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Greater London Authority Mental Health Specialist and Supported Housing Research

Lived Experience Consultation: Findings Report

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Report by Groundswell & Becky Rice

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1 Summary

This report is based on the Lived Experience consultation conducted by Groundswell and Becky Rice as part of the wider Greater London Authority (GLA) Mental Health Specialist and Supported Housing: Research & Market Development Project. This output is intended to provide themes from the consultation undertaken with staff and residents at services rather than being a self-contained research report - it should be read in conjunction with other published outputs from the project.

1.1 Introduction

- The lived experience consultation ensures the voices of those living in mental health supported housing are integral to the overall research project.
- The emphasis of this report is feedback from those living in supported housing, as staff feedback is considered in other parts of the project.
- The main methods used were face-to-face semi-structured interviews and a focus group with people living in supported housing. 31 people participated in these as well as two people who had moved on from supported housing into independent tenancies. This was preceded by 17 interviews with staff with operational responsibility for supported housing services. There were significant limitations to the consultation which are explained in the Introduction and methods chapter of this report.
- The research focused on people's experience of their accommodation and their views on supported housing. A wide range of locations and type of accommodation were covered across the visits, for example, high support needs services, a dedicated forensic service, semi-independent flats and a women's service.
- While individual data about people's mental health was not gathered in interviews, those living in the services attended generally had Severe Mental Illnesses (SMI) significantly impacting their lives; many had spent long periods in inpatient care. .

1.2 Findings from people living in supported housing

1.2.1 The overall role of supported housing

> *"The best thing is the element of freedom but knowing you have the support if you need it. Freedom and privacy so it's not smothering - the best of both worlds."*

- Residents described the overall role of supported housing as providing a combination of independence and support. Supported housing was often described very positively in contrast to previous settings, usually hospitals. Some people spoke in terms of recovery and progression, but others focused on managing as well as possible in their current situation.
- Most people preferred self-contained flats because of the sense of independence they provided, though (very) low ratio sharing could benefit some people. Large, multi-purpose communal spaces were felt to be important in higher support needs services but less important in independent settings.
- Some facilitators to achieving this valued sense of independence and support included positive risk taking, reducing rules and providing caring, flexible, and personalised approaches to support. Activities programmes, opportunities for choice and encouragement for people to act in line with their own preferences also contributed.

- Although supported housing was seen as more supportive than independent living, many people, especially those without close local family networks, still felt isolated and lonely.
- Several people said that living in accommodation with others who were experiencing mental health problems was conducive to a supportive environment; but for those ready and planning to move on, this could be detrimental.
- The amount of choice and control people had over their own living spaces varied. Some spaces were like any other home while others felt more restricted. Generally, people appreciated the freedom to personalise their spaces.
- Interviewees often reported that living in mental health supported housing had prevented returns to hospital, risk of continued or escalating exploitation and bullying, and signs of escalating need or crisis going unnoticed. These outcomes were achieved through the daily contact and care provided by support staff, in some cases including assisting with medication and promptly addressing escalating need.
- A small number of people described having previously lived in services with poor quality support, which had resulted in a deterioration of their mental health. Examples of poor-quality support include a sense of staff not being very available and, in one case, feeling that that staff are laughing at clients.

1.2.2 A home within a home

> *"My room is basically like a studio flat... only for me to use. No one is coming to my room to share my bathroom, no one is going to share my kitchen. Everything is for me to use for myself, so that's what makes it amazing."*

- Most services attended had around 15 spaces. People compared this favourably with larger, more institutional settings, such as some homelessness hostels and hospitals. Most services had some form of reception and office, which fostered a sense of a professional staff presence. In contrast one of the services attended was a shared home for three people, with no real sense of the home being a 'service'.
- People valued having their own home within a wider supported housing project that was also homely and inviting. Generally, people found fully self-contained flats highly beneficial, though several people did not see sharing in low ratios as a problem. Factors in this were good cleaning services or support through a care package.

1.2.3 Shared spaces

> *"At the [the other] service I lived at, the communal space was never used. A lot of them look really clinical; white, beige walls and brown leather sofas – random pictures, but no books! Here there is the TV, the computer, crafts, books – staff come in here too sometimes just to eat lunch – there is not that divide between us and staff that you often have."*

- A sense of homeliness and warmth in the design of spaces was appreciated. High quality communal areas encouraged social contact for people who have social anxiety.
- Most visits were to services that providers would consider to be of high quality and were often purpose-built.

- One of the most popular activities amongst those interviewed was cooking and sharing food in shared spaces. This provided a break from eating alone and was an opportunity to get together with staff and residents.
- Where projects had a variety of spaces for different purposes, this was very helpful. Examples included a shed/garden room and smaller interview rooms in addition to communal spaces.
- Having a reasonable sized outdoor space was reported as very beneficial for wellbeing; in some cases, these are underutilised but can still provide a change of scene and an occasional barbecue. In others, they are used heavily, including for gardening activities.

1.2.4 Amenities and repair

- One provider supported a visit to a more challenging building, which was very insightful, demonstrating the critical need to improve or replace some existing projects as well as developing new services. The unsuitable structure and layout of the building and a lack of upkeep made it impossible for staff to provide a comfortable, homely environment.
- More broadly, issues with repairs and maintenance were fairly common. Usually these were fairly minor issues. More serious issues (usually described in reference to previous accommodation) could become the focus of residents' interaction with staff and could detract from the quality of support relationships.
- Maintenance handled locally tended to be more satisfactory. Complex processes or a need to escalate cases to an external organisation or the RP often led residents experiencing delays.
- People commonly reported small or broken TVs in communal areas and/or poor signals in their rooms. Good quality Wi-Fi was very important to people. Access to working shared computers was important for managing benefits and accessing email.
- Shared spaces need far more upkeep than standard accommodation, but landlords had not always taken this into account. Even in high quality accommodation, there were often weak spots, or it was clear that more upkeep would be beneficial.

