

MENTAL HEALTH & HOUSING: TOWARDS A TYPOLOGY FOR SUPPORTED HOUSING

PURPOSE

To build on the recommendations from GIRFT and further develop the Mental Health Minimum Data Set in relation to "supported living". The Mental Health Network's Mental Health and Housing Forum together with the Global Leadership Exchange in Mental Health want to develop a typology to describe different models of supported housing, the likely standards, staffing competencies and capabilities required to support people with serious mental health problems to live better lives.

OVERVIEW

There are 60 - 80,000 people living in mental health supported accommodation in the UKⁱ. However, services are poorly described and there is a considerable degree of inconsistency in relation to terminology. The shape and effectiveness of services is affected by different economic, political and social contexts in which they are operating.

Housing services support independent living, avoid unnecessary admission and provide step-down from inpatient provision for those who need it. The support people to be independent from institutional forms of provision and, as such they are a key component of the rehabilitation pathway. However, the term 'supported housing' is a generic term that lacks the granularity necessary to inform commissioning, clinical and patient decision-making. So, providers of these services want to set out models for delivery with a clear set of standards and definitions of good practice to reduce unwarranted variations in care, improve outcomes and reduce costsⁱⁱ.

Most service users state a preference for independent, self-contained forms of accommodationⁱⁱⁱ. Traditionally, clinicians and carers have stated a preference for service users to live in more supported forms of accommodation^{iv}. In most countries that have seen deinstitutionalisation the majority of mental health supported accommodation provides shared facilities. There is also a concern that many services lack a rehabilitative and recovery ethos.

To achieve clinical and social recovery goals and move care and / or support to less restrictive - and more cost-effective - environments requires a combination of recovery-based practice, a focus on an individual's human rights together with the provision of accommodation that provides a degree of physical and psychological security and the opportunity to connect with friends, family and / or the wider community.

A national research programme in England found that at 30 months follow-up, 2/3 of people receiving floating outreach were able to manage with less visiting support, 1/3 of those living in supported housing had been able to move on to housing with less support and 1/10 of those living in residential care had been able to step down to some form of housing with support. Overall, 41% of people moved on to less restrictive more independent accommodation at an average lower cost of £427 per year^v.

If we were to multiply this £427 by 60,000 (the estimated number of people living in supported accommodation) and assume that 41.5% successfully move-on at 30 months then that suggests a saving of over £10.6m through people moving-on successfully. Given that services that are more recovery orientated and focused more on people's human rights are better at supporting people to move on successfully then embedding these principles across all such services could deliver even better outcomes.

THE MODELS

Whilst the political, social and economic contexts vary there are very similar models found across Europe – including the UK. We have identified four basic models i) floating outreach, ii) supported housing with 24-hour staffing on-site, iii) supported housing with staff on-site Monday to Friday and iv) residential care. In Figure 1 we have set out an overview of these together with key principles relation to each model.

Figure 1: Supported Housing Models

SUPPORTED HOUSING MODELS FLOATING OUTREACH <i>For people with moderate needs. The majority have common mental illness such as anxiety, depression or substance misuse problems.</i> Person lives in own accommodation which is usually self-contained and permanent. Staff visit person in their home 1- 2 times per week. Provides limited support with day to day living. Includes Housing First. <i>This model aims to gradually reduce support over time, without the person having to move home.</i> SUPPORTED HOUSING Can be shared or self-contained in some sort of cluster such as a block of apartments. This model is usually time-limited with the expectation that the person gains skills and confidence to move to less supported accommodation. Staff on-site 24 / 7 <i>For people with severe mental illness and higher support needs.</i> Provide monitoring of the person's mental health and any risks. Prompting and encouragement to attend to personal care and house-keeping. Medication supervision. Activities to inspire confidence and develop social skills. <i>Where services have a staff presence for the purposes of building security/concierge only, this would not be classed as having staff on-site 24/7.</i> Staff on-site 9-5pm Monday to Friday <i>For people with severe mental illness and moderate needs</i> Provide lower intensity monitoring, prompting and support with activities of daily living and medication supervision (e.g. intermittent checks rather than daily supervision). Signposting to activities and engagement in wider community. <i>There may be variations in support hours in these settings.</i> RESIDENTIAL CARE <i>For people with severe mental illness and high support needs.</i> Shared accommodation. 24-hour staffing. Meals, cleaning, medication administration provided.
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QUALITY INDICATORS

Services need to demonstrate that they have the **capacity and capability** to deliver services that are aligned with NICE Guidance^{vi}:

- build relationships with residents that enable staff to 'check-in' on them without being intrusive
- enable residents to build their own support networks and own community
- show curiosity about the person's history and the person's current experience
- have systems in place for supervising medication adherence effectively
- hold regular 'huddles' with the team responsible for supporting the person to discuss their progress and engage in reflective practice
- use recovery-based approaches that enable residents to achieve their individual recovery goals
- support residents with activities of daily living and accessing physical health monitoring and support.
- spot relapse indicators and report to the relevant clinicians appropriately
- rely on the strength of the relationship with the person rather than the power of the institution.

Services need to show how they can build confidence with clinicians referring into the service so that there is a shared understanding of risk and shared understanding of quality.

To effectively support **move-on** services need to engender therapeutic optimism and employ a strengths-based approach to care planning. Support is particularly important at points of transition as this is where problems may arise. Services need to set an expected maximum length of stay and support residents to gain / regain skills for community living - including involving service users in running the service and having people with lived experience on the staff team.

Services also need to provide access to advocacy and legal representation, actively provide privacy and dignity and be clear about how service users can make complaints. It needs to link people to local community activities such as assistance with voting in elections.

Given that we're talking about mental health and mental illness, concepts such as "trauma informed" and "psychologically informed environments" should be seen as a basic minimum and not necessarily as an indicator of quality.

Services should do their own quality assessment on an annual basis using the Quality Indications for Rehabilitative Care adapted for supported accommodation (QuIRC-SA) www.quirc-sa.eu. The QuIRC-SA is the first standardised tool for quality assessment of specialist mental health supported accommodation services.

CONCLUSION

This paper provides an overview of the models of mental health supported accommodation that are needed across any locality to meet the needs of the local population. It also sets out what the competencies and capabilities that providers should be able to evidence that they are delivering to provide care in the least restrictive environment, to enable people to live better lives and achieve their recovery goals. If these principles were embedded across a local system this would deliver better outcomes and deliver significant cost savings.

ⁱ Killaspy and Priebe, BJPsych, 2020

ⁱⁱ Molyneux P, Mental Health and Housing a Review 2021.

ⁱⁱⁱ Richter and Hoffman, Adm Policy Ment Health 2017

^{iv} Holley et al Psychiatric Services 1995

^v Killaspy H Supported accommodation for people with mental health problems: the QuEST research programme with feasibility RCT. 2019.

^{vi} NICE CG181 - Rehabilitation for Adults with Complex Psychosis