disposable income, a means by which they could be socially included and lead 'normal lives', treating themselves to a cup of tea or buying cigarettes. Yet they were also concerned that these sizeable sums (on average, £37 per week) might provide them with too many options to choose from, such as drugs or, in one case, an air hockey table. According to all managers, the reductions in DLA will affect people in care homes by reducing the mobility component of DLA, rendering people unable to get taxis to and from the SHS for example, even though some suffer from physical disabilities or insecurity over going out. Users who were aware of the cuts were extremely anxious about their future situation, and this lends itself to additional insecurity according to managers:

"DLA cuts will affect them profoundly. Talking about social exclusion, it's unthinkable. And it's such a meagre amount of money. They're so impoverished anyway in terms of disposable income. And disposable income is such a big part of normal life. And their rehabilitation and reintegration into society. It will undoubtedly impact on their mental health."

Manager, rural care home

Yet most managers believed that people in residential care, and even supported housing services, would eventually be looked after in one way or another, and the reductions in DLA would mostly affect people living in the community. Although some service users in supported housing had felt empowered to look for jobs following the cuts announcement, not everyone within an SHS would be able to work. There was a need for transparency in letters and assessments, for assessors to be properly trained in mental health and to understand their needs, and greater clarity as to what DLA should be used for:

"The reforms are talked about. And I think that's when people can become quite anxious. What's basically happening is that they're all getting letters, saying they've all got to have medicals. In reality, when they are living in supported housing it cannot be cut just like that. There was a lady, we asked her to bring her form in and she said I've filled a form in, I've sent it back and I think I'd like to go back to work! But oh dear! We'll just wait and see what happens. This is stuff we tend to watch, because we've got a hotline straight to the DWP. So we help service users with the forms. But the terminology is extremely complicated. There is not much explanations as to why decisions are made, and the processes where you have to appeal."

Manager, rural supported housing service

Service users were nearly evenly divided as to whether they were happy with the amount of benefits they received. These reportedly ranged from £19 to £100 per week, and this was positively associated with their respective housing satisfaction. People who commented on not getting enough money mostly complained that they could no longer buy cigarettes, possibly their only luxury:

"Don't get much money. Things you want to buy like fags, you can't do it."

Andy, rural care home

People enjoyed going to the pub or restaurant, but said it was at times too expensive to do so. Indeed, one person complained that low amounts of benefits was preventing them from leading 'normal' fulfilled lives, making them socially excluded and creating a wish to leave their home as a consequence. This aspect of benefits was also portrayed by managers, mainly when discussing their reduction.

Benefits, then, although offering service users a chance to buy basic services and goods, could also tie them down to their current situation:

"One of the reasons I want to leave is because I don't get enough money. Having a social life, meeting people, all costs money, doesn't it? And if you met someone and you wanted to have a relationship, I don't know how I would do that with the funds that I've got. These are sorts of things that normal people do when they're working. So it sounds like I get a lot of money, but it doesn't go very far."

Olivia, urban care home

One service user on the other hand said that they were receiving more money on benefits than they had ever received during their previous full-time employment:

"I've been unemployed for about 30 years now, and I've always had more money being unemployed than I had when I was working. And it's not only because of the benefits but also because you learn different things, you learn to conserve. Like when I was working, I used to go to the pub a lot, and I was spending money that I didn't have."

Tarek, rural care home

Not many people interviewed seemed to be aware of the impending cuts, although most managers thought it was important to inform people of the future situation. One person, who kept up with current affairs, had come to the conclusion

that the assessments were flawed; no one seemed to have received support in the matter:

"Keeping up with the news, especially now, with the benefits system. It could affect me, it probably will. I've got lots of health problems and it's expensive. So hopefully they won't cut it. I think it's very mean. 40% of those reviewed are getting an appeal, so their tests for assessing people were wrong. I'm very interested in this. Problem with the assessments is that they don't take fluctuations into account, and my health."

Paul, rural supported housing service

Money imbalances

Some service users were aware that at times their counterparts were receiving larger amounts of benefits, and felt unfairly disadvantaged in that respect, yet none knew the reason for the disparity:

"I barely get enough to survive. Some people get £500 a fortnight on their DLA."

Anthony, urban care home

Managers voiced their concern on this issue more intensely in comparison, hinting that service users were not very aware of funding and entitlement mechanisms, and were hence not in control of a major aspect of their lives. They

explained that one of the reasons for these discrepancies in funding arrangements was due to the sectioning laws, more specifically section 3 of the Mental Health Act and then receiving section 117 aftercare; this was not based on current need. People who are on a section 117 are not required to contribute towards their housing placement from their benefits, and are left with hefty sums of money in consequence. An unfair and arbitrary situation is hence created, one that is reportedly very frustrating for service users who live under the same roof and are not able to afford the same 'luxuries':

"It's a wonderful system! If you've been sectioned, on a 1 or a 2 or a 3, then you'll get 117 aftercare when you're in residential care so you don't have to contribute for any of your care. But if you've been informal, or not under the right sections at the right time, then you end up contributing to your care. So you have to be really bad. Get yourself sectioned! I think the benefit system should be worked on a much fairer level, that they all got the same amounts. All the guys here are living in a residential home, everything is provided for them. So they need X amount of money to spend on themselves for a week. That would be better for all of them. Because they talk about money, and it frustrates some people, like why am I only getting £100 a month when you're getting £500?"

Manager, rural care home

10.4.4 Master theme 4: Social exclusion of people living in specialist housing services

Closely related to money issues is the master theme of social exclusion. Service users receiving social security benefits were limited in the types of activities they could undertake, as well as the frequency with which they could undertake them (chapter 9). There is also a threat that these entitlements may be reduced.

Here, social exclusion is explored with regard to the services available to people with mental health problems, and the possible stigma associated with them. The four main themes for discussion are (1) public attitudes, (2) the private rental market, (3) obtaining employment and (4) day centres.

10.4.4.1 Public attitudes

Accounts from managers were somewhat discouraging. Speaking of public attitudes in general, they said there was still discrimination, fuelled mainly by the negative press and media picking up on extreme cases of mental health service users, in order to produce sensational headlines. It was argued that a lack of reported public awareness, combined with the absence of campaigns to promote mental health, may prevent the public from forming a rational opinion about people with mental health problems:

"I don't think there's a lot more understanding now than there was 20 years ago. And you're labelling people, it's just the words "mental health". People will always go to the top end of the scale. Because of the word mental. We need to do more for people to get heard."

Manager, rural care home

A few managers gave some examples of how discrimination was experienced by service users. Two reported having trouble registering their service users at the local college, and being inadvertently redirected to facilities for people with 'specific needs'. One manager recounted a story of how one of their service users was 'accidentally' not told of an outing by their local church group. Another spoke of discrimination from a local community club:

"It's really hard for people here to get accepted in the community clubs. The community club said if they're living with you, then you should be able to provide...We can provide some things within, but it's not the same as being out there in the community. It made me very sad."

Manager, rural care home

Managers also highlighted the role the local community played with regard to service users. Many, when asked about stigma, said that the community did not discriminate, and that everybody 'knew' the service users in the area. Hence, service users were still labelled in some way, yet accepted within the community, with one manager adding that it was more difficult to be prejudiced against someone when you know them. One manager stressed the importance of the community being small as a barrier against prejudice, whilst another cited the fact that if service users had been living in an inner city, they would have experienced more discrimination. One manager recounts the experience of when they "took out" users into the community:

"It's wonderful. We take people out twice a day usually, our service users are very mobile. And they like to be in the community. But as soon as you go out into the community, with one of our gentlemen, he says hello to everybody, they all know his name, we're known in the coffee shops. Even when I go into the town myself, people know me because of my service users. So they do have a huge community presence."

Manager, rural care home

Only one service user reported having been the victim of direct discrimination from the public due to their mental health problem, due to their home being distinctive from the rest on the street:

"Didn't like it before...they had a sign on the house that indicated that it was vulnerable housing so people used to bother me."

Paul, rural supported housing service

10.4.4.2 The private rental market

Another indication of the practice of discrimination was the reluctance of private landlords to lease their properties to people with mental health problems. Many managers discussed this issue, with a few having experienced it first-hand when moving service users on. Service users were seen to be a danger to themselves and others, and unreliable tenants. A few managers spoke of the increased difficulty if the mental illness was particularly apparent, for instance where the service user externalised negative symptoms. Preferential treatment was given to people with no mental health problems, so service users were then re-directed back into SHSs. One manager advised service users to go through the council as the tenancies were more secure:

"If they wanted to go into private rented accommodation then it would be a different story. I think if they went and didn't tell anyone that they had a mental health problem, then they'd probably be ok and probably get housed. But I think if a landlord knew they had a mental health problem then they would probably think twice about housing them. Because of the stigma and discrimination in mental health. There aren't many people out there who do understand about mental health."

Manager, rural supported housing service

These barriers prompted two SHSs to establish links with private landlords through a housing pathways programme, in order to facilitate the letting process. Landlords were then assured about the 'behaviour' of their potential tenants as these organisations acted as their guarantors:

"[Name of organisation] has a partnership, and it's all about establishing links with landlords, good landlords, and trying to help people access those pathways through the private rented and access deposit schemes. But that's very new, and obviously we're still building networks with landlords. But previously it has been difficult and still is...I mean i think we have 10 landlords on our books. [...] But previously you would have landlords that perhaps weren't very reputable, or who had issues with benefits. And if problems were happening, then they would lose their tenancies very quickly."

Manager, rural supported housing service

Otherwise, the service users who were interviewed and were living in independent flats were renting from the council. None reported experiencing discrimination from private landlords (possibly because they were not specifically

asked); however, it may be possible that they may not have been able to access the private rental market in the first place for that reason.

10.4.4.3 Employment attitudes

Another sphere of life from which service users seemed to be excluded was employment. Here, accounts from service users and managers are discussed with regard to experiences, ambitions, and barriers preventing access to or sustaining employment.

Experiences of employment

Although some managers said that their service users were employed, in fact they were mainly talking about voluntary work. Only a handful reported that their service users did any part-time paid work and only one reported that one service user had been in full-time employment, but had stopped as they found it too difficult to manage. Volunteering activities revolved around manual labour, such as volunteering at a day centre and doing gardening jobs:

"We have some people who do voluntary work, we have some people who are working actually on a part-time basis. We have had people who were linked in with [organisation]. That's actually where they start off as voluntary and it turns into paid employment. And that's a great organisation. It does gardening and some other element like woodwork or something. They also do picking up and transport, so that's been really successful."

Manager, rural supported housing service

Eighteen service users were in voluntary employment and a couple were employed part-time. Indeed, most were involved in gardening tasks or were working in charity shops. The three people who worked at a café or behind the tills at a charity shop reported positive experiences, with two people saying that this sort of stimulation had improved their mental health and made them more focused. The few who conveyed their feelings about doing gardening or other manual work seemed despondent and preferred being involved with members of the public:

"I'm excited about my new job at [charity shop]. I'll be working at the tills. And I love clothes and I love talking and meeting new people."

Mary, rural supported housing service

Ambitions

Some service users also shared their ambitions and prospects for future employment. None of these included manual labour or working in a charity shop; options ranged from working in the stock exchange, to teaching English, to working as an artist:

"There isn't anything I've set my heart on really. As I said I do the two jobs that I did, I worked as a bookseller and I worked as an assistant manager in a cinema. I loved both those jobs. I last did those jobs in '88, and that's a hell of a long time ago. I worked for 7 years just down the road from here. In an actual business, not sheltered employment that employs disabled people. Now what would I like to do? Maybe something to do with computing, or admin..."

Tom, rural independent flat

Employment barriers

Managers discussed a wide range of factors that stopped people from seeking or maintaining employment. These were mostly out of the hands of service users, except for a lack of motivation.

In terms of capabilities, some managers believed that some service users lacked assets that would enable them to obtain and sustain employment, such as a limited cognitive abilities, a short attention span, and in some cases a poor control of language. The influence and side effects of medication were important here:

"Medication affects them a lot, it makes them tired and drowsy. Especially that in some cases they're required to do hard labour and full time. They feel very tired, they give up."

Manager, urban care home

Indeed, a few managers believed that potential employers abused peoples' situations by giving them jobs requiring solely manual labour:

"Some guys did some voluntary work, but I found that there was an element of exploitation about that. So this guy was going in, he was putting in all these hours, he was helping out at an old people's home, and he ended up doing all the teas, all the coffees, all the cleaning and everybody else was just sitting back watching. And he was becoming really tired, so we stopped that. So there is that worry of voluntary work."

Manager, rural care home

Many managers also noted that employers rarely offered the flexibility needed by someone with a mental health problem, stemming possibly from their

lack of awareness and understanding of mental illness. For instance, some service users had gaps on their CVs or a criminal record due to their time in care or hospital. In addition, they often had a lack of confidence in finding employment. The economic situation was also cited, so there were few jobs on offer and a lower priority would be given to someone with a mental health problem. A couple of managers mentioned the lack of mental health awareness and understanding from organisations such as Jobcentre Plus:

"I don't think a job would allow for the kind of chaotic lifestyle our service users live. You know we have days where we don't feel too good, but we find the strength to kick us out of the bed. But they don't often have that mechanism. And I'm not sure there's an employer in this present climate who would be willing to go that extra mile with our service users, because it is about tolerance and patience and understanding."

Manager, urban supported housing service

Many managers noted that service users believed that they would lose their social security benefits, or receive lower amounts should they take up a job; none seemed to be aware of the employment rules. However, only two managers said that they had actually seen the 'benefits trap' in action. It was also said that a wish to receive benefits was closely connected to the desire to be dependent on somebody and be taken care of:

"Motivation is a massive factor. You mainly work because of remuneration. But in residential care you can't really earn more than £20 per week without it affecting your benefits. Also there's a psychological factor of a desire to be dependent. People like having other people do things for them."

Manager, rural care home

Of the whole sample of working age service users (74), not many wanted to work (39). The most common reason cited was, quite simply, having a mental health problem. It was not clear whether this label instilled in them low self-confidence and a belief that they were not capable of working (because they believed it or someone else had made them feel that way), or whether this reflected their lack of capability as also reported by managers:

"Don't want a job. I have paranoid schizophrenia."

Nasser, rural supported housing service

Another common concern was their medication, and the toll it had on intellectual capability, motivation and energy levels. Some people felt unsure about what they could do in terms of a job, perhaps because they had not worked for so long and instead had spent large amounts of time under the umbrella of care, and may have forgotten the place of employment in one's life:

"I haven't really thought about it. The thing is that I've been out of work for such a long time, I can't say for certain. Part time possibly but not full time. It might affect my benefits...and it might make it all a bit you know..."

George, urban care home

Issues that were intensely voiced by managers, such as the stigma attached to mental health, and discrimination from employers, were not recognised by service users, as none of them mentioned this as a potential barrier to their employment. Instead, they cited their mental illness as the primary barrier against obtaining employment. The 'benefits trap' barrier did not figure prominently either within service users' accounts, although one person who did mention it exhibited a considerable awareness of the benefits system and subsequent calculations and reductions:

"The rent is £126 per week, and Supporting People charge £176 a week so that's £300 gone. And £300 would be about my wages! So it's not really a practical decision."

Greg, rural supported housing service

A few people mentioned that they would want to move out to an independent flat first, and one person stressed that for them to be motivated to seek employment, it would really need to be a job that was stimulating but part-time:

"I wouldn't mind having a job [...]. Maybe having a part-time job would be ok. Maybe moving to my own flat would make it better. I'm not really sure at the moment. It's about motivating myself to do things, that's my problem. I find it difficult to motivate myself, and I end up in a little bit of a rut. I have good days and bad days...and how I would cope with the routine, I don't really like routine. [...] But it has to be something that I'm interested in."

Olivia, urban care home

10.4.4.4 Day centres

One proposed strategy for social inclusion has been the creation or maintenance of day centres. Managers tended to report higher rates of attendance, compared to service users' accounts (chapter 9).

In some cases, funding was being cut back and day centres were either shutting, or staff were being replaced with voluntary workers, much to the supposed detriment of service users. A couple of managers mentioned the role day centres played in 'normalising' people, by providing a structure to their day which added the security that service users seemed to crave. The cutbacks meant that managers were obliged to provide day activities within the home, with no additional allocated funding:

"It's right that things should move on and should be reactive to what people want and need, but there's still a place for something that's structured. When someone has a serious disability, how insecure is their world? And if their world is they take the same bus every week to the day centre and see the same people, and they do stuff, they have a structure to their life. They are devastated without it. They need security, that's how they understand their world."

Manager, rural Shared Lives scheme

However, most managers also thought that day centres should be more innovative and modern. The current structure did little more than reassert the label and peoples' social exclusion from society, as they are lumped together solely on the basis of having a mental health problem:

"Yes they've got a day centre they can go to and they can do activities, but they're organised activities. They can't go there and meet the opposite sex or just friends really. It seems to me that they just want to stick them all in, let's put all the people with mental health problems in one place, instead of mixing people up. Just doing everyday activities or courses, not only for people with mental health problems."

Manager, urban care home

Not many service users discussed day centres. Some could see that they were a source of links, such as the person who was moving to a different town who had been encouraged to keep in contact with their (old) local day centre. One service user went to the day centre mainly to see her friends:

"Will miss it here. Can still come back and visit people. And from [name of town] it's not very far. Can take the bus. And it was suggested that I continue to go to [name of day centre] after I leave. So I come to the house, continue my links. I'll try that to start with, see how convenient it is."