1.2.5 Activities

> *"I like that there is a scheduled… plan for the week, every week... A couple of weeks ago, during the summertime, there was a trip to the zoo. And that was good, because I actually met some of other people from [other services], and got to meet someone new as well … made a friend. And … I think the music has been also really fun."*

- For those in staffed projects, offers of activities were central to people's perceptions of the service. There was wide variation, but most services had a programme of activities for people to take part in. In the services that received the most positive feedback, people were very proactively encouraged to undertake activities and, in one service, to volunteer in the community.
- Participants in several services felt there had been a decline in the provision of trips and activities since the Covid-19 pandemic. People also reported that activities and trips were often cancelled without explanation, but, when they did happen, they were enjoyable and energising. It was important that staff avoided cancelling planned activities, as this left people feeling disappointed and less motivated to engage.

- One-to-one walks and visits to coffee shops were described as a good way of building relationships and encouraging people to get outside into a different environment.
- Participants across the projects visited undertook a wide range of self-directed activities, and it was helpful for staff to encourage and acknowledge this. Many other people, however, relied on support services more to ensure they were active. In some cases, people did not spend much time being active or participating in structured activities.

1.2.6 Move on

> *"It depends on every person. You can't say two years. Some people go back to hospital. I don't want to go back. …The two years hangs over you even if you are not ready. I didn't take two years to get that bad; it's not going to be two years to fix me."*

- Most supported housing is commissioned for shorter term stays (most commonly two years). Some people had been living in supported housing services for many years – seven to ten years was not uncommon – in some cases preceded by long hospital stays, unsettled accommodation or homelessness. Some had never experienced independent living. Unrealistic expectations of short-term 'progression' therefore created tension for some residents.
- Move on was a difficult area to explore, with people feeling worried about having to move on before they were ready. For those ready to move on, long waits and a lack of choice could be frustrating.
- The main move-on challenges people anticipated were isolation and lack of support.
- Two participants had moved on from supported housing many years ago, after very long periods in hospital and supported housing. They were managing well, with daily visiting social care packages and support from a voluntary sector mental health service, which included a weekly lunch club.

1.2.7 Beyond the project: mental health services and social networks

- People reported limited contact with mental health services. Some participants felt the views of external clinicians were sometimes given undue primacy over those of supported housing staff. Supported housing staff have a unique perspective as they see residents so regularly.
- Some people reported frequent changes in Care Coordinators and some delays or a lack of input in progressing the things they needed. One person said they felt fatigued by having to repeat their story each time their Care Coordinator changed.
- A small but significant number of participants had a lot of contact with family members, usually parents – particularly mothers – but also siblings in some cases. In these cases, it was often helpful for them to be involved in the person's accommodation and care.

1.3 Findings from staff

1.3.1 Aims of mental health supported housing

- There was a strong emphasis on supporting residents to become more independent and lead active lives.

- At first, the question of 'what you are trying to achieve?' was often answered in terms of independence, progression and move-on, but further feedback highlighted a deeper level at which staff were more engaged with people's welfare, quality of life and relationships than move-on planning.
- The aim for many teams is to create projects that 'feel like home', which help residents move on from institutional experiences. Managers described the importance of an 'open door policy' and 'reducing physical barriers'.
- Services commonly aimed to prevent hospital admissions by supporting (or, in some cases, ensuring) compliance with medication and by maintaining daily contact to spot deterioration in mental health.
- Having a fairly settled, high quality staff team was essential to support this work, but low salaries and the pressures of the work meant that workforce issues were common.

1.3.2 Standards of accommodation

- There was a view that self-contained accommodation was the best option for most people. There was some feedback to challenge this though, with some advocating low ratio sharing within the overall mix of accommodation, due to concerns of social isolation.
- Where people shared in higher ratios or in buildings not suitable for the level and type of use, it caused tension and sometimes conflict. Where people had complex needs, including substance use, sharing was not a favourable model.
- There was generally poor feedback on older houses that had been converted into supported housing. Most of the services attended during the research were reasonable, but this was by no means always the case. Providers struggled with supporting people when accommodation was unsuitable, impacting residents and staff wellbeing and retention. Some RP landlords reportedly considered the poor repair of buildings a low priority.
- Move-on was a huge challenge for most of the services included in the consultation. Issues included a gap between longer term supported housing options and the provision of care and support services for people with complex health needs. As expected, there was also a serious lack of 'general needs' move-on accommodation.

1.3.3 Working with mental health services

- The effectiveness of working relationships between support providers and mental health services varied substantially. Some services struggled to get the support and input they needed. Some felt sometimes carried an unreasonable level of risk without enough external support, for example with hoarding and unacceptable behaviour towards staff.
- Most reported that it is easier to get the right input if the client has a Care Coordinator. Turnover and the pressure on Care Coordinators was cited as a barrier to getting input.
- Prematurely discharging people to GP care was felt to be risky and could impede quick support at times of crisis.
- Decisions, including whether to discharge cases to GPs and sustaining placements following incidents, were felt to be made by clinicians; not enough weight was given to the skills of support staff, especially in light of their unique perspective through daily contact and observation.
- At the forensic high support service attended, the involvement of social services was more consistent than at some other services. For example, move-in is planned and coordinated, and there is a rapid response to potential crises.

