



Developing High Relational Support Services for Individuals with Long Term Mental Health Needs: Scheme Description and Phase 1 of a Longitudinal Service Evaluation

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3 **Title:** Developing High Relational Support Services for Individuals with Long Term
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6 Mental Health Needs: Scheme Description and Phase 1 of a Longitudinal Service
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8 Evaluation
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11
12 **Abstract**
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15 Providing care in the community has been an important principle within mental
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17 health service provision within the UK. However, there are a group of individuals
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19 with severe and enduring mental health difficulties who have often remained within
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21 inpatient settings. This paper describes the development of a not-for-profit (third
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23 sector) social care facility designed to provide tenancy and high relational support and
24
25 a multi-method evaluation of the service. Findings show that with the support
26
27 provided the health and wellbeing, personal and community safety, independence and
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29 social integration of all the tenants has been maintained or enhanced using this social
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31 care model and that all have managed their finances with help. The support needed
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33 has varied over time, however, as would be expected, almost all support is provided
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35 during waking hours with varying levels of individual support provided to each
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37 tenant. The model provided here needs to be replicated, however, this evaluation
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39 shows that high relational social care provided by not-for-profit providers can be
40
41 effective, sustainable and cost efficient for those with complex, enduring and severe
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43 mental health problems.
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53 Key words: Community care, mental health, third sector, evaluation, social care
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What is known about this topic

- Individuals with severe mental health problems often require long term support
- Housing options for those with complex and enduring mental health problems are limited
- Social care as opposed to nursing care provision has received limited evaluation for this client group

What this paper adds

- Not for profit (third sector) social care agencies can provide high relational support for those with complex mental health needs
- Positive outcomes including increased independence and enhanced social integration have been demonstrated
- This model of care might provide increased opportunities for providing care and tenancies in the community for those who often remain in hospital settings

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4 Providing care in community settings for those with severe and enduring
5
6 mental health problems is an important aspect of mental health care in the UK and
7
8 elsewhere (Macpherson, Shepherd, & Edwards, 2004; Fakhoury, Priebe, & Quraishi,
9
10 2005; Middelboe, et al., 1998). Much of this has grown out of the process of
11
12 deinstitutionalisation, which has occurred around the world (Fakhoury & Priebe,
13
14 2002). Many forms of supported accommodation now exist in addition to long-stay
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16 wards including staffed hostels, group homes (Macpherson et al., 2004) and
17
18 independent accommodation with or without outreach support (Chilvers, Macdonald,
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20 & Hayes, 2006). Descriptions of such services and the clinical characteristics of those
21
22 residing in them have been published (e.g. Lelliott, et al., 1996) however the lack of
23
24 availability of accommodation of the varying types has been noted (Fakhoury, et al.,
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26 2002).

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32 Previous research has indicated that residential facilities for those with mental
33
34 health problems typically share common goals of facilitating independence,
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36 supervising medication, encouraging community involvement and improving social
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38 functioning and self care skills (Lewis & Trieman, 1995). More specifically,
39
40 research within “24-hour nursed care” has suggested that individuals might
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42 experience an increase in social functioning, larger social networks and fewer
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44 negative symptoms whilst those in “core and cluster units” show improvements in
45
46 social functioning and quality of life (Macpherson et al., 2004). In addition, although
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48 residential options may be short or long term, the preference for providing relative
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50 permanence through long term housing solutions for this population has been reported
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52 (Lewis & Trieman, 1995).

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58 Cost considerations are an important aspect of care delivery particularly in the
59
60 current climate of health service efficiencies, budget freezes and cuts (e.g. Triggles,

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3 2010; BBC, 2010). Previous research has indicated that providing 24 hour staffed
4
5 community facilities rather than inpatient hospital care can result in significant cost
6
7 savings (Knapp, et al., 1997). However, as Knapp and colleagues acknowledge, such
8
9 transitions require pump priming or bridging finance in order to be developed.
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12 Although there has been interest in this area since the mid 1990's a Cochrane
13
14 review of supported housing (Chilvers et al., 2006) found no studies which met their
15
16 inclusion criteria. Work by Fakhoury et al., (2002) highlighted the many limitations
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18 with the research conducted to date in this area, and it would appear that little
19
20 evaluation evidence has been published since then.
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24 At a local level, the Welsh Assembly Government, in its One Wales agreement
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26 (Welsh Assembly Government, 2007) stated that "We firmly reject the privatisation
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28 of NHS services or the organisation of such services on market models." (p8) and
29
30 reported an intention to bring to an end the use of private sector hospital care by 2011.
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32 This position prioritises health and social care provision being delivered by public and
33
34 not-for-profit agencies. In addition, the 'Raising the Standard' document provides a
35
36 framework and action plan for the delivery of mental health care within Wales. This
37
38 includes Key Action 9 which states that "Each Local Authority area are to ensure
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40 there is a range of housing options with appropriate levels of support available for
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42 people with mental health problems (Welsh Assembly Government, 2005, p15).
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48 Taken together these documents create a structure, which supports the development of
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50 'not-for-profit' approaches to the housing and other needs of those with severe and
51
52 enduring mental health and associated difficulties within Wales. A critical
53
54 component of developing a range of community options and solutions is the creation
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56 of high relational support facilities which provide 24-hour support from dedicated
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58 care staff. Such facilities have been referred to as high staffed hostels and 24-hour
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nursed-care units within the literature (Macpherson et al., 2004). These facilities aim to provide support to those with the greatest level of severe and enduring mental health need within a community setting.