Chloe, rural care home

Others reported that they did not particularly like day centres, because of the types of activities on offer as well as the environment, preferring to spend time on their own, or doing 'their own thing'. One man disliked going because he felt he did not fit in:

"I don't classify myself in that category, I like to find my own...I went beach combing with them once, but I felt so queer, I didn't do it again."

Tarek, rural care home

10.5 Within-group differences

The within-groups differences concern mainly variations in SHS types, population density (urban versus rural), and age. Differences by SHS type were interesting in this respect due to the varying support levels available to service users and provided by managers, as well as the policies that govern them.

It was also interesting to evaluate whether experiences differed by age, specifically whether managers influenced different housing environments depending on whether they were younger or older (this may also relate to the number of years living in or managing SHSs). It was also interesting to explore whether service users in turn experienced SHSs differently according to their age. Services and SHS environments may vary by population density (urban versus rural), due to differing funding mechanisms for example, or proximity to public amenities.

10.5.1 Within-group differences: housing types

Independence and autonomy: managers' perspectives

Some interesting differences appeared between the different types of SHSs sampled in this study, with regard to mechanisms for – and definitions of – independence. It is important here to reiterate that supported housing services, where service users had Supporting People contracts, had mandates to fulfil within two years, and different environments were therefore created.

Care home managers defined independence as being autonomous but within limits. They promoted 'independence' by focussing on service users' ADL skills: what was achievable within the remit of each individual's ability. Supported housing managers, in contrast, focussed more on rehabilitation, *recovery* and empowerment: for them, an individual's personal motivation for further independence was key. They taught people how to manage their tenancies for the future, with the aim of ensuring that they would be able to move on successfully:

"Our main aim is to help people learn how to manage their tenancies and learning what their rights are...Like if they get a landlord who doesn't fix things, then they know they have the right to have things repaired."

Manager, rural supported housing service

Having such an aim meant that supported housing managers were more prepared for a move than their care home counterparts, as this was their expectation. They worked with their tenants with a two-year goal in mind:

"When people move in now, we tell them what they're signing up for, and in the assessment we'll tell them it's for two years, and once a week they'll have to attend...and we'll have to work with them. And for people who move in to this service, someone looked in to the statistics, and people were moving on after 18 months on average."

Manager, rural supported housing service

Independence and autonomy: service users' perspectives

People differed on how they experienced their present housing situations, as well as how they perceived their future ones according to the type of SHS they were living in. Users in supported housing services, although most expressed knowing that they had two-year contracts, and possibly had more control over their lives than people in care homes, still felt it was not up to them where they lived, and that social services mapped out their lives for them, not necessarily based on their needs or preferences; this relates to the choice theme as well. Most were very clued-up on the funding situation:

"When I was first with [charity], the system was that you could stay in housing as long as you wanted to. Now, it's basically you can stay in housing as long as they want. That's the effect of Supporting People. That's quite a big change, actually. Going from where you could say, "I want to stay here" to the housing workers saying you can't stay here."

Tom, formerly in rural supported housing service

Care home residents, when discussing less supported facilities or independent accommodation in the community, seemed more concerned with their lack of potential security or safety from the outside world, such as being burgled, than their lack of choice. They conveyed a greater image of vulnerability than their counterparts in supported housing, who in turn were more aware of their own capacities for dealing with the unknown. Care home environments have a greater staff presence and structure; this may be a reason behind the discrepancy between care homes and supported housing services:

"I've progressed well, but I'm not too certain about living on my own – if I get lonely, if I hear voices."

Jenny, rural supported housing service

With regard to anxieties about moving, those living in Shared Lives arrangements all reported feeling worried about their future, and possibly losing their placement. The ethos of Shared Lives is to create homely living environments, where service users can share in the life of their Shared Lives carer and become part of their family. Indeed, most people living within Shared Lives schemes reported that they greatly appreciated the family environment they were living in, being taken care of as a family member, and being integrated within their circle of friends and extended family. This possibly created anxiety within them about losing their 'family':

"Don't want to go anywhere else. It worries me sometimes. I just don't want to go anywhere. Someone did say to me that I would be here for life. It would be nice to think that. Because it is like my home."

John, rural Shared Lives scheme

Housing experiences

In terms of freedom, supported housing schemes managers' seemed to place very few restrictions on their service users, although many of their users nonetheless complained about their lack of freedom. People in care homes were more content with these rules which were even more stringent in comparison. Indeed, the key to a good environment for a care home service user was to be taken care of and protected, and have that sense of security:

"My friends can come round, but one of them he's an alcoholic and I've known him for quite a while. But he's not allowed to come in here when he's drunk. But that's ok. I can't cope with him sometimes! And it's difficult because there are other people here, and they might complain about him."

Olivia, urban care home

Money or personal finances were also experienced differently by SHS types, with individual differences being seemingly more apparent in care homes. Many care home managers reported having people on section 117, and it creating disparities; no managers from other SHS types mentioned this. Further, money was a relatively major issue amongst people in care homes, as most felt they were not getting enough:

"I barely get enough to survive. Some people get £500 a fortnight on their DLA."

Anthony, urban care home

Social exclusion

Otherwise, stigma and discrimination from the public were highlighted mainly by care home managers. They were also the only ones to report having experienced the NIMBY effect:

"When they first opened this house as a residential care home, there was a lot of opposition from neighbours. But there has been no hassle, there's been nobody going on with guns or knives. I mean that's what they thought, that it was going to be this house full of mad people, but they're fine with us now. But it took a while. And it took some proving. And I think because the home has got a good reputation now that...I mean you can drive past here and not know that this is a care home."

Manager, rural care home

10.5.2 Within-group differences: population density

Choice and control

Managers working in urban areas seemed to be feeling financial pressures more than their rural counterparts. Managers, who reported pressure from social services to move people to less supported settings, or to repatriate service users to their original boroughs, were for the most part managing SHSs in urban locations:

"They'll get a 12-monthly review, with a social worker they've never met, and they'll ask them religiously "would you like to move?" and they do give it like a positive spin. Some of them get really frightened, but it's a done thing really. It seems to be very rushed, and they don't involve the home enough in the process of it or the after-care in terms of moving people out."

Manager, urban care home

Service users in rural areas more commonly reported that they had seen their home before moving in, possibly suggesting that more time and power to decide was accorded to them:

"I chose the place. There are a lot of places I could have gone to but I chose this one. We visited different places and I chose this one, which I'm happy with."

June, rural care home

However, no service users in rural areas were on personal budgets or direct payments.

Housing experience

Managers and service users in rural areas emphasised providing and experiencing homely and caring environments. Yet many of these homes were in rural countryside away from public amenities and many service users reported feeling lonely and bored at times:

"It's great here. I've got plenty of room, and they do everything for you. I can be quite content at times. I'm not too exacting. It depends what's required. But I feel a bit enclosed, especially in winter."

Dominic, rural care home

Social exclusion

Interestingly, all the managers who discussed the closure of day centres were in rural areas, and were expecting to provide day activities within the home henceforth:

"They expect us to provide the day care within the fees that they pay. So it's a bit of an eye opener really. So that's really why we take people out, and we do baking and arts and crafts, and try to give them a normal life."

Manager, rural care home

The two managers who highlighted the importance of small communities in providing a sense of inclusion for people with mental health problems, because, for

example, local people would recognise service users and say hello to them, were in rural areas:

"If you're in rather wider communities, like [city], then there might be other problems. When it's smaller community, then it's somewhat easier. Because that person has a presence."

Manager, rural Shared Lives scheme

In terms of employment barriers, managers in urban areas mentioned stigma from the public much more than their rural counterparts, who in turn blamed their service users' lack of employment prospects on their desire to be dependent. Although many service users in rural areas said they were too old or disabled to work, many others were happy in voluntary employment (and there was a greater number of people working compared to urban locations):

I've been at [charity] café for more than a year now. And it's been very therapeutic.

Jenny, rural supported housing service

10.5.3 Variations by age

Within-group differences were common by age. As a reminder, the mean age of service users was 52 years, whilst that of managers' was 46. Age was collapsed into three categories for participants: 20-44 years; 45-64 years; and 65 years and older for the benefit of qualitative analysis.

It was notable that the younger managers appeared to be more innovative in the running of their services. They frequently mentioned empowerment and choice when speaking about mechanisms to achieve independence; middle-aged managers focussed more on improving service users' ADL skills in comparison. For example, younger managers were also more positive about the introduction of DPs and PBs:

"We're trying to help people turn their lives around and help them gain some understanding of what's happening to them and where they fit in society. So they can go on and have successful lives and good quality of life. I've been doing this for 10 years now and I think I've been quite successful. People have moved on and very few have gone back to hospital. We kind of assess people and where they're at and it's not about giving them false hope. And I think one of the reasons I've been so successful working with people with mental health problems is because I've always kept it real."

Manager, 41, urban supported housing service

In addition, younger managers were seemingly more relaxed about rules and restrictions around the house than their older counterparts:

"Freedom is very important to them. If you stop someone from going out then really you're in the wrong."

Manager, 23, urban care home

The youngest service users seemed to place particular value on their freedom, and complained when it was impeded. The oldest service users were generally content with their lives, and especially with staff; in contrast, to the youngest service users, who frequently complained about being ignored by staff members. Older service users were the only ones who expressed consistent gratitude towards members of staff, and for the existence of SHSs:

"If you do get the chance of going into housing for people who are unwell, like this... spending the day with people who are there and have the opportunity to see how people are living, it's very helpful. It's just that they're closing a lot of residential care homes. Throughout my life I've found these places very helpful. Provided that the owners and managers are nice."

Polly, 70, rural care home

There were significant differences in terms of how social exclusion was experienced and perceived by participants of different age groups. Discrimination from the public was mentioned much more often by the older managers (aged 45 and above), who felt there was still a considerable stigma attached to people who had mental health problems:

The main challenge they face is social inclusion because of stigma from the public. But also exclusion because of people's behaviour because of how they perceive they are viewed by the general public.

Manager, 68, rural care home

10.6 Discussion

This section provides a summary of the results, discusses the overlap between themes and sub-themes and identifies a possible common factor to all four themes. The strengths and limitations of the qualitative study are also discussed.

Summarising the results: independence and autonomy

The first two master themes – independence/autonomy and choice/control –were closely inter-related in the accounts of both managers and service users. Managers were somewhat divided about promoting independence. On the one hand, some regarded it as a concept that had been imposed by society, creating false hope among service users under the ideal that ‘one size fits all’. On the other, some felt it was an ideal worth striving for. Real-life examples were offered to explain these opinions, both negative situations where service users had become isolated and had deteriorated in the community and positive ones where they had flourished. For the former, the main concern was the lack of appropriate support within the community, and a lack of a ‘personal touch’ due to funding restrictions.

Some service users were highly ambivalent on the issue of independence: they wanted to be autonomous, yet feared the potential insecurity arising from a loss of support. Nevertheless, it can be said, that the study participants who had moved to less supported SHSs, or were now living on their own, reported positive outcomes, although reporting feeling slightly wary of the prospect at first.

Summarising the results: safety and security

Safety and security figured highly in service users’ accounts when speaking of moving, sometimes linked to the concept of freedom, for instance with regard to rules and regulations. Although some, particularly the younger service users, complained that rules impeded their sense of freedom, none had complete freedom and were constantly bound to the SHS in some way. Some service users felt that restrictions did provide a sense of security.

Some managers stressed the need to restrict freedom to protect service users.

Most service users seemed to enjoy environments where they were taken care of by caring staff; for most, staff represented security. A sort of family environment was portrayed as desirable, for instance where warm meals were provided, in contrast to poor environments where they felt ignored, as well as bored, with hints of possible hospitalisation. McCarthy and Nelson (1993) also mentioned the negative impact of perceived ‘staff favouritism’ in qualitative accounts of service users.

Managers also stressed the importance of staff, highlighting the nature of their personalities and mental health sensitivity, experience and training. Some endeavoured to offer a somewhat less institutionalised feel to their homes by not having set meal times, or not having all service users go out to town at once – yet this was sometimes deemed not possible due to funding restrictions.

Summarising the results: choice and control

The issue of offering service users choice was found to be important in this study from the viewpoint of both service users and managers. In fact, it was commonly the case that users were not able to see their future SHS prior to a move.

As mentioned previously, choice, or its absence, was closely related to independence and autonomy. Under the pretence of greater autonomy, service users were sometimes relocated to lesser supported accommodation without their full understanding, possibly sometimes against their wishes. Managers in turn felt helpless in those situations. Managers who spoke of a lack of choice in these situations also reported negative outcomes for the service user who had moved on.

Some people living in supported housing services, and who presumably had Supporting People contracts, experienced a lack of choice and control over their tenancy, and possibly did not like the idea of a 'deadline'. Macpherson et al. (2012) had commented that having a tenancy may provide security.

Another way in which a lack of choice was perceived when wanting to move out of their own will was when service users were faced with impossible options due to low housing stock or poor housing quality.

Regardless of these externalities that were not under service users' control, service users were sometimes coerced into accepting a particular form of support because of a supposed lack of insight and a poor understanding of their desires and needs. Three managers spoke of this discrepancy between needs and wants, a finding also discussed by Minsky et al. (1995), who found that psychiatric inpatients often underestimated their needs for support, preferring less structured environments:

"Quite often when it comes to people with mental health problems, their views on what they think they want, might not go hand in hand with that of professionals. And quite often they would think that they can move on to independent living but the care team disagrees."

Manager, urban care home

Summarising the results: social exclusion and discrimination

Service user choice was also curbed by the difficulties with accessing the private rental market due to discrimination from landlords. This point was largely missing in the literature on SHSs (chapter 3) and the only review to mention inability to access housing due to the stigma of mental health problems was that by Kyle and Dunn (2008).

The NIMBY phenomenon was mentioned by some care home managers, and one service user had experienced direct discrimination due to the fact that their home differed in appearance from the rest, a barrier to integration also reported by Parkinson et al. (1999).

Stigma and discrimination from public institutions such as a college or church were also reported by some managers, as service users found difficulty accessing some services. Service users did not mention discrimination directly, yet indirectly conveyed an impression of social exclusion: when asked why they did not want to work, most replied that it was because they had a mental health problem (which may have been a rationalisation), and possibly may be feeling to have lost their sense of purpose by being unemployed for so long (Boardman & Killaspy, 2010, p. 82). Other studies have also mentioned the mental health reason (Grove, 1999; Secker, et al., 2001), along with a fear of losing their entitlement to benefits, or having them reduced (Bond et al., 1997; Sainsbury Centre for Mental Health, 2004; Secker, et al., 2001). Other perceived barriers to employment were discussed in chapter 9.

Personal finances and funding were topics that recurred throughout the interviews. Cuts to DLA were looming, inciting mixed reactions from service users and managers. Benefits were naturally very important to service users, yet this was out of their control as they felt that the awards given to people were arbitrary. Some service users were very dissatisfied with their money situation, finding

themselves unable to do simple everyday things, like go out to the pub or buy a pack of cigarettes.

The closure of day centres also had an effect on the housing environment, as some service users now had all their activities limited to one physical space.

Managers struggled to provide day activities without having their funding raised, and called for more innovation with regard to services to be provided.

Interpreting what it all means

Housing is an essential need for people with mental health problems. Reports from focus groups with people with mental health problems show that it is the single most important factor they feel they require in order to live independently in the community (Audit Commission, 1998).

Although a person's home should represent a secure base, in this sample the home was a source of anxiety and insecurity for those service users who were expected to move to other SHSs, or other areas, disrupting their sense of a home life. These more precarious living arrangements and uncertain future prospects, as well as the negative experiences they observed in the community, created an insecure world for service users, one over which they had no control. Many expressed a need for continuity, as they aimed to move out but keep links with their SHS or community; all service users sampled had never fully cut the 'umbilical cord' with their previous SHS. Otherwise, several managers had reported that ex-residents or ex-tenants frequently came to visit their former SHS. The appreciation for continuity was also reflected in a study by Shepherd et al. (1996): service users who had moved from long-stay wards with people and staff they already knew was acknowledged and appreciated.

Independence and autonomy were clearly inter-related, yet different concepts. Some service users wanted to move on to less supported settings where possible, yet also wanted to feel secure. Although the literature suggests that more restrictive environments lower well-being scores (McCarthy & Nelson, 1993; Shepherd, et al., 1996), in this study, it was not clear what service users wanted and whether being restricted would actually make them 'unhappy'. It was also not obvious what managers advocated; yet for both, independence and autonomy were

important issues. Possibly the ideal would be to be to provide a secure environment, without it impeding on a person's autonomy.

Recent policy changes and funding cuts may have somewhat blurred the definition of a manager's role and responsibilities. This has also possibly led to relative confusion amongst service users about what they should expect from the care team: should they be taken care of, cared about, or supported? Regardless of which SHS they were attached to, in this study, managers at times assumed roles other than the traditional one of manager: cook, cleaner, carer, protector, family member, business owner. The role of 'business owner' seemed to conflict the most with the other roles as owners strived to have service users' best interests at heart, yet at the same time did not want their business to suffer. The role of personal incentives in this case was also discussed by Shepherd et al. (1996).

For the most part, managers assumed the role of 'carer'. Certain service users seemed to respond to that role, and many conveyed a desire for a family life, in terms of being taken care of. Some enjoyed their reliance on benefits and staff, as well as the need for restrictions, security and protection; however and unfortunately, this was constantly put into question by the threat of a move. What seemed to be important for service users was to have the choice to control their housing situations, and possibly security of tenure on the long-term.