1.4 Recommendations from the lived experience consultation

1.4.1 Services and pathways should be designed to:

- Create a sense of independence plus support. Provide privacy and self-contained accommodation in most cases, but with some shared options.
- Provide a diverse range of services for different levels of required support, including those who might need care and support as their health needs become more complex.
- As an alternative to traditional models, consider semi-independent or independent accommodation, even when people need their medication monitored.
- Enable personalised services within minimised rules and restrictions, in which staff constantly seek ways to promote choice and control, proactively building on residents' interests and skills.
- Enable residents to personalise their private space and input into the decoration and use of communal areas.
- Address the tensions between short-term support models and the ongoing needs of many residents. For example, provide more upfront flexibility in how long people can stay in services, with realistic planning supported by external colleagues in mental health services.
- Create homely and inviting spaces that do not feel institutional. In higher support services, Including include bright, comfortable and spacious communal areas with multiple functions. Ensure that TVs and Wi-Fi are maintained and are of a high standard and appropriate for usage levels.
- Ensure that landlords and RPs regularly refresh and update premises, including internal decoration and flooring.
- Incorporate multiple spaces for working with clients, including communal areas and private meeting spaces. Create outside spaces that are well maintained and attractive.
- Provide an ongoing schedule of activities with input from residents. Promote social contact with staff and other residents for those who are isolated and struggle to connect with others.

1.4.2 External mental health colleagues should:

- Respond to concerns raised by supported housing providers.
- Respect the skills and experience of supported housing staff and the unique insights gained from daily contact with residents.
- Recognise supported housing services for their preventative outcomes as well as being short term progression-based services. Provide flexibility for staff to go offsite with residents.

1.4.3 In addition, GLA should:

- Consider ways to support the improvement of existing stock as well as investing in new services.

2 Introduction and methods

2.1 Introduction

The lived experience strand of the project is to ensure the voices of those living and working day-to-day in mental health supported housing are central to the findings.

The aims were:

- To consult with people who live in mental health (MH) supported housing, so their experiences are central to the overall project.
- To gather feedback from people who work in or manage mental health supported housing services operationally.
- To ensure future projects influenced by the research are informed in a small way by recent lived experience.

2.2 Methods

The Research Team at Groundswell partnered with Becky Rice, an independent researcher, to deliver the research.

The main method was qualitative, semi-structured interviews with people living in mental health supported housing. This was preceded by interviews with project managers to get their perspectives and to discuss the best approach for arranging fieldwork.

Staff were asked about how visits to services would work best and whether one-to-one interviews or group discussions were preferred. In one case, the service manager felt that standard research approaches would not work for clients living in a shared house, so an informal house visit was arranged with careful consideration of how to ensure that informed consent was obtained.

The best forums to engage with residents varied, and included attending a health and well-being day, a coffee morning and a lunch club.

Some interviews were recorded. Detailed notes were made during others. The team also noted their own observations from visits. The research team discussed the findings as the work progressed through debrief meetings after fieldwork visits. Themes were taken from these discussions as well as from a review of transcripts and notes.

2.2.1 Research Tools

Topic guides were designed by the team with input from the wider IBA team. The Information and Privacy Notice and Consent forms for the project overall was used for the lived experience consultation. The topic guide was adapted after initial fieldwork visits to ensure it was accessible for all those participating.

2.2.2 Sampling

A purposive sampling approach was used based on the mapping undertaken by other parts of the IBA team and through existing contacts with providers. The sampling approach was to include a

broad range of services in terms of service type (step down, 24/7 staffing and semi-independent), size of service, and location.

2.2.3 Fieldwork

In total, between September and early October, 33 people currently living in supported housing participated in the research. Most took part in one-to-one interviews, while three joined a focus group and two participated in an informal visit. A very flexible approach was adopted.

The way in which people engaged with questions, and the level of feedback given, varied widely. This ranged from providing a small amount of feedback about current experiences to feedback about mental health and supported housing systems overall. The researchers sought to value all feedback and take a lead from participants' answers in terms of pace and the type of questions asked. For example, discomfort with talking about move-on was noted and the conversation was moved on.

Online and face-to-face interviews were undertaken with 17 staff – largely team leaders, managers and area managers. In addition, researchers had many useful, informal conversations with project staff during fieldwork visits.

The profile of participants who currently live in mental health supported housing represent the following:

- Six organisations: Peabody, Riverside, SHP, St Martin of Tours, Look Ahead and Evolve.
- 11 London local authority areas.
- Four ICB areas.
- Forensic services, high support need services, 24/7 staffed services, semi-independent services and a supported house share.

Some features of the participant profile:

- It was common for people to have lived in the area they were resident in for many years, sometimes all their lives. Many were in regular contact with family members. In some cases, a parent provided very active support.
- People had usually spent time in hospital, often for long periods. Many were subject to community treatment orders.

2.2.4 Challenges in the fieldwork

Some participants were significantly affected by severe mental illness (SMI). This impacted on the research fieldwork.

Challenges included:

- There were at least three people who decided to take part in interviews but were unable to proceed due to their mental health.
- Despite efforts to make the research accessible and to adapt to varying ways in which people were able to – or wanted to – communicate, the sample was biased towards people comfortable sitting with a stranger and answering questions. In some projects, researchers found that this would be impossible for many residents. Coproduction work on mental health needs a more creative and longitudinal approach than this small-scale consultation allowed. While reaching those currently living in supported housing was vital to the research

– and we support the voices of those we spoke to here – the limitations should be recognised.

- One participant withdrew consent at the end of their participation. The researcher ensured they were able to see that all their comments had been removed from the notes.
- One interview was terminated as the researcher felt the consent process had not been understood and was concerned about informed consent.
- Not all interviews with managers lead to fieldwork visits. Barriers included the time pressures on services, and in one service, fieldwork shifts being cancelled due to a client being unwell.
- The fieldwork lead-in time was longer than would have been ideal given the time pressure on the project; securing visits with services generally took two to four weeks after initial contact.
- The 'conversion rate' of leads for research to fieldwork shifts was not as high as expected. Where an organisation agreed to take part and assist with the consultation, it tended to result in one – or sometimes two – services attended rather than the two or three anticipated. The lead-in and preparation time reflects the needs of residents and care of staff when providing access. The team were grateful to be welcomed to the services they attended.

In many cases, researchers felt the Information and Privacy Notice and the consent form were very problematic, with participants not engaging or barely understanding the consent process. Where this was an issue, researchers explained the research as clearly as possible using formal tools and verbal explanations.