This paper provides an outline of a newly developed ‘not-for-profit’ high relational support scheme in South Wales (UK) and provides a multi-method systematic evaluation during its first year of operation.

Developing a high relational support scheme

The context and scheme

A pilot high relational support scheme was created as part of a wider redevelopment of rehabilitation and recovery services within the locality. The redevelopment had three components: i) a ‘repatriation process’ which sought to return those with severe and enduring mental health problems who were receiving care outside the NHS and / or outside the area to local NHS and ‘not-for-profit’ services; ii) a ‘discharge process’ which aimed to support long stay inpatients within the hospital based rehabilitation service to move into a community placement iii) a ‘service development process’ which was designed to broaden the range of available local services to include low secure mental health facilities, assertive outreach community services and various forms of supported accommodation. Although this paper only concerns the pilot high relational support component, other aspects (i.e. the low secure mental health development) have been described elsewhere (Davies, Maggs and Lewis, 2010).

At a strategic level, the scheme described here was designed to address the needs of those with complex and enduring mental health needs who require high levels of staff support in order to live and function within a community setting.

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3 Needs include those relating to daily living; general social functioning; mental
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5 wellbeing, managing finances and risk. Risk in this context included to self
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7 (encompassing self harm and unintentional harm e.g. risk associated with poor traffic
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9 awareness or poor social skills) and to others (e.g. aggression, physical assault and
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11 damage to property). The scheme was planned to provide a cost effective not-for-
12
13 profit resource that could support recovery by a) improving health and well being b)
14
15 providing an alternative to institutional (hospital) care and c) promoting opportunities
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17 for increased independence. Based on these aims, specific service outcomes included
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19 improving independent living skills; maintaining individuals in a community setting;
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21 improving health, well-being and quality of life; fostering links with family carers and
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23 community groups; developing social inclusion and promoting community integration
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25 within a supported housing based service not a registered care home.
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32 An important principle in the development of the scheme was to connect the
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34 care package (including the staff resource) to the needs of the tenants and not the
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36 property. This was to ensure that the level and nature of staffing could be governed
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38 by the needs of the residents with the primary intention to minimise the need for
39
40 residents to move from the property should their needs change.
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44 The scheme was planned by the local Rehabilitation and Recovery Service and
45
46 commissioned in conjunction with social care colleagues and the local Supporting
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48 People Services (SPS). SPS are part of a UK wide programme launched in 2003,
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50 which brought together several funding streams. SPS follows guidance from the
51
52 Welsh Assembly Government on how allocated money is to be used (Aylward, et al.,
53
54 2010). SPS oversee the provision of accommodation related tenancy support to a
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56 variety of vulnerable and disabled people within different housing models and via
57
58 different housing providers. Their aim is to reduce the likelihood of tenancy
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3 breakdown and allow people to maintain their tenancies and homes and so reduce
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5 reliance on traditional forms of care and/or hospital admissions.
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8 Local organisations were asked to provide tenders and the successful
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10 organisation was tasked with providing the scheme. Routine evaluation was to be
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12 provided by the scheme itself (in conjunction with the Rehabilitation Service) and a
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14 project board was established to oversee this (consisting of key stakeholders from
15
16 health and social care). Additional monitoring is undertaken by SPS and other
17
18 agencies to ensure that the service is meeting the service contract and the standards
19
20 set for domiciliary care (Welsh Assembly Government, 2004). The organisation
21
22 chosen had a track record of providing a wide range of care and support services to
23
24 individuals with complex mental health needs although not in the same format as was
25
26 intended for this scheme.
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31 In order to be eligible to enter the scheme, 'would-be tenants' had to be
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33 assessed as eligible for Continuing Health Care funding i.e. that their needs were
34
35 deemed to be *primarily* related to their mental ill health (Welsh Health Circular (54),
36
37 2004 / National Assembly for Wales Circular (41), 2004). Each resident living in the
38
39 scheme has their own Assured Shorthold Tenancy (providing them with some security
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41 of tenure) and their own keys for both their individual rooms and main access points.
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48 The property, management and operation

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50 A large domestic property was refurbished to provide six individual en-suite
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52 rooms (each with their own lockable door) together with a communal kitchen, lounge,
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54 dining room and 'quiet room' and two small paved outside areas. The house is
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56 located in a suburban residential area of a small city. Within walking distance there is
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3 a small collection of shops, a bus stop and a park. It is managed by a Registered
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5
6 Social Landlord.