Choice has figured prominently in the North American literature on SHSs (Sylvestre, et al., 2007), which often advocates democratic management styles and greater choice (Parkinson, et al., 1999; Srebnik, et al., 1995; Sylvestre, et al., 2007). Nelson et al. (2003a) added that service users living within their preferred housing choice report greater satisfaction. UK academics have been somewhat slow to respond to calls for research on these issues, in spite of choice being highlighted frequently within policy papers on service provision (Department of Health, 2005b, 2006b, 2008a; Secretary of State for Health, 2004) and, to a lesser degree, on housing (Department of Health, 1989; Department of the Environment Transport and the Regions, 2000). In this study, choice was explored from various angles, from housing pathways into and out of SHSs, the services people received and the structure of their environments.

Moving into or out of an SHS was at times not seen as a *specific choice*, as there was no other alternative and many factors constrained a move: doctors, social services, SHS managers, care managers, discrimination from the public, and a lack of move-on options. Yet the bottom line was that many service users in this sample were not really able to exercise a choice when it came to housing preferences due to these externalities beyond their control.

CBLs, DPs, and PBs were in theory available, but not to everyone. Their uptake depended on SHS type, population levels, and perhaps on managers' willingness to innovate, itself linked to age. In general, uptake of personalised services was poor, and managers for the most part held negative attitudes towards them. There was the occasional exception, such as one who noted that a person now could 'see what they were bidding for'.

The low uptake of direct payments and personal budgets, and managers' apparent apathy towards them, begs the question as to whether these services were actually something that service users want, or whether these were imposed by a culture driven by a belief in independence and control.

Some service users in this sample went to the day centre and did benefit from this service as a way to see their friends, adding a structure to their day and getting out of the house. However managers in some areas spoke of their closures, and being forced to provide day services; now there was less reason for people to leave the SHS, hence reducing their opportunities to interact with the community in some way. Some service users did not like the activities provided, or associating with other service users. This form of 'containment' and the reassertion of the mental health patient label, were issues found by a Department of Health report (2006a) on day services. That report also called for more innovative services that reflect the needs and preferences of service users, a view also expressed by some managers in this study. A way to innovation was also through direct payments, where service users could possibly access different social and community activities that would have been otherwise unavailable (Craig, 2010, p. 354); however as mentioned previously, their uptake was not widespread in this sample. Employment options that seemed to be available for service users also called for innovation. Options were somewhat limited to gardening or other forms of routine manual

labour, and 'work environments' were often exclusively shared with other service users. Service users seemed to thrive when interacting with members of the public such as when working in a café for instance. Of course, considerations must be taken with regard to the side-effects of medication as well as – more importantly – personal preferences.

Social exclusion was further reinforced by covert and overt manifestations of stigma and discrimination. However, it was mainly managers in this study who expressed an awareness and concerns with regard to the stigma attached to mental illness perpetuated by the media, the lack of public mental health awareness, the discrimination from private landlords, and the inflexibility of employers. Only one service user in this study reported experiencing discrimination due to their mental health. However, it must be noted that a direct question on discrimination did not figure in service users' interview schedules, unlike managers'. Managers in rural areas emphasised the importance of small communities with regard to acceptance. Indeed, rural areas usually comprise small networks, where people are relatively well-known to each other (Nicholson, 2008), however it may also mean heightened visibility (Aisbett et al., 2007), apparent when rural managers spoke about the fact that everyone in the community 'knew' their service users. Living in a rural area may therefore reinforce the mental health 'patient' label further.

Many recommendations have been made in order to tackle stigma and discrimination (Department of Health, 1999b; Social Exclusion Unit, 2004). The old National Institute for Mental Health in England (NIMHE) further added to the discussion by promoting behavioural change through the Department of Health's *Mindout for Mental Health* campaign which targeted the public at large, specifically employers, the media and young people (Rethink, 2003). More recently, the campaign *Time to Change* vowed to end mental health discrimination as well as improve the nation's well-being. It included local community projects and activities, a high-profile anti-stigma campaign, legal challenges as well as training opportunities for doctors and teachers (MIND, 2011). Hence, forms of stigma and discrimination still exist for this sample of service users, although not directly expressed, and further hinder their choices.

Although privacy figured highly in the existing literature as a value important to service users (Fakhoury, et al., 2002; McCarthy & Nelson, 1993; Sylvestre, et al., 2007), its importance was not particularly reflected in participants' accounts in this study. Most participants however mentioned enjoying having their own bedrooms, with their own belongings – possibly indicating that they enjoyed this aspect of privacy.

As previously discussed, Massey and Wu (1993) found that factors such as privacy, independence, personal choice, convenient location and proximity to mental health services are significantly more important to residents than to their case managers. In this study, these topics figured prominently in both managers' and service users' accounts.

Some of the arguments put forward in this chapter may be linked to financial pressure: the lack of housing stock, moving people to less support, day centre closures, benefit cuts and less personalised care. Financial pressures may also have affected service users' housing experiences *in anticipation* and created an insecure world for service users.

Strengths and limitations of the qualitative study

The qualitative study generated a large amount of data, with various potential interpretations. Maintaining a consciousness of reflexivity, and having independent qualified researchers verify the analytical process as well as the results, provided additional rigour.

The study sought to ensure that most criteria for 'good' qualitative research were applied (Willig, 2001, p. 142), such as reflexivity, documentation of the different steps undertaken and the reasoning behind them, negative case analysis (accounting for cases that do not fit well with the themes), integration of theory (relationships between different units of analysis), providing credibility checks by independent researchers and providing examples and quotes.

Although the framework analysis attempted to include all participants, the accounts of some service users had to be omitted, due to their brevity when answering open-ended questions or slurred speech possibly due to medication. This is because the aim of qualitative studies is to analyse the content of what was actually *said*. Although this may be an indication of greater psychological disability,

all peoples' views were eventually captured in this study, whether in the quantitative analyses or qualitative.

A qualitative data analysis package was not used for this study, although it can produce more consistent coding schemes than manual methods, prove less time-consuming, analyse relationships between codes quicker, and offer innovative ways of displaying results. On the other hand, such packages may also present disadvantages that may hinder the analysis (Robson, 2011, p. 472), including oversimplification and encouraging the researcher to take shortcuts (Weitzman, 2000, pp. 807-808).

Ideas for future research include a direct comparison between the accounts of service users and those of their managers to see whether managers' views had an impact on those of services users within a single home. More interviews might be conducted with people living independently in the community to learn whether the support received is always poor. Stigma and discrimination might also be explored further with service users, including an understanding of the impact of service users' own views about themselves and their employability.

Chapter 11 Conclusion

11.1 Introduction

The overarching question addressed in this study was “*What are the factors that are associated with the housing satisfaction of service users with mental health problems within specialist housing services?*”. The study sought to fill some gaps in the evidence base concerning SHSs for people with mental health problems. The paucity of research suggested a study that would tap into peoples’ experiences, needs and wants from their own perspectives, as well as their managers’ experiences. Are people satisfied with their homes? What are the factors that are associated with housing satisfaction?

The landscape of mental health provision in England has been completely transformed in the past few decades with the closure of large psychiatric institutions and more concerted policy encouragement of community-based care (Chapter 2). This shift in emphasis laid the foundations for the establishment of new approaches to housing for people with mental health problems, whether in care homes offering high-level support, or integrated into ‘ordinary’ homes as part of someone’s family (Shared Lives schemes). Although this study specifically focussed on specialist accommodation-based services, the unpredictability of fieldwork meant that a very small number of people living independently were sampled as well.

The aim of this concluding chapter is to summarise and discuss the results of the study, triangulate the results of the quantitative and qualitative analyses, discuss the study’s strengths and limitations as well as what could have been done differently, and suggest some implications for policy and practice.

11.2 Thesis summary and discussion

The next sections will discuss the methods and main results of the study. In each section, a bullet-point summary will be presented first, followed by a discussion of the main points and results, where applicable.

A bullet-point summary of the main results of this study is presented first:

- Supported housing service users more likely to express a desire of wanting to move compared to people in care homes.
- Care home residents more likely to express not having wanted to move to their current residence.
- People in care homes more satisfied with their privacy compared to people in supported housing services, even after controlling for size of home, length of stay, and problems on the EQ-5D-3L anxiety/depression subscale.
- Main factors associated with housing satisfaction: size of home, living in a rural area, attending a day centre, feeling secure, subjective quality of home environment.
- Low rates of engagement in occupational activities; higher rates in rural than urban areas.
- Barriers to future employment centre around mental health disability.
- Care home residents very reliant on staff; also socially isolated in comparison to people in supported housing services.
- Sense of security figures highly in accounts of service users but is hindered by insecure funding arrangements and cutbacks. Increased security, and possibly restrictiveness, generally not associated with sense of freedom.
- Service users offered few choices with regard to occupational activities, where to live or what support they receive.
- Managers divided as to whether to promote independence within their services.
- Role of managers is confused; all strived to promote warm and caring environments yet restricted by funding cuts and perhaps conflicts of interest.

11.2.1 Methods and design

- Literature search identified eight overarching themes, as well as methodological and substantive research gaps.

- Methodological gaps called for a mixed-methods study, as well as a specific sampling strategy.
- Power calculations conducted to estimate the sample size, based on medium effect sizes.
- Sampling strategy took into account geographical and support variability.
- Substantive gaps called for a study that explored service users' and managers' own experiences.
- Semi-structured interviews conducted with service users and managers focussing on peoples' experiences.
- Quantitative analyses: univariate and multivariate techniques employed.
- Qualitative analyses: framework analysis applied.

Several methodological and substantive gaps were identified following the review of the literature on SHSs: the review of reviews not only aided identification of gaps, but also highlighted the key studies conducted on English SHSs; more recent studies were added to the review. Research questions were then formulated, and a study design was developed to address them.

The gaps in the literature called for a study that would sample a number of participants from SHSs with varying support arrangements within various geographical locations: these requirements suggested a quantitative approach alongside an in-depth account of participants' lives within SHSs.

Therefore, the study employed a mixed-methods approach: semi-structured interviews were conducted, and then coded and (in some respects) quantified. Some responses to particular open-ended questions were transcribed for the qualitative analysis. Where applicable, quantitative analyses were conducted, making use of a range of techniques whilst ensuring robustness, in order to extract information from the interviews. Qualitative analyses were conducted in the form of a framework analysis, and participants' answers were examined for meaning and content. Employing a mixed-methods approach aided in obtaining a complete picture of personal experiences within SHSs.

Effect size and sample size estimates took into consideration the mixed-methods approach that was to be used for this study. However, as the approach was primarily quantitative, the respective statistical analyses (mainly independent samples t-tests) served as a guide as to the minimum required sample size for this study. Effect size estimation for this study was based on one of the primary outcome measures: housing satisfaction. Previous studies in the field had reported large effect sizes (which would require relatively small sample sizes). However, for this study, a medium effect size, which would hopefully account for geographical and support variability, as well as the use of quantitative and qualitative methods, informed the power calculation – a common practice in research when effect sizes are difficult to estimate. An online power calculation tool (Soper, 2013d) was used to estimate the necessary sample size. Sample size calculations for an independent samples t-test (the statistical test most likely to be used for this study, as well as the most appropriate as it permitted exploration of differences between groups) were conducted using an online tool (Soper, 2013c), and yielded a minimum sample size of 128; this was to be used as a guide for the target sample size.

This specific online power calculation tool (Soper, 2013a) can also produce required sample sizes for multiple regressions with at least three predictors in the model: it would be likely that at least two independent variables were to be inserted into any regression model, alongside the control variable for psychological disability. Table 5.3 presented minimum required sample sizes for multiple regressions, so as to better comprehend the power of the models estimated in this study.

Four geographical areas were chosen using stratified random sampling, and SHSs listed and selected using a random number generator. An additional area was chosen because it had a high proportion of people from BME groups.

Semi-structured interview schedules were designed for the study, one for managers and one for service users. Interview schedules took into consideration already established scales, which were at times modified for the purpose of the study. Some questions were included that were especially formulated for this study. Interview schedules were piloted and revised a number of times to improve reliability and validity.

11.2.2 Implementing the study design

- Poor responses in some areas and SHSs meant that the number of areas and SHSs per areas was to be revised.
- Care homes and rural areas oversampled.
- Some supported housing schemes sampled, but very few people from Shared Lives participated.
- BME groups under sampled.

The review of the literature (chapter 3) demonstrated that one limitation of previous research within SHS settings was unrepresentative samples. Indeed, access to SHSs in this study was sometimes problematic, due to gatekeeping for example. Barriers to access may be an indication as to why some previous studies had not achieved large samples or had recruited participants solely from one geographical location. However, for this study a reasonably good sample size was nevertheless achieved; in total, 126 interviews were conducted with service users and managers.

In contrast to much previous work, the present study sampled people from a variety of different settings, across a range of geographical localities and types. The sub-sample sizes were unequal however; this will be discussed in the limitations section.

Overall, managers were somewhat more responsive in rural areas, allowing for more people to be sampled (both managers and service users). Similarly, the study sampled more people in care homes than in other settings. There are a number of reasons why this may have occurred:

- 1) There were more care homes for people with mental health problems listed in the directories that were created of all available SHSs in a given locality and which were used as a sampling frame.
- 2) Managers of care homes were more responsive when contacted (over the phone or via correspondence) and were thus more willing to have a researcher visit their premises.
- 3) Care homes were slightly larger in size than (for example) supported housing schemes, rendering the probability of interviewing a care home service user higher.

Oversampling from care homes meant that relatively few services were sampled from supported housing schemes and Shared Lives. Similarly, only one area was selected due to a high prevalence of people from BME groups, however with poor results.

Numbers of areas and SHSs were increased due to poor response rates.

11.2.3 Describing specialist housing services sampled

- Previous literature inconclusive with regard to definitions and the taxonomy of specialist housing services.
- New, more systematic classification needed.
- Some discrepancies between managers' accounts and official documents.
- Care homes in this study provide 24-hour care.
- Supported housing services here provide relatively less care, with staff usually on site during office hours only.
- Defining feature of supported housing services versus care homes: service users hold tenancies that are for the most part time-limited. Home size, level of privacy and house layout (self-contained accommodation or not) not distinguishing factors.
- Shared Lives schemes provide support that is flexible within a family environment.
- Some care homes de-registering for the benefit of service users.

The thesis developed a careful classification system based on previous literature, which was used in order to code the SHSs in this study. This was necessary because previously developed classifications did not fit today's service provision very well, and perhaps these were subsequently incorrectly labelled in official documents. Indeed, a few discrepancies appeared between official classifications and terms used by managers. Supported housing schemes, which had been expected to be smaller in terms of number of residents housed, were in fact not much smaller than care homes. However, a few care homes accommodated a very large number of people: eight care homes had 15 or more residents. Another difficulty encountered with classifying SHSs in this sample was that some care

homes offered self-contained accommodation within them, although this had been used to define supported housing services. In supported housing schemes, service users had *tenancies*, and also received much less support in comparison. All care homes in this study provided 24-hour support.

11.2.4 Movements and pathways

- Variations in lengths of stay: shorter stays in supported housing services compared to care homes, as reported by service users and their managers.
- Statistically significant differences found by SHS type in service users having achieved their preferences in moving to their current home: care home service users less likely to report having wanted to move in.
- Statistically significant differences found by SHS type in service users reporting a desire to move.
- All supported housing service managers said they promoted independence for their service users.
- Many cases of delayed discharge from hospital as reported by service users.
- Use of choice-based lettings still not widespread in SHSs. Despite some reservations, managers reported that CBLs provide choice and transparency.

Current lengths of stay varied by SHS type, and were shorter in supported housing schemes compared to care homes, hinting at higher turnover rates; and for many care home residents, it was their first time experiencing SHSs.

People in supported housing schemes were more likely to want to move compared to their counterparts in care homes. This in turn might be explained by many factors, such as longer current lengths of stay, expectations, or manager influence: some care home managers did not openly promote independence, whilst all supported housing scheme managers did, and aimed to achieve this through different mediums. In addition, supported housing schemes service users were likely to be on two-year contracts and be relatively more willing to move to less

supported arrangements such as an independent flat in the community. This may add emphasis to the argument that the home environment may have an influence on a service user's expressed desire to move.

Hospital is a major gateway to SHSs (mostly for care home service users, the largest sub-sample in this study). Analyses of hospital experiences revealed that several service users had reported experiencing delayed discharge because move-on accommodation was not available.

Care home service users were less likely to report having wanted to move in (although many of them had been living in hospital), and may have had less opportunity to exercise choice compared to people in supported housing services. Possibly the prospect of moving into a care home is generally not desirable and people may have preferred to move to supported housing services or an independent flat in the community, but it seems that this choice was rarely available to them. The prospect of a change in circumstances might also be considered as negative. Most people who did not want to move to their current care home were previously living in less supported arrangements. Care home residents who wanted to move on were less likely to have lived in more supported settings - such as hospital - previously.

More generally, care home residents were less likely to want to come to their current residence, yet they were less likely to express wanting to leave it as well, compared to people in supported housing services. This may be an expression of their need for continuity.

What is certain is that mechanisms for greater independence are not straightforward, and there may be other factors that mediate whether a service user expresses a desire to move out or not.