The research was limited in terms of the depth of feedback it was possible to obtain from some participants. This research suggests that a research and consultation approach is helpful to quickly incorporate lived experienced into a project, but it has limitations. Coproduction efforts need to be twofold:

- Ongoing direct work with people about their own support and housing. Without trusting relationships and understanding, some people's views won't be heard fully.
- Developing coproduction opportunities that require more commitment for those who would like to take part. These people could be invited to take part in future opportunities.

3 Themes in consultations with people living in supported housing

3.1 The overall role of supported housing – combining independence and support

Many people had experienced long periods in hospital. Several had experienced homelessness and rough sleeping. Supported housing often represented a very positive contrast to previous settings, providing a combination of independence and support. Getting this balance right for people at different stages of their recovery requires multiple, flexible models.

> *"The best thing is the element of freedom but knowing you have the support if you need it. Freedom and privacy so it's not smothering - the best of both worlds."*

Most people preferred self-contained flats because of the sense of independence they provided, though (very) low ratio sharing could benefit some people. The required level of staffing and staff input varied. A key distinction between services is whether people are supervised by project staff or external care staff to take medication. Another key distinction is between services that are staffed 24/7 and those with minimal or no 'night cover'. In higher support needs services, large, multi-purpose communal spaces are important. In a semi-independent setting, this was sometimes felt to be less important as the structure provides something very close to fully independent living in generic housing.

> *"When I'm in a care home or hospital I have to share a room, at least when I come here, it might not be the best-looking [space], but I can choose when to be here - I can go back to my room, my own door… it's so important to have that space."*

> *"[The best thing is] the freedom and the independence that I have got. The fact that I can go out in the night as I please. The fact that I have got my own space, in my room. I have got my own kitchen, my own bathroom, my own toilet. I don't have to share no facilities with anyone. [In my previous accommodation] … you have to share bathroom and kitchen and stuff. Which I wasn't a big fan of. Because people mess up the bathroom. And the kitchen sometimes. All you want is just peace and quiet sometimes. (SM54)*

Achieving this valued sense of independence and support is facilitated by the following:

- Positive risk-taking and reducing rules, ensuring that rules are explained and make sense.
- Minimising 'barriers' between residents and staff – caring, flexible, personalised approaches to support.
- Ongoing efforts to maintain and promote activities programmes, aiding a more active life and recovery.
- Constantly looking for opportunities to create choice and encourage people in line with their own preferences – even where people have very little choice. This includes compliance with medication for forensic placements, where people may be recalled to hospital if they do not comply.
- Diverse staff teams in terms of age, including those with lived experience.

> *"So sometimes you get to go to the park with [a staff member], you get to go for a coffee or something like that. And it's like… you can talk to them and stuff. There is always someone around. So you can chat to someone and I feel like that is very important to always being able to talk to anyone or something like that." SM1*

Some barriers to creating a sense of independence with support were:

- Rules that restrict people having visitors or those that feel unnecessary or are poorly explained. The theme of not being allowed visitors was common in the research and was a factor that motivated people to move on to independent living. Some services do welcome guests.
- Some services do not constantly promote interaction and activity for people. Staff moving around services, using spaces and interacting was more helpful than being 'deskbound'. Several people reported feeling very isolated, and felt that other people had friends and social contact but that they were struggling and needed more help to achieve this.

> *"I don't like that you are in the community but not. So for example you are not allowed any alcohol in your room. I know it's cos some are going through rehab. But I could go to a pub and come back smelling of alcohol. I can't get a Chinese and sit and watch TV with a beer on a Friday night."*

While living in supported housing was viewed as being more supportive than living independently, there was still a strong theme of people feeling isolated and lonely, especially those without close, local family networks. Some people felt that they would like more proactive help to connect with others. Where staff were able to take people away from the building, and/or help people pursue interests, this could help alleviate loneliness. Some projects had a stronger sense of community than others. The nature of the physical environment was a factor in this (see section below).

> *"I just have these moments when I am really lonely and stuff. I would rather spend [time] out in the garden [than in my room] and know more of the community. Because if I spend in my room I am just going to be more and more depressed, or alone with no one to talk to."*

3.2 Choice and control within the home

The level of choice and control was often limited by the rules or needs of project and, for some, medication compliance requirements. There was a strong theme around people finding rules restrictive and not really understanding why they were in place. One participant felt there should be a more flexible and dynamic approach to risk assessment. He also felt there was a need to shift from a 'why can't we?' to a 'how can we?' approach (this was in the context of feeling positive towards staff overall). In contrast, a participant in another service reported that staff had encouraged positive risk-taking and had taken chances on opportunities that stretched her.

There was variation in the amount of choice and control people had over their own living spaces, ranging from spaces that were like any other home to those in which people felt more restricted. A practical example of this is one project where furniture has to be sourced from approved suppliers compared to another where someone was looking through websites with a staff member to make their own choice.

3.3 Prevention outcomes

Interviewees often reported that living in mental health supported housing had prevented:

- returns to hospital
- exploitation and bullying
- signs of escalating need or crises going unnoticed

These outcomes were achieved through the ongoing daily contact and care shown by support staff, in some cases support to take medication and to deal with any issues arising with medication quickly.

In one interview, a participant compared the time she spent in poor quality supported housing (for example, with repair and vermin cases issues) where she felt staff were 'laughing at me' with being far better supported in a semi-independent setting. In this more favourable environment, staff had been able to reduce contact with A&E, use targeted support to avert crises, support her to attend hospital when necessary, and link quickly with mental health services. Another contrasted a period in unsupported temporary accommodation at a young age when they made multiple attempts with the recovery made in a high-quality supported setting.[1]

> *"[This accommodation has] prevented me going back to hospital – I have not been into hospital for three and a half years."*

> *"I have lots of problems with health anxiety disorder. Staff support me even though I was going to A&E quite a lot. I'm going less now. They will come and calm me down. It's two weeks yesterday I last went. I was going about once a week before."*

Several people described being at risk of exploitation in their local area. Being able to speak with staff and take steps to avoid this, or just knowing someone was 'keeping an eye on them', could make them feel safer. One person was being asked for money in the café they visited, so had had to change their routine. Another reported being hassled for money when visiting a cashpoint. Another described becoming unwell after taking pills from a stranger in the street. One person explained what cuckooing was and felt that people with mental health problems could be at risk without the right support.