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8 The scheme is intensively staffed with 18.1 whole time equivalent staff
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10 working a shift pattern which provides 4 staff from 08.30-21.30 (ratio 0.67 staff : 1
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12 tenant) and 2 'wakeful' staff outside these times. The daytime staffing is close to the
13
14 average ratio of 0.8 staff : 1 resident reported elsewhere (Lewis & Trieman, 1995).

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16
17 An on-call system means that access to a senior manager is available 24 hours a day.

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19
20 Staff for the scheme comprised a mixture of individuals with experience of
21
22 working with people with complex mental health needs from other projects run by the
23
24 service provider (including the Registered Manager and all staff with supervisory
25
26 responsibilities) and individuals newly recruited into social care work.

27
28
29 Staff underwent a nine week training programme before the scheme opened.
30
31 This included relevant knowledge and skills and formed a critical period for the
32
33 development of the team identity. Staff have a range of skills and formal
34
35 qualifications including National Vocational Qualifications (NVQ) Level 4 (in
36
37 Management) and Levels 2 and 3 (in Health and Social Care and Promoting
38
39 Independence). Staff sickness and turnover rates are 2.5% and 16.8 % respectively.
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41 Turnover during the first year has been higher than expected and was largely
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43 accounted for by two new staff members not completing their initial six month
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45 probationary period. Prior to opening, 'would be' tenants visited the facility, met and
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47 worked with the staff and were consulted on issues such as room decoration and
48
49 furnishing before signing their tenancy agreements.

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52 The day to day running of the scheme is overseen by a Manager based in the
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54 house, registered under Domiciliary Care Regulations. Tenants access local
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58 community resources (e.g. shops, GP) for their daily needs and have contact with the
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3 Community Mental Health Service from where their mental health care is managed.
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5 The project staff have regular contact with an occupational therapist and clinical
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8 psychologist from the local NHS Inpatient Rehabilitation and Recovery Service who
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10 provide consultation on individual tenant and group / service matters.
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13 14 15 The tenants

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17 Specific tenant details have not been provided in order to maintain
18
19 confidentiality, however there are general characteristics which are provided to allow
20
21 comparisons with other services to be made. Since the facility opened, seven
22
23 individuals have held tenancies – five for the full period reported here, a tenant who
24
25 has recently joined the scheme and a tenant who returned to hospital a few months
26
27 after joining the scheme. This tenant reported being uneasy in the community and
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29 following a period of unsettled behaviour, asked to be readmitted to hospital.
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32 Therefore, evaluation data presented in this paper relates only to the five who held
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34 their tenancy for the duration of the first year of operation.
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39 Of the five tenants, three are men and two women; ages range from mid 30's
40
41 through to mid 60's. All tenants have an enduring serious mental health problem
42
43 typically with an onset during teenage years or early 20's. This means that some
44
45 tenants have experienced their mental health problem for over 30 years. Most have a
46
47 history of challenging behaviour which has included violence and self-harm
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49 (including in the six months prior to signing their tenancy). Two of the tenants
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51 moved to the house directly from a long stay inpatient facility where they had lived
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53 for over 10 years each and three moved from private residential care facilities.
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Service evaluation

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4 A multi-method service evaluation was undertaken to determine a) the level
5
6 and type of individual support provided; b) the impact of support on the tenants and c)
7
8 the views of the tenants, carers and professionals of the service provided. The
9
10 approaches to gathering information for the first two of these were influenced by
11
12 principles outlined by Davies (2010) and Davies, Jones & Howells (2010). Each form
13
14 of evaluation will be presented in turn followed by a general discussion of the
15
16 findings. Due to the evaluative nature of this work, and the nature of the setting NHS
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18 ethical approval was not necessary.
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22 23 24 Evaluation 1: Analysis of service 'inputs'

25 26 *Method*

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29 Prior to the project being launched, a bespoke recording system was
30
31 developed to enable staff and tenant activity to be recorded routinely. Data were
32
33 collected relating to the type and amount of staff activity each day and this was
34
35 entered into a database for reporting. 'Individual support' was defined as dedicated
36
37 support and assistance provided to a single tenant by a member of staff either inside
38
39 or outside the home including guidance, encouragement, reassurance, planning,
40
41 advice, instruction, role modelling or de-escalation. It did not include support given
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43 to two or more tenants at a time (which was classed as a group activity) nor the
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45 general day to day interactions and conversations between staff and tenants.
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51 52 53 *Results*

