STAKEHOLDER EXPERIENCES OF HOUSING AND RELATED SERVICES (HRS) IN MENTAL HEALTH: A UK CASE STUDY

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A thesis submitted in partial fulfilment of the requirement of Staffordshire University for the degree of Doctor of Philosophy

October 2014

Acknowledgements

Firstly I would like to thank all of the tenants and staff who participated in this study. Without your generosity and co-operation this PhD would not be possible. Thank you for your contributions and time you gave to take part.

Secondly I would like to thank my six PhD supervisors for their invaluable guidance and ongoing support. I would like to thank Professor Eleanor Bradley who has continued to support me since my first day. Your firm but kind guidance has developed me academically and you will continue to be a role model to me. Special thanks are reserved for Professor Wilf McSherry who rescued me in a hard time of write up. Your perseverance and direction instilled motivation which I needed to get through my final year. Thanks also to Dr Steve Suckling for your humour and belief in me when my confidence faltered. For all the times you listened to my ideas with support and without judgement I am grateful. Finally, many thanks to Dr Clio Spanou and Dr Emily Buckley for your invaluable guidance and psychology input which you both knew was important for me; and to Professor Paul Kingston for your interim support.

In addition I would like to thank my family and friends for their continued emotional support, and their endless patience and understanding throughout this journey. I wouldn't have got through it without you all. Especially thank you to Brogan for being my rock and being there when I needed it most. Lastly, to my mum and dad I dedicate this thesis to you as a token of my appreciation for your unfaltering love and support.

Contents

Abstract

Housing and related services (HRS) were developed as part of the deinstitutionalisation movement, as alternative accommodation arrangements for people living with mental health problems. Despite this movement starting over fifty years ago there are still many approaches to HRS, and no clear model of best practice. Furthermore, even with an extensive evidence base and many reviews of HRS, there is still no agreement on what a successful HRS organisation and service look like. The purpose of the study was to re-evaluate the area of HRS, working inductively rather than imposing parameters on the subject. The aim was to capture the experiences of HRS stakeholders in order to gain a richer understanding of how HRS are delivered and received in practice.

A Case Study approach was adopted using an organisation that has provided HRS for people living with mental health problems for over thirty years. The stakeholders who constituted the participant group were tenants (service users) and staff (support staff, housing staff and executives on the board of trustees). The study was guided by a Grounded Theory framework, and the stakeholders participated in interviews, joint interviews and a focus group.

The results were broken down into change, factors affecting HRS, and a conceptual model which formed the basis of substantive theory of HRS. A Critical Interpretive Synthesis (CIS) was undertaken to explore previous literature in HRS. The results explore descriptive information, ambiguity, black-box evaluations and theory driven evaluations in HRS. Together the study

findings and the CIS were used to construct a conceptual framework which can be used to understand the processes and outcomes in HRS. Future work is needed to establish cause and effect of identified factors, but the work of this thesis makes important progress in critically exploring the area of HRS.

Chapter One: Introduction

Housing is valued as an important concept on a theoretical level, in policy, and in practice. The homelessness charity Shelter describe home as a basic human need (Shelter, 2014). The United Nations' International Covenant on Economic, Social and Cultural Rights (ICESCR[1]) (UN Assembly, 1966) included housing in 'the right of everyone to an adequate standard of living' (ICESCR, article 11).

The importance of housing is linked to its relationship with wellbeing, ill health, disability, mental health, educational attainment, unemployment and poverty (Equality and Human Rights Commission, 2011), These relationships are significant as research has demonstrated that poor, or complete lack of housing can cause detrimental effects on health, education, and economic wellbeing (Shelter, 2006).

Despite housing being identified as important The NHS Confederation (2012) noted that people living with mental health problems can 'find it difficult to secure and maintain good quality accommodation' (p.2). In turn this may result in temporary accommodation, assisted accommodation or homelessness. Shelter (2007) noted that people from vulnerable groups are more likely to experience homelessness. 'Vulnerable' here refers to those 'who may encounter discriminatory treatment or need special attention to avoid potential exploitation' (Reichert, 2006; p.78). Supporting People (SP) (CLG 2009a,

[1] A list of abbreviations can be found in Appendix 1a.

2009b) identified the following that could be regarded as vulnerable groups, which can be found in Table 1A[2].

Table 1A.
Vulnerable groups as identified by Supporting People

• Refugees • People with physical or sensory disability • Ex-offenders • Young people at risk (e.g. leaving care) • Older people • Homeless families with support needs • Teenage parents	• People with mental health problems • Gypsies and Travellers • Alcohol and/or substance misuse • Homeless/rough sleepers • People with learning difficulties • Those living with HIV-AIDs • Victims of domestic violence

People living with mental health problems can be defined as a vulnerable group as there is a strong link between homelessness and poor mental health (The NHS Confederation, 2012). Crisis (2009) reported that mental health problems may play a significant role in what causes a person to lose their accommodation in the first place.

Over the last fifty years housing and related services (HRS) have evolved to aid vulnerable people in relation to their accommodation, and this subject will form the basis of this study.

[2] A full list of Tables can be found in Appendix 1b.

This chapter will firstly set out the parameters of HRS, clarifying what is meant by using the term. The focus on people living with mental health problems is identified for this study. The relevance of HRS will then be discussed, identifying why research is so important, and the gaps in current research which underpinned the rationale for this research. Finally the structure of the following chapters is laid out to guide the reader through the rest of the thesis.

Setting the parameters: explanation of terms

To avoid ambiguity or confusion an explanation of the terminology used in this thesis are provided.

Housing and Related Services (HRS)

An explanation of HRS is important as it has been highlighted on multiple occasions that differences in terminology have caused confusion in the area (Fakhoury Murray, Shepherd and Priebe, 2002; Kane et al, 2007). However, a definite definition is difficult due to the wide number of housing models that have been implemented (e.g. staircase models, Supported Housing, Housing First). Because of this Housing and Related Services (HRS) is adopted as an umbrella term to encompass all forms of accommodation with accompanying support/care/supervision for vulnerable groups. This term has been chosen as it includes the full range of housing models which provide varying levels and types of assistance for certain groups of people. Using an existing term (e.g. Supported Housing) is avoided when referring to the area as a whole as such terms are associated with specific features which may not be evident in other HRS organisations (e.g. a timeframe, funding streams, support provided).

HRS is usually tailored for each vulnerable group, for example HRS for older people, or a HRS for women fleeing domestic violence. In this study the focus will be on people living with mental health problems.

Participant group

In this thesis the term ‘people living with mental health problems’ has been adopted as it acknowledges that a person ‘is a person first, not a psychiatric diagnosis’ (Mental Health Foundation, 2014). The word problem is also used, instead of illness or disorder to avoid medical labels.