Eight managers reported that people had moved out of their SHS using choice-based lettings (CBLs). When comparing to the old waiting list system, managers felt that CBLs definitely gave people more choice, as they could actually see what they were bidding for. Not many service users in this sample had actually visited their SHS before deciding to live there. Although this study does not specifically quantify how many people had moved out of their SHS using CBLs, the small number of managers who had service users with previous experience of CBLs

corresponds to the small proportions of people reported by CORE (COntinuous REcording of Lettings and Sales in Social Housing in England (CORE), 2012).

11.2.5 Housing satisfaction within specialist housing services

- Highest reported ratings for staff, housing, privacy.
- Lowest reported ratings for social situation, community activities and fellow tenants. Significant positive correlation found between home size and satisfaction with social situation.
- The only statistically significant difference found when comparing satisfaction ratings of service users living in care homes and supported housing services was with regard to privacy.
- People in care homes significantly more satisfied with their privacy than people in supported housing services. This held true even after controlling for home size and length of stay (and psychological disability).
- Homely and familial environment achieved in Shared Lives schemes: their service users expressed high satisfaction with their Shared Lives carer, their home and community and activities.
- People living in independent flats reported dissatisfaction with support received.
- People living in rural areas significantly more satisfied with certain aspects of their lives and the housing environment compared to people in urban locations.
- Service users being presented with a choice, or exercising it, was not statistically significantly associated with housing satisfaction ratings.

When asked about domains of housing satisfaction, service users generally felt most satisfied with the staff, their housing service, and their amount of privacy; social situation, community activities and fellow tenants received lower ratings.

Only one statistically significant difference by SHS type was found, given the different support levels and environments offered within these services. Privacy ratings differed depending on whether a person was living in a care home or a supported housing service, with possibly unexpected results: people in care homes

scored their privacy higher compared to their counterparts, and in fact the presence of staff and support received had the opposite effect of hindering their privacy. People in less intensely supported settings were possibly dissatisfied with this aspect of their lives because they may be more autonomous than their counterparts and perhaps any 'intrusiveness' might affect them more adversely. Privacy is mediated mostly by having one's own space – all care home service users in this sample had their own bedrooms (in most cases with en-suite facilities), and as mentioned previously, some were living in self-contained flats within the home.

People in other support types such as Shared Lives schemes, for example, gave high ratings for staff (or carers in this case), possibly attesting to the importance a carer plays in their life. They were also particularly satisfied with their home and their community activities – hence these Shared Lives schemes had fulfilled their mandate in this case, to provide a homely environment where people share in the life of a Shared Lives carer.

The two former residents of supported housing schemes, now living in independent flats, were not particularly satisfied with staff: this may point to their dissatisfaction with the lack of staff presence in their lives, or to the possibly inadequate support received.

Although ratings for social situation were rated comparatively lower than other aspects, these ratings were influenced by the size of the home. The relationship between size of home and privacy did not achieve statistical significance.

Population density also had an effect on ratings of housing satisfaction: people living in rural areas were more satisfied with the social aspects of their lives, such as community activities, freedom and social situation. Could this be an indication of the type of neighbourhood the SHS is in, hence allowing individuals to flourish in this regard? Most (rural) SHSs visited in this study were in rural countryside, rich environments (Nicholson, 2008), which may have contributed to service users reporting higher housing satisfaction compared to people in urban areas.

Care home residents who wanted to move were generally less satisfied, and were also specifically less satisfied with their freedom and social situation. Could

these last two aspects be major influences on a person's satisfaction with their current situation?

Previous location was also an important variable influencing housing satisfaction. Unlike those previous studies which compared life before and after hospital, this study compared people who had moved from hospital and those who did not: people were significantly more satisfied than their peers with regard to certain aspects when they had previously been living in hospital.

Comparing managers' and service users' responses with regard to aspects of housing satisfaction could prove instructive (table 11.1). Managers rated the most important concern for service users to be the staff, their SHS and income. The least important concern - for both service users and managers - was employment. Managers believed service users valued their social situation, income and fellow tenants very highly; however service users were relatively dissatisfied in those respects. More concurrence occurred with other aspects, such as (for example) staff and amount of comfort.

Table 11-1: Comparison of service users' mean housing satisfaction ratings and means of service users' concerns (as judged by managers)

	Service users	Managers
Rating	Mean housing satisfaction rating (SD)	Mean concern rating (SD)
Social situation	73.9 (± 19.9)	80.2 (± 19.1)
Income	74.1 (± 26.3)	86.2 (± 17.5)
Fellow tenants	74.3 (± 20.6)	79.3 (± 16.6)
Community activities	74.4 (± 22.3)	70.4 (± 19.4)
Job	76.8 (± 23.7)	47.7 (± 25.4)
Amount of freedom	82.7 (± 22.1)	85 (± 20.8)
Amount of space	82.8 (± 18.5)	76.9 (± 19.9)
Amount of comfort	83 (± 17.1)	84.5 (± 20.9)
Amount of privacy	83.9 (± 17.3)	85.1 (± 19.2)
Housing situation	84.8 (± 16.7)	87.1 (± 16.2)

	Service users	Managers
Rating	Mean housing satisfaction rating (SD)	Mean concern rating (SD)
Social situation	73.9 (± 19.9)	80.2 (± 19.1)
Staff	86.5 (± 16.6)	87.2 (± 14.2)

Choice and preferences were not statistically significantly associated with housing satisfaction.

11.2.6 Social inclusion

Occupational activities

- Low rates of paid employment within SHSs.
- In terms of occupational activities, most people engaged in voluntary jobs.
- Occupational activity rates varied according to several EQ-5D-3L dimensions.
- Rates of engagement higher within supported housing services and rural areas.
- People in rural areas less likely to report wanting to work in the future compared to their counterparts in urban locations.
- Supported housing managers more supportive of occupational activities and employment in general compared to care home managers.
- Reported barriers to future employment differed by SHS types in managers' and service users' accounts.

A challenge faced by service users that was frequently mentioned by managers was employment – although they generally did not think it important to service users.

As mentioned previously in this thesis, not many service users were in 'formal' paid employment; most were in voluntary 'work'. Therefore, employment in this sense is referred to as an occupational activity. When discussing barriers, this is still termed employment as it discusses a potential *future* job.

Rates of engagement in occupational activities varied by population density and SHS type: people living in rural areas or in supported housing services were more likely to report being active in that sense. However, unengaged people in rural areas were less likely to report a desire to work in the future compared to their counterparts. Barriers to future employment also differed between groups, specifically by SHS type. Supported housing scheme managers also reported higher rates of engagement in occupational activities by their service users compared to the rates reported by care home managers. Compared to answers from care home managers, supported housing managers placed higher importance on employment.

Stigma was not apparent in service users' reports of expected future employment barriers. In comparison to a well-known study on the occupation of people with mental health problems, service users in this study gave more varied answers in terms of employment barriers. Participants in the Secker al. (2001) study had to select pre-specified answers from a list; the most frequent answer was "employer attitudes", a barrier never mentioned by service users in the present study. Alongside their concerns that service users may feel disconnected from the work environment, managers in this study were very concerned about negative external perceptions and lack of mental health awareness affecting their job opportunities, such as employers being inflexible.

Supported housing service users more commonly thought that a barrier to their future employment was their lack of confidence, whilst people in care homes blamed their 'disability'. Individuals' perceived lack of confidence and readiness was an important consideration in this case. A key objective of the *Healthy Lives Healthy People* White Paper (2010) was to promote service users' choice and confidence. Negative feelings of self-worth and low self-esteem within the mental health population were repeatedly voiced concerns by managers. As well as admitting that some people were just unable to work, or it would be difficult for them to do so due to their mental health problems, cognitive deficiencies or their medication interfering, some managers reported that some service users feared that their benefits would be reduced as a result. On the other hand, only one service user mentioned this point during their interview. This does not mean that social security

benefits are unimportant to service users, but it is possible that managers may have overestimated the magnitude of this disincentive.

In the Secker al. (2001) study, the high frequency of participants considering the possible reduction in their benefits as a disincentive to work shows that they may have been more ready to subscribe to a pre-determined answer. The Secker et al. study also reported a majority of people with mental health problems willing to work, although information was not reported on participants' housing situations. Admittedly, three people in the present study felt that they needed to move out of their SHS prior to acquiring employment. Hence, could living in an SHS be hindering their desire to want to obtain employment? Interestingly, there was a statistically significant difference between working-age participants' desire to move and obtain employment. People who wanted to move reported to be also more willing to get a job in the future compared to people who did not want to move.

Personal finances

- Number of benefits positively associated with engagement in community activities.
- Managers concerned about different funding arrangements in place and impending funding cuts and how these may affect lives of service users.
- Concern expressed by managers over availability and suitability of current places in SHSs.

Number of benefits received may be associated with the choices people made and their engagement in community activities. People not receiving DLA were also more likely to spend their days within the home. Staying in and watching television was also the most commonly reported activity.

Although the question of number of benefits received may be subject to recall biases, people in care homes were less likely to report receiving DLA compared to people in other settings; this may also be due to the different funding arrangements in place. However, it must be noted that, overall, care home residents scored their income highly.

Clearly, receiving DLA, or a higher number of benefits, may be an enabler to people participating in activities and lead somewhat more 'purposeful' lives. The

impending changes to DLA could cut these awards by 20% (Watt, 2012). Although service users were not specifically asked their opinions about funding cuts, managers' accounts show that the potential reduction in the amounts of DLA received may create difficult situations for service users, more so for those in supported housing than in care homes, and possibly make them lose links with the community and also stop them from doing everyday things, such as going out for a meal or buying a gift.

Hence, managers had mixed views about the impending cuts, with some managers mentioning the imbalances with regard to how much money service users received. A care home manager in this sample mentioned that some people - identified as being on section 117 of the Mental Health Act - could potentially have £50,000 saved in the bank. Having differing amounts of disposable income creates inequalities between people living under the same roof.

More specifically, the service users who were on section 117 awarded maximum housing satisfaction scores to the amounts of freedom and comfort they enjoyed, as well as very high scores to housing, staff, privacy and most importantly income.

Managers also spoke about the funding situation in general, and about the cuts to residential care. Supported housing schemes may present a cheaper option to care homes, but managers commented that there would always be a place for residential care. There were also reports of people being pushed out of residential care into supported housing services, sometimes against their will or without their consent, and also against the wishes of managers. Writing around two decades ago, Shepherd et al. (1993, p. 240) reported a gap in the availability of accommodation with high levels of supervision and waking night cover that could offer placements in the community for former long-stay psychiatric hospital patients, and that there were problems with regard to the care of young patients with chronic mental health problems in community settings. They also mentioned a problem with regard to the shortage of permanent as opposed to transitional places, especially in high-support environments. Clearly, in their experience, there was often a tendency to underestimate the need for highly supervised and permanent homes, whilst overestimating the capacity of some people with chronic mental health problems to

improve their level of functioning and move on to less supervised SHSs, possibly being associated with the under-provision of permanent housing with high levels of support. The consistency of findings across the two decades suggests that policy action is needed.

Social networks

- Statistically significant differences by SHS type: care home residents more reliant on staff than people in supported housing.
- Statistically significant differences by population density: people in urban areas seemingly more socially isolated in terms of the quality of their social networks, compared to people in rural areas.
- Significant associations between quality of social networks and ratings of housing satisfaction: better socially 'supported' individuals rated aspects of satisfaction higher compared to their counterparts.
- Living out of area was positively associated with barriers to seeing family and friends.

The quality of social networks varied by SHS type: people in care homes relied more on staff for certain situations, probably since more staff were available and for longer periods of time. However, they did not seem to have much contact with the 'outside world' compared to people in less supported settings.

People in urban areas also seemed to be more socially isolated; and as mentioned previously, service users in rural areas scored their social situation significantly higher than the former. Several other studies have found that people with mental health problems in urban areas are more socially isolated (McKenzie, 2008; Van Os et al., 2001; Van Os et al., 2002).

The quality of a person's social network was statistically significantly associated with housing satisfaction ratings, matching results from Goering et al. (1992). It would seem that satisfaction with privacy was indeed mediated by having understanding and available staff, possibly providing further evidence on the perhaps unexpected result of care home residents being more satisfied with their privacy than their counterparts elsewhere.

Many people were living away from their places of origin, which as the literature suggested, resulted in severing ties with their communities.

Discrimination: managers' perspectives

- Issues of discrimination reported only from a manager's perspective.
- Stigma from the public still apparent.
- Service users faced with lack of choice.

Managers were asked if they thought people with mental health problems were discriminated against. Most of them thought that service users had limited choices in terms of their accommodation and who they lived with, and there were limited places in terms of SHSs. UK studies on stigma and discrimination have focussed on the fact that service users perceived that they had a lack of choice in terms of their accommodation (Prior, 1996; Read & Baker, 1996) – a point that was brought up frequently by managers in this study.

Managers also pointed to the discrimination that people with mental health problems faced with regard to the public and the media. This was a recurrent theme - the public should be better educated with regard to the reality of mental illness, and that negative portrayals in the media of people with mental health problems were not necessarily true.

Service users were not directly asked about discrimination, but one person reported being the victim of direct discrimination. Stigmatisation of mental illness is pervasive (Corrigan et al., 2003). However, in this sample, not many reported feeling stigmatised.

Personalisation

- Low uptake of personalised services.
- Lack of awareness of personalised services amongst managers and subsequently service users.
- Mixed feelings expressed by managers over their use and access.

Choice and personalisation have been at the heart of the UK policy agenda for some time (Department of Health, 2005b, 2007b). However, uptake of direct payments and personal budgets has been relatively low among the mental health population. In terms of uptake, the evidence obtained in this study was in line with national figures. Only one service user in this study confirmed being on a direct payment, and no one was receiving a personal budget. Indeed, most service users

did not know what direct payments or personal budgets were. Five managers reported that some of their clients were on direct payments, and reported diversity in their use. Three managers expressed confusion over the mechanisms of direct payments, and from a service user's point of view, they felt that the latter would not want to change their current arrangements and would not want someone else to manage their money for them. Uptake of personal budgets was also low according to managers, with some managers expressing concerns that service users might not be able to cope with managing their money on their own.

Engagement in activities

- Most commonly reported activity: staying in and watching television. Significantly more frequently reported by care home service users than those in supported housing.
- Managers perhaps more positive about service users' level of community engagement than service users themselves.
- Higher housing satisfaction reported amongst attendees of day centres.

With regard to community activities, some discrepancy was found between service users' and managers' answers. Most service users reported participating in tenants'/residents' groups, and nearly half had a hobby. Some enjoyed shopping and several people went to the day centre regularly. Specifically, people in care homes were more likely to spend time at home watching television, compared to people in less supported arrangements.

Managers reported high engagement by their service users with regard to community activities, especially in terms of participating in religious activities and attending a day centre. In comparison to service users' accounts, the former figures may have been slightly ambitious. More than half of managers reported that their service users went to day centres on a regular basis. However, as mentioned previously, the unfavourable current funding and financial context means that some day centres had closed. Research findings have been mixed concerning the effectiveness of day centres in the case of people with mental health problems (Beecham et al., 1999a; Catty & Burns, 2001; Catty, et al., 2006). In this study, most managers were keen advocates of day centres, as they felt they encouraged people

to socialise. Moreover, it would otherwise have been necessary for some SHSs to provide the day activities themselves from their limited resources, with one manager adding in their interview that sometimes service users' day care had to be funded out of staffs' own pockets. Indeed, compared to those who did not, service users who went to day centres regularly reported higher housing satisfaction with certain aspects.

11.2.7 Summarising the results of the qualitative study

- Framework analysis of experiences within SHSs: four emergent themes.
- Independence, autonomy, and 'moving on' important aspects amongst service users and managers. Both strived for this 'ideal' in different ways.
- Lack of choice faced by service users in terms of where they move to, the type of accommodation they are presented with, and the timing of that process. Choice further hindered due to receipt of benefits and discrimination from public institutions as well as the wider community.
- Lack of choice and subsequent powerlessness also expressed by managers, as they struggle with tightening budgets, cuts to funding and pressure from social services. These challenges present barriers to managers who strived to provide personalised and caring environments.
- Day centres should be more innovative and responsive to current needs.
- Quality of occupational activities poor and limited to manual labour; perhaps further reinforcing the mental health label.
- Secure environments figured highly in service users' accounts as important aspects to them.

Four strong themes emerged from the qualitative analysis relating to the personal experiences of living in and managing SHSs in England.

Autonomy and independence were expressed differently by managers than by service users. Service users wanted to be more independent but within limits, and have people around to take care of them on a needs basis. Managers were divided with regard to the ideal of 'independent living', perhaps due to witnessing negative experiences of service users, and external pressures forcing their hand.

Neither service users nor managers generally expressed being presented with choices, and even when they did, they were prevented from exercising them.

Service users were at times coerced into accepting a form of support, be it when moving out of hospital or an SHS. When wanting to express a desire for a particular form of support, they also faced the obstacle of having professionals deciding for them what their needs were, or not being able to rent on the private rental market due to the stigma attached to mental health.

Stigma was not directly reported by service users, yet it was apparent – and also reported by managers – that they were excluded from several spheres of life due to this reason. Managers reported people facing discrimination from public institutions, adding to their social exclusion. Service users also seemed to be excluded from future employment due to internal as well as external factors. Even those individuals engaged in occupational activities may be experiencing exclusion: opportunities were limited to gardening or other manual labour; very few people in this sample were offered placements where interaction with members of the public was necessary.