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55 As expected, individual support needs varied between tenants and across time.
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57 Over the entire recording period, the average individual one to one input per tenant
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59 was 37 ½ hours per week (almost 5 ½ hours per tenant per day) which represents
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3 almost 60% of available staff time. Within this, individual tenant needs varied from
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5 around 23 ½ hours per week (3 hours 20 minutes per day) of one to one support, to 47
6
7 hours per week (6 hours 50 mins per day). Staff time not accounted for by one to one
8
9 support is spent on group based activities, administration, information exchange and
10
11 house keeping.
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15 As shown in figure 1, the level of individual support has reduced over time
16
17 from an average of 67 hours per week per tenant during the first two months of
18
19 recording to an average of 32 hours per week per tenant during October and
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21 November. The slight increase to 34 ½ hours per week during December reflects
22
23 additional support with Christmas arrangements. The lower level of support has
24
25 remained relatively constant over the last 7 months. Some variations can be seen
26
27 which are accounted for by planned changes to individual activity programmes, e.g.
28
29 Tenant A received a higher level of individual staff support during August as a result
30
31 of additional trips to the local parks and beaches.
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39 INSERT FIGURE 1
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41 ABOUT HERE
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49 The nature of the support currently provided as of December 2010 is shown in
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51 figure 2. These inputs fall into three broad categories: managing the home
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53 environment (13%; e.g. cooking, cleaning, shopping for food); managing mental,
54
55 physical and social well being (83%; e.g. occupational therapy goals concerning
56
57 leisure and self care, managing medicines, healthy living) and managing personal
58
59 affairs (4%; e.g. managing money, dealing with mail, attending appointments).
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3 Within the social well being category, on average 47% of the support time occurs
4 within the home and 53 % outside the home. This means that on average the tenants
5 are individually supported in community related activities for 9 ½ hours per week
6 which represents 25.3% of the overall individual tenant support provided.
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27 Although the specific times when tenants receive individual support varies,
28 figure 3 provides an illustration of the typical pattern of planned activity for each
29 individual. Most planned individual support occurs between 10:00 and 18:30, with
30 some group activity during the evenings consisting mainly of leisure activity such as
31 playing games and watching the TV. With the exception of the first month of
32 tenancy (during which there were 25 episodes of support recorded), night-time
33 support (from 23:00-08:00) has been low, averaging less than five support episodes
34 per month up to July 2010 with none since then. Most of these have been to support a
35 tenant when they are physically or mentally unwell.
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53 INSERT FIGURE 3

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3 Although staff deal with agitation, raised voices and swearing from tenants on
4 an almost daily basis, challenging behaviour is only formally recorded when this is
5 directed at a member of the public, staff feel challenged by the behaviour displayed or
6 when property is damaged. During the first year of operation, 20 episodes of
7 challenging behaviour were recorded with only one involving physical aggression
8 directed towards a member of staff. All other episodes involved verbal aggression
9 towards staff members; there has been no challenging behaviour directed towards or
10 involving other tenants or members of the public.
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25 Evaluation 2a: Tenant outcomes – routine information

26 *Method*

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28 Within the service, a procedure was developed to ensure that care plan
29 evaluations, daily recording and notes for the tenants were collated monthly and
30 entered into a database. This information is used routinely to provide individual
31 progress reports and to influence service planning. The information contained within
32 this database was subject to thematic analysis (e.g. Boyatzis, 1998) in order to
33 determine tenant outcomes. Themes were pre-determined using the four areas of
34 delivery specified in the service outline i.e. Health and Wellbeing; Personal and
35 Community Safety; Independence and Social Integration and Financial Control.
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50 *Results*

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52 The main findings relating to recorded tenant outcomes are shown in figure 4.
53 As can be seen, some outcomes were seen across all tenants whilst others were less
54 generalised. Unless otherwise indicated *all* outcomes were in the context of specific
55 1-1 staff support.
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INSERT FIGURE 4

ABOUT HERE

Health and wellbeing: For all tenants, stability or improvement in their mental and / or physical health was recorded which for two tenants meant that they continued to experience regular and persistent intrusive thoughts or delusional ideas. Tenants were reported to be engaging in healthy living including for some, avoiding substance misuse problems of the past. Specific areas of improvement in physical and mental health were also reported such as an increase in confidence, a reduction in anxiety and in one case a large reduction in 'hiding their face' in social situations.

Personal and community safety: All tenants were reported to feel safe with staff in the house and the community. All have learned to use equipment in the house safely and most have succeeded in making safe use of public transport.

Independence and Social Integration: All tenants are exercising choice over aspects of their life. All have made significant gains in the area of social integration (i.e. positive relationships with other tenants and staff; increased family contact; increased social contact with others (e.g. local shops, day centres, internet)).

Financial control: Although most tenants are subject to some form of external control over their finances all have managed money, purchases and maintained their rent payments.

