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## **Stability versus Progress: Finding an Effective Model of Supported Housing for Formerly Homeless People with Mental Health Needs**

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### **Abstract**

Finding an effective model of support that enables homeless people with mental health needs to sustain accommodation has presented a continuous challenge to both policy makers and practitioners. This article is based on a study of a residential hostel for formerly homeless men with a variety of mental health conditions in a Midlands city. The hostel was selected because it appeared to work in terms of anecdotal evidence of reduced hospital re-admissions and engagement with support services. By studying the views, experiences and perspectives of all stakeholders, the research sought to understand what was distinctive about the hostel, what worked well and for whom.

The findings revealed that three things were of particular importance to stakeholders: residents' willingness to engage with support services; increased stability in residents' lives; and increased independence. A common element in the factors that contributed to the hostel's success against these criteria was the sense of community between staff and residents, which was maintained following moves to independent accommodation. The policy implications for the long-term sustainability of this model will be explored in the conclusion.

### **Introduction: Supporting homeless people with mental health needs**

The link between homelessness and mental health problems has long been recognised. People with long-term mental health problems are more likely than the rest of the population to experience poor housing conditions and homelessness (Koffman and Fulop,

1999; Social Exclusion Unit, 2004), while homeless people exhibit much higher rates of mental illness than those with adequate housing (Sims and Victor, 1999). These conclusions for the UK are supported by evidence from elsewhere (Combaluzier and Pedinielli, 2003; Holmes *et al.*, 2005).

Finding effective models of support that enable homeless people with mental health needs to sustain accommodation has therefore presented a continuous challenge to both policy makers and practitioners. In the UK, the importance of secure housing to effective community care for vulnerable adults has been recognised at least since the community care reforms of the early 1990s, and the introduction of the Care Programme Approach (CPA) for the continuing support of people recovering from long-term mental health problems (Shaw *et al.*, 1998; Cameron *et al.*, 2001). Meanwhile, Government initiatives to tackle rough sleeping, such as the Homeless Mentally Ill Initiative (Bines, 1997) and the Rough Sleepers Unit (1999), have also acknowledged the way psychiatric conditions impede the resettlement of street homeless people.

More recently, studies have confirmed that the right kind of accommodation can provide a springboard to recovery for people with long-term mental health needs (Borg *et al.*, 2005), while proper social support is an essential adjunct to housing for people whose homelessness is compounded by mental health problems (Fichter and Quadflieg, 2006). These findings have been reflected in further policy developments in the UK. Mental health services are currently governed by the National Service Framework (NSF) for Mental Health (DoH, 1999) under which there is a requirement 'to identify the housing status of clients receiving a care plan within the Care Programme Approach and to ensure that the care plan addresses their housing needs' (Watson and Harker, 2003: 8). Standards Four and Five of the NSF are of particular relevance in requiring investment in 'a mix of accommodation ... including staffed and supported accommodation' (Watson and Harker, 2003: 12). Mental health clients who are in contact with secondary services such as community mental health teams are entitled to a CPA assessment under the NSF. The four key elements of CPA in this context are: providing the client with an assessment of care needs, agreeing a care plan, reviewing the plan and providing a care co-ordinator. The written care plan should include 'action needed to secure accommodation, appropriate to the service user's needs' (DoH, 1999: 53).

Supporting People is the other main Government programme relevant to providing housing related support to vulnerable people, by helping to prevent problems that lead to homelessness and facilitating the transition to independent living for those leaving hostels. Administered through local authorities, Supporting People serves to link housing support with the care and mental health services funded under the CPA. Housing related support services under Supporting People may include: 'enabling individuals to access their correct benefit entitlement, ensuring they have the correct skills to maintain a tenancy, advising on home improvements (and) ... an on-site full-time support worker for a long period of time' (ODPM, 2004: 2). However, personal care such as washing and dressing, specialist counselling, childcare and healthcare and medication, are not eligible for funding by Supporting People.