When available, day centres did provide a structure to peoples' days, however some complained that they disliked the activities offered and being around other service users. Managers called for more innovation with regard to day services; many hinted that services were not responsive to service users' needs, especially with regard to personalised services. However, in this case, considerations of direct payments or personal budgets and positive attitudes towards personalised services, and in turn a more democratic management style, were perhaps associated with a manager's willingness for innovation, itself may be linked to managers' age.

Personal finances and funding were recurrent topics throughout interviews with service users and managers, and were clearly very important aspects in their

lives. Levels of funding affected experiences within the home, as managers struggled but strived to provide appropriate care and activities. Tightening budgets meant that in some cases social services departments placed pressure on managers, and in turn service users, to favour less supported settings that may be cheaper for them (social services departments).

This created precarious arrangements for service users, who thrived on continuity, and secure and stable environments, with friendly staff presence, where a manager or other staff member would take care of them and create a safe environment. Otherwise, service users were not particularly satisfied with their personal income, at times not being able to afford certain 'luxuries' such as cigarettes, which they heavily depended upon.

11.3 Triangulating the results of the quantitative and qualitative analyses

Moving on towards greater independence and autonomy?

- Concurrence between both types of analyses with regard to 'greater independence' being more widely expressed and supported within supported housing services.
- A need for continuity expressed in quantitative and qualitative analyses in terms of moving on.
- Care home residents' greater dependence on staff in terms of support and social networks perhaps linked to a need for continuity and concern over this loss in support.
- No concurrence between analyses with regard to managers' roles and promotion of independence.

In the quantitative analysis, service users were somewhat divided as to whether they wanted to move to less supported arrangements. In terms of specific support types, both supported housing scheme service users and managers expressed greater support for this goal. Specifically supported housing managers believed in *recovery*. Focussing on recovery perhaps instilled greater confidence in service users in supported housing services to successfully live in the community. Of course, there were many other factors that were at play here, possibly the most important of which were individuals' Supporting People contracts, as well as

individual capabilities – people living in care homes were most likely to be there because they required intense support.

The quantitative analysis showed that care home residents who had not been living in an SHS or hospital beforehand were more likely to want to move compared to people who may have been moved around many times. Similarly, service users' narrative accounts revealed their longing for continuity, and ultimately security. A chi-square test using Fisher's exact test (two-tailed) found that people whose first time it was in SHSs were more likely to report wanting to move compared to people who had lived in SHSs beforehand ($p=.048$); possibly experiencing multiple moves increased their desire to remain within one location. Tsemberis et al. (2003) found that care home residents were more satisfied with their safety compared to people receiving less support within their homes, possibly hinting that this was an important aspect for them, as it was for service users in this study.

Care home service users displayed greater vulnerability in their narrative accounts when speaking about the future and the possible loss of support from the members of staff in their lives; to them greater autonomy may represent a rupture from their current social worlds. Indeed, quantitative analyses of social networks showed that staff were at the centre of their social worlds, as they relied on them for practical as well as emotional support. Otherwise, they were significantly less likely to want to move compared to people in supported housing services.

Managers' accounts otherwise showed that when they were also owners of the SHS in question, they were sometimes torn between what was best for their business and for their service users. However, cross-tabulation statistics found that in fact the four owners/managers (of care homes coincidentally) did promote independence for their service users, and did so through encouragement and support.

A lack of choice?

- Lack of choice aspect much more apparent in qualitative accounts; quantitative analyses did not reveal significant differences.
- Age of managers had significant bearing in both analyses: younger managers were perhaps more permissive home environments.

Service users were asked in various ways whether they were faced with a choice of where to live (for example “did you have a choice to come here?”, “do you think the move was a good decision?”), although quantitative analyses did not reveal significant differences with regard to housing satisfaction. Qualitative analyses revealed that service users may be feeling powerless, and that having insecurity of housing tenure, as well as limited powers and options by which to exercise their choice with regard to housing preference do create anxiety and may well be associated with poorer outcomes. The choice theme was much more apparent in the *qualitative* analyses of service users’ and managers’ accounts.

Nevertheless, managers strived to create personal and homely environments for service users, with younger managers displaying more democratic and innovative management styles according to the qualitative analysis. Further quantitative analyses, using Pearson’s correlation, revealed that manager’s age was significantly associated with rules within the SHS. Older managers were less likely to allow outsiders to stay overnight with the service user ($r(38)=-.330$, $p=.043$) or permit the service user to spend the night outside the SHS ($r(39)=-.315$, $p=.050$). Shepherd et al. (1996) reported a positive correlation between managers’ time in role and the frequency of negative interactions with service users. Hence this study’s result may indicate either that older managers were less permissive in their management style, or that their length of job tenure had made them more ‘negative’ in consequence.

Housing experiences and satisfaction

- Factors that are associated with certain aspects of housing satisfaction within SHSs according to quantitative and qualitative analyses: SHS type, population density, engaging in community activities, going to the day centre, age, number of people living in the home, receiving DLA, previous location, being satisfied with benefits, wanting to move out, being socially supported - especially by staff - quality of staff and the home, and a sense of security.
- Setting restrictiveness perhaps also provides security; hence translates into greater housing satisfaction.

- Care home service users reported receiving less income/benefits compared to their counterparts, and qualitative analyses showed that this hindered their engagement in certain activities; they scored their income highly nevertheless.
- Day centres seemed to be linked with positive experiences. They also provided a sense of comfort and security for those who were contemplating a move from their SHS.

Qualitative analyses showed that freedom was mediated by the rules within the home and ultimately managers' ethos. Older service users were also shown in this case to be more satisfied with staff, their freedom and lives in general. Quantitative analyses had shown that age was positively correlated with satisfaction with staff, community activities, and comfort but only marginally significantly correlated with freedom ($r(78)=.208$, $p=.068$).

Qualitative analyses also revealed that care home service users seemed to be more satisfied with their freedom, and complained less about rules and restrictions than their counterparts in supported housing services.

A recurrent factor in the literature was setting restrictiveness. However in this study, care home residents, who received 24-hour support, seemed satisfied – possibly this sense of restrictiveness also provided security and safety, a value most service users thrived on.

More generally, and in spite of feelings of insecurity and a lack of choice, service users seemed to be faring relatively well when housing satisfaction ratings are taken into consideration. One of the lowest scores was attributed to income: could this be the result of the funding situation limiting their choices and opportunities for community engagement or purchasing goods and services?

Qualitative analyses suggested that it was particularly people in care homes who were the most apprehensive with regard to personal income; indeed quantitative analyses revealed that they were less likely to be receiving DLA compared to their counterparts in supported housing services. However, with regard to actual housing satisfaction scores, care home residents seemed to be particularly satisfied with their income.

Attending a day centre seemed to be positively associated with ratings of housing satisfaction as revealed by the quantitative analyses in chapters 8 and 9. Qualitative analyses revealed that some service users relied on day centres to see their friends, get out from under the roof of the SHS and establish outside contact. A few service users regarded it as a link back to their SHS once they had left it.

Social exclusion

- Both analyses support the view that service users within SHSs are perhaps still discriminated against, itself associated with social exclusion, as reported by managers.
- No concurrence between the analyses when testing for differences by population density with regard to managers' accounts of discrimination.

Quantitative and qualitative analyses of evidence gathered in the managers' interviews revealed that the stigma of mental illness is still pervasive and discrimination does occur; however, it was not directly reported by service users. The most vivid accounts in this case were relayed by care home managers.

Qualitative accounts of managers within rural settings highlighted the link between small communities and tolerance; however a subsequent quantitative analysis showed that it was mainly managers in rural areas who were more likely to recognise that service users may be discriminated against by private landlords.

11.4 Strengths and limitations of the study

11.4.1 Strengths

The study design

One of the strengths of this study was that a mixed-methods design was employed, answering the call for such methods to be used for studies within SHSs in England, and better use of qualitative data (Macpherson, et al., 2012). This design seemed to fit this type of context well. Analysing interview responses using both quantitative and qualitative methods extracted rich information. The problems with recruiting and sampling meant that sometimes sub-groups were too small for robust statistical analyses; however accounts from particular groups, for example

people in Shared Lives schemes, could still be captured using qualitative methods, providing valuable insight and information.

A large number of in-depth interviews with users of care homes was undertaken. Although not planned for in the research design, two service users were sampled who were living in independent flats, and qualitative analyses revealed some useful information about their experiences, and that they were faring relatively well.

Mixed-methods designs allow for the triangulation of quantitative and qualitative analyses. The triangulation did prove informative in this case, especially in the exploration of stigma and housing satisfaction.

Data collection methods

As Pinfold (2000) notes, there is valuable knowledge that can only be gained through face-to-face interactions; here the aim was to obtain in-depth accounts of the experiences of people living in and managing SHSs. The advantages of face-to-face interviews are many. The interviewer can guide the participant through questions, and in some cases, is able to prompt the participant for further information or explain misunderstandings, allowing for higher response rates (Hall & Hall, 1996, p. 101). In this study, there were relatively few missing responses, and hence relatively few missing variables in the statistical analyses. Semi-structured interviews aimed to capture what the participant really believed. Possibly, when using closed-ended prompts, participants are more likely to rapidly subscribe to a pre-determined answer. For example, many studies on employment barriers experienced by people with mental health problems found that stigma and discrimination from the public was an important disincentive (Secker, et al., 2001). In comparison, the more open-ended nature of questions in this study did not produce a similar result, but may have instead captured what participants really thought were barriers to their employment.

Interview schedules were specifically constructed for the study and carefully designed. Two pilot exercises were conducted to highlight any unanticipated problems with the interviews, to decide whether further response options should be considered if the answers are closed-ended, and to discover if participants bring up any issues that had not been considered previously (Hall & Hall, 1996, pp. 126-

127). Seeing that interviews were conducted with people whose cognition or attention may fluctuate, it was essential that care was taken with the wording of questions. The two pilot exercises, the careful development of the questionnaires and most importantly the ethics procedure (where all study materials – consent forms, information letters, and interview schedules - were carefully scrutinised by an independent committee) contributed importantly to the quality of the study.

Sampling areas and participants

A rigorous sampling technique was employed to select areas for this study, taking into account different population variables; stratified random sampling was employed thereafter. Previous literature on satisfaction within different SHS types found large effect sizes with regard to differences in satisfaction ratings. The sample calculation for this study took into consideration a smaller effect size, as this study was interested in other aspects of individuals living in SHSs. The size of the sample for this study exceeded the one stipulated by a large effect size, however not many statistically significant differences appeared in the housing satisfaction ratings of people in care homes versus supported housing settings, perhaps disappointingly; this is explored further in the next section. Qualitative analyses proved more informative.

Classifying specialist housing services

A classification of SHSs was proposed and subsequently used for this study, by synthesising the previous literature; doing so provided consistent definitions and descriptions of the different accommodation types that constitute the SHS spectrum. Lists of available SHSs were compiled for every area using established databases and assigned with a random number, to allow for transparency. The different classifications (official documents, managers', the study's) were compared and contrasted. The new classification was particularly useful when conducting statistical analyses to explore differences by SHS type.

Data analysis

Analyses followed a rigorous approach. Where applicable, variables to be tested were selected based on 1) previous literature, 2) univariate analyses and 3) qualitative interpretations of what the data was saying. Quantitative analyses were introduced with preliminary explorations of the data, taking into account potential

issues such as non-normal distributions. All analyses - where applicable - were thereafter tested for the influence of psychological disability.

Housing satisfaction was explored within service user interviews, and although ratings were rescaled to 100, resulting in a possible loss of the reliability of the original scale, it also meant that service users had more options to choose from. Responses to some questions were skewed, but this was accounted for in the statistical analyses.

Qualitative analyses were carefully conducted, supported by use of framework analysis; this systematic approach was also guided and later checked by three independent, experienced qualitative researchers.

The triangulation of the quantitative and qualitative results provided additional information, and aided in interpreting the data. It may have perhaps demonstrated the strength of a mixed-methods approach: qualitative analyses helped in interpreting what these housing satisfaction scores meant. In sum, employing both approaches deepens our understanding of experiences of people in SHSs.

One of the (unplanned) strengths of this study was that fieldwork was undertaken prior to the present wave of funding cuts to health and social care; this allowed for the opinions and views of people who were going to be directly affected by these cuts to be sought and thereafter analysed.

11.4.2 Limitations

The limitations of this student study are unfortunately numerous, possibly due to the difficulty of the subject matter and the limited number of studies conducted in the field. These limitations challenge the generalizability and perhaps validity of the results. It is therefore important to acknowledge and discuss these constraints.

A non-hypotheses driven approach

At several instances in this thesis the approach taken is described as 'descriptive' and 'exploratory'. Indeed, the literature review in chapter 3 stated that there was an insufficient number of studies in the field of SHSs. Samples were at times unrepresentative, studies poorly designed and results difficult to understand.

This poor literature base made it harder to formulate formal hypotheses to test. For example, the literature on satisfaction did not reveal any consistent associated factors, rendering it problematic to decide which factors to test and what direction of the relationship to expect between dependent and independent variables. Instead this study relied on more broad research questions, which arose from the gaps in the literature, a limitation in itself in research. Since these research questions aimed to answer 'what' and 'how' questions, the study is therefore very broad. The choice of variables to test in analyses, although driven by the literature, univariate analyses and qualitative analyses, would have been more justified should hypotheses been set out from the start. Not knowing what relationship to expect between variables may lend itself to error in its interpretation. Furthermore it may increase the chances of committing a Type 1 error. In hindsight, forcing the formulation of hypotheses in this case would have made for a more robust and focussed study, and increased the confidence and validity of obtained results. Furthermore, it would have perhaps better equipped the reader to follow the logic behind the analyses and subsequent interpretations.

Semi-structured interviews: the other side of the coin

Interviews also have their limitations as a source of research evidence, and they can lead to some biases. The quality of data can differ from one interview to another, as it is dependent on the rapport between interviewer and interviewee. Perceived characteristics of the interviewer, such as gender, age and ethnic group, may influence the information obtained, as participants may provide the answers they think the interviewer would want to hear – the so-called acquiescence effect. Another disadvantage of interviewing is that the task of obtaining high-quality data is time-consuming, and there is obviously a limit to how many interviews can be done in one day (Hall & Hall, 1996, pp. 101-102).

The use of two different interviewers does threaten inter-interviewer reliability, despite the use of a very detailed protocol for the study. The protocol included instructions for the interviewer (an opening statement), key research questions to be asked, probes to follow the key questions, transition messages for the interviewers, space for recording comments, and space where the interviewer

could record reflective notes (Creswell, 1994). Nevertheless, differences in personal characteristics may have played a role in influencing responses.

Challenges to the specialist housing services classification systems used

Although a synthesis of the previous literature on SHSs was perhaps necessary and informative, it also provided a challenge to the representativeness and generalizability of results obtained when comparing different SHS types.

A table was presented at the end of chapter 4, depicting the three types of SHSs that were eventually sampled in this study, alongside their descriptions. The selection of the types of SHSs in this sample was somewhat guided by this final classification table (table 4.1), leading to several interconnected limitations.

Starting with the directories used for the selection of SHSs in this sample, it is difficult to be confident that the directories used are a reliable source of information given the general lack of consistent data on the numbers of people within different SHSs in England. These directories, from where SHSs in this sample were randomly selected, represented an amalgamation of data from Supporting People (which is only concerned with Supporting People-funded placements, and is more geared towards floating support), Rethink (a mental health charity) and the Care Quality Commission (which is perhaps more geared towards registered residential care homes). The subsequent use of multiple (perhaps unreliable) directories does question the representativeness of the directory used for this study. These directories may have been incomplete and some SHSs may have been missed. Care homes were over-represented in them.

The synthesis of the selected literature in chapter 4 revealed a type of SHS that had been salient in the development of SHSs: group homes. Although attempts were made to sample this type of home (and there were group homes listed in the databases, perhaps incorrectly labelled), none were actually visited for this study. This is perhaps an indication of the evolution of SHSs, and the similarities with supported housing services (this point is also mentioned in chapter 4): group homes may now no longer exist due to these reasons. It is also possible that the homes sampled in this study labelled as supported housing schemes are the remnants of old group homes. The perhaps incorrect inclusion of group homes in the source documents does represent another limitation of the directories used for this study.

Other concerns and questions that arise, highlighted by the fact that few statistically significant differences were found between the different SHSs in this study (mainly care homes and supported housing services) are whether the study's classification system is valid and whether another measure should have been taken into consideration to differentiate between SHS types. It is somewhat puzzling that no statistically significant differences were found between SHS types on measures of health, for example (going by the premise that people are in more intensive support because they need it).

Further analyses using the official classification and that of managers as independent or dependent variables provided somewhat similar results compared to when this study's classification was applied. This result may provide support for this study's classification system, but also adds support to the argument that another measure could have been used to differentiate between different housing types.

What is a salient differentiating factor between care homes and supported housing services? Perhaps data supplied by managers on expected lengths of stay, expected type of move-on accommodation, and/or whether service users within a said SHS had tenancies or not would have been more instructive. Contrasting the two large-scale studies on SHSs may also give an indication: Priebe et al. (2009), who, unlike Lelliott et al. (1996), did not develop a rigorous and comprehensive classification system to label their services, did not find significant differences in health.

An incorrect approach to sampling areas and participants?

Employing stratified random sampling which took into account different area variables may have overcome the problem of choosing areas based on non-random criteria, however it still yielded a higher number of SHSs in rural areas. Similarly, randomly selecting SHSs may have yielded a larger number of care homes due to the fact that there were a larger number of them listed in the databases in this study (perhaps incorrectly, as discussed above). However, this strategy was not properly equipped to answer the research questions.