Evaluation 2b: Tenant outcomes – Indicative occupational therapy assessment

Method

Independent, objective assessment of outcomes and change has been assessed using occupational functioning measurement. For the purposes of this paper, the Model of Human Occupation Screening Tool (MOHOST; Parkinson, Forsyth, & Kielhofner, 2006) was reviewed for one tenant who moved to the project from hospital and another who moved from a private sector provider. Two time points were used – in the three months prior to moving to the project and at the end of the first year of tenancy. A descriptive review of the findings are provided here.

Results

According to the report of the occupational therapist, both individuals have shown improvements in occupational performance in a number of areas since moving to the scheme. No areas assessed showed any deterioration since moving to the scheme. The areas of improvement were unique to the individual but between them represented the full range of performance domains assessed by the tool. One of the individuals was rated at 4 (supports occupational participation) across 20 of the specific areas (and 3; minor interference with or risk to occupational participation for the remaining four) at the end of the first year of tenancy (a change from eight rated 4; 14 rated 3 and two rated 2 prior to tenancy). Overall, this individual showed total gains of 14 points. For this individual, all the specific areas within the domains of 'Motivation for Occupation', 'Pattern of Occupation', 'Communication and Interaction' and 'Motor Skills' were rated at 4 after the first year. The second individual was rated at 4 across nine specific areas and rated 3 for fifteen areas at the end of the first year of tenancy (a change from three rated 4; none rated 3; 16 rated 2 and five rated 1). Overall this individual showed total gains of 32 points. For this

High relational support description and evaluation

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3 individual, all the specific areas within the domain of 'Motor Skills' were rated at 4
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5 after the first year. For both individuals, the occupational therapy assessment reports
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7 stress that the "positive high relational support offered has facilitated an increase in
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9 occupational performance and optimum functioning".
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Evaluation 3: Opinions of tenants, families and professionals – independent

evaluation

Method

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22 In order to gather feedback from tenants, their relatives and professionals who
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24 had contact with the project, an independent evaluation was commissioned by the
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26 service provider. The researcher was not connected to the delivery of the project in
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28 any way. Data were collected via semi-structured interviews with four of the tenants
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30 and four others (family members or professionals) after the first six months of the
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32 project (August 2010).
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Findings

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41 Findings provided to the service suggested that there were high levels of
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43 satisfaction with the scheme. These were largely reported to be a result of the
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45 availability and professionalism of the staff. Feedback contained much praise for the
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47 staff team. Initial fears about the ability of the scheme to meet the needs of the
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49 tenants and provide a safe and supportive environment were all allayed however some
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51 issues were raised about transition into the scheme which had been problematic for
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53 some.
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Discussion

The findings reported indicate that individuals with severe and enduring complex mental health problems can live successfully and make progress in not-for-profit high relational support services. In this evaluation, outcomes, especially in terms of social functioning and occupational therapy goals (self care, productivity and leisure) have been impressive. The general findings reinforce those found previously in 24 hour nursing and core and cluster units (e.g. Macpherson et al., 2004) and provides some reassurance against the concerns raised by Lelliott and colleagues (Lelliott et al., 1996) about the possible implications of having staff without nursing or social work qualifications providing such care in non-hospital facilities. Although not directly evaluated, it is possible that the training undertaken prior to opening the scheme, the ongoing training and support provided within the scheme, the experience of provider of managing projects for mental health service users and the ongoing relationship with health care professionals has contributed to this. As noted by others (e.g. Fakhoury et al., 2002) this needs further study.

Prior to entering the scheme, no tenants were using public transport, none cooked for others nor regularly for themselves, community activity and integration was low and all experienced very limited choice in relation to a wide number of areas of their lives. For those previously in hospital care there was an expectation amongst those who had cared for them in inpatient settings that readmission was likely especially given previous placement breakdowns. Overall the scheme evaluated here has delivered an improvement in *quality of life* for all tenants. All have shown enhanced relationships, stable or improved mental and physical health, increased use of community amenities and all report being happy in their tenancy.

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3 All tenants have experienced *increased independence* as their care needs have
4 reduced and they have done more for themselves whilst for five of the original six
5 tenants, *providing a suitable and sustainable home* has been achieved. *Social*
6 *involvement and inclusion* is evident in a wide range of ways and tenants are
7 exercising more choice over the way in which they live their lives. Together, these
8 gains correspond to the housing values such as accountability, security of tenure and
9 community integration highlighted in previous research (Sylvestre, et al., 2007)
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20 *Managing risk* has been a central issue throughout the scheme development
21 and delivery. There have been lower than anticipated levels of challenging
22 behaviours and very few incidents of violent behaviour either inside or outside the
23 house. As has been found elsewhere (e.g. Lewis & Trieman, 1995) the behavioural
24 problems exhibited, although common can be dealt with successfully by non-nursing
25 professionals in this setting. In addition, all tenants report “feeling safe” and there
26 have been no incidents of substance misuse despite some tenants having a history of
27 this. All tenants have taken their medication as prescribed with no refusals recorded.
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39 The interrelationship between the areas assessed must be acknowledged, for
40 example, the value of providing such a wide range of therapeutic activities is likely to
41 have an impact on the maintenance and improvement in tenants’ health and well
42 being. The evaluation findings showed that 1-1 support needs and level varied across
43 individuals, across the 24 hour period and over time. This means that flexibility can
44 be exercised in relation to the staffing structure and pattern of working to allow
45 managers to increase staffing at times of greatest demand and reduce staffing at other
46 times without compromising safety. Monitoring is necessary in order to ensure that
47 such changes do not disadvantage tenants or impact negatively on them however such
48 flexibility ensures that resources rather than tenants are moved. This helps to
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3 maintain the scheme as a long term housing solution for the individuals living there
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6 (Lewis & Trieman, 1995).