Setting the scene: the Case Study organisation

In this study the organisation selected for the Case Study is a third sector organisation which has been established for over thirty years, providing HRS to people experiencing mental health difficulties. The organisation has not been created in response to new funding techniques or as the result of a ‘gap in the market’. Originally the housing project was designed as a sanctuary for adults living with enduring mental health problems when hospital wards were closing in line with the deinstitutionalisation movement. The organisation has evolved over time, adapting to changes in models, policy, and funding streams.

Accommodation

The organisation’s accommodation for tenants varied throughout the course of the study but the maximum capacity was approximately forty tenants. The organisation provided a range of accommodation including single and shared lodgings. The shared accommodation ranged from 2-6 bedroom properties. The properties were located in a number of areas, some of which were in close

proximity to the organisation's offices (short walking distance) and some which were situated further afield.

Staff

The organisation comprised of a board of trustees, housing staff, and support/key workers. The board of trustees consisted of a chairperson, a treasurer and a secretary. The housing staff consisted of management staff and a maintenance officer. Staff turnover was high during the course of the study but the organisation size was approximately twelve.

Tenants

The tenants within the HRS are adults living with mental health problems. This term is intentionally vague as the organisation did not specify particular diagnoses or severity of mental health issue as criteria for entry for accommodation. The primary criterion for a person to be accepted as a tenant is the presence of a mental health issue, and the tenants were commonly known to the community mental health team. However, the organisation regularly accommodates complex cases. This refers to people who, as well as living with mental health problems may have physical health problems, substance misuse issues, a history of offender behaviour, and/or a learning disability.

Furthermore, the tenants have resided with the organisation for a number of different time periods, reflecting the trends and changes of policy and accommodating people living with mental health problems. This Case Study provides a unique insight into how different tenants (i.e. with different

diagnoses, lengths of time accommodated) are catered for according to different housing models, within the same organisation.

Establishing the researcher's position in the research

In this study the researcher was positioned as a mediator between the organisation and the research. The researcher was match-funded by a Higher Education institute and the Case Study organisation. Because of this a centrality was maintained throughout the course of the research that allowed an insider perspective to the organisation but which also held an objective element due to the external nature of the University. The researcher perceived themselves as a vessel through which the stakeholders could tell their story, but who would also attempt to critically interpret the stakeholder experiences of HRS. The researcher's position will be further discussed in the methodology and methods chapter.

Relevance of Housing and Related Services (HRS)

The importance of housing has already been mentioned, but it has also been noted that some people may struggle to maintain their own tenancy. Because of this HRS can provide critical assistance to people who may otherwise end up homeless. This consequence was highlighted when significant increases in rough sleepers were recorded in authorities who had made drastic cuts to homelessness-related SP services (CIH, 2014). This reinforces the importance of HRS. Furthermore, the use of temporary accommodation averaged 56,000 cases in 2013 (CIH, 2014). This demonstrates that HRS is not an isolated issue, but one which is largely relevant today. The scale of HRS is in fact larger than this as many other countries in addition to the UK also implement HRS (e.g.

USA – Tsemberis and Eisenberg, 2000; Canada – Trainor, Morell-Bellai, Ballantyne and Boydell, 1993; the EU – Edgar and Doherty, 2001).

Investigating the area of HRS is important as, despite almost fifty years of implementation, there is still no model of best practice or consensus on the best way to accommodate people living with mental health problems (O'Malley and Croucher, 2005; Bowpitt and Jepson, 2007). Cross cultural issues such as differing funding and policy frameworks have created different HRS models, but these differences have also complicated comparisons between, and even within models, which has been confounded by inconsistent use of terminology (Tabol Drebing and Rosenheck, 2010; Pleace and Wallace, 2011).

One conclusion is that there is a need to 'start again' with the research, inductively, to try and gain a rich and deep understanding of how stakeholders experience HRS in mental health. Supporting People (the government funders of HRS) have attempted to document outcomes and statistics on HRS but this does not give any indication about how HRS is experienced, both implementing it and receiving it. An understanding of what HRS services look like now, how they are being delivered, and how they are received in practice is needed to further the area.

The need for this research formed the basis of the study, whereby a Case Study (CS) approach was adopted in order to attain a unique insight into stakeholder experiences of HRS in mental health. A Case Study approach is implemented when there is a desire to derive a close/in-depth understanding of a case with an aim to produce 'an invaluable and deep' understanding, which will result in

'new learning about real world behaviour and its meaning' (Yin, 2012; p4) Furthermore 'Case studies are often used to provide context to other data (such as outcome data), offering a more complete picture of what happened in the program and why' (Neal, Thapa and Boyce, 2006; p4). This is very relevant to HRS as the outcome data that has been previously undertaken has not been able to answer what is the best way to accommodate people living with mental health problems. The current literature base on outcomes studies is superficial in that, whilst it can highlight questions of significant importance (e.g. which HRS model scores highest in quality of life measures), it is unable to provide a rich understanding of the service-user experiences within HRS. In undertaking a Case Study approach it is hoped this can be achieved.

Aims and objectives

As the study is an inductive piece no hypotheses were made about the area and/or research. Instead an aim and related objectives were created to guide the study, although there was flexibility as the researcher did not want to apply any restrictions or parameters to the research. The aim and objectives are presented here to reflect the true nature of the study. The literature review was completed after the research was undertaken, and so initially there was a more general outlining of inquiry to be pursued which was refined as the study developed. The researcher started with this initial guidance but allowed the responses of the participants to lead the direction of the study.

Aim

The aim of this study is to explore stakeholder perspectives of success and goals in HRS, and measurement and evidencing in HRS. In addition, the aim of

the study is to capture stakeholder experience of HRS and explore what HRS model (if any) is being implemented in practice. A critique of these issues will create new knowledge and advance theory in HRS.

Objectives

- To explore how the evolution of HRS has been documented in literature
- To explore how HRS has been investigated in research
- To explore how HRS has been experienced (both delivered and received) in practice

Structure of subsequent chapters

The structure of this thesis is presented to represent the order in which the study was taken. Thus, the thesis proceeds with the history chapter followed by the methodology and methods which guided the study. The results of the study are then presented. The results chapter is followed by the Critical Interpretive Synthesis. This decision was made to reflect the inductive nature of the study and in line with the methodology and methods chosen (which are described in chapters three and four). As a qualitative piece of work the researcher did not want pre-conceptions about HRS to inform, bias or lead the results of the study. Although complete neutrality is arguably not possible the researcher implemented a number of measures to attempt this. This included completing the Critical Interpretive Synthesis after the research was undertaken. The thesis moves to the discussion chapter before finishing with a conclusion. Each chapter will briefly be discussed in turn.