> *"[Compared to living on my own] I prefer to be here because of my mental health. It's a high crime area – with gangs…. I would be worried about both getting drawn in or being fearful…it keeps you out of hospital; monitoring you and keeping an eye on you."*

3.4 The physical environment

3.4.1 A community feel

Most services attended were around 15 spaces. People compared this favourably with larger, more institutional settings, such as some homelessness hostels and hospitals. Most services had some form of reception and office, which fostered a sense of a professional staff presence. By contrast,

[1] Attempts refers to suicide attempts and is presented in the words used by the participant.

one of the services attended was a shared home for three people. They had visiting support and had lived in the house for many years. They had no real sense of the home being a 'service'. The items in the home were the clients' own, sometimes with interesting backstories; some were from previous residents who had died. People had visits from social care staff to administer medication and to assist with online food shopping and cooking, while a support worker attended once a week and was available in between times.

> *"Obviously it's better to share with a small number of people. With a large number of people it's too much chaos. I lived [name of larger accommodation service] before and it was too crowded - there were ten people. People in the kitchens all the time and only two bathrooms between ten people."*

Most people liked the location of their accommodation. Some were in residential streets and some on more 'main' roads. In the latter case, people said that the busyness of the area made them feel less isolated. Several people mentioned anti-social behaviour in their local area.

3.4.2 Private space

People valued having their own home within a wider supported housing project that was also homely and inviting. Generally, people found fully self-contained flats highly beneficial. People in the shared house of three did not find sharing problematic. One person who shared both kitchen and bathroom facilities said they were happy to share as the spaces were cleaned by a cleaner regularly. Even in one facility with very high-quality self-contained provision, however, sharing a washing machine across many people was challenging and created frustration.

> *"Really good ...My room is basically like a studio flat. So I have got a bathroom and toilet in one room, with a shower. And I have also got a separate bedroom with my bed and a little kitchen area. So I have got everything in one room. Only for me to use. No one is coming to my room to share my bathroom, no one is going to share my kitchen. Everything is for me to use for myself. So that's what makes it amazing."*

3.4.3 Communal spaces

A sense of homeliness and warmth in the design of spaces was highly valued. One very high-quality communal area had been recently redecorated, which was deeply appreciated by the three residents interviewed in the project. The space encouraged someone who sometimes tended to stay in their room to spend time in a more social area. It was also cited as creating a more atmosphere that connected staff and residents.

> *"It's a good communal area for socialising, nice and vibrant and bright. It's nice watching TV here while I wait for my washing. I try and come down but sometimes I feel safer in my room."*

> *"I come down here to watch TV go on the computer and check my emails – send emails to my mum and my brother and to the council. I love it [the lounge area]."*

> *"At the [the other] service I lived at the communal space was never used. A lot of them look really clinical; white, beige walls and brown leather sofas – random pictures, but no books! Here there is the TV, the computer, crafts, books – staff*

> *come in here too sometimes just to eat lunch – there is not that divide between us and staff that you often have."*

This contrasted with researcher observations at a project in a very challenging building where the staff team struggled to create a pleasant environment due to the unsuitable structure and layout of the building and a lack of upkeep. In this project the shared spaces looked uninviting and sad; there were no pictures and the furnishings were old and stained. The environment was reminiscent of a run-down hostel or a poorly maintained temporary accommodation property. In a project that was more average (not the most up to date but not of poor quality), someone commented:

> *"Yes, the computer needs updating. The TV needs updating. And I think the sofas could do with a change as well. The sofas aren't comfortable at all. There is no cushions or anything. It's very cold when you sit on it. That's why I have to wear a jacket because it's very cold. There is no cushions. It's not comfortable at all."*

One of the most popular activities amongst those interviewed was cooking and sharing food in shared spaces. This provided a break from eating alone and an opportunity to get together with staff and other residents. Most larger communal areas had reasonable cooking facilities though, in some cases, people felt they could be further enhanced.

3.4.4 Multiple spaces

Residents found projects with a variety of spaces for different purposes very helpful. For example, in one service, a building in the garden was helpful for providing a change of scene and for facilitating guest visits. In another project, the only private office space was viewed as a 'medication room', making it less inviting for other private meetings.

> *"We have got a little shed as well. When you have got a meeting going on, you can sit in there and talk with them. When you've got family over, you can have a chat with them in there." (SM4)*

3.4.5 Technology

It was very common for people to report small or broken TVs in communal areas and/or poor signals in their rooms. In some services, people watched TV together quite a lot, so a good standard of TV is beneficial. Good quality Wi-Fi was very important to people, and access to working shared computers was also important for managing benefits and access to email.

> *"And also we have told them about the computer here – it's not really working properly either. The computer is like, it's an apple mac computer. But it's never worked properly."*

In the focus group, people were asked what they would invest money in at the service if they were given a budget. One person said they would invest in handheld tablets so staff could record key data like medication being taken 'on the spot', rather than having to note things down and enter this on the computer later. This would free up time for more useful work and increased interactions with residents.

3.4.6 Maintenance and repairs

Some people had issues with repairs and maintenance within their homes or had unclear responses to issues raised with accommodation. For example, someone only had a bath and would have liked a shower attachment. Issues with lighting and hot water were also mentioned.