### **Alternative models of support**

We can identify a spectrum of housing support models for people with mental health issues, which vary in the level of support from full support with staff on site 24 hours per

day at one end to independent living with support through home visits by key workers at the other. Boyle and Jenkins identified three general models of accommodation: specialist housing with on-site staffing; specialist housing with visiting staff; and non-specialist housing with floating support (2003: 36-37).

For those who fit into the first category, Crisis (2005) has identified various models of provision that have been developed to assist homeless mental health clients to engage with support services. The core and cluster approach is described by the Scottish Association of Mental Health as a house or a group of flats providing accommodation for a number of residents, with staff based in a core building (SAMH, 2005), and is considered effective for those not wishing to use shared facilities (Dean and Craig, 1999). Specialist hostels provide supported housing, care and life skills training for homeless people with mental health problems and complex needs. Supported housing will have 24-hour staffing, which may be waking or sleep-in.

The second category differs in providing the services of non-resident housing support workers only for so many hours per day and often only on weekdays. In the third category, a lower level of floating support is offered that is not specifically tied to a unit of accommodation. In this model, clients are likely to live in their own tenancy and support will be provided to them there. This model of provision has been encouraged by policy makers and has therefore increased since the advent of the Supporting People programme (Boyle and Jenkins, 2003).

How do we decide which model is appropriate for whom and under what circumstances? Edgar and Doherty (2001) have provided a useful framework for analysing models of support according to their aims, distinguishing between re-integrating people into mainstream society by providing the skills to sustain independent housing, rehabilitating people whose lifestyle and behaviour threaten their accommodation in ordinary housing, and preventing homelessness by providing for the personal and healthcare needs of those who might otherwise be institutionalised.

They then went on to consider to whom these aims might be most relevant, classifying need groups across two dimensions according to the permanence of their need for support and their risk of institutionalisation. Where both factors are high, as in the case of people with learning disabilities or mental illnesses or the frail elderly, the aim is the prevention of homelessness or institutionalisation by providing permanent personal support and healthcare services. The article finishes by giving special consideration to people with mental health problems. Their support needs render mainstream accommodation hard to access or sustain, while their medical condition may make group living inappropriate, all of which puts them at risk of homelessness, hospitalisation or even imprisonment. The authors argue that 'it is the fluctuating nature of the support requirements, combined with the difficulties of assessment and allocation and a relative scarcity of appropriate housing, which ... leaves this group of people particularly susceptible to homelessness' (Edgar and Doherty, 2001: 72).

### **Determining success in supported housing: the policy dilemma**

To be effective, supported housing for people with long-term mental health needs must therefore recognise both the high risk of homelessness and institutionalisation, and the varied and fluctuating nature of this group's support needs, and these considerations

provide the key to evaluating the effectiveness of supported housing projects such as the one under investigation. In particular, three criteria are suggested by the literature.

Firstly, enabling residents to engage with support services is essential if prevention is to be effective. A tendency to resist engagement has been detected, for instance, by the Sainsbury Centre's review of care for people with mental illness (SCMH, 1998a), which estimated that between 14 and 200 per 100,000 of the population with enduring mental illnesses were difficult to engage. Others have explored the reasons for this non-engagement (Stephens, 2002). Moreover, encouraging an increase in engagement has been shown to be of benefit to those with enduring mental health conditions (Pinfold and Corry, 2003). In keeping with this, engagement with services has become a Government priority under Standard 4 of the NSF (DoH, 1999), which states that care should be provided for those with severe mental illness such that it 'optimises engagement'. However, there is conflicting evidence concerning the role of assertive outreach teams in bringing this about (SCMH, 1998b; DoH, 1999; cf Craig *et al.*, 2004). What is important for our purpose is how engagement with support services might be measured, and the indicators developed by Hall *et al.* (2001) (see Appendix A) and Gillespie *et al.* (2004) will be employed for this purpose.