Chapter two presents the background to the study and documents the evolution of mental health services in the UK. It explores the progression from detainment

and control of people living with mental health problems to inclusion and service users as people. There has been a shift from the medical model of disability which concentrates on what is ‘wrong’ with people (Scope, 2014), to a social model of disability where ‘recovery’ was seen as possible. Chapter two also acknowledges deinstitutionalisation as the start of accommodating people living with mental health problems as a housing issue.

Chapter three is the methodology chapter which is split into two sections. In the first section the philosophical underpinnings to research are explored, including ontological and epistemological considerations. A number of philosophical frameworks are considered before Grounded Theory is identified as most appropriate for this study. Glaserian, Straussian and Constructivist approaches to Grounded Theory are distinguished and the most appropriate for this study clarified. In the second section the research design is presented, including a discussion of criteria for evaluating qualitative research. Here the Case Study approach is introduced and contextualised within the current study.

The methods are presented in Chapter four, describing the techniques and process adopted to undertake the research. Here the Grounded Theory method is explored, along with its key features including theoretical saturation, sampling and sensitivity; memoing; coding and constant comparison; and substantive theory. Further methods of the study are then presented, including sampling, an overview of participants, and procedure. The second half of the chapter is dedicated to ethical considerations, which include safeguarding, and impacts of being funded by the organisation being used as the Case Study.

Chapter five contains the results of the study, which is split into five sections. The first section discusses the experience of change in HRS. The second section presents the consequences of change, which discusses five themes that emerged from the data (economic issues, duration, progress, boundaries and independence). Participant quotes are provided to support the themes. The third section includes important factors in HRS which affect an individual's experience of HRS. Here processes and outcomes which emerged from the data are presented and themed with supporting participant quotes. The fourth section presents a conceptual model which developed from the data and formed the basis of a substantive theory. Here clusters of characteristics aligning with different HRS models will be explored and discussed. The fifth section concludes the chapter and details how the results informed the literature review.

The literature review is outlined in Chapter six, which is divided into three sections. The first part introduces the Critical Interpretive Synthesis (CIS) framework which was adopted to explore how HRS in mental health has been reviewed in research. The second part details the methods and procedure for undertaking the CIS. The third part provides the results of the CIS. Here the trends for reviewing HRS are discussed, including black-box and theory-driven evaluations. Background, descriptive information is also given, along with details regarding ambiguity in HRS research/literature. Finally, processes and outcomes previously used in HRS literature are identified and themed. The implications of the findings are critically discussed.

Chapter seven forms the discussion of the thesis. Here the results are critically explored and related back to previous research and theory. Three main issues which emerged from the thesis are discussed in more depth: change, HRS in practice, and measurement in HRS.

Chapter eight concludes the thesis by providing an overview of the previous chapters, discussing the significance of the research, and offering suggestions for future research.

Summary

The parameters of the thesis were laid out, thus the next chapter provides a history of HRS in mental health.

Chapter Two: Historical background of Housing and Related Services

Housing and Related Services (HRS) is a relatively recent concept, only implemented in approximately the last fifty years. Housing and Related Services for people living with mental health problems has originated from asylums and other institutional settings, and has evolved over hundreds of years (Mechanic, 1987). Housing and related services are a product of the interaction of a number of factors, including policy, law, social movements, theory, and research (Carling, 1993; Ridgway and Zipple, 1990). This chapter will present the context for the birth of HRS, acknowledging the important aspects of its evolution and discussing the impact and implications this has had for people living with mental health problems. The chapter will take a chronological, time-lined approach to exploring its history to document the progression from asylums to war-time conditions, to non-hospital arrangements and HRS. The chapter will conclude with a discussion of the development of HRS for people living with mental health problems.

Origins of Asylums

Bethlem Hospital situated in London was founded in 1247 as the Priory of St Mary of Bethlem and is credited as the oldest psychiatric establishment in Europe (Andrews, 1997). Prior to this mental illness went relatively unnoticed in society, or people living with mental health problems were found in prisons and poor houses (Jones, 1993; Bewley, 2008). Bethlem hospital and other ‘lunatic

asylums'[3], 'madhouses' and 'insane hospitals' were the first attempts of accommodating people living with mental health problems. A motive for segregation was due to the negative perceptions of people with mental health problems. Historically mental illness has been seen, amongst other things, as punishment for displeasing the Gods; an indication of demonic possession or evil; and the mentally ill as animals and less than human (Videbeck, 2010). For these reasons institutions had poor reputations and were renowned for their bad conditions. First-hand accounts surfaced from people visiting, which included families of 'inmates' and people who paid to visit Bethlem, where they mocked and laughed at patients (Andrews, 1997). Stories emerged of squalid conditions, poor treatment of patients and use of heavy physical restraints such as strait (straight) jackets, manacles and chains (Andrews, 1997). Law and legislation surrounding 'lunatics' was sparse at this time but a statute of Edward II (1320) declared the property and estates of lunatics were 'vested in the crown' (Bewley, 2008; p.6). This meant the rights for their possessions were handed over to the monarch. What's more there was no lunacy legislation until the 'Madhouses Act' (1774) which attempted to regulate private asylums.

The beginning of mental health legislation came in the age of enlightenment where long-held, negative beliefs about people living with mental health problems were challenged in a push towards equality for all (Mora, 1992). The enlightenment was a cultural movement in the 17th and 18th Century. Intellectuals and philosophers headed the movement which was grounded in using reason, and involved the analysis of observed facts and questioning and contesting ideas based on tradition and faith (Rempel, 2003). Applying this

[3] Terms placed in quotations to illustrate historical context but could now be regarded as politically incorrect or carrying stigma

ideology to people living with mental health problems it meant questioning whether 'lunatics' were sub-human, or possessed animals as previous understandings had accepted. The enlightenment applied to mental health was mirrored by the 'moral treatment' movement which started in the latter half of the 18th Century (Scull, 1979). Negative perceptions of people living with mental illness were being challenged and the French physician Philippe Pinel (1745-1826) has largely been credited for having 'struck the chains from the insane'[4] (Goldsmith, 1994; p.4). Pinel 'set an entirely new standard for how people with mental illnesses were to be viewed and treated by those who cared for them' (Davidson, Rakfeldt and Strauss, 2010; p.25). The authors wrote:

> *'Not only did Pinel paint such pictures in sympathetic terms with kindness and understanding, but he went so far as to suggest that many people with mental illnesses – far from being from an inferior race or species – were in fact suffering from an over-abundance of sensitivity and other highly valued human qualities'*. (Davidson et al, 2010; p.25).