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8 There are an important cluster of financial considerations for the development
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10 and maintenance of such schemes. In the scheme evaluated here, *resource*
11
12 *management* has been a success. Data suggests low unit costs at around 18% less
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14 than benchmark rates, and high levels of satisfaction with the scheme from tenants,
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16 families and outside professionals. A dedicated, creative and highly trained staff team
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18 has been maintained, and routine data collection and monitoring has been used to
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20 develop the service over time. However, in order to create such schemes, there is a
21
22 need for initial investment and start up funding. Despite the clinical governance,
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24 quality assurance gains and long term cost efficiencies such schemes can bring, this
25
26 set up cost may prove difficult especially in the current financial climate. A related
27
28 issue is the ongoing funding for such services especially as this typically relies on an
29
30 assessment of someone's overt level of 'disability' which creates a tension between
31
32 recovery and stagnation. Specifically, maintaining and promoting health, social
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34 inclusion and quality of life may reduce someone's apparent care needs if their
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36 functioning rather than the factors underpinning this functioning are assessed. In this
37
38 scheme tenants have shown massive gains in a wide range of areas **because** of the
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40 support they receive not **in spite** of it. This must be factored into the ongoing
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42 assessment of someone's disability and resultant care needs and has particular
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44 importance when specific functional abilities might affect the source of funding.
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53 Despite the wide range of gains the tenants have made during the first year of
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55 this scheme, all continue to have significant mental health problems. Clearly there is
56
57 a close relationship between the staff input and tenant outcome, however over time
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59 the nature of this is shifting from 'doing with' to "providing prompts, support and
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3 encouragement” across a wide range of tasks. In this way, all tenants continue to
4
5 have multiple needs and require a wide range of support in order to maintain the gains
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7 they have made.
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10 As with other evaluation and research in this area, there are a number of
11
12 limitations with this evaluation. In order to address some of the many points raised
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14 by Fakhoury et al. (2002) in their critique of research in support housing this
15
16 evaluation is multimodal (drawing on a range of methods for data collection and
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18 analysis) and provides an in-depth investigation of a single service over a period of
19
20 time. However it is acknowledged that there remain many limitations in this and
21
22 other research in this area. The representativeness of this study is unclear and the
23
24 small numbers and relatively short evaluation time frame is acknowledged. However
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26 the description of the service and tenants has been presented in an attempt to
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28 contextualise the service.
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36 Conclusion