Otherwise, one of the issues this study had originally set out to investigate was whether people from BME groups had different experiences in SHSs, compared to people from White backgrounds, due to the fact that they might have had different experiences in psychiatric hospital (Bhui, et al., 2003). However, and an admitted limitation of this study, a large enough sample of people from BME groups was not achieved in order to conduct rigorous analyses, even though sites had been specifically targeted for sampling due to their high BME group proportion.

A similar approach – purposive sampling – could have been taken into consideration in order to obtain adequate and comparable numbers of people living in different types of SHSs (care homes, supported housing, Shared Lives schemes). Employing purposive sampling in this case, and perhaps over-selecting participants from supported housing schemes and Shared Lives schemes, would have aided the statistical analyses and made for a better study. In this case, information obtained would have been more appropriate to one of the principal aims of the study – to explore differences between the different SHS types. More generally, the numbers in the sub-samples of SHSs obtained in this study do question the representativeness of this sample as an appropriate picture of SHSs in England.

Selecting scales and instruments for the study

The interview schedules that were designed for the study employed some already established scales, and in some cases modified them. Modifying scales in such a way renders the original reliability redundant; however it was perhaps necessary to do so in order to obtain more varied responses from participants.

Data from the housing satisfaction scale was envisaged to be used as a proxy for well-being, although it is important to keep in mind that in reality it only taps into *housing satisfaction*. In the case where higher order concepts (for example quality of life) were to have been explored, it would have been more appropriate to employ relative scales, for example the MANSA.

Another acknowledged limitation in this study was the absence of a formal measure of psychological disability (as discussed in chapter 6). Analyses used the anxiety/depression subscale of the EQ-5D-3L as a proxy for psychological disability; this did not produce significant results and perhaps questions the construct validity of this measure, as well as its sensitivity to detect significant differences when used

with a sample of people with mental health problems. A possibility would have been to use the EQ-5D-3L VAS, despite the fact that it taps into the ambiguous construct of 'health' and may signify mental and/or physical. It would have also been possible to include more than one item from the EQ-5D-3L subscales in regression models, although this would have been difficult due to the relatively small sample. Another possibility would have been to create a composite of the EQ-5D-3L subscales to include in the analyses. In hindsight, a better measure of psychological disability should have been employed.

More generally, and taking into consideration several of the points discussed above, there are many reasons why, in some cases, statistically significant differences by SHS type were not obtained in this study. These so far include: 1) the chosen scales were not sensitive enough to detect differences or were inappropriate, 2) the directories used did not aid in obtaining a representative and informative sample of SHSs and their users, 3) the classification of SHSs for this study was flawed and service users should have been differentiated by some other salient characteristic, 4) the subsample sizes were too small and lacked statistical power, the product of a perhaps unsuitable sampling strategy. All these points limit the validity of the results obtained.

A representative sample of service users?

Gaining access to participants was somewhat problematic and very time-consuming on occasion. Reaching managers to schedule an interview date sometimes proved difficult, as did convincing them of the advantages of participating in the study. All these constraints, gate-keeping, ensuring a representative sample whilst guaranteeing anonymity and confidentiality, limited the number of people sampled. The sample of service users (N=86) was perhaps therefore somewhat smaller than desired, and over-represented with care home residents. Collecting primary data is necessarily time-consuming.

It could be argued that this study may have only included the people who were 'healthier' or more capable of answering interview questions, or in other ways more willing to participate in research, and that it excluded the more 'disabled' members of the SHS household. As laid out by the Ethics committee, participants should grant researchers their informed consent prior to participating in the study –

hence excluding people who could not or would not give it. This is one limitation of the study that must be noted.

Challenging the quality of the data obtained from service users

Conducting interviews with mental health service users can present challenges, although precautions were taken to ensure that the questions posed were easy to understand and presented no strain to participants.

Answers regarding questions such as current length of stay in SHSs, previous accommodation, types of benefits received and previous lengths of stay in hospital, and their inclusion in certain analyses should be treated with some caution, as these may be subject to recall biases. It may have been more rigorous to have obtained this information from managers instead/as well. Similarly, nature of psychiatric diagnosis was obtained from participants, and perhaps should have been confirmed with managers at the end of each interview.

Another consideration is the time of day when the interview with the service user took place: was it in the morning or afternoon? Was it before or after having taken their medication (if applicable)? In that sense, timing of the interview may affect a person's mood and cognition and may have influenced the results obtained. Being aware of this is essential.

Although precautions were taken to ensure the clarity of the interview schedule questions, the use of different interviewers, and perhaps a lack of consistent instructions does question the validity of some constructs, for example: housing satisfaction. Participants were asked to give a rating of their social situation at first, and this was described as whether they had friends and family and saw them often. However, there are several threats to validity and reliability here that must be acknowledged: 1) was the question posed in the same way to every participant using the same terms, 2) did the different interviewers explain the question in the same way, 3) did the interviewers elicit different responses from participants due to their differing personal characteristics, 4) and consequently and most importantly, were the different aspects of housing satisfaction understood in the same way by all participants? Having had one interviewer conducting the interviews with a strict protocol to follow would have helped minimise these biases; however, and unfortunately, collecting primary data is not always so neat. The use

of a mixed-methods approach in this study does aid with better understanding responses with regard to housing satisfaction. The framework analysis in chapter 10 also made use of other questions in the interview schedule to explore the different aspects of housing satisfaction.

Intrusion into peoples' lives, and in this case their homes, 'being visited' for research purposes can be greeted with suspicion, perhaps even hostility, especially if there are minimal perceived gains for participants. It also needs to be remembered that the present study did not remunerate participants for their time (Pinfold, 2000). However, and fortunately, the majority of research participants, managers and service users alike, appeared to be very happy to participate.

The problem of multiple testing

Finally, numerous statistical tests were conducted in this study, and in the absence of clear testable hypotheses, the probability of committing a Type 1 error is increased. One way to have decreased these chances was to have conducted Bonferroni corrections, and made the alpha, or significance level, more stringent, and more likely to detect *real* differences (Abdi, 2007).

For ANOVAs, and since sub-samples were usual unequal in size, the Scheffé post-hoc test was conducted to identify which variable(s) contributed to the overall difference (also discussed in chapter 5).

11.5 Research implications and policy recommendations

Main points:

- More work needed to develop a rigorous and up to date classification of SHSs. Official websites should be encouraged to adopt a consistent classification. New classifications should take into account lengths of stay and security of tenure.
- Data, with regard to the numbers of people living in different types of SHSs, their pathways and outcomes should be more routinely and consistently collected.
- Future studies should focus on the outcomes of service users living in the community, and the appropriateness of support they are receiving.

- Future studies on SHSs should perhaps adopt a more focussed and purposive way of sampling, due to difficulty with access and recruitment.
- More studies needed focussing on the outcomes of people from BME groups within SHSs.
- More research should be conducted that compares the experiences, housing satisfaction, preferences and choices of people living in different support arrangements.
- More transparent and responsive services, in terms of paid employment and housing, should be in place, which cater to the needs and preferences of service users.
- More work still needs to be done with regard to the choices offered to service users: clearly homes for life are not 'healthy' but neither is living within insecure arrangements. Service users should be aware of their housing situations, and be helped to make informed decisions.
- Independent advocates should always be present along with the care team when service users are faced with decisions such as future work, changing homes or areas, or revision of benefits.
- Better information to be made available on personalised services.
- With the closure of day centres, alternative arrangements should be made available that offer people a chance to socialise and get out from 'under the roof of the SHS'.
- Integrated mental health campaigns, that tackle stigma, should be more pervasive. Private landlords should be encouraged to lease properties to service users.
- Befriending schemes should be made available more commonly to people living within SHSs, especially care homes.

This study offers an in-depth look into the lives of people with mental health problems living in SHSs, their housing satisfaction, their housing pathways, their social inclusion, and other aspects of their lives, with additional and helpful insights

from managers. Face-to-face interviews with service users seem to be a particularly good way to obtain good quality data from individuals with mental health problems.

Although the study proposed a new SHS classification system, further work is needed in order to establish a taxonomy of SHSs that could be adopted by researchers in the field. More particularly, researchers should provide greater detail on their respective classifications and definitions of SHSs, as well as how they obtained them, due to the previous discrepancies found between official documents and managers' descriptions in this study, and the numerous problems that ensued.

Given the apprehension conveyed by service users and managers vis-à-vis independent living, future research should perhaps focus on the outcomes of people now living independently in the community.

The failure of this study to recruit enough people from BME groups should be considered. It would be interesting to conduct a follow-up comparative study, specifically targeting people from BME groups, investigating some of the same topics broached by the present study. Similarly, given the difficulty with access and sampling encountered in this study, future studies should perhaps adopt purposive sampling in order to obtain participants from a range of SHSs, in order to compare outcomes.

Accounts from some managers and service users revealed that future budget cuts might impact upon their lives significantly. It would be interesting to compare the lives of people in SHSs since the implementation of the present public expenditure cuts, and investigate associations with experiences within SHSs.

Choice and preferences were recurrent issues throughout the study, and were thought to affect housing satisfaction. However, quantitative analyses did not find statistically significant links between choice and housing satisfaction. Possibly a more comprehensive measure of choice should be included in future research (Srebnik, et al., 1995), in order to explore possible associations.

Personalised services are still not common for people with mental health problems living in SHSs, and it is unclear whether managers' general pessimism, respective lack of training and awareness as well as influence may be a barrier towards innovative practices. However, the fact that direct payments at the time of

interviews were not largely available to people within residential care must also be noted (Directgov, 2012a).

Direct payments and personal budgets could be beneficial for people living in SHSs, and could promote their independence, thereby easing their transition into independent living in the future, as they will be to some extent responsible for budgeting their money and managing their tenancies thereafter. Greater use of such personalised services may aid in bridging the gap left by the potential closure of day centres.

It has been mentioned previously that there is a lack of consistent data on people living in SHSs, and their pathways in and out of different accommodation settings. Some data exist courtesy of the Health and Social Care Information Centre as well as the Centre of Housing Research, but a more systematic and consistent approach needs to be taken to gathering appropriate data in order to inform future policies. Data collected should in turn be more comprehensive. Also, data on the number of people who have left different SHSs, and where they may have eventually moved to, are missing.

Future data collection should possibly make use of a consistent typology of SHSs as described above. This would generate better data and hence the potential for more adequate planning and policy-making. Aims of particular SHSs should be made clearer, in terms of whether these constituted transitory accommodation or 'homes for life', and should be subsequently made clearer to users of services. This may lessen the anxiety experienced by service users with regard to future housing prospects, and may be associated with better outcomes. In turn, roles of service managers will possibly be more clearly defined.

Occupational activities were perhaps a big issue in this study because so few service users were actually working at all or expressed such a desire. One of the reasons for such low-level engagement within this sample, mentioned more by managers than service users, is the belief that social security benefits may be reduced should service users engage in employment. However, there are specific guidelines available (Directgov, 2012b) that may explain how to potentially prevent loss or reduction of benefits whilst being in paid employment. However, managers and service users seemed to be unaware of these guidelines; hence better training

and education are needed to raise awareness with regard to the benefits system among service users and care managers. Secker et al. (2001) suggested that impartial and trustworthy advice is required from people who understand the benefits system, in addition to expert careers advice from people with an understanding of mental health and employment issues. They also highlight the importance of providing information about opportunities in day centres through talks and written material, as well as the provision of information in a range of different languages. Indeed, a survey by the Care Quality Commission (2012a) found that 34% of people sampled had not received any help from anyone in NHS mental health services in getting help with finding or keeping work, and would have liked to have received support.

Hence, there seems to be a consistent lack of information available for mental health service users with regard to paid employment, social security benefits, as well as aspects of personalisation such as direct payments and personal budgets. A better understanding of these may make people more engaged in their care, and increase their sense of empowerment in making decisions about their own lives. A couple of voluntary-sector SHSs in this study had leaflets and information packs available on these topics; however, their use should be more widespread. Furthermore, managers, social workers or care managers should be encouraged to take responsibility for explaining these concepts to service users whilst making sure they are fully aware of their rights and choices. Also, as reported by many managers, some service users seemed to be forced into making decisions without the proper information being available to them. These decisions were sometimes life-changing, as in the instances where social services influenced service users' decisions into moving to a less supported environment or even back to their original boroughs by making it seem more attractive. Service users were also sometimes unfairly assessed for employment support allowance, when they may have been unable to maintain a job.

There appear to be clear conflicts of interest between what is good for a service user and what makes financial sense. When service users are faced with such important decisions, be it in terms of housing, benefits or future employment,

it is imperative that an informed and unbiased advocate be present when such a meeting takes place, making sure they are making a fully informed decision.

A significant barrier to employment according to service users interviewed in this study is their lack of self-esteem and confidence; issues that are pervasive and common amongst the population of people with schizophrenia (Bradshaw & Brekke, 1999). Studies have shown that people with mental health problems can benefit from self-esteem groups as well as cognitive behavioural therapy (Newns et al., 2003; Waite et al., 2012). In turn, Bond et al. (2001) found that the employment of service users could be associated with improved self-esteem. Could it be possible that people with mental health problems living in SHSs could benefit from self-esteem 'therapy' to remove that as a barrier to their employment? However, employment options offered to service users should still be considered worthwhile and not just concern themselves with routine manual labour as a form of containment; in this study, certain individuals seemed to thrive when interacting with people other than service users. Hence, future employment options should take into consideration service user *preferences* first and foremost, as well as ambitions, previous work histories where applicable, and strengths and weaknesses in terms of skills.

Another policy issue to consider here is the closure of day centres. Previous studies on the 'effectiveness' of day care centres may have produced mixed results, but accounts from managers in this study show that their closure has had a significant and negative effect on service users, as well as on the activities that they will consequently have to provide at their SHS. Clearly, should day centres be forced to close, and service users not have a place to socialise as a consequence, alternative solutions should be provided, possibly in the form of more funding being provided to SHSs to allow them to provide day activities. Conversations with managers of a well-known charity have revealed that new centres, termed well-being centres, have emerged, but are sometimes very costly to access for the service user. A typical well-being centre would provide, for example, a befriending scheme, advice and information, counselling, complementary and alternative therapies, exercise, and volunteer opportunities. Of course, these should ideally be made available and affordable to all mental health service users.

Otherwise, service users' social networks were not particularly extensive and some people were quite isolated, showing negative associations with housing satisfaction and other aspects of their lives. Many mental health charities, as well as some local authorities, run befriending schemes as part of their service. These schemes are most commonly run by the voluntary sector, and are defined as an intervention that introduces the client to one or more individuals whose main aim is to provide the former with additional social support through the establishment and evolution of an affirming, emotion-focused relationship over time (Mead et al., 2010). An RCT of befriending and CBT produced positive results in both cases (Sensky et al., 2000). From a more 'social' perspective, interviews with people with a diagnosis of schizophrenia revealed that befriending was helpful to them, with most mentioning it was nice to have someone to talk to, adding that it had helped them boost their confidence and decrease their levels of anxiety (Bradshaw & Haddock, 1998). Although not much research has been conducted with regard to befriending and people with mental health problems, it does seem to have its benefits. In this study, not many service users had friends, or did not keep in regular contact with them, so a befriending scheme tied to an SHS could certainly have a positive effect. As Leff and Warner (2006, p. 96) suggest, befrienders need to be selected carefully in order to match service users' preferences and needs, and also be provided with some educational awareness on mental health.

More specifically about SHS provision, many managers in this study complained about the poor range of available SHSs, the limited number of spaces, the inadequacy of after-care support, and the lack of one- and two-bedroom properties. Manager-inspired solutions included a version of extra-care housing but designed specifically for adults as well as accommodation that resembles student halls. However, extra-care housing, as defined by Netten et al. (2006) for older people, although providing security of tenure, may run the risk of creating mental health 'ghettos', with no hope for social integration or inclusion. 'Student halls-style accommodation' would seem to be a better option in this case, with communal facilities such as a kitchen and living room that everyone could use. Furthermore, the similarities between discussions in this study and that by Shepherd et al. (1993)

demonstrate that a range of SHSs, that would cater to the wide needs and preferences of service users, is still valid, and necessary.

More targeted and integrated mental health awareness campaigns (Thornicroft, 2007) should be launched in order to tackle stigma, especially amongst private landlords. A voluntary-sector supported housing manager in this study mentioned an innovative solution, where links were established with private local landlords, hence providing incentives to lease to service users. Such schemes should be encouraged and further developed.

Many topics have been broached in this thesis, with a specific focus on social exclusion, and whether service users with mental health problems living in specialist housing services in England were engaged enough with regard to community activities and relationships inside and outside the home. There is no simple answer as to whether this specific cohort of people was socially included, or put simply, whether or not they were happy.

This picture of service users' lives in 2011 and 2012 reminds us mainly of the importance of housing to each and every one of us. Indeed there is no place like HOME.

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Appendices

Appendix A

Letter to directors of SHSs organisations



THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE

PSSRU
Personal Social Services Research Unit

PSSRU
LSE
Houghton Street
London WC2A 2AE
Tel: 07876 724634
Email: m.saidi1@lse.ac.uk

<Date>

Dear Directors of

Housing Services for People with Mental Health Needs

I am writing to you about a research project I would like to undertake as part of my PhD study. As you know, housing is a very important part in the lives of people with mental health needs, but there is still so little good research evidence to inform policy debate.