Secondly, the frequency of re-admission episodes to acute hospital wards will indicate the effectiveness of preventing institutionalisation and enhancing the stability in people's lives that is essential to managing and recovering from mental illness. Medical professionals (Bartlett *et al.*, 2001) and service user groups (SCMH, 1998a) are of the belief that community based services are likely to be more effective in managing psychiatric conditions. Moreover, Fleischmann and Wigmore's study (2000) sought the opinions of people with experience of both homelessness and mental health problems and found that the support of project staff, through key-working and informal networks, was critical in crisis support.

Thirdly, moving into independent accommodation with appropriate support has been found to be the most effective pattern of provision for homeless people experiencing mental health problems to avoid homelessness, manage their medical condition and generally live a more settled existence (Power and Attenborough, 2003). Accordingly, Supporting People is described as a programme that 'promotes independence' (ODPM, 2004: 1). However, given that this is seldom an immediate option for homeless people moving directly from the streets, supported housing projects will play a key role in managing the transition to independent accommodation.

Nevertheless, there is a tension between the quest for stability and the potentially destabilising implications of encouraging people towards independent living, and this tension translates into a critical dilemma at the level of policy. The stability that is crucial to people being able to manage mental health conditions is often rooted in place and the security that might attach to it. Yet policy targets that make funding conditional on a continuous flow of clients towards independent accommodation militate against this kind of stability, particularly if it comes to rest in supported housing projects defined for policy purposes as 'temporary'. One of our key research questions was to see how effectively this tension is managed in one such project.

## **The project and the evaluation methods used**

The subject of our investigation was a small residential housing project for twelve formerly homeless people with long-term mental health needs, run by a local housing association in a Midlands city. Funding comes substantially from Supporting People and all residents have care plans under the CPA. Since care staff operate on site continuously, the project belongs to the first of Boyle and Jenkins' (2003) supported housing models. However, support continues to be provided to numerous former residents who continue to use the project's facilities. Residents are referred to the project from external agencies, and their backgrounds vary between institutional settings, rough sleeping, acute wards or other supported housing projects. Residents come with a range of mental health conditions, but they have in common recent experiences both of homelessness and hospitalisation.

The project operates on principles of a shared house with communal living areas. The project is set in two adjacent semi-detached houses in a quiet residential area close to the city centre. The houses have been converted to provide twelve individual bedrooms. Residents have their own bedrooms, are free to come and go as they please and have their own key for the house and their bedroom. Staff may only enter rooms if invited by residents, although weekly pre-arranged health and safety checks also take place. The communal areas include a kitchen, TV room/lounge, a laundry and a gym area in the basement. There is an open door policy to the staff room at the front of the house which effectively also allows open access to residents, although some restrictions exist around team meetings or if confidential meetings are taking place. There is a staff bedroom for overnight cover and an office that is used by the project manager and for confidential meetings between residents and their support workers. Two further rooms are used for activities, one as a complementary therapy room and the other for art activities, and staff from an FE College visit weekly to deliver basic education sessions.

Project staff prepare an evening meal for residents, but independent use of the cooking facilities is also encouraged and there are basic cooking facilities in each of the bedrooms. Other services provided by staff also reflect the wide range of traditional residential care services, rather than what might be associated with housing support. They include help with taking medication and with day-to-day tasks, accompanying people on social and leisure activities including holidays, advice or assistance regarding education and employment, accompaniment when engaging with other services, and the prevention of harm to themselves and others.

The aim of the study was to explore what was distinctive about the project and to identify successes and the reasons for them. We further sought to discover what was important about the project to various stakeholders and appraise it according to the criteria that emerged. Since we found a fair degree of consonance between the official aims of the project in terms of promoting independence, achieving stability and engaging with secondary care providers, then these considerations remained central to our evaluation.

The research should be seen as a case study in patterns of supported housing for people with mental health needs. Data were therefore gathered from as many stakeholders as possible, using a variety of methods. Stakeholders included current and former residents at the project, care staff and managers from the housing association, professionals providing secondary support services and the managers of other projects providing supported housing to mental health service users in the locality. Data sources

included semi-structured one-to-one interviews, informal individual and group conversations, observations and diary records, completion of an 'observer' questionnaire to measure engagement, and documentary sources such as Supporting People returns.

