Abstract

Background De-institutionalization has led to the provision of various forms of housing with or without support for people with mental illness in the community. In this paper, we review the conceptual issues related to the provision of supported housing schemes, the characteristics of residents, research methods and outcomes, and the factors influencing the quality of care provided. Methods A Medline and hand search of published literature was complemented by information derived from contacting expert researchers in the field. Findings There is considerable diversity of models of supported housing and inconsistent use of terminology to describe them. This makes it difficult to compare schemes, processes, and outcomes. Patients in supported housing are characterized by deficits in self-care and general functioning, whilst behavioral problems such as violence, drug abuse and extreme antisocial habits predict exclusion from supported housing. Most evaluative studies are merely descriptive. In terms of outcomes, it seems that functioning can improve, social integration can be facilitated, and residents are generally more satisfied in supported housing compared with conventional hospital care. Further evidence suggests that most patients prefer regimes with low restrictiveness and more independent living arrangements, although loneliness and isolation have occasionally been reported to be a problem. Little information is available on the factors that mediate outcomes and on skills required by staff. Conclusion Research in supported housing for psychiatric patients has so far been neglected. Large scale surveys on structure, process, and outcomes across a variety of housing schemes may be useful in the future to identify some of the key variables influencing outcomes. The use of direct observation methods in conjunction with other more conventional, standardized instruments may also highlight areas for improvement. In conducting research, structure and process, as well as outcomes, need to be considered. Thus, we need to know not just what to provide, but how to provide it in such a way that it will maximize beneficial outcomes. This represents a considerable research agenda.

Key words

supported housing – community care – outcome – staff training – mental illness

Introduction

Over the last 30 years in North America and Western Europe there have been major changes in the forms of residential care provided for people with mental illness. The move towards ‘de-institutionalization’ has led to increasing numbers of patients with long-term needs being placed in the community and requiring housing with or without support. Historically, mental health services and mental health researchers have distanced themselves from housing, which they have apparently considered a ‘social care’ issue, defining their role more narrowly around “treatment” (Carling 1993). However, housing is arguably one of the most important factors affecting long-term outcomes (Bigelow 1998). Most countries are now struggling to provide a comprehensive and effective range of housing provisions, along with the necessary support, to enable people with mental health problems to lead fulfilling and satisfying lives in the community (Carling 1992a; 1992b).

Throughout Western European countries, changes in mental health services – particularly the decreasing use of placements in long-stay hospitals – have led to an in-
increasing demand for housing provision for people with mental illness. In the UK, concerns have repeatedly been expressed that the range of available housing is insufficient or of a poor quality (e.g., Audit Commission 1998). It has been argued that this lack of supported housing has enhanced the 'revolving door' for patients who experience repeated admissions to hospital, unstable adjustment in the community, followed by further admissions (Caton and Goldstein 1984; Shepherd 1998). Whatever the validity of this hypothesis, access to suitable housing is a problem for this 'new' generation of long-stay inpatients and failure to make specific provisions for them has meant that they have often begun to accumulate on acute admission wards (Lelliott and Wing 1994; Johnson et al. 1996).

Similar processes have occurred in other European countries. For example, in Germany the number of hospital beds has reduced, particularly since 1990, resulting in increased demand for supported housing. In Berlin the number of places for mentally ill patients in supported housing has risen by threefold over the last decade (Kaiser et al. 2001). A similar situation exists in Italy where, despite considerable reliance on extended family support, demands for sheltered and supported housing following the cessation of admissions to the old psychiatric hospitals in 1978 have steadily increased, especially in central and northern regions.

Research on the effectiveness of housing provisions for the mentally ill must also be placed within an economic context. Across Europe, health systems are striving for maximum cost effectiveness and efficiency. That means knowing what works, but also knowing how much it costs. In the UK, the cost of housing per resident week ranges from £462–362 in a staffed care home to £459–362 in a high-staffed hostel (24-h nurses' care) and £212–158 in a low-staffed hostel, depending on the location, i.e., in or outside London (Chisholm et al. 1997). In 1996, the National Health Service Executive estimated that set-up costs per place for '24-hour nursed beds' was in the range between £35,000 and £50,000 per annum (i.e., £700–1000 per week). In view of these costs, it seems reasonable to expect that housing schemes for people with mental illness would have been subject to rigorous evaluation, both in terms of their effectiveness and efficiency. However, there is currently a marked imbalance between the high costs of supported housing on the one hand and the limited number of evaluative studies on the other.

**Methods**

“For the purposes of this review, studies that were concerned with" supported", "sheltered", "supervised", or "protected" housing (accommodation or living arrangements) where the majority of residents were regarded as having severe and enduring mental illness were included. Throughout the paper, the term "supported housing" will be used in reference to those settings where housing and support - for more than 6 months (thus excluding acute interventions in community placements) – are intrinsically linked. Studies focusing on housing for people suffering primarily from drug or alcohol dependence, specific 'geriatric' (old age) provisions, services for those under 18 years of age with a mental illness, and for those with learning disabilities were excluded. A Medline search of published literature with search items such as "supported housing," "sheltered housing," "protected housing" and "supervised housing" provided only 148 papers. No limit was imposed on the year of publication in any of the searches. Adding the terms "mentally ill" or "schizophrenia" to the above searches, and restricting the literature to the aforementioned criteria, yielded fewer results than expected. Altogether, 87 articles (reviews or studies) were identified by the database Medline; 21 of which were empirical studies and are presented in Table 1. Given this, it was decided to complement the Medline search with the traditional hand search of the literature. Table 1 shows a wide range of European and non-European studies evaluating supported housing for mentally ill patients and is by no means designed to be inclusive of all studies in the field.

This review provides an overview of the literature with the aim of summarizing the existing information and identifying areas of future research to improve the effectiveness and efficiency of various forms of supported housing. More specifically, the paper addresses the following questions:

1. What is the historical background of housing for mentally ill people?
2. What are the concepts of supported housing?
3. What are the characteristics of people receiving supported housing?
4. What is the range of research designs and methods that have been used to evaluate supported housing?
5. What are the outcomes?
6. What factors seem to influence quality of housing and support?

**Results**

- **The Development of Community Care**

The process of moving the locus of long-term residential care from hospital to community has proceeded at different rates in different countries (Mangen 1988). It has been driven by a number of factors such as assumed financial savings, the wish to exploit the benefits of new medications, changing social attitudes, etc. (Jones 1972). One of the important initial factors was the gradual conviction that there were features of institutional environments that made them intrinsically unsuitable for delivering high-quality therapeutic long-term care. These criticisms first emerged in the 1950s (Barton 1959; Goffman 1961) and it was not until some time later that empirical studies of ‘institutionalism’ were undertaken, which highlighted the association between poverty of the physical environment and severity of primary symptoms and secondary handicaps (Wing and Brown 1970). Around this time, the first attempts were also made to develop systematic measures and institutional care practices as a basis for designing and maintaining better quality of residential care in hospital and community settings (King et al. 1971). However, during most of the 1960s and 1970s, the hostility towards ‘institutions’ (i.e., hospital) was fuelled by a series of well-publicized ‘failures’ of hospital care in which patients appeared to be the victims of a ‘system’ in which staff were at best negligent and at worst cruel and exploitative. These incidents have been analyzed by Martin (1984) who drew