One or more of the housing services within your organisation has been selected for possible participation in my project, and I am approaching you to ask if participation would be possible. I would like to approach the manager of each service to seek their agreement too. My research will take the form of face-to-face interviews with service managers (asking about the different aspects of their work) and also interviews with some tenants (asking about their lives, social contacts and health). The full aims of the study are given in the summary overleaf. I appreciate the pressures on everyone's time, and I anticipate that each interview will last no more than an hour.

All information will be treated as strictly confidential, and anonymised. No individual person, housing setting, organisation or locality will be named or identified in my report. Information collected in the study will be kept secure and processed in full accordance with the Data Protection Act. I will obtain Ethics Committee approval prior to starting the study.

I am a second year PhD student at LSE, based within the Personal Social Services Research Unit (PSSRU). The Unit was part of the research centre that was recently awarded the Queen's Anniversary Prize for Higher and Further Education for its work as an innovative international research centre influencing government policy in the UK and internationally. Prior to my PhD registration, I worked as a researcher for the East London and City NHS Mental Health Trust (as it was then known), where one of my projects involved housing services for people with mental health problems. As you can see, I am really passionate about this subject!

I do hope that your organisation will be able to take part in this important research project. Could you respond by returning the enclosed reply form using the enclosed postage paid envelope? It would help if you could do so in the next two weeks so that I can continue to progress with my research. I would be happy to discuss this further by phone if you have any questions about the study. You could also contact one of my supervisors, who are overseeing this work: Professor Martin Knapp (m.knapp@lse.ac.uk) and Professor Jennifer Beecham (j.beecham@lse.ac.uk).

I will send a summary report of my findings to all participants once the work is completed.

Thank you very much in advance for your help.

Yours faithfully

Marya Saidi

Housing Services for People with Mental Health Needs – Aims of study

Marya Saidi (LSE)

Over the past 30 years in North America and Western Europe, there have been major changes in mental healthcare provision. One of the most significant has been the shift from hospital-based to community care. Today, many people with mental health and other needs are living in the community, a number of them in specialist housing settings. Supported housing services, which are one of the most common forms of accommodation for people with mental health needs in the UK, provide either semi-supervised or fully supervised living arrangements, with some level of mandatory mental health provision. More generally, there is a range of housing services meeting individuals' accommodation and other needs in a variety of ways.

However, there is relatively little information about these housing services for people with mental health needs, or about the people who live in them (their characteristics, needs and aspirations). There is also little information available about people's movements into and out of these accommodation settings, and how these moves are experienced by individuals.

As is well known, people with mental health needs are among the most socially excluded groups in our society. I am interested, therefore, to talk to a sample of tenants about their lives, particularly their social contacts and networks, and to try to understand how this affects their wellbeing. I am also interested in the impact that the recent policy emphasis on 'personalised services' (including choice-based lettings, personal budgets and direct payments) may have had in terms of empowering individuals and contributing to their social inclusion. It may be, for example, that a psychological sense of community (the feeling of being part of a group, and that the group is cohesive and integrated) contributes to a person's wellbeing and social inclusion.

The aims of my study are:

- To provide a general overview of housing services as well as tenants' individual experiences
- To compare tenants' experiences of moving in and out of housing services
- To assess tenants' housing satisfaction levels
- To explore tenants' uptake of personalised services such as personal budgets and direct payments
- To ask tenants about their social contacts and networks
- To measure tenants' use of community-based services

I am planning to collect data through interviews with around 32 managers and 120 tenants. I will select four areas of England (PCT areas), and in each area I am hoping to visit 8 housing settings to interview the manager and up to 4 tenants. Information collected will be treated as strictly confidential, and no individual person, housing setting, organisation or locality will be named or identified in any of my reports. I am currently seeking Ethics Committee approval for the study.

Appendix B
Information letter (managers)



THE LONDON SCHOOL
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<Date>

Dear Manager,

Housing Services for People with Mental Health Problems in England

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our research team will go through the information sheet with you and answer any questions you have. Please ask us if there is anything that is not clear.

The study

The following research project will hopefully influence future proposals on housing services for people with mental health problems in England as well as give us a much clearer picture of those housing services.

The study is part of my PhD thesis and is funded and sponsored by the London School of Economics and Political Science. We would like to measure levels of housing satisfaction in people with mental health problems within housing services, as well as look at their patterns of how they move in and out of these services.

The study has received ethical approval from the LSE research ethics board. A research ethics board is an independent group of people who review research to protect the dignity, rights, safety and well-being of participants and researchers.

Your service has been selected to take part in the study, and we would be most grateful for your support. We know that you are very busy so we have designed the study in a way that it will not take up too much of your time!

Your interview

We would very much like to schedule an interview with you, and ask you some questions about the housing service you manage. The interview will not last for more than 30 minutes. It will be a face to face interview, so we will arrange a time that is convenient for you for me to come and see you.

How we would like you to help us

We would also like to talk to up to 4 tenants in your service and interview them. We would like to find out about their housing satisfaction (see back of this page for full details and aims of the study). Interviews with tenants will not last more than 30 minutes each. We'd like you to choose the tenants to be interviewed, so please select the tenants' whose birthdays fall closest to the date you received this letter (in order for results to remain completely anonymous). It would be very helpful if you did so before we meet. Also, please ensure that the tenant selected has been using the service for at least a month – otherwise they will not be able to answer some of the questions posed in the interview. If you pick a tenant and they refuse to participate, please select another one in the same way. Please note that if you cannot find 4 tenants to be interviewed then that's fine, our aim is to interview at least one!

How to take part

It is up to you to decide if you want to take part in the research. We will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Your employment rights will not be affected.

Confidentiality

All information collected about you during the research will be kept strictly confidential and will never be disclosed to anyone. Because your name and address will not be written on the questionnaire, what you say to me will remain anonymous and confidential. Data from the study will be kept in a secure location for a period of 6 years then deleted. Should you wish to withdraw from the study, data you have provided will be deleted as well.

Interviews will be audio-recorded, and then transcribed. Quotations from the transcripts may be used in the final research report, however no names, or identifiable information will be published.

We very much appreciate the time you will spend taking part in this study and making this project! THANK YOU!

If you would like to participate in this study, please let me know by ../... via my contact details supplied below.

Please contact me at any time using my details below in order to arrange a suitable time or if you'd like me to answer any questions you may have regarding the study.

Sincerely,

Marya Saidi

The London School of Economics and Political Science

PSSRU Houghton Street

WC2A 2AE

Tel: 07876724634

E-mail: m.saidi1@lse.ac.uk

Housing Services for People with Mental Health Needs – Aims of study

Marya Saidi (LSE)

Over the past 30 years in North America and Western Europe, there have been major changes in mental healthcare provision. One of the most significant has been the shift from hospital-based

to community care. Today, many people with mental health and other needs are living in the community, a number of them in specialist housing settings. Supported housing services, which are one of the most common forms of accommodation for people with mental health needs in the UK, provide either semi-supervised or fully supervised living arrangements, with some level of mandatory mental health provision. More generally, there is a range of housing services meeting individuals' accommodation and other needs in a variety of ways.

However, there is relatively little information about these housing services for people with mental health needs, or about the people who live in them (their characteristics, needs and aspirations). There is also little information available about people's movements into and out of these accommodation settings, and how these moves are experienced by individuals.

As is well known, people with mental health needs are among the most socially excluded groups in our society. I am interested, therefore, to talk to a sample of tenants about their lives, particularly their social contacts and networks, and to try to understand how this affects their wellbeing. I am also interested in the impact that the recent policy emphasis on 'personalised services' (including choice-based lettings, personal budgets and direct payments) may have had in terms of empowering individuals and contributing to their social inclusion. It may be, for example, that a psychological sense of community (the feeling of being part of a group, and that the group is cohesive and integrated) contributes to a person's wellbeing and social inclusion.

The aims of my study are:

To provide a general overview of housing services as well as tenants' individual experiences

To compare tenants' experiences of moving in and out of housing services

To assess tenants' housing satisfaction levels

To explore tenants' uptake of personalised services such as personal budgets and direct payments

To ask tenants about their social contacts and networks

To measure tenants' use of community-based services

I am planning to collect data through interviews with around 32 managers and 120 tenants. I will select four areas of England (PCT areas), and in each area I am hoping to visit 8 housing settings to interview the manager and up to 4 tenants. Information collected will be treated as strictly confidential, and no individual person, housing setting, organisation or locality will be named or identified in any of my reports.

Appendix C
Information letter (Service users)



THE LONDON SCHOOL
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POLITICAL SCIENCE

PSSRU
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Houghton Street
London WC2A 2AE
Tel: 07876 724634
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m.saidi1@lse.ac.uk

<Date>

Dear service user,

Housing Services for People with Mental Health Problems in England

Before you decide if you'd like to take part, we would like you to know why the research is being done and what it would involve for you. I am doing research into housing services and would like to invite you to participate in my study.

The study

The research will give us a much clearer picture about the housing service you live in. We hope our findings will help better housing services to be provided.

We would like to measure how happy and satisfied people are with their accommodation and support services as well as look at how people move in and out of these services.

The study has received ethical approval from the LSE research ethics board. A research ethics board is an independent group of people who review research to protect the dignity, rights, safety and well-being of participants and researchers. The study is part of my PhD thesis and is funded and sponsored by the London School of Economics (LSE).

The interview

We would like to interview you as part of this research. The interview should not last for more than 30 minutes. We are also talking to managers but we'd like to ask you some questions, and some will be about whether you are satisfied with your accommodation, how often you see your friends, how you came to choose this particular place. We will also like to ask you some questions about your health and how well you manage to look after yourself.

How to take part

It is up to you to decide if you want to take part in the research. We will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. Taking part in the research will not affect the care/support you receive. If you would like to take part, please let your manager know and he will introduce us. We will go through the information sheet with you and answer any questions you have. Ask us if there is anything that is not clear.

Confidentiality

All information collected about you during the research will be kept strictly confidential and will never be disclosed to anyone. Because your name and address will not be written on the questionnaire, what you say to me will remain anonymous and confidential.

We will keep data from the study in a secure location for 6 years and then delete it. If you want to withdraw from the study, data you have provided will be deleted promptly. We will record the interviews on an audio tape and then transcribe them. Some things you said may be used in the final research report but no names, or identifiable information will be published. Everything you say is confidential unless you tell us something that indicates that you or someone is at risk of harm. Before telling anyone else, we would discuss this with you.

We very much appreciate the time you will spend taking part in this study and making this project successful! THANK YOU!

Sincerely,

Marya Saidi
The London School of Economics and Political Science
PSSRU
Houghton Street
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Tel: 07876724634
E-mail: m.saidi1@lse.ac.uk

Appendix D
Consent form (managers)

Centre Number:
Participant Number:

MANAGER CONSENT FORM

Housing services for people with mental health problems in England

Thank you for considering taking part in this research. If you have any questions please ask a member of the research team before you decide whether to take part. You will be given a copy of this Consent Form to keep and refer to at any time.

	Please tick each box
I confirm that I have read and understand the information sheet (version 6.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to change my mind and withdraw at any time without giving any reason, and without my employment or legal rights being affected.	
I understand that information about me will be recorded anonymously, stored electronically and analysed for the purposes of the research study. It will not be linked to my name or address and will not be disclosed to anyone at any time.	
I understand that if I withdraw from the study the data collected up to that point will be destroyed.	
I agree to take part in the above study.	

Name of participant (please print) _____

Signed _____ Date _____

Name of researcher (please print) _____

Signed _____ Date _____

Appendix E
Consent form (service user)

Centre Number:
Participant Number:

TENANT CONSENT FORM

Housing services for people with mental health problems in England

Thank you for considering taking part in this research. If you have any questions please ask a member of the research team before you decide whether to take part. You will be given a copy of this Consent Form to keep and refer to at any time.

	Please tick each box
I confirm that I have read and understand the information sheet (version 6.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to change my mind and withdraw at any time without giving any reason, and without my medical care or legal rights being affected.	
I understand that information about me will be recorded anonymously, stored electronically and analysed for the purposes of the research study. It will not be linked to my name or address and will not be disclosed to anyone at any time.	
I understand that if I withdraw from the study the data collected up to that point will be destroyed.	
I agree to take part in the above study.	

Name of participant (please print) _____

Signed _____ Date _____

Name of researcher (please print) _____

Signed _____ Date _____

Appendix F
Interview schedule (managers)

**HOUSING SERVICES INTERVIEW PACK
(MANAGERS)**



Interviewer's Name <i>(initials)</i>		<i>Code Interviewer</i>			
Date of interview <i>dd/mm/yy</i>	<i>..../..../...</i>	Manager's ID			
Housing service ID					

My name is Marya Saidi, and I'm a PhD student at the London School of Economics. The topic of my thesis is housing services for people with mental health problems. I'd like you to help me understand the housing structure and the environment people with mental health problems live in. I'd like to ask you some questions about the housing service as well as the general attitude of the tenants. I'm really interested in what you have to say on these matters. The interview is expected to last about 45 minutes. You can stop me at any time during the interview if you don't understand a question and would like me to clarify. If you feel distressed or uncomfortable at any point you should tell me. I will stop recording and ask you whether you'd like to take a short break. We will only resume if you feel more comfortable and would like to continue with the interview. You have the right to stop the interview whenever you want and withdraw from the study. Your rights will NOT be affected in any way. The study has received ethical approval from the London School of Economics research ethics board.

To begin with, I was wondering if you could answer some general questions about this service.

Section A: About the housing service

1.	What type of housing service is this? <i>Follow-up questions: Are staff on the premises 24 hours a day? Are staff awake at night?</i>			
1 Care home		2 Supported living		3 Supported group home
666 Refuse to answer		777 Don't know		888 Not applicable
				999 Missing

2.	Do you have any information packs about your housing service that you usually give to prospective tenants? Could I have one?	
1 Yes		2 No

666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing
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3.	What would you say are the main challenges that tenants face? <i>Follow-up questions: challenges such as employment, relationships with friends and family, health issues, their mental health</i>								
1 Employment		2 Relationships		3 Health		4 Mental Health		5 Other	
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing		

4.	What are you trying to achieve within this housing service? What does the home offer?								
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing		

5.	Do you feel that you push tenants towards independent living? How so?								
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing		

Section B: Tenants' movements

6.	How do tenants usually get referred to this housing service?						

666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

7.	How many people live in this housing service? And do any other people use this service? <i>(Follow-up questions: can people use this service for respite care, as a day centre, etc.)</i>						
Number of ppl living here				Number of other ppl living here			
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

8.	How many people have moved into this service in the past 12 months? <i>(Follow-up questions: And these are all new residents, not people returning to live here)</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

9.	Typically, how long does a tenant stay in the service?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

10.	In the last 12 months, how many tenants have left this service?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

11.	In your opinion, why do tenants usually leave this service? <i>Follow-up questions: like for more support, less support</i>					

666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

12.	Where do tenants usually move to after being discharged? <i>Follow-up questions: to their own flat, to supported housing</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

13.	Are there any people that you would exclude from this housing service? <i>(Prompts: older people, people with substance misuse disorders, etc.)</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

Section C: Personalised services

14.	Are any tenants on direct payments? <i>If not go to question 16</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

15.	To the best of your knowledge, do you know if they are satisfied with them?

666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing
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16.	Are any tenants on a personal budget? <i>If not go to question 18</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

17.	To the best of your knowledge, do you know if they are satisfied with it?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

18.	Has any person moved here via a choice-based letting? <i>If not go to question 20</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

19.	How do you feel choice-based lettings compare to the waiting list system?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

Section D: Tenants in general

20.	Approximately how many tenants living in this service are employed?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

21.	In your opinion, what do you think stops tenants from seeking or maintaining employment?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

22.	Are tenants within your service engaged in community-based activities, such as going to the gym, pub, church etc.?			
Gym		Pub		Church Other
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

23.	What do tenants usually do when they go out?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

24.	Do tenants have responsibilities around the house? How do they contribute to the functioning of the house?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

Section E: Concerns and issues

Please rate the following on how important you feel that these would be to tenants on a scale of 0 to 100 (0 being the least important and 100 being the highest, i.e. most important).

Very important										
25 Social situation	26 Housing Service	27 Community Activities	28 Job	29 Income	30 Amount of space	31 Staff	32 Amount of privacy	33 Fellow tenants	34 Amount of freedom	35 Amount of comfort
100	100	100	100	100	100	100	100	100	100	100
90	90	90	90	90	90	90	90	90	90	90
80	80	80	80	80	80	80	80	80	80	80
70	70	70	70	70	70	70	70	70	70	70
60	60	60	60	60	60	60	60	60	60	60
50	50	50	50	50	50	50	50	50	50	50
40	40	40	40	40	40	40	40	40	40	40
30	30	30	30	30	30	30	30	30	30	30
20	20	20	20	20	20	20	20	20	20	20
10	10	10	10	10	10	10	10	10	10	10
0	0	0	0	0	0	0	0	0	0	0
Very unimportant										

36.	Do you think that people with mental health problems find it difficult to find suitable accommodation? Do they face any sort of discrimination in your opinion?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

37.	How do you think people with mental health problems are going to be affected by the new DLA cuts?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

Section F: Tenants' Networks

38.	Are there rules in place that limit the times outsiders can visit tenants? Follow-up questions: How often are they allowed to visit? How often do they see their friends? Can people stay over?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

And now if you could answer some questions about yourself.