The drive for moral treatment was not an isolated incident. Parallel advances towards better treatment for people living with mental health problems had been apparent in England with the Manchester Lunatic Hospital (completed in 1765) forbidding sightseeing and the York retreat, founded in 1792 by William Tuke was based on Quaker principles of compassion and humanity (Paterson, 2008). Although working from different directions, reformers such as Evangelicals (which pitied people living with mental health problems), and Benthamites (which realised the public had responsibility for their care and treatment), agreed that the state should intervene to regulate, investigate and improve asylums (Andrews, 1997). The Evangelicals were groups of Protestant Christians whose 'vital Christianity' campaign challenged 'the treatment of the

[4] Although Weiner (1990) stated that it was Jean Baptise Pussin (supervisor at Bicetre asylum where Pinel worked) who should have been given the credit for starting the non-violent and non-restraint approach

insane incarcerated in asylums and elsewhere' (Rollin, 1994; p.627). For the Evangelicals 'It was seen as an instrument of Christianity to bring lunatics within the compass of the Established Church in order that their personal salvation could be guaranteed' (Rollin, 1994; p.627). Benthamites were reformers influenced by Jeremy Bentham and his development of utilitarianism (Quinn, 1977). The underlying ethos for this movement was to strive for 'the greatest happiness of the greatest number' (Burns, 2005; p.46). Bentham argued that the government had a responsibility for reform and he has been noted as the first English writer to criticise English law as a system (Montague, 1891). This applied to reform for people living with mental health problems.

Another significant figure to mention when discussing the moral treatment and improving conditions for the 'mentally ill' is Dorothea Dix. Dix was an American school teacher and writer from a wealthy background. She had personal experience of problems with her health, and during a 'restorative trip' to Europe met Elizabeth Fry (prison reformer) and Samuel Tuke (founder of the York retreat) (Parry, 2006; p.624). Influenced by her experiences with reformists, and meeting people living with mental health problems Dix investigated, wrote and published pamphlets of memoirs to highlight the mistreatment of people living with mental health problems (Parry, 2006). Her work challenging the conditions for people living with mental health problems impacted more than ten countries and directly impacted thirty institutions (Reisman, 1976).

The movement was mirrored in government where the 1808 'County Asylums Act' (also known as Wynn's act) proposed better care and maintenance for 'lunatics' and a bill to amend the law for the regulation of 'lunatics' was passed

which allowed the release of anyone improperly confined (Jones, 1993). The 1845 Lunacy Act expanded on the County Asylums Acts by outlining laws on spending on Asylums and the building of County and Borough asylums. Until this point asylums had been implemented sporadically and their running was largely not monitored, evaluated or regulated (Rogers and Pilgram, 2005).

In line with the County Asylums acts, progressions developed around the late 1830s with the non-restraint movement. The aim was to completely abolish the use of physical restraint as a form of control (McCandless, 1996). Thomas Prichard (medical superintendent) from Northampton Asylum; and Robert Gardiner Hill (house surgeon) and Edward Charlesworth (physician and governor) from Lincoln Asylum were the pioneers for this movement (Haw and Yorston, 2004). Robert Gardiner Hill even presented a lecture titled 'total abolition of personal restraint in the treatment of the insane' to the Mechanics Institute in 1838 (Pateman, 2012). The use of restraints were avoided as much as possible, only being used as a very last resort; where instead 'Prichard used solitary confinement, low rations and shower baths to control aggressive behaviour' (Haw and Yorston, 2004; p.142). Whilst one motive for the non-restraint movement was to improve conditions for the wellbeing of patients, a less positive, more practical reason was also proposed. Following the death of a patient due to being strapped to a bed overnight in a strait jacket, the Lincoln Asylum imposed a rule whereby attendants must be present in the use of restraints (Pateman, 2012).

It is important to note here that although great advances were made with moral treatment and early parliamentary acts, the ideas concentrated on improving the

conditions of asylums, and not challenging the concept of institutional living. The enlightenment movement may have changed people's perceptions of the individuals living with mental health problems themselves, but not how they should be accommodated, as segregation remained the dominant approach. Nevertheless, the change in attitudes towards the 'mentally ill' still represented significant progress. The early perceptions of mental illness indicate a lack of education and knowledge. People simply did not understand the causes, symptoms and behaviours involved in mental health so the topic was met with fear, suspicion, ignorance but also fascination and curiosity (Weckowicz and Liebel-Weckowicz, 1990). For negative views to be challenged so that 'lunatics' were beginning to be seen and treated as people abundant in valuable qualities demonstrated a big shift in opinion. Even though the mental health problems were still prevalent the social reception mental health received was more moral and humane because prejudice and misconceptions were challenged.

The turn of the 19th Century also demonstrated a change in the attitudes towards mental illness. The medical model of illness had dominated to this point, revolving around ideas drawn from Hippocrates circa 400b.c. that abnormalities require physical treatment (Adams, 1849). There was a reductionist approach to patients in asylums who were categorised as 'curable' or 'incurable upon arrival (Killaspy, 2006). This demonstrated a lack of confidence in being able to successfully treat mental health problems. However, a student of Pinel called Jean Itard believed the 'mentally retarded' could learn and taught a feral child (the Wild boy of Aveyron) to dress himself and read (Reisman, 1976). Itard was a French physician who primarily worked with deaf and hearing-impaired children, which had implications for theories of child

development, and the nature-nurture debate (Gutek, 2004). This belief in the ability for conditions to improve was important as it promoted potential for recovery rather than resigning people to a poor future under the assumption that they have no hope of improvement.

Another leading figure in the changing approach to mental illness was Eli Todd who was an American psychiatrist, and also the first superintendent of the Hartford retreat in Connecticut (Goodheart, 2003). Todd was influenced by environmental psychology, believing that 'the subject is shaped by sensations from his surroundings' (Goodheart, 2003; p.37). This also had implications for the nature-nurture debate. Todd's work weakened the belief that insanity is incurable and was key in the trend for hospital superintendents competing for the percentages of patients they 'cured' (Reisman, 1976). His 'therapeutic optimism' (Goodheart, 2003; p.45) indicated that the concept of recovery in mental illness was beginning to be considered.

However, whilst the enlightenment and moral treatment were invaluable advances for the treatment of people living with mental health problems, they were movements headed by professionals and academics, and therefore represented the middle-class (Van Dulmen, 1992). These people had the power of influence whilst the people living with mental health problems themselves were rarely heard. The main service-user 'voice' came from ex-patients who retrospectively documented their experiences in asylums after being released. Appendix 2a documents examples of such patients.

World War One (WW1)

Any progressions that had previously been made were interrupted when the First World War broke out and the war time conditions reduced the standard of staffing and accommodation (Jones, 1993). Despite the setbacks that WW1 produced in terms of physical conditions of asylums, it arguably created conditions which allowed for developments both during and after it to be made in mental health (Tomes, 2008). Notable factors included the issue of shell shock and the mental hygiene movement (or social hygiene movement).