Broadly speaking, maintenance that was handled locally tended to be more satisfactory. Where there were more processes to go through or cases had to be escalated to an external organisation or the RP, people experienced delays.

Issues within people's flats or rooms distracted from more valuable ways to spend case work and could negatively impact wellbeing. An example of this was someone who became very distressed about an infestation in their previous supported housing which led to a decline in their mental health.

Shared spaces need far more upkeep than standard accommodation, but this is not always taken into account by landlords. Even in high quality accommodation, there were often weak spots, or it was clear that more upkeep would be beneficial. In one project, a serious issue with the building had restricted access to a communal area for a sustained period.

3.4.7 Outside space

People found gardens in projects helpful for their wellbeing. One person commented that without this they would 'feel trapped'. In some cases, this was just an extra space for a barbecue and to smoke in but, in others, outside spaces were used more for gardening and spending time enjoying the fresh air, watching birds, and simply sitting. Gardens with interesting seating and landscaping were less common but appreciated when they were available. Participants at the women's project placed particular importance on the outside space.

3.5 Activities

For those in staffed projects, offers of activities were central to perceptions of the service. In the service that received the most positive feedback in this area, people were very proactively encouraged to undertake a physical activity and to volunteer in the community.

> *"It's very good they take us to badminton, the cinema, bowling. We have a meeting once a month to decide what to do and also have active minds – which is tennis, badminton, yoga…"*

Participants in several services felt there had been a decline in the provision of trips and activities since the Covid-19 pandemic. People also reported that activities and trips were often cancelled without explanation but, when they did happen, they were enjoyable and energising.

> *"Not so much as we used to. We don't have the day trips and the breaks we used to have pre Covid. Day trips to the coast. Mid-week breaks to camping sites. We're meant to have a movie night but that doesn't seem to take place." SM*

> *"I like that there is a scheduled… plan for the week, every week... A couple of weeks ago, during the summertime, there was a trip to the zoo. And that was good. Because I actually met some of other people from other [services]. And got*

> *to meet someone new as well… made a friend. We were planning to go to the beach, but we didn't go. And… I think the music has been also really fun." SM5*

People described how important it is for staff to stick to plans made with people as cancellations can be disappointing and leave people less motivated to engage with activities.

> *"Sometimes someone will say 'I'll take you out tomorrow' and then they can't be bothered or can't do it. Even if it's just to the park, you have made that commitment and someone might be really looking forward to it – buzzing about it!"*

> *"Cooking group is my favourite thing. Sometimes it doesn't happen [due to issues accessing a staff credit card]…it's very disappointing. I cook for myself but I don't have enough money for a lot of [different ingredients]. And it's nice to take a break [from cooking alone]"*

One-to-one walks and visits to coffee shops were described as a good way of encouraging people to get outside to a different environment and to build relationships. One person described how she would go to the park and use the outdoor gym with a staff member. This was quite common but was not possible in all projects due to staffing levels.

Participants across projects visited undertook a wide range of self-directed activities and it was helpful for them to be encouraged and recognised by staff for this. One person was working 16 hours a week. Three people had recent achievements in higher education. Many other people however relied on support services more to ensure they were active. In some cases, people didn't spend much time being active or undertaking structured activities. One person had not left their accommodation for a very long time.

3.6 Move on

Overall themes in discussing move on were:

- It was a difficult area to explore with some people feeling worried about having to move on before they were ready.
- There was a disconnect between what's realistic, what people are told initially, and the length of time people end up staying in supported accommodation.
- For those who are ready to move on, long waits and a lack of choice can be frustrating. This leaves people trapped out of work as rents are so high in supported housing but are covered by benefits when people are not working.

> *"I am not the person I was... It will be a loss when I leave but little things are starting to get to me now. I really want to get back to work but while I am here I can't afford the rent. It's leaving a bitter taste in my mouth – I am a bed blocker now!"*

People had often been living in supported housing services for many years (7-10 years was not uncommon) and this was sometimes preceded by long hospital stays or unsettled accommodation or homelessness. Most supported housing is intended for shorter term stays (most commonly two years) when it is commissioned. This means there is a tension between the sense of a service being intended for short-term 'progression' and the situation of some residents. For some the idea of move on was scary and upsetting.

> *"It depends on every person. You can't say two years. Some people go back to hospital. I don't want to go back. This type of housing does (prevent a return to hospital)…If I was in my own house it's more pressure…The two years hangs over you even if you are not really. I didn't take two years to get that bad it's not going to be two years to fix me."*

In one service the researcher observed that the move-on/more independent accommodation was viewed by clients as the 'holy grail' and something that is a 'good' achievement for people. But for some people it's quite unlikely that they will move to the more independent option in the near future.

> *"Ideally I would love to move to a council flat. But I think that's not really realistic because of my behaviour. So basically, what I have got to do now is I have got to show them I am able to live by myself. I want to show them there will be no concerns when I am in the community by myself. So I have got to start taking my medication properly, make sure my room is always clean."*

The main challenges people anticipate when moving on are isolation and lack of support.

> *"If you are living alone and let's say you are not working, and all your friends are working, they got jobs, they got girlfriends, they have got busy lifestyle, they might not always have time to check up on you. And you are going to be there in your one-bedroom flat and sat just watching TV the whole day and that might… you might relapse in your mental health so that's what I am scared of… leaving like too soon."*

For the two interviewees who had moved on (many years ago) a strong support network including the local community-based mental health service, alongside a care package, was proving effective. Another person from the same area was due to move on soon.

> *"I am on the housing list now, I don't bid - I will be allocated a place... I will miss the company, I will be alone. But I will get a couple of visits a day (for medication and support) … I will need help with budgeting… I was only meant to be here a while but have been here [10+] years."*

3.7 Working with external services and social networks

People reported limited contact with mental health services. Most had periodic reviews of medication and had Care Coordinators, while others had had their care discharged to a GP. Some participants felt that the views of external clinicians were sometimes given undue primacy over those of supported housing staff or residents who saw them on a more regular basis. Two contrasting examples:

- A sense that project staff (and residents) do not have enough say over who can live or remain at a project when there have been issues or incidents.
- Someone who felt that his wellbeing was very poor on his current medication but was being told he must continue with this as there had been a marked reduction in his ASB.