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38 Developing community based high relational support services is an important
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40 element in providing a modern mental health service with an appropriate balance
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42 between hospital and community care (Thornicroft & Tansella, 2004). This
43
44 evaluation provides evidence that not-for-profit social care organisations can meet the
45
46 needs of individuals with severe and enduring mental health problems. Specifically
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48 this study shows that positive outcomes can be achieved in a wide variety of areas and
49
50 importantly that these can be met by social care led rather than nurse led services. It
51
52 is important to acknowledge that this evaluation is based on a single scheme and a
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54 small number of individuals, however the level of need for such schemes is large with
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56 local estimates suggesting the need for several more such services. Further
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3 expansion would enable the approach of this scheme to be replicated and where
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5 necessary modified and the methodology of evaluation to be incorporated to provide
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7 the necessary outcome evidence. In particular, although this scheme includes those
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9 who have been described elsewhere as the 'new long stay' there remains a need to
10
11 consider whether additional adaptations to the model would be necessary to include
12
13 more of this population (Fakhoury et al., 2005). However schemes such as the one
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15 reported here should form part of a total system approach (Macpherson et al., 2004) to
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17 meeting the needs of those with complex and enduring mental health problems.
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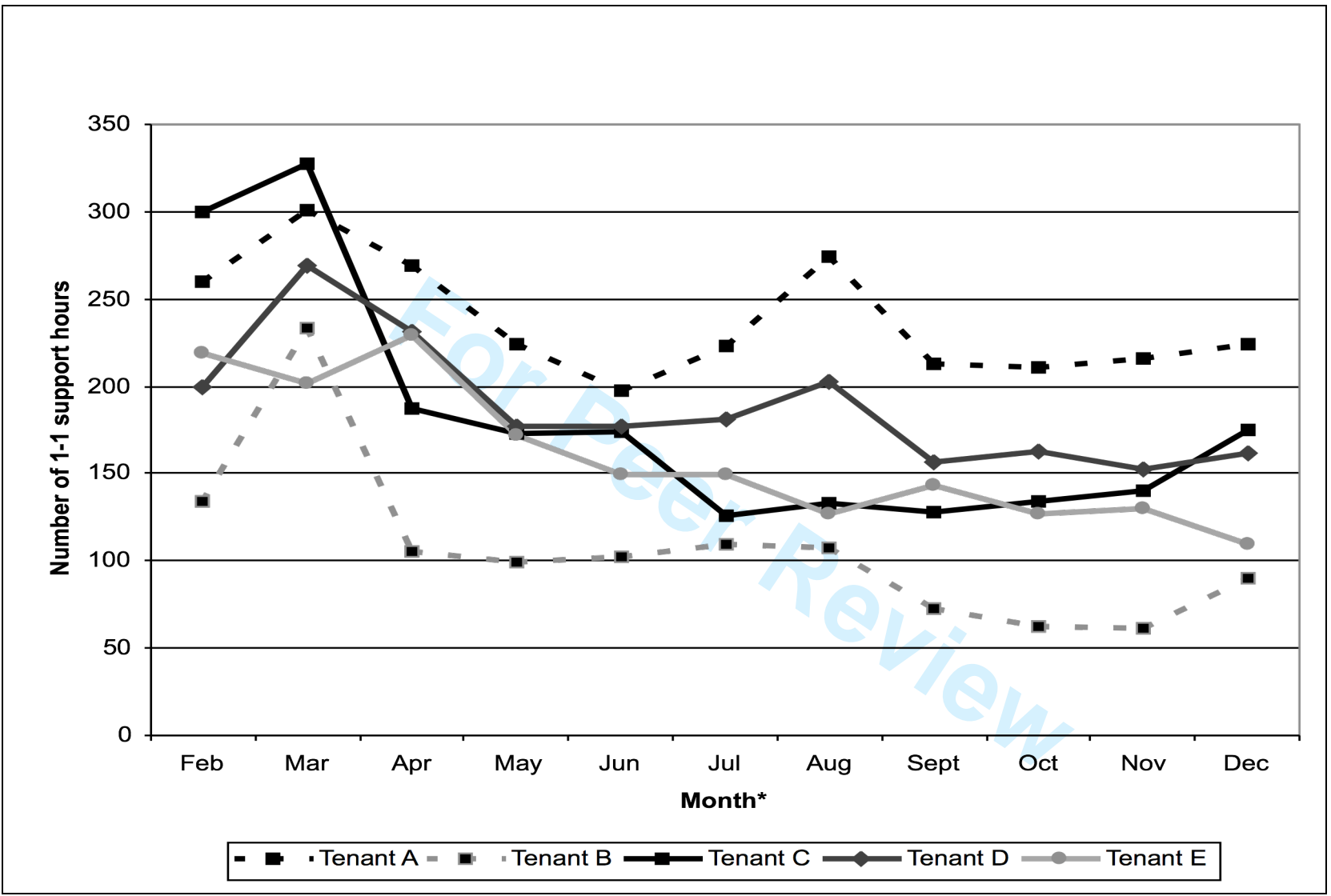


Figure 1: Monthly support input trend by tenant.