Formal interviews were held with three current and three former residents, but these were supplemented with informal conversations with a further four current residents, the purpose being to find out what living at the project meant to its residents and the continuing impact it was having on their lives. The manager of the project and three housing association managers were all interviewed to gain insight into the strategic approach adopted by the project. The project manager also completed a 'measure of service user engagement' questionnaire (Hall *et al.*, 2001; Gillespie *et al.*, 2004) (see Appendix A) for all current residents. The 'Supporting People strategic relevance form' provided aggregated move-on data for former residents. We also recorded observations systematically in a diary.

### **Independence, engagement and stability**

Evidence from all stakeholders reflected a high degree of agreement both with the importance of our three criteria and with the success of the project in meeting them. However, there were some important differences in the way different stakeholders interpreted their meaning.

With regard to promoting independent living, the housing association management team were clearly aware of the success of residents leaving and finding accommodation, but doing so in a managed way.

People move on but they don't take unnecessary risks; there's a danger that you can move people too quickly and reduce their opportunity for success.

Discussions with project staff also elicited examples of ex-residents who had moved to their own tenancies. Quantification of these examples was possible by reviewing Supporting People returns. Between April 2003 and March 2004, eight residents moved on, representing two-thirds of those who had been resident at the beginning of that period. All eight were recorded as having achieved a move in a planned way, an indicator of success for short-term residential projects like this one.

Changes in behaviour resulting in residents engaging more with their care support team were also apparent from the study, as demonstrated for instance in residents taking their medication, attending key working sessions and being available for review meetings. It was suggested by one external stakeholder that the project is good at achieving engagement because of systems in place to prompt residents:

Being able to engage clients somewhere where there is a diary and there's prompting about the importance of these meetings. It can make a difference seeing somebody every week or fortnight in six months or only seeing them once in six months.

To quantify engagement Gillespie *et al.* (2004) used a questionnaire based on responses to eleven, five-point Likert scale questions (see Appendix A). The project manager completed the observer version of this questionnaire for each of the current

residents. The range of possible scores is from 55 (full engagement) to 11 (no engagement) where scores of 33 or above show the service user as 'engaging well'; scores below this point suggest poor engagement (Gillespie *et al.*, 2004: 442). In two thirds of cases (8 residents) the engagement score exceeded 33. One further resident scored within 1 point of 'engaging well', while three scored less than 30, demonstrating poor engagement. However, the general picture showed a majority of residents to be engaging well.

There was also a widely held belief that residents were readmitted less to acute wards whilst at the project, which was one of our measures of increased stability. Where an admission was unavoidable, it would be effectively managed on two levels. Firstly the time spent on the ward would not be as long as previously experienced, as one housing association manager noted:

What they're good at is seeing shorter admissions...some of the clients there, once moved to an acute ward, would have been there for 6, 7, 8 months; it'd take ages to get their mental health stabilised.

Secondly, the staff team would work with residents in order to try to achieve an informal admission by increasing their self-awareness. Such a level of self-empowerment is acknowledged in this field as being a positive step for mental health clients, creating confidence.

Project staff also gave examples of residents achieving greater periods of stability in their lives. For instance, regarding one client who had previously followed a pattern of repeated involuntary admissions, a staff member was able to affirm that, since being at the project, 'it's the longest he's ever been (out of hospital) since he's been going into hospital'. External stakeholders had experience of working with clients prior to their moving to the project and were therefore able to comment on changes in behaviour patterns and to give further examples of greater stability. For instance, one resident, who had previously experienced difficulties because of his drug use, was now 'in control of himself, in control of his bodily functions ... (because) ... he knows he'd be out there struggling if he didn't have the stabilising influence of (the project)'. A staff member illustrated the importance of not rushing clients to change. 'It could be argued that they're safer, more stable; they may not be going anywhere but they're not any worse and that can be a success in itself depending on what their past life was like.'