Shell shock

Shell shock was originally explained as a result of a head injury or toxic exposure (Jones, Fear and Wessely, 2007). However, soldiers who had been near to explosions but hadn't suffered an organic lesion were presenting with similar symptoms to those that had suffered brain injuries/head traumas. The impact of shell shock was large; with 15% of British soldiers discharged from the Army because of the issue (Pols and Oak, 2007). This forced 'the British military authorities to acknowledge military mental health problems despite all pre-existing taboos' (Reid , 2010; p.14). This had great implications on the perception of mental illness as nations experienced what were previously regarded as fit and healthy men were susceptible to break down under sufficient stress (Howarth, 2000). WWI is important as it is viewed as 'the period in history when "modern" warfare coincided with a "scientific" psychiatry that endeavoured to define diagnostic entities as we understand them today' (Crocq and Crocq, 2000, p.49). Shell shock was also important as it gave evidence to 'a psychological stressor resulting in physical symptoms' (Webb, 2006; p.342).

Mental hygiene movement

The mental hygiene movement was a ‘mission of radically extending the reach of mental health care’ (Thompson , 2010; p146). It was linked with Adolf Meyer’s work who promoted the importance of prevention and early intervention instead of the previous focus of treatment and cure (Meyer, 1918). The main aim of mental hygiene was the conservation and promotion of a healthy mentality and a healthy personality (Russell, 1930). The mental hygiene movement (in addition to shell shock) can be identified as emphasising the importance of ‘psychosocial’ factors, which refers to ‘any exposure that may influence physical health outcome through a psychological mechanism’ (Macleod and Smith, 2003; p.565). Examples of psychosocial factors include stress, hopelessness, depression and hostility (Macleod and Smith, 2003).

Tomes (2008) proposed that the war time crisis created conditions which gave various disciplines chance to prove their importance with regards to mental health. For example, she proposed WWI provided the opportunity for psychology and social work to be acknowledged and established as competing fields alongside psychiatry. The war ‘acted as a catalyst, consolidating the acceptance of purely psychological causes for mental symptoms’ (Howarth, 2000; p.225).

In addition to psychology and social work there were vast progressions with the occupational therapy movement (Creek and Lougher, 2011). This was in line with a ‘resurgence of interest in reform and in structuring the patient’s day in a more productive manner’ (Creek and Lougher, 2011; p.8).The Tavistock clinic was founded in 1920 in London, for the out-patient treatment of nervous

disorders (Griffiths and Franks, 2005; p.57). The clinic was renowned for its treatment of shell shock and drew from a number of disciplines such as psychiatry, psychology, social work and nursing (Griffiths and Franks, 2005; p.58).

Post-WWI policy

As well as in practice, developments were also seen in government. The Mental Treatment Act (1930) saw the term 'asylum' replaced with 'mental hospital' and 'lunatic' replaced with 'person of unsound mind' (Bartlett, 2009). This suggests that improvements to conditions for people living with mental health problems were not just the ideology of radical reformers, but representative of a mass scale shift which was also evident within both government and the public. However, it could be argued that this Act was simply a paperwork exercise brushing up on terminology. Evidence of the acceptance of shell shock as a genuine disorder can also be seen in the removal of the death penalty for desertion and cowardice (Howarth, 2000; p.227).However, the humanism echoed in legislation still did not extend to challenging the institutional structure for the containment of people living with mental health problems.

World War Two (WWII) and post-war progressions

The cycle of improvement and regression seen in World War One repeated in the Second World War. Once again conditions in mental health looked bleak as locked doors returned, there was understaffing in hospitals and isolation was frequently used due to tuberculosis outbreaks (Jones, 1993). Like the First World War the Second represented a time of stagnation for mental health hospitals, and physical health remained the main concern. For example, levels

of bacterial infection took medical priority, and mental health issues such as shell shock were low down on the military agenda (Jones et al, 2007).

However, in terms of a public agenda, WWII led to pacifists who refused to go to war ("conscientious objectors" – COs) taking up roles in mental hospitals and institutions Taylor (2009). In WWII over 2,000 men in 41 mental hospitals in 22 states worked as COs (Krehbiel, 2012). The COs had a significant impact in their campaign for reform, they 'rattled the psychiatric establishment by beaming a public spotlight on the squalid conditions and brutality in our nation's mental hospitals...they brought about exposes reported in newspapers...and led a reform effort to change public attitudes, revise institutional commitment laws, and improve pay, status and training for institutional staff' (Taylor, 2009; p.1).

In the 1950s, following the end of WWII there was a pharmacological revolution (also referred to as psychopharmacological, pharmacopsychiatry or pharmacotherapy) in post-war psychiatry. Le Fanu (2011) noted how the treatment of mental illness was revolutionised by four groups of drugs: chlorpromazine for schizophrenia, lithium for 'manic depression', antidepressants for depression, and benzodiazepines (e.g. valium) for anxiety. The impact of this was that it allowed conditions to become more manageable, and meant that more patients 'could be responsive to rehabilitation programmes, occupational therapy, physical and social activities than had been the case before' (Gittins , 1998; p.213). As previously mentioned, other factors had impacted upon perceptions of *people* living with mental health problems, but not focusing on the illness itself. Instead of having strict categories of healthy and ill, the pharmacological revolution offered potential improvements in

some conditions, which blurred the boundaries of recovery. This in turn made it possible ‘to imagine that people with severe psychiatric problems could be managed outside the hospital’ (Rose, 2011; p.14). This is important as for the first time alternatives to asylums for accommodating people living with mental health problems were seriously considered. Initial ideas for mental illness revolved around segregation and separate accommodation, whereas developments in pharmacology offered drugs as a new management tool.

In the late 1940s the legislation for accommodating people living with mental health problems became very out-dated. For example, the topic was still being governed by ideas set out by the 1890 Lunacy Act, more than fifty years earlier (Jones, 1993). Consequently, aware that there had been no major consolidation of law relating to mental illness for sixty-four years a ‘royal commission on the law relating to mental illness and mental deficiency’ was undertaken from 1954-1957 (Jones, 1993). The commission included the abandonment of terms such as ‘idiot’ and ‘imbecile; a call for compulsory powers used only when necessary; and an end to restriction of liberty (Morris , 1958). Rapoport (1960) highlighted the importance of the influence of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1958). The recommendations included promoting active attempts to treat patients in ‘medical rather than penal institutions’ (Rapoport, 1960; p.2). Furthermore, an improvement in the social climate was attributed to the capturing of ‘social disapproval regarding the dismissive treatment of patients’ (Rapoport, 1960; p.3) in the Royal Commission of public opinion.

In 1959, in response to outdated mental health law and as a result of the commission a Mental Health Act was introduced as:

> *'An Act to repeal the Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938, and to make fresh provision with respect to the treatment and care of mentally disordered persons and with respect to their property and affairs; and for purposes connected with the matters aforesaid'.* (Mental Health Act, 1959).