* - complete months only

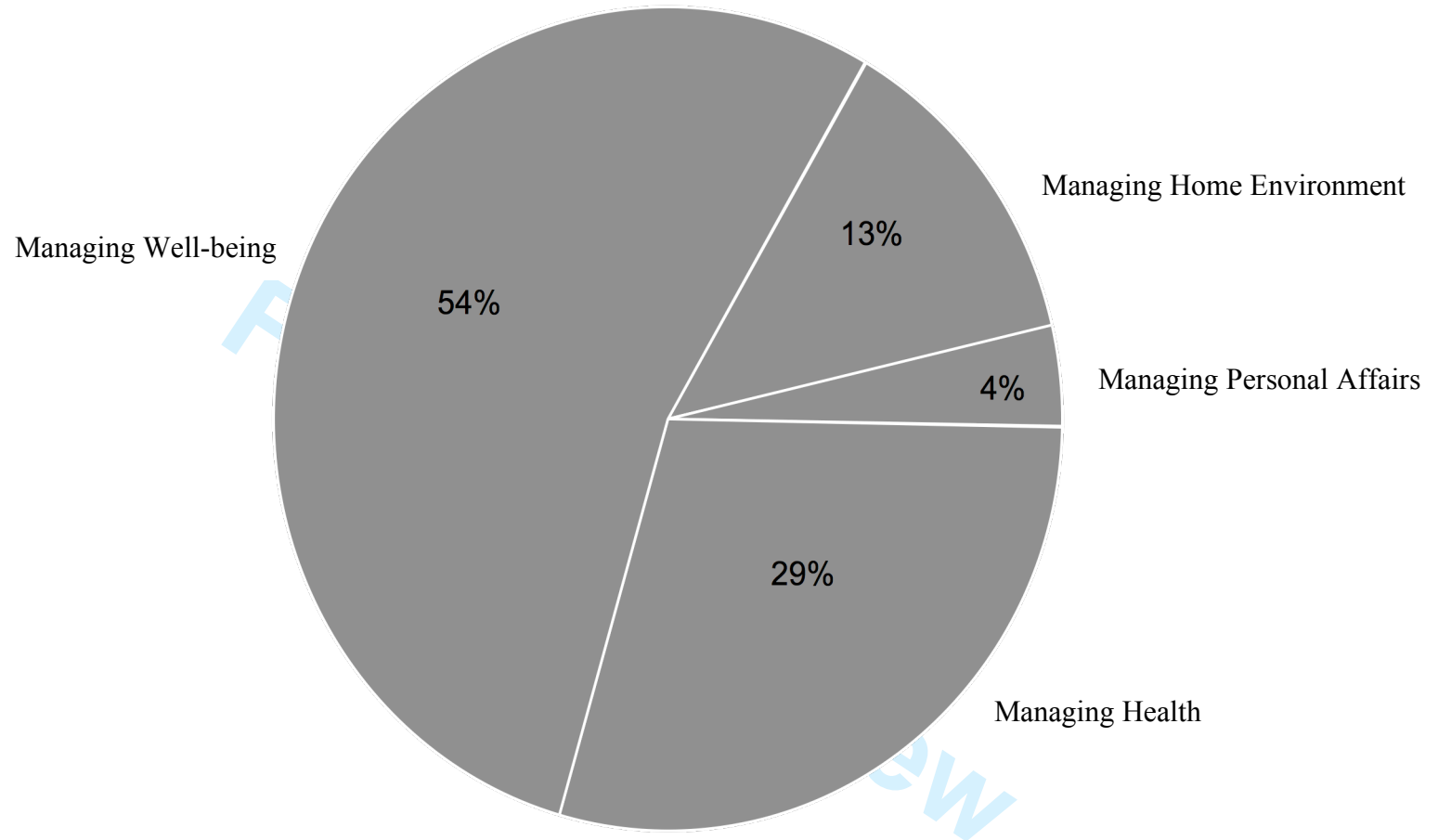


Figure 2: Types of individual support provided to tenants.

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	Time											
Tenant	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00
A		X	X			X	X		X	X		
B	X		X	X	X			X	X	X		
C		X	X	X	X	X		X	X	X	X	
D		X	X	X	X	X	X	X	X	X		
E	X	X	X	X	X	X	X	X	X	X		

Figure 3: Typical times when planned individual support is provided (by tenant)

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Health and well-being:

- Physical and mental health is stable (n=3) or improved (n=2)
- Increased coping with symptoms (less distress caused) (n=2)
- No admissions to hospital
- All tenants taking regular exercise
- Pre-existing smokers continue to smoke however this is outside the property only (n=2)
- All tenants making healthy food choices
- No substance misuse amongst those with problems in this area (n=3)
- Improved confidence (n=2)
- Reduced anxiety (n=2)
- Two tenants have lost weight as part of a planned diet

Personal and community safety

- All tenants report feeling safe at the property
- All tenants feel safe in the community when with staff
- All tenants respond appropriately to fire drills
- Tenants are able to use all house equipment (n=3) or kitchen equipment (n=2) safely under supervision
- Four tenants are using public transport safely
- No incidents of aggression or violence in the community
- Few incidents of risk to others or property in the home and no incidents of self harm

Independence and social integration

- All tenants exercise choices over aspects of their lives (e.g. meals; activities; what support they receive and when)
- Three tenants use the computer to access the internet and for leisure purposes

- All tenants regularly visit local facilities (e.g. shops, parks, cafes) with staff
- All tenants have developed positive relationships with one another and with project staff
- Increased social contact (n=3)
- All tenants have increased contact with family members
- All tenants have a bus pass and four use public transport with staff support
- Two tenants have joined day centres, one has engaged in volunteer training
- Two tenants clean their room independently
- All tenants can prepare snacks for themselves and three regularly cook meals for the household

Financial Control

- One tenant has financial independence, two have appointees and two are subject to receivership
- Two tenants have opened bank accounts
- All rent accounts are up to date
- All tenants manage their money on a daily basis, one independently
- One tenant has undertaken a volunteer work placement
- All tenants able to make appropriate purchases, two relatively independently

Figure 4: Tenant outcomes relating to the four service areas.