Herein lay the seeds of the potential conflict of interests with the quest for independence that we began to examine earlier. The project and what it had to offer were central to the stability that residents had been able to achieve in lives previously rendered chaotic by the combined effects of homelessness and acute mental health needs, often exacerbated by substance misuse. Managing moves to greater independence without jeopardising these gains is the toughest challenge faced by projects like this one.

### **The project's distinctiveness**

To understand the reasons for the project's success in meeting this challenge, our study sought to identify the features that stakeholders recognised as distinctive. These all sprang from the basic ethos that underpins the project, expressed by the original project manager:

I wanted to take as much of the stress that's inherent in communal living out of it and provide people with as much choice, dignity, respect, autonomy as possible. So people could choose to cook in their rooms if they wanted, have the choice of another communal room as well as the lounge ... Shared living can be very stressful and sometimes projects can focus on just managing that level of conflict which takes precedence over individuals' own difficulties.

This ethos was very much reflected in the way staff worked and interacted with residents. They were encouraged to make their own choices, without pressure to take part in activities. They even chose their own key-worker and co key-worker at the end of the first month's residence. Moreover, the large kitchen dining room, good sized bedrooms and access to the staff area, gave residents alternative spaces in which to meet or escape altogether if they chose.

This level of self-determination necessitated a high degree of tolerance from staff towards resident behaviour that may not have been acceptable elsewhere, even to the point of working with an excluded resident to facilitate his return. Stakeholders contrasted this atmosphere with practice elsewhere. Residents talked about experiences in other settings where they had been threatened with eviction for behaviour permitted at the project. An external stakeholder described how this approach brought stability and a sense of security in the life of one resident who had experienced eviction elsewhere for his behaviour:

When he was at (another project) he was getting some support, but not enough. They were never that happy about him, making moral judgements about his room. He wouldn't be allowed to have his room like he does at (this project); it wouldn't be tolerated.

This is not to suggest an indifference to hygiene, but a greater concern for more important issues in a resident's life, in this case a drink problem. With an assurance of security, this deeper issue could be addressed, bringing more lasting stability.

Two other features of the way residents were treated marked the project out. One was the open door policy towards the staff area, which contributed to a playing down of the role distinction between staff and residents. This effect was further promoted by the informality with which staff provided support, characterised by the fluidity in the boundaries around the issues that staff were willing to address. Once again, a former resident was conscious of the difference from other residential facilities:

The staff at (a previous hostel) wanted to get away with doing as little as possible. But you can talk to the staff here; they'll talk to you if you've got a problem, support you and encourage you. At (the previous project) they'd say 'we're just a housing association; if you want counselling you'll have to go elsewhere'.

The approach of project staff played a large part in fostering a distinctive ethos that was apparent to all stakeholders. They noted how welcoming staff were to visitors and former residents, with the front door always open and the staff area located in the front room of the house to greet people on arrival. A staff member put his finger on it when he described the project as less institutional, pointing out that:



...some places are like projects; (this project) is more like a house.

An external professional confirmed that:

...it's more like a home, a community that's together (with) things like celebrating birthdays.

A resident took the view that:

...it's like an extended family.

Moreover, this concept of a residential community was further fostered by the proximity of the move-on accommodation to which most former residents had relocated. Another housing association owned many of the flats in the area, which former residents now rented. To them, it was 'being close by that's important'. A current resident explained why:

You realise the support's going to be less, but you want the same sort of support when you're on the outside as when you're here. ... The best way to get the support of the team is to be living locally.

This expectation was confirmed by a former resident who explained how:

I find, if you've got any problems, or if you have a rough time, or if you become unwell, there's the support there'.

The project fell far short of being a complete residential community in the L'Arche tradition. For instance, there was still a recognisable staff group who had homes elsewhere. But there was plenty of evidence that the original vision, with many of the characteristics and benefits of communal living, was being realised in practice. As a current housing association manager reminded us:

When the place was set up (the founder) wanted somewhere like home, not permanent but somewhere a bit more stable ... where people feel they belong ... whatever length of time they're there.'