As well as annulling previous acts relating to mental health other notable actions included terminating the board of control[5], setting out functions of mental health authorities; regulating conduct and inspection of 'mental nursing homes'; and setting out procedures relating to compulsory admission to hospital and guardianship (Mental Health Act, 1959). The definition and classification of mental disorder also changed, with the terminology shifting from concentrating on the individual ('lunatic'), to the illness ('mental disorder'). The Lunacy Act 1890 included the following definitions for 'lunatic' and 'lunatic patient':

> *'"Lunatic" shall be construed to mean any person-idiot lunatic or of unsound mind and incapable of managing himself or his affairs and whether found lunatic by inquisition or not'*
>
> *'"Lunatic patient" and "patient" shall be construed to mean any person detained at the commencement of this Act under any Act hereby repealed or hereafter received into and detained in any asylum hospital or licensed house under the provisions of this Act'*

The definition in the Mental Health Act (1959) was:

> *'In this Act " mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and "mentally disordered" shall be construed accordingly' (*p.2).

The acknowledgement of poor terminology, updating legislation and plans for future in mental health again shows broadening understanding and progress in

[5] UK body overseeing the treatment of the mentally ill

the provision of care for those living with mental health problems. However, it could be argued that the Mental Health Act only impacted at a policy level. After the realisation that documentation was outdated and a review was overdue the papers/acts set about rather administration-based tasks such as dissolving other acts, defining terms and amendments for politically correct language. The practical issue of accommodating people living with mental health problems was largely unaffected by these changes.

An attempt at applying the 1959 Mental Health Act in a practical manner came in 1961 from the then new Minister of Health Enoch Powell in his famous 'water tower' speech, which announced a vision of abolishing mental health hospitals (cited in Glasby, 2012; p.54). Two white papers supported Powell's suggestions. *'Health and Welfare: The Development of Community Care'* (DHSS, 1963) urged desirability of community care; and *'Hospital Services for the Mentally Ill'* (DHSS, 1971) reinforced Powell's proposal for complete abolition of the mental hospital system (Rose, 2011; p.15). This challenged the segregation and method of accommodating people living with mental health problems. The '*Hospital Services for the Mentally Ill'* paper recognised that people living with mental health problems had previously been isolated with separate services which meant they had been treated differently. The changes which meant people living with mental health problems accessing and using the same services as the general population demonstrated a sign of inclusion instead of exclusion. This gave the possibility for people living with mental health problems to live and be treated (in a hospital, not asylum) similarly to the rest of the population.

The 1960's saw the development of '*Therapeutic Communities*[6]' (TCs). The approach adopted in the TCs involved a redistribution of power (away from doctors and more shared between other staff and patients), and change in staff/patient relations (Bridger, 1990). The experiment reportedly had begun to succeed, but was stopped as 'the chaos created...was intolerable to wider hospital staff who clung on to the traditional model' (Bridger, 1990; p68). Since the first unsuccessful attempt a couple of other TCs were implemented (e.g. Northfield experiment II, Mill Hill in London), but it wasn't until the 1960s that TCs expanded throughout the country (Campling, 2001). A definition for this concept is difficult as TCs were constantly evolving, which complicates categorisation, definition and study (Campling, 2001). However, there were similarities in the underlying philosophy of TCs in which the concept was grounded. Principles underpinning TCs included patient involvement, collective responsibility, citizenship, empowerment, culture of enquiry (openness to questioning), encourage mutual support and co-operation in living (Campling, 2001). Therapeutic Communities were based on a self-help approach with the aim of treating the whole person through peer community support (De Leon, 2000).

The context for TCs were hospitals or NHS residential settings (often referred to as 'units'), and wards were split up into communities (Campling, 2001). However, the information on TCs is not greatly detailed, and despite conducting a systematic international review of therapeutic community treatments Lees, Manning and Rawlings (1999) found no mention in the research studies about service integration or monitoring procedures, and limited information regarding

[6] Therapeutic Communities originated from 'the Northfield experiments' in 1942-1948, by psychoanalyst Bion and Rickman at Northfield Hospital, Birmingham, England (Harrison and Clarke, 1992).

‘the service contexts of therapeutic communities, on referral procedures, support structures, staff training, and financial information’ (p.57).

Despite the limitations of the evidence base, on a theoretical and conceptual level TCs can be seen as positive steps for the ‘patient’/‘service user’[7] being treated as an equal and a more person-centred approach to treatment of people living with mental health problems. However, the context in which the intervention was undertaken had not changed. Although terminology had attempted to reduce stigma by naming them ‘units’, ‘residencies’ or ‘communities’, it was still an inpatient service. Again, whilst progress was made in *how* to treat people living with mental health problems, the question of *where* remained unchallenged, with hospitals and institution-based living dominating.

The anti-psychiatry movement

The anti-psychiatry movement was a backlash to the discipline of psychiatry. Opponents of psychiatry argued that the ‘coercive powers of psychiatry are used to suppress individual freedom’ (Thomas and Bracken, 2004; p.370). The movement criticised the ‘social control’ aspects of modern mental health care and its methods of treatment of patients such as Electric Convulsive Therapy (ECT) and medication (Kinsella and Kinsella, 2006). The movement was a large, multi-national one with Rissmiller and Rissmiller (2006) attributing Foucault (France), Laing (UK), Szasz (USA) and Basaglia (Italy) as key people involved. An example of Foucault’s contribution to the anti-psychiatry movement was terming insanity as ‘a social and cultural invention of the eighteenth century’ (Dain, 1989; p.8). Laing was a Scottish psychiatrist whose work

[7] TC (and used elsewhere) related term to describe person living with mental health problems

focused on people with a diagnosis of schizophrenia. He argued that the condition was ‘an understandable, even normal response of sensitive people to a mad world and a possible vehicle for personal growth’ (Dain, 1989; p.8). Szasz (1960) argued that there was no such thing as mental illness and that instead we have ‘problems in living’. The closing sentence of his seminal article ‘the myth of mental illness’ stated that ‘mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations’. (Szasz, 1960; p.118). Franco Basaglia was an Italian psychiatrist who developed the belief that mental illness was an expression of human need, not a disease (Rissmiller and Rissmiller, 2006). He has been accredited as mobilising the anti-psychiatry movement in Italy, which resulted in the Italian Mental Health Act (1978) that prohibited asylums and compulsory admissions (Rissmiller and Rissmiller, 2006).

Psychiatry was also tainted by bad publicity, a well-known example being the novel ‘*One Flew Over the Cuckoo’s Nest’* which exposed abuse of patients (Rissmiller and Rissmiller, 2006). What’s more, the 20th Century use of ECT and medication caused new problems of drug dependency and severe side effects (e.g. tremors, tardive dyskinesia, extrapyramidal symptoms) (Fann, Sullivan and Richman, 1976; Salzman, 1980; Freeman and Kendell, 1980). This had an adverse effect on the discipline, reinforcing claims that psychiatry was a social construct motivated by power and suppression over individuals (Brown, 1995).