Some people reported frequent changes in Care Coordinators and some delays in progressing the things they needed or a lack of input. One person said they felt fatigued with several changes of Care Coordinator and telling their story again each time they met with someone new.

> *"[My freedom pass] expired …That's one thing that I really want. Certain things like freedom pass, [my Care Coordinator] could apply for it on my behalf. She could help a lot of that. And she could check up on me how I am doing, how my new place is going and I don't feel like she is doing any of that. The plans going forward, the stages, and like what's happening and all that other life stuff."*

> *"Every three months, they change so I try not to get too close to them. It does it's very annoying. Because you just get to know them, and then they are gone. And you have got to start all over again, the same thing."*

A significant minority of participants had a lot of contact with family members, usually parents and particularly mothers, but also siblings in some cases. Where this was the case, it was often helpful for them to be involved in the persons accommodation and care.

> *"[My current Care Coordinator] won't come to my mum's house. She says it's confidential. So I say well why have the other four Care Coordinators all come to my mums to visit me?"*

> *"You have to sleep here but weekends I go to my mum's. I go every day to stay – I am allowed two days."*

> *"When my mum came here for the first time she said 'it feels like home' … She never slept well before [when I was in other accommodation]. It's how staff are with not just me but my family and friends too…"*

Jennifer lives in a self-contained flat in a low – medium support needs project in East London.

"At this stage I don't need as much support, but staff are still here for me. It's really nice. I have been locked up since I was in my early teens – and I've been out 10 years.

When you first get out its really hard – it's tempting, drugs and alcohol, to turn back to behaviours - but you overcome that. 10 years…it feels amazing.

I didn't take my medication for two days. I ended up in A&E with [staff member] – she was really helpful. She didn't leave me until I was in the cab back. [She] made me an appointment to go and see my psychiatrist.

I feel safe and secure. I need another year or two… I am getting better but I've not found my feet yet. I have got a routine, comforts and people who care. I have worked so hard and I'm happy."

4 Themes from staff interviews

4.1 Aims of mental health supported housing

There was a strong emphasis on supporting residents to become more independent and lead active lives. Trying to identify personal interests and creating flexibility when inviting for engagement were ideal. Some services where resources and space are more limited were constrained in the range of activities and opportunities they could offer. Providing opportunities to eat and cook together such as BBQs or cooking activities were commonly felt to attract engagement.

> *"We try and give people as much independence as possible and encourage them to try and achieve it. They can do that even though they are on medication... Everyone has interest so it's finding that - some things can't be done but where we can we do. We've done everything from art class, knitting, cooking, we used to bring people to the cinema, we have a lunch club which is part of our day programme set up so that people will have one hot meal a week [for anyone in the borough not just residents at the houses]."*

> *"The way I manage the service is different to when it was opened ten years ago – it was the first forensic service, and we could search bags, go into flats without saying anything. But that's not how it works, it works culturally now. We know more about housing law too! Argument now is if you get the customers to trust you then you get better outcomes. Them being able to put up shelves and paint their flats for example."*

At first the question of 'what you are trying to achieve' was often answered in terms of independence, progression and move on, but further feedback highlighted that at a deeper level staff are more engaged about people's welfare, quality of life and relationships than move on planning. Whether or not someone is in recovery or progressing (or even moving backwards towards possible admission), the aim is to do the best for each person. Having fairly settled, high quality staff teams is essential to support this work.

Preventing hospital admissions was a common goal of services through supporting (or in some cases ensuring) compliance with medication and maintaining daily contact to spot deterioration in people's mental health. Services often commented that they are able to reserve a person's space if they are in hospital for a limited period (several months to a year). Two high support services said they visit people when they are in hospital, and this was felt to be very beneficial in terms of fostering relationships with the hospital teams as well as for the client.

> *"We very closely monitor medication; it keeps people out of hospital. We try to help them live as fulfilling lives as possible. The goal would be to move on to some sort of independence but the reality is that … it's unlikely [some people] will live independently. We were under that pressure [to move people on]…"*

> *"The outcome ideally is that we want them to move out in their own accommodation and able to manage their mental health and not reoffending, that's our extraordinary goal but the reality is it doesn't always work out that way."*

4.2 Buildings

4.2.1 Self-contained versus shared facilities

There was a was a view that self-contained accommodation was the best option for most people. There was some feedback to challenge this though. Low ratio sharing both within supported housing projects and through the shared house scheme visited were felt to have advantages. There was also a wider theme of concern around social isolation and this exacerbating mental health problems. One project manager in a high-quality building with some shared flats (with two people in) felt there could be benefits to this.

> *"Some shared kitchen and bathroom – our assessment process is very good. In just over a year we had one breakdown of a friendship within a flat but usually a good healthy conversation can address issues. Some people thrive on having someone next door but for some people their MH means it's better to be alone. But – it's very important to have a communal space."*

Where people share in higher ratios or in not suitable for the level and type of use accommodation, it causes tension and sometimes conflict.

> *"Where people get flash points is when they share facilities or because someone is leaving the bathroom untidy and unclean, people are bickering about that. As a human myself I would find it challenging sharing an environment or living space with someone I have not met before. Different challenges."*

4.2.2 Architecture and design

There was generally poor feedback on older houses which had been converted into supported housing. One project was a very old, converted building but was of a high quality - it had been radically altered and had not previously been a private dwelling. Most of the services attended during the research were in reasonable or high-quality accommodation in purpose-built settings – some in 'flagship' services. However, it is important to note that this is by no means always the case and it's not uncommon for providers to struggle supporting people in unsuitable accommodation, which impacts residents and also affects staff well-being and retention. Buildings in poor repair were reported to be a low priority for RP landlords.