### **Reasons for success**

It remains to consider how the distinctiveness of the project might explain its success by our three criteria and what the implications might be for its future and that of housing support for people with long-term mental health needs. Our study found that the sense of community was paradoxically the source both of the project's success and of unresolved tensions that potentially threaten its future. The policy implications of this paradox will be explored in the conclusion.

*Engagement*

It was some of the characteristics of the project as a community that enabled residents to engage, both with the services that the project itself offered and ultimately with outside agencies. We have already seen how, despite clearly operating within professional boundaries, there appeared to be no sense of 'them' and 'us' within the relationships between staff and residents. Residents were able to come and go as they pleased. Staff spent time talking informally with residents, either in the communal TV room, the staff room or the kitchen. This apparent reduction in power relationships would seem to be a factor that encouraged residents to 'buy in' to the project, something that has been reported as significant by other researchers (Fleischmann and Wigmore, 2000). Moreover, as one housing association manager observed, the small scale of the project is significant:

It's a medium size project. I think that's crucial to that sense of community ... that would be compromised if the project increased in size'.

The stability of the core staff team was also relevant. The importance of staff retention has always been high on the project's strategic agenda. An external stakeholder suggested that this might help encourage engagement:

They're a good team of staff there, and they seem to stay for a while. That's good for the client to know ... for me too, to know there's some continuity.

This was confirmed by a resident who had experienced a number of enforced changes of key-worker, and reflected that:

...you get used to someone (so) it made a big difference when they (previous key-workers) left; it knocked me back ... Now I've had (current key-worker) for a while, I feel I'm back on track again.

Moreover, the staff communication system, through the twice-daily handover meetings, was crucial to the continuity of the support for residents. Team members were all aware of what was happening and noticed if someone was not engaging. As a team, they would discuss this and agree a strategy to work with the client to change this. One resident described the results in his case:

Last year, I had 4 or 5 days where I just used to come down for my meals and I'd go back upstairs and you really wouldn't see me. And of course that's then noticed, and they'd sort of have a word with you about that.

The net effect of all this was that it gave residents an experience of a service that was worth investing in because it was staffed by people who were willing to invest in them over a period of time, who treated them as equals and who noticed if they became disengaged. This experience was then carried over into a more positive attitude towards other services.

### *Stability*

Similar arguments also explain the greater stability in people's lives, with, for instance, fewer and briefer hospital admissions. For example, one external professional noted the importance of a sense of belonging to one resident who:

...made an effort not to get thrown out ... because he knew the place was far too good.

Moreover, residents appreciated the support network that exists both from the project staff and from other residents:

(The project), it's like an extended family. You get to know the residents. They seem to get on. They accept you.

It was this sense of being at home, with all its positive associations with belonging and acceptance, which gave residents a new stability to their lives.

It is here that the tension emerges to which we alluded earlier. That stability will be compromised if residents are under pressure to move on. This tension is sharpened by the conditions that attach to Supporting People funding. If residents appear to be too stable, and see the project as their home, there is a danger that its status as a short-term residential project will be threatened, along with its funding. But if residents are moved on before they are ready, then their stability will be jeopardised, undermining a key measure of the project's success and threatening its funding from another angle. The project's ability to promote independence without destabilising residents' lives was the key challenge that its distinctive character sought to meet.

### *Independence*

As we have already seen, the project was clearly working well by this criterion, with eight planned moves during 2003-04. Moreover, former residents had not simply been 'moved on'; they genuinely led more independent lives.

How was this achieved without compromising stability? The evidence suggests that the answer lays both in the way the moves were managed and in the manner that residents' independence was enhanced in other ways within the project, long before independent living was contemplated. Living more independently may be measured in a less obvious way. Some residents had prior experience in long-stay mental institutions where care staff did everything for them. Project staff noted a tangible difference in the behaviour of those residents who could be described as living more independently, such as taking responsibility for their own meals, their personal hygiene and their own medication.