<u>The social model of disability</u>

The social model of disability aligns with criticisms of psychiatry. The social model of disability argues that ‘it is rarely the impairment which disables people,

rather it is the failure of society to make appropriate provision for the full range of its citizens' (Moore, 2002; p.402). It also turned attention 'to topics such as discrimination, the relationship between disability and industrial capitalism, or the varying cultural representations of people with impairment' (Shakespeare, 2006; p.30).

Therefore the focus moved away from treatment and causes of mental illness and onto the impact and implications of disability on a broader scale. Whilst the anti-psychiatry movement and social model of disability made advancements in the theoretical field, in terms of research, academia and social perceptions, this was not converted into practice as accommodation for people living with mental health problems remained institution-based .The beliefs of how people living with mental health problems should be viewed, treated and accommodated were evolving, but how the person living with mental health problems actually received and experienced mental health care in practice largely remained the same. This could be due to the preoccupation with other issues which have been discussed, such as addressing clinical symptomology with drug use.

Reorganisation of health authorities

The previously mentioned Acts and papers in Government demonstrate there was a growing desire and support for change in health services. The National Health Service Reorganisation Act (1973) could be seen as an attempt to put these papers into practice. The reorganisation saw the definition of what was considered health care, and assuming responsibility of issues regarding health. Funding could be seen as the motivating factor behind this, as the NHS were to take financial responsibility for health issues, and the government covering

social care. The reorganisation may be regarded as a positive and necessary step for health and social care services as compared with each other they had different responsibilities, patterns of organisation, styles of management, planning cycles, budgeting cycles, professional personnel and organisational imperatives (Basaglia, 1980). However, despite the gains that health and social care reaped from the reorganisation, the definitions that created a clear divide between them also created a gap through which mental health services appeared to fall. The National Health Service Reorganisation Act (1973) did indicate the responsibility for people detained under the Mental Health Act (1959):

> *"The duty imposed on the Secretary of State by Special section 1 of the principal Act to provide services for the hospitals. purposes of the health service shall include a duty to provide and maintain establishments (in this Act referred to as " special hospitals ") for persons subject to detention under the Mental Health Act 1959 who in his opinion require treatment under conditions of special security on account of their 'dangerous, violent or criminal propensities"* (National Health Service Reorganisation Act, 1973; p.41).

And responsibility for 'mental nursing homes':

> *"There are hereby transferred to the Secretary of State the functions which, immediately before this subsection comes into force, were exercisable by local authorities by virtue of any provision of the following enactments (which relate to the supervision of nursing homes and mental nursing homes)"* (National Health Services Reorganisation Act, 1973; p.41).

However, the responsibility of people living with mental health problems outside of the inpatient environment was not accommodated in these changes. As a topic that can be seen as belonging to both health and social care it was left in the middle as the concept didn't exactly fit into either. This was perhaps acknowledged in 1975 when the government published a white paper; *'Better Services For the Mentally Ill'*, which was seen as an attempt to streamline

mental health into existing patterns of health and welfare (Jones, 1993). The paper also represented a fresh bid to progress mental health services as 1975 was the year Enoch Powell had predicted mental health hospitals would have virtually disappeared, yet not one had closed.

'Better Services for the Mentally Ill' (DHSS, 1975) set out an ideal service and ideas of long term services for people living with mental health problems (for example, a range of local services). But the paper contradicted itself by admitting that little progress could be made until the economic situation improved, and it might not be achieved in twenty-five years (DHSS, 1975). In terms of accommodating people living with mental health problems the reorganisation of health authorities potentially complicated whose responsibility it was to develop and provide non-hospital based or non-segregated services.

Evolution of a housing issue

'Better Services for the Mentally Ill' (DHSS, 1975) can be seen as a vision for mental health services, but one which could not be carried out at the time due to the lack of financial backing and the services available not being as advanced as the ideas proposed (Sims, 1991). This issue was highlighted in a report of the House of Commons Social Services Committee (1985) which, although supporting the concept of community care, raised concerns that there were inadequate support services for the growing number of people leaving institutions (Thane, 2009). Furthermore, in 1987 the Audit Commission criticised progress of community care, claiming it was slow, and highlighting the bias of funding to hospital care over domiciliary care (Thane, 2009).

'Better Services for the Mentally Ill' reinforced the idea of 'integration not isolation' (DHSS, 1975) which was mirrored in concepts such as normalisation and deinstitutionalisation. Normalisation arose from the 1959 Mental Health Act in Denmark where the aim of services was defined as creating 'an existence for the mentally retarded as close to normal living conditions as possible' (Bank-Mikkelsen, 1969; p.56). Normalisation could be associated with the way in which people living with mental health problems are viewed, and a more contemporary movement towards treating people living with mental health problems as people and individuals. Institutional or segregated living is not a common style of accommodation so the normalisation movement required a transfer away from historical asylums and 'mental hospitals', and progress towards ordinary living arrangements.

Despite not being a new ideology in the 1970s it was at this point that normalisation was advanced by authors such as Wolf Wolfensberger with his concept 'social role valorization' (SRV) (Wolfensberger and Nirje, 1972). Social role valorization reflected 'the highest goal of the original concept of normalisation, i.e. the creation, support and defence of valued social roles for people who are at risk of social devaluation' (Mitchell, 2004; p.10). The premise of SRV is that if people hold valuable roles in society they are likely to receive the same 'good things in life' (Wolfensberger, Thomas, & Caruso, 1996) that the wider society enjoys (Osburn, 2006). Examples of this were identified as 'a decent standard of living' and 'an at least normative place to live' (Osburn, 2006; p.4). The strategies to implement SRV were enhancing the social image and the competencies of people at risk of social devaluation (Osburn, 2006).

Normalisation holds relevance for the area of HRS as it directly referred to people living with mental health problems as at risk of not experiencing a 'normative' place to live.

A process by which to achieve normalisation and the push towards long term services for people living with mental health problems was deinstitutionalisation (Landesman and Butterfield, 1987). Deinstitutionalisation envisaged the removal of people from long term institutional and segregated living to being integrated into the community in a movement away from inpatient services. Oliver (1992) proposed that a combination of factors collectively contributed to the deinstitutionalisation movement. For example, political pressures (such as mounting performance crisis), functional pressures (such as increasing competition for resources), and social pressures (such as changing institutional rules and values) (Oliver, 1992). Fakhoury et al (2002; p.1) outlined the effect of deinstitutionalisation, showing it led to decreasing use of placements in long-stay hospitals. This signified the start of accommodating people living with mental health problems as a housing issue. Previously, despite many changes regarding people living with mental health problems (for example, in treatments and approaches to illness), one thing had remained constant: isolation/segregation in inpatient, institution-based services. The impact was increased demand for housing provision for people living with mental health problems and people with long-term needs being placed in the community and requiring housing with or without support (Fakhoury et al, 2002: pp.1-2).