> *"Clients and staff working in that environment. It just goes on and on. It's unbelievable really. It's good to bring light to it [through the research]".*

> *"We get referrals sometimes but due to state of building people turn them down… unfortunately the buildings we operate from are not purpose built for some of the roles they have – cramped spaces, steep stairwells, and some of the rooms are not that big...That's why when I heard about capital funding for MH I was very interested and wanted to know more - I think there is a need to improve our facilities."*

The aim for many teams is to create projects that 'feel like home' which help people move on from institutional experiences. Having an 'open door policy' and 'reducing physical barriers' were concepts mentioned by managers.

"This is their home. We come into their home to work. People are in hospital, it's very secure, there are a lot of rules; people have grown out of that, they are in a better space. There needs to be an environment that doesn't remind you of that (hospital setting). What I appreciate about [this space] is that it doesn't look like a hostel, it helps people come and feel settled. We have cooking workshops, customer meetings. In some projects you have reception with the Perspex – it's a barrier. In some places it's appropriate but they are still barriers - here it's more homely."

4.3 Move on

Move on was a huge challenge for most of the services included in the consultation.
Issues were:

- For some residents the aim was move on to independent living, but some staff felt there was a gap in terms of either being able to offer supported options for longer or for some moving to care and support provision.
- There was some tension between the idea of pathways which have very low volumes at some 'stages' as people get stuck and/or spaces are not often freed up for people to move through.
- 'On paper' move on targets in commissioning agreements often remain the same (typically two years) but the reality is often that commissioners simply know this is not realistic and work more flexibly. Some people who have moved into supported housing after decades of institutional life were sometimes felt to be unlikely to move into independent settings.
- Staff report gaps in services for people with complex needs and those where physical health needs are escalating. This includes people who have a forensic history and/or substance misuse who are felt to be poorly catered for in terms of onward care provision.

"Move on is our biggest obstacle. We did have… [a specific] resettlement officer to resettle our residents but they left and were never replaced and now we are stuck. The longest time someone is here at the moment is 7 years."

"For some of them we can no longer meet needs as they are so old, [they have problems] largely related to age not mental health; a few people die in an undignified way as we can't meet the needs, and we don't have right of access [to assist them]."

4.4 Working with mental health services

The effectiveness of working relationships between support providers and mental health services was very varied across different areas – and sometimes even within the same area according to individual clinicians. Some services reported struggling to get the support and input they needed.

Most reported that it is easier to get the right input if the client has a Care Coordinator. Turnover and the pressure on Care Coordinators was cited as a barrier to getting input. Prematurely discharging people to GP care was felt to be risky and impedes quick support at times of crisis as people had to be referred back into specialist mental health provision. Decisions such as discharging cases to GPs were felt to be made by clinicians without giving enough weight to the role

of housing support workers. There is felt to be a sense of professional hierarchy which does not fully appreciate the skills of support staff and their unique perspective resulting from daily contact and observation.

> *"Unfortunately we are not being considered or the relevance of our role is being diminished. We are not seen as that significant in the conversation about whether someone can be closed [discharged to GP]"*

> *"Just because someone has been stable they have been discharged to GP - they say 'yes we can fast track you' back but there is no fast track; that is a frustration as the person is deteriorating further."*

The ways in which people's mental health will fluctuate on leaving hospital are unpredictable and services sometimes feel they are left carrying a high level of risk when things deteriorate for someone post discharge, but not to the point of a return to hospital. Services feel they are 'left holding the baby' with issues such as hoarding - a serious housing management and H&S issue but not one that would result in a hospital stay.

> *"When you have a really good Care Coordinator it makes a lot of difference. We only make contact if something is not working so we need someone to respond and take action. Maybe it's because of caseloads or people are stretched but sometimes our concerns are not prioritised and sometimes it's out of their hands. Most hospital admission is based on risk; if you are not aggressive and confrontational it's a case of seeing how it plays out and that's not always a comfortable watch when someone is non-compliant [with medication]… it's really sad."*

> *"The moment someone is accepted into the accommodation there is disengagement; the level of communication and coordination decreases significantly….Banging against a wall to get the support before crisis spirals out of control."*

With the forensic high support service, the involvement of social services is more consistent with each part of the process planned and coordinated and a rapid response to potential crisis.

> *"We specifically have the forensic team working with us…They are incredible, they are very responsible - very tight relationships with them. They will do clinics from the service. This is where we are different – no, we don't get left with people [due to close working relationships and MH team attending the service]. I wish we could do this for all of the [MH supported] accommodation."*

4.5 Working in supported housing

Interviewees (staff and residents) were asked about the characteristics needed to work effectively in mental health supported housing settings. Examples given were being caring, curious and empathic. A quality that came through in the research is being flexible but also persistent in encouraging people who are often demotivated and/or findings that medication side effects make it harder to remain active. The workforce is often very experienced in terms of the years and breadth of experience people have. For example, staff interviewed included someone who had

been working in mental health supported housing for 19 years, and another who has worked across a range of types of supported housing including young people, LD and mental health over many years.

> *"Really good team member – empathy and care and I think it makes difference. Understanding that this place, as nice as it can be, it's not the place people want to be if they have a choice. It is having the curiosity – to ask what the person is up to. If they say they haven't had good night asking why is that, or saying I have noticed that this week you have hung out a lot here but you used to go to your mum each day or what music are you listening to?"*

The role of support workers is challenging. In some services staff do not always feel safe and this impacts on how clients feel too.

> *"It is tough work especially around customers with personality disorder. Front line you get a lot of emotional and verbal abuse. It's not the resident's fault - if they could do it in another way they would."*

Recruitment and retention are an ongoing challenge especially where the resources provided to a project and the environment are poor. Some people felt that burnout is a risk and there needs to be turnover in the workforce.