Section G: Background Information

39.	Gender:				
Male	1	Female	2		

40.	How old are you?		666	Refuse to answer	999	Missing
41.	What's your title as a member of staff?		666	Refuse to answer	999	Missing

42.	How long have you been in that role for?		666	Refuse to answer	999	Missing
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43.	Could you tell me what level of education you've had? <i>Circle one code</i>			
Less than secondary school	1	Secondary school or equivalent	2	
Further education college	3	University/Polytechnic	4	
Higher degree (e.g. MA, MSc, PhD)	5	Refuse to answer	666	
Missing	999			

44.	Where were you born?				
Refuse to answer	666	Missing	999		

45.	What is your ethnic group?				
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White British	1	White Irish	2
Other White background	3	Black or Black British – Caribbean	4
Black or Black British – African	5	Other Black background	6
Asian or Asian British – Indian	7	Asian or Asian British – Pakistani	8
Asian or Asian British – Bangladeshi	9	Other Asian background	10
Chinese or other ethnic background	11	Mixed White and Black African	12
Mixed White and Asian	13	Other – Mixed background	14
Mixed White and Black Caribbean	15	Other ethnic background	16
Refuse to answer	666	Missing	999

And now for some final questions.

46.	Is there anything else you would like to add? <i>Prompts: about your experience working here, about new policies, about housing services in general</i>			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

47.	Would you like to be sent a summary of the results of the study?		
1	Yes	2	No

Thank you for your time, and for helping me out with my PhD project.

Appendix G
Interview schedule (service users)

HOUSING SERVICES INTERVIEW PACK (TENANTS)



Interviewer's Name (<i>initials</i>)		Code Interviewer			
Date of interview <i>dd/mm/yy</i>	<i>.../.../...</i>	Tenant's ID			
Housing service ID					

My name is Marya Saidi, and I'm a PhD student at the London School of Economics. I'm researching housing services for people with mental health problems. I would like to ask you some questions about your health, your views about where you live, and what you spend your time doing.

I would like to better understand housing services and what tenants think about them so I am really interested in what you have to say.

The interview will last no longer than 30 minutes and you can stop me at any time during the interview if you don't understand a question and would like me to clarify. If you feel distressed or uncomfortable at any point you should tell me. I will stop recording and ask you whether you'd like to take a short break. We will only resume if you feel more comfortable and would like to continue with the interview. You

have the right to stop the interview whenever you want and withdraw from the study. Your rights or care will NOT be affected in any way.

The study has received ethical approval from the LSE research ethics board.

To begin with, I was wondering if you could tell me some things about yourself.

Section A: General introductory question

1.	Tell me about what a typical day for you would be like. What did you do yesterday for example?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

Section B: Movements

2.	What's the reason you're living in this place? <i>(Follow-up questions: Is it because you had nowhere else to go? Did you want to come here? Did someone else want you to move here, like your family etc.?)</i>			
1 Nowhere else to go		2 Wanted to		3 Forced to move in
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing
3.	Why did you move into this accommodation?			
<i>Follow-up questions: Is this your first time in specialist housing services? Where were you living before? Is the housing service you're in at the moment in the same area where you've lived most of your life? Why did you move? Do you think it's been a good thing for you to come here? How easy or difficult was the move?</i>				
1 First time in HS		2 Living in another area before		3 Living in this area before
				4 Good decision to move
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

4.	How long have you been staying here? <i>(Follow-up questions: Do you think you'll be here long? Where do you plan to go after this? You must be looking forward really to the next step, right?)</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

5.	How were you referred to this housing service? <i>Follow-up questions: How long was the process? Did you have to wait long before you moved in? Did you check out other places before deciding on this one?</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

6.	Where would you live if you could choose? <i>(Follow-up questions: Would you want to live in a place similar to this one? Or somewhere with more/less support provided? Is there anything that you're missing here?)</i>					
666	Refuse to answer	777	Don't know	888	Not applicable	999 Missing

Section C: Satisfaction with housing services

Please rate the following on how satisfied you feel on a scale of 0 to 100. Interviewer: try to get interviewee to fill it in themselves, if not do it yourself.

Very satisfied										
7 Social situation	8 Housing Service	9 Community Activities	10 Job	11 Income	12 Amount of space	13 Staff	14 Amount of privacy	15 Fellow tenants	16 Amount of freedom	17 Amount of comfort
100	100	100	100	100	100	100	100	100	100	100
90	90	90	90	90	90	90	90	90	90	90
80	80	80	80	80	80	80	80	80	80	80
70	70	70	70	70	70	70	70	70	70	70
60	60	60	60	60	60	60	60	60	60	60
50	50	50	50	50	50	50	50	50	50	50
40	40	40	40	40	40	40	40	40	40	40
30	30	30	30	30	30	30	30	30	30	30
20	20	20	20	20	20	20	20	20	20	20
10	10	10	10	10	10	10	10	10	10	10
0	0	0	0	0	0	0	0	0	0	0
Very unsatisfied										

Section D: Occupational Activities

18.	Do you have a job?			
Follow-up questions: Full-time/part-time? Do you do any volunteer work? If not working, would you like to? What's stopping you?				
1 Employed		2 Unemployed		3 Full-time
				4 Part-time
				5 Voluntary job
666 Refuse to answer		777 Don't know		888 Not applicable
				999 Missing

19.	Do you receive any social security benefits?				
Prompts: Such as income support, disability living allowance, jobseekers' allowance? Are you happy with them?					
1 Income support		2 DLA		3 Jobseekers'	4 HB
					5 IB
					6 Other
666 Refuse to answer		777 Don't know		888 Not applicable	
				999 Missing	
444 Never heard of them			555 Don't understand		

20.	Do you receive direct payments?			
Follow-up questions: Would you like to? Have you heard of them?				
Yes		1		No
				2
666 Refuse to answer		777 Don't know		888 Not applicable
				999 Missing
444 Never heard of them			555 Don't understand	

21.	Are you on a personal budget?			
Follow-up questions: Tell me more...Would you like to be? Have you heard of them?				

Yes	1	No	2
666 Refuse to answer	777 Don't know	888 Not applicable	999 Missing

Please answer the following questions to the best of your knowledge. They all ask about services you may have used in the last three months. (Fill in the corresponding codes for refuse to answer, don't know, not applicable, never heard of them or don't understand as above).

22.	How many times have you attended a day centre/day activity?	_____
23.	How many days have you stayed in hospital?	_____
24.	How many outpatient attendances have you had?	_____
25.	How many A&E attendances have you had?	_____
26.	How many times have you seen a GP?	_____
27.	How many times have you seen a psychiatrist?	_____
28.	How many times have you seen a psychologist?	_____
29.	How many times have you seen a Community Psychiatric Nurse (CPN)?	_____
30.	How many times have you seen a social worker/care manager?	_____
31.	How many times have you seen another CMHT member?	_____
32.	How many times have you used any other service (specify _____)?	_____

33.	Are there rules here about how often your friends or family can visit you?
Follow-up questions: How often are they allowed to visit? Where do you see your family and friends? How often? Would you like to see them more often?	

666	Refuse to answer	777	Don't know
888	Not applicable	999	Missing

Please answer yes or no to the following questions. Are you actively involved in any of the following? <i>Circle one code</i>							
34.	Religious activities	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999
35.	Sports/supporters club	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999
36.	Hobby or interest group	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999
37.	Political party	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999
38.	Tenants' group	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999
39.	Other local group	Yes	1	No	2	Refuse	666
		777	DK	888	N/A	M	999

40.	What do you do in your free time?						
Follow-up questions: Do you go to the pub/gym/library? Do you use the internet?							
1 Pub			2 Gym			3 Library	
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

41.	Who have you chatted to or done something with in the past 2 weeks?							
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing	

42.	Who have you spoken to on the telephone within the past 2 weeks?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

43.	If you had some really good news, who would you tell?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing
44.	If you had a serious personal crisis, who would you turn to for comfort and support?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

45.	Who would do small favours for you?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

46.	Who would you ask if you needed to borrow a small amount of money?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

47.	Who would you talk to if you were feeling low?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

48.	Who would give you a lift in their car?						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

49.	Who would help you with your shopping?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

50.	Who would look after you if you were ill?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

Section E: Miscellaneous

51.	Is there anything else you would like to add about your experience within housing services accommodation? <i>Circle one code</i>			
	Yes	1	No	2
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

Section F: Health

Can I now just ask you a couple of questions about your health?

52.	How is your health in general? (<i>Circle one code</i>)			
1	Very good	2	Good	3 Fair 4 Bad 5 Very bad
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

53.	Have you ever been in a psychiatric hospital?
<i>Follow-up questions: Do you remember how long you stayed? Were you sectioned?</i>	

666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing
-----	------------------	-----	------------	-----	----------------	-----	---------

54.	If you have been in hospital, think about the last time you were there. Were there any problems when you wanted to leave?						
<i>Prompts: Did you have difficulty moving out? If yes, was the cause a lack of a suitable place to move in to?</i>							
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

55.	Do you usually manage to (Circle one code)					
		On own without help	On own with difficulty	Only with someone else	Not at all	Not Applicable
a)	Get up and down stairs or steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b)	Go outdoors and walk down the road	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c)	Get around indoors (except steps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d)	Get in and out of bed (or chair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e)	Use WC/toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f)	Wash face and hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g)	Bath, shower or wash all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h)	Get dressed and undressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i)	Feed yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I will read out three statements now, please choose which one of them describes you best.

56.	Please indicate which statement best describes your own health state today regarding mobility.						
1	I have no problem in walking about			2	I have some problems in walking about		
3	I am confined to bed						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

57.	Please indicate which statement best describes your own health state today regarding self-care.					
-----	---	--	--	--	--	--

1	I have no problems with self-care	2	I have some problems with washing or dressing myself
3	I am unable to wash or dress myself		
666	Refuse to answer	777	Don't know
888	Not applicable	999	Missing

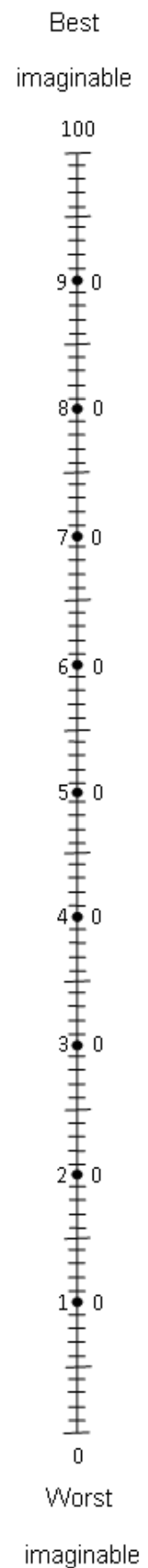
58.	Please indicate which statement best describes your own health state today regarding usual activities (e.g. work, study, housework, family, leisure activities)		
1	I have no problems with performing my usual activities	2	I have some problems with performing my usual activities
3	I am unable to perform my usual activities		
666	Refuse to answer	777	Don't know
888	Not applicable	999	Missing

59.	Please indicate which statement best describes your own health state today regarding pain/discomfort		
1	I have no pain or discomfort	2	I have moderate pain or discomfort
3	I have extreme pain or discomfort		
666	Refuse to answer	777	Don't know
888	Not applicable	999	Missing

60.	Please indicate which statement best describes your own health state today regarding anxiety/depression		
1	I am not anxious or depressed	2	I am moderately anxious or depressed
3	I am extremely anxious or depressed		
666	Refuse to answer	777	Don't know
888	Not applicable	999	Missing

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.



Section G: Demographics

61.	Tenant's gender (circle):			
	Male	1	Female	2
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

62.	How old are you?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

63.	What is your marital status? <i>Circle one code</i>						
	Married	1	Partnered	2	Widowed	3	
	Separated	4	Single	5			
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

64.	How many children do you have?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

65.	Could you tell me what level of education you've had? <i>Circle one code</i>			
	Less than secondary school	1	Secondary school or equivalent	2
	Further education college	3	University/Polytechnic	4
	Higher degree (e.g. MA, MSc, PhD)	5		
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

66.	Where were you born?			
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

67.	What is your ethnic group? <i>Circle one code</i>			
-----	---	--	--	--

	White British	1	White Irish	2	Other White background	3
	Black or Black British - Caribbean	4	Black or Black British - African	5	Other Black background	6
	Asian or Asian British - Indian	7	Asian or Asian British - Pakistani	8	Asian or Asian British – Bangladeshi	9
	Other Asian background	10	Chinese or other ethnic background	11	Mixed White and Black African	12
	Mixed White and Asian	13	Other- Mixed background	14	Mixed White and Black Caribbean	15
	Other Ethnic background			16		
666	Refuse to answer	777	Don't know	888	Not applicable	999 Missing

68.	What is your primary diagnosis? <i>Circle one code</i>				
	Organic disorder (dementia)	1	Substance dependence syndromes	2	
	Schizophrenia/schizoaffective disorder	3	Learning disability	4	
	Unipolar depression	5	Neurotic, stress-related & somatoform disorders (OCD, etc.)	6	
	Eating disorder	7	Personality disorder	8	
	Bipolar affective disorder	9	Disorder of psychological development (autism, etc.)	10	
666	Refuse to answer	777	Don't know	888	Not applicable 999 Missing

And now for some final questions.

69.	Is there anything else you would like to add? <i>Circle one code</i>						
666	Refuse to answer	777	Don't know	888	Not applicable	999	Missing

70.	Would you like to be sent a summary of the results of the study? <i>Circle one code</i>			
	Yes		No	
666	Refuse to answer	777	Don't know	888 Not applicable 999 Missing

Thank you for your time and for helping me out with this PhD project

Appendix H
Framework analysis chart

Master theme	Theme 1	Theme 2	Theme 3	Theme 4
1. Independence and autonomy	1.1. Interpretations of independence	1.2. Concerns and fears	1.3. Success stories	
Overarching question(s)	Do you feel you push people towards independent living (M)? Do you think it's been a good thing for you to move here (SU)?	How do you feel you push people towards independent living (M)? Do you want to move somewhere else (SU)?	How do you feel you push people towards independent living (M)? Where do people move to after leaving here (M)? Do you want to move somewhere else after this (SU)?	
Potential sub-themes	Subjectivity; Autonomy; to move to less support; deinstitutionalised; moving on	Risk of abuse; risk of deterioration; loneliness; state of homes; lack of security; not the norm; previous failings; poor community support; money issues	Keep in touch with people here; effect on self-esteem; mechanisms for independence	
2. Choice and control	2.1. Policy changes	2.2. Choice of where to live	2.3. Choice based lettings	2.4. Personalisation
Overarching question(s)	Typically how long does a person stay within the service (M)? Do you feel you push people towards independent living (M)? Do you plan to go anywhere else after this (SU)? How long have you been living here (SU)?	Do you feel people with mental health problems find it hard to find suitable accommodation (M)? Did you have a choice of where to live (SU)?	Have any of your service users moved out using choice based lettings (M)? Have you heard of choice based lettings (SU)?	Are any people here on direct payments or personal budgets (M)? Do you receive any direct payments or personal budgets (SU)?
Potential sub-themes	Homes for life; Supporting People	Limited housing options;	Transparency; more information;	Direct payments; personal budgets;

M: Manager; SU: Service User

	contracts; anxiety; unpreparedness; no choice; pressure from social services; relocation policies; managers not consulted; financial pressures; service users have no say	poor quality of housing; funding restrictions; no other or better alternatives; care team interference	disappointment; no housing stock; pressure	person-centred care; one to one funding; complicated; gives more choice and control; not what service users want; lack of capacity
3. Housing experience	3.1. Freedom and safety	3.2. Staff	3.3. Environment quality	3.4. Money
Over-arching questions	Are there rules in place that limit the times outsiders can visit service users (M)? Are there rules about how often your friends or family can visit you (SU)?	How important do you feel staff are to service users (M)? How satisfied do you feel about the staff (SU)?	Is there anything you would like to add about your experience as a housing manager (M)? Is there anything you would like to add about your experience living here (SU)?	What concerns do people have in terms of income (M)? How do you think people are going to be affected by the DLA cuts (M)? Are you satisfied with your income (SU)? What benefits do you receive (SU)? Are you happy with the benefits you receive (SU)?
Potential sub-themes	Rules; protection; vulnerability; liberty; security; concept of freedom	Personalities; diversity; training; quality; personalised care; care	Privacy; taken care of; housing structure; feeling ignored; feeling bored; improved outcomes	DLA; cuts to DLA; imbalances; section 117; unfair system; too many choices; social exclusion; satisfaction
4. Social exclusion	4.1. Public attitudes	4.2. The private rental market	4.3. Employment	4.4. Daycentres
Over-arching questions	Do you feel people with mental health problems face any sort of discrimination in your opinion (M)?	Do you feel people with mental health problems find it hard to find suitable accommodation (M)?	How many service users in this service are employed (M)? What do you think stops tenants from seeking or maintaining employment (M)? Do you have a job (SU)? If you don't have a job, would you like one (SU)? What's stopping you (SU)?	How many tenants are engaged in community-based activities (M)? What do you do in your free time (SU)?
Potential sub-themes	Negative media; extreme cases; lack of public awareness; discrimination from public	Unreliable and dangerous tenants; insecure tenancies; benefits	Voluntary work; manual labour; outcomes; ambitions; medication; inflexibility;	Normalising; something to do; somewhere to go; failure; closure; innovation

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	institutions; importance of community		motivation; disinterest; disability; mental health problem; housing; benefits	
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