Regarding the management of the process of moving on, the formal support provided by staff through key-working was crucial. One ex-resident reflected on how he had been helped when he was close to moving on:

They came over with me when I went to look at the flat ... helped me get some stuff ... talked to me about how it would work and we sorted out the bills. We did it in stages so that made it easier.

The security of the support from the project once people have moved on also provides assurance to current residents contemplating a move. One resident knew that once he left the project he would have ongoing support while trying to be more independent:

It's that reassurance that you've got someone there, even when something goes wrong. I wouldn't come back just at the drop of a hat; mainly I would come back for a progress report, or if anything crops up.

The availability of properties in close proximity to the project appears to be important to facilitating this continued sense of security during residents' first forays into independent living. For some residents, this was but a stepping-stone to moving further afield. Here, the key to continued success was a new support network, as a housing association manager explained:

Some people move further away: (ex-resident) was ready for that, but he's got a good family support network; he's got something else there. A lot of people that have moved away from here have got nothing. ... They might be involved in services ... but that's not a daily basis. If people can move from here, it's another stepping stone in moving on and getting the skills that you need, maybe to say 'well I'm ready to go a bit further afield now.

What this suggests is that, to retain stability, residents do not so much move to *independence*, but to a different form of *interdependence*, either with the project or some other support network. What is critical is that the project cannot be bound to some formulaic requirement that all residents move to independent living within a fixed timescale, as one housing association manager explained:

You can't treat every single person the same. It's all very well people coming in and saying: 'you're short term, you move people on'. Life's not like that; people aren't like that. You've got to work with each individual on what's right for them.

Ex-residents who live close by are still part of the community, and their proximity has been discussed positively, both for them in terms of retaining their tenancy and also for current residents seeing people who have achieved successful outcomes. Thus the tension between securing independence at the expense of stability has been resolved by retaining the trappings of stability in the context of independent living. The source of stability in residents' lives is not so much the supported housing project as a place as the community that has grown out of it into the surrounding neighbourhood. This throws up issues of sustainability that will be addressed in the conclusion.

## **Conclusion**

Formerly homeless people with long-term mental health needs suffer the double risk of returning either to hospital or to the streets, because their circumstances, which often combine with substance misuse, render mainstream solutions inappropriate or inaccessible. A residential housing project for this client group was evaluated because of the project's apparent success in curtailing these risks. This success was confirmed by

three criteria. First, residents were more willing to engage with the formal support services that helped to prevent homelessness and hospitalisation, as indicated by a measure of service user engagement. Secondly, residents enjoyed a greater degree of stability in their lives, as measured by the reduced frequency and duration of hospital admissions, and the increased likelihood that these would be voluntary rather than compulsory. Thirdly, two thirds of residents successfully moved into independent accommodation in the course of a year, while others led increasingly independent lives within the project, looking after themselves and taking control of their medication.

Our study went on to look for distinctive features of this project that might help to explain this level of success. Two characteristics stand out: resident autonomy and domestic community. They gave residents a sense that the project was worth buying into, which generated a more positive attitude towards other services with which they more readily engaged. These distinctive features also gave residents a sense of security and belonging, which enhanced the stability of their lives. They further meant that moves towards greater independence were under the control of the individual resident and conducted within the embrace of continuing community membership.

If projects of this nature are ever to become instruments of a wider policy programme for vulnerable adults, important policy dilemmas need to be resolved. This project depended for its funding on a government funding programme that allocated resources in part on satisfying a centrally driven policy agenda to maintain a continuing throughput of clients from the streets and hospital wards into independent accommodation. As we have seen, this can only be achieved at the client's own pace under circumstances that sustain the stability that is essential to prevent relapse. Policy targets that link funding too rigidly to throughput, and require length of stay at the project to be limited, will jeopardise that achievement.

This project achieved a precarious balance between stability and independence by allowing clients who have moved out to retain their sense of belonging to the project community. But this has given rise to a further policy dilemma. It is difficult to see how to make the step from offering informal drop-in support to former residents without reaching a point where existing residents receive a diluted service. This will be an inevitable consequence of government funding regimes restricting housing related support to current residents and making no allowance for support offered elsewhere. The threat that this poses can only grow as more residents move out into the locality, but continue to press their claim to continued support.

**Appendix A: Engagement measure (observer version)** (© Hall, Meaden, Smith & Jones, 2001)

Date Rated:

Client's Name:

Rater:

Therapist's length of involvement with client:

For each area please circle the number that best describes your client at the current time.

Terminology: 'Treatment' refers to the whole treatment package, not just medication.

'Therapist' refers to the person most involved with the client; this will usually, but not always be the key-worker.

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**Area (1) Appointment keeping**

*(Include attendance of outpatient appointments and keeping other appointments, i.e. being at home when arranged)*

**(a) Without support:** (i.e. without key-worker bringing them)

1		2		3		4		5	
Never	keeps	Rarely	keeps	Sometimes	keeps	Usually	keeps	Always	keeps
appointments		appointments		appointments		appointments		appointments	

**(b) With support:** (i.e. key-worker bringing client to appointments)

*(Note: Even if client attends without support, please rate what their attendance would be like with support)*

1		2		3		4		5	
Never	keeps	Rarely	keeps	Sometimes	keeps	Usually	keeps	Always	keeps
appointments		appointments		appointments		appointments		appointments	

**Area (2) Client-therapist interaction**

**Quality of relationship**

*(The extent to which the client relates well with the therapist, giving rise to a positive atmosphere during sessions)*

1		2		3		4		5	
Never	relates well	Rarely	relates	Sometimes	relates	Usually	relates	Always	relates
with therapist		well with therapist		well with therapist		well with therapist		well with therapist	

**Area (3) Communication/Openness**

*(The extent to which client volunteers relevant personal material, is open in discussing feelings, problems and current situation)*

**(a) Personal feelings** (i.e. anger, depression etc.)

1		2		3		4		5	
Never	discusses	Rarely	discusses	Sometimes		Usually	discusses	Always	discusses
personal feelings		personal feelings		discusses personal	feelings	personal feelings		personal feelings	

**(b) Personal problems** (i.e. difficulties in current life situation)

1		2		3		4		5	
Never	discusses	Rarely	discusses	Sometimes		Usually	discusses	Always	discusses
personal problems		personal problems		discusses personal	problems	personal problems		personal problems	

**(c) Symptoms**

1 Never discusses symptoms	2 Rarely discusses symptoms	3 Sometimes discusses symptoms	4 Usually discusses symptoms	5 Always discusses symptoms
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**Area (4) Client's perceived usefulness of treatment**

1 Never perceives treatment as useful	2 Rarely perceives treatment as useful	3 Sometimes perceives treatment as useful	4 Usually perceives treatment as useful	5 Always perceives treatment as useful
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**Area (5) Collaboration with treatment**

*(The extent to which client agrees to proposed intervention, as stated in their care plan, and is involved in carrying it out, i.e. keeping diaries, practicing relapse drills etc.)*

**(a) Agreement with treatment**

1 Never agrees with proposed intervention	2 Rarely agrees with proposed intervention	3 Sometimes agrees with proposed intervention	4 Usually agrees with proposed intervention	5 Always agrees with proposed intervention
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**(b) Passive involvement in treatment**

*(Passive involvement: client goes along with treatment)*

1 Is never involved in proposed intervention	2 Is rarely involved in proposed intervention	3 Is sometimes involved in proposed intervention	4 Is usually involved in proposed intervention	5 Is always involved in proposed intervention
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**(c) Active involvement in treatment**

*(Active involvement: clients clearly want to involve themselves in the treatment process)*

1 Is never actively involved in intervention	2 Is rarely actively involved in intervention	3 Is sometimes actively involved in intervention	4 Is usually actively involved in intervention	5 Is always actively involved in intervention
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**Area (6) Compliance with medication**

*(Extent to which client agrees to take medication and will take it freely)*

1 Never complies with medication	2 Rarely complies with medication	3 Sometimes complies with medication	4 Usually complies with medication	5 Always complies with medication
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