Normalisation and deinstitutionalisation may be seen as key mechanisms which transformed accommodating people living with mental health issues into a

housing issue. This further fragmented services for people living with mental health problems into health care, social care and housing. Arguably this could cause diffusion of responsibility and/or confusion in establishing what section (health care, social care, housing) is accountable for what aspects of mental health services.

Mental Health Act (1983)

The 1983 Mental Health Act saw another attempt to update legislation governing mental health. The main aim of the updated act was to ensure: *'people with mental disorders get the care and treatment they need for their own health or safety or for the protection of other people'* (DH, 2013; para. 1). The 1983 Act referred to powers to impose conditions on patients living in the community. However, the concepts in the Act were vaguely described. It stated that patients 'may be kept in the custody' of the hospital (s17:3), and that health professionals could 'revoke the leave of absence and recall the patient to the hospital (s17:4). Although now it is seen as carving the role of firstly Supervised Discharge Orders (SDOs) then Community Treatment Orders (CTOs) and Supervised Community Treatments (SCTs) (which will be discussed later), these were not implemented until years later (1995 for SDOs, and 2008 for CTOs and SCTs).

Furthermore, despite concepts such as normalisation and deinstitutionalisation being backed by the 1983 Mental Health Act, the ideas needed taking forward in practice. Understanding why deinstitutionalisation, which was conceptualised in the 1950s, wasn't actualised by the 1980s is helped when the process is not viewed as one swift movement. Deinstitutionalisation has been described as

having three components: the release of people from psychiatric hospitals into the community, the redirection of new admissions to alternative facilities, and the development of specialist services for a non-institutionalised mental health population (Bachrach, 1976). The first two have proceeded much faster than the third, where 'the greatest problems have been in creating adequate and accessible community resources' (Lamb and Bachrach, 2001). These observations could help to explain why homelessness and relapse occur in housing as it indicates that the process of deinstitutionalisation has not been completed simply by releasing people from psychiatric facilities. There is more to the process than simply removing people from hospitals and this was captured in The Mental Health Act (1983), and steps were made with SDOs, CTOs and SCTs.

Care in the Community

As deinstitutionalisation began to take place people living with mental health problems were being referred into the community but inadequate services in the community led to the neglect of vulnerable people which in turn led to homelessness (Craig and Timms, 1992). In an attempt to address the third component of deinstitutionalisation that was previously mentioned the concept of 'Community Care' was born.

Community Care can be represented as 'a progressive and humane approach to the care of needy and vulnerable individuals, rather than consigning them to the depersonalised regimes of large institutions' (Audit Commission, 1998; p1). Practical applications of the concept were set out in '*Making a Reality of Community Care'* (Audit Commission, 1986). The Audit Commission's report

highlighted the need for clearly defined boundaries between health and social care, and this was seconded by the 1988 *Griffiths Report: 'Community Care: Agenda for Action'.* The report claimed that mental health as a whole has been as issue which lacked ownership, stating 'community care' was something everyone was involved with but nobody owned. The report addressed the grey area that had been left between health and social care which included people living with mental health problems. The report emphasised the inadequacies of resources and finances and showed that responsibility was fragmented (Jones, 1993).

The *National Health Service and Community Act* (proposed by the Crown in parliament[8] in 1990 put into practice in 1993) split the role of health authorities and local authorities, with the transfer of community care responsibilities to local authorities. This shift is an example of the 'pass the buck' processes that mental health services have had to endure, constantly on the move and change without solid grounds for identification. The Act also addressed funding issues by identifying local authorities as responsible for state-funding residential care. Prior to this the state had covered most of the costs of care, even for people staying in independent services, as people could use supplementary benefit for funding residential care. Supplementary benefit (formally National Assistance), was known as the 'safety net' benefit with the aim of ensuring a minimum standard of living for all (Fry and Stark, 1987).

The Care Programme Approach (CPA) was introduced in 1991 to 'provide a framework for effective mental health care' (DH, 1999a; p.2). The CPA

[8] 'Crown in Parliament' is used to describe the British legislature, which consists of the Sovereign, the House of Lords and the House of Commons (British Monarchy, 2014)

contained four main elements: assessing health and social needs, the formation of a care plan, the appointment of a key worker, and regular review (and any necessary changes) to the care plan (DH, 1999a). The introduction of the CPA is important as it aimed to ease the transition from inpatient to outpatient environment, rather than simply leaving people unsupported in an attempt to demonstrate deinstitutionalisation. The implementation of a key worker could decrease the chances of feelings of abandonment following discharge from inpatient services. The undertaking of an assessment provides the opportunity to ensure a person's needs are accommodated and supported, which are documented in their care plan. The implementation of reviews also acknowledges that a person may need ongoing assistance, and/or their situation may change. Additionally, reviews where the care plan is revisited at later dates indicate a longer term arrangement, rather than being left to manage without help. A positive of CPAs is that they should be negotiated with 'users' (Kingdon, 1994). This means that people living with mental health problems should be given the opportunity to have their own input, and some autonomy in their care. Whilst still heavily controlled by health professionals, this was a positive step for enabling the 'service user' to have a voice.

The 1995 *Mental Health (Patients in the Community) Act* introduced Supervised Discharge orders (SDOs), which came into operation in 1996. The SDOs were developed 'to ensure that patients discharged from Section 3[9] or Section 37[10] receive appropriate aftercare' (Knight et al, 1998; p.418). The sections are related to the Mental Health Act (1983), specifically to the detaining, or sectioning of patients (MIND, 2012). The SDOs were an attempt to put into

[9] Section 3 refers to sectioning that can be requested for six months (then extended by six months, and then further renewed for 12 months at a time).
[10] Section 37 refers to the compulsory admission to hospital by a criminal court (MIND, 2012).

practice plans originally set out in the *Mental Health Act (1983),* which included a requirement to attend treatment, allow access to clinicians for assessment and even for clinicians to specify where people lived; but did not have the power to enforce medication in the community (Pinfold, Bindman, Thornicroft, Franklin and Hatfield, 2001). Franklin, Pinfold, Bindman and Thornicroft (2000) undertook a national survey on consultant psychiatrists' experience of SDOs in England. They found that 77% found SDOs 'helpful' or 'very helpful', 10% found them 'not very helpful' or 'very unhelpful' and 13% were unsure. However, the authors also recognised that on the whole SDOs were not widely used (identified 596 cases in 170 mental health provider trusts) and whilst they may be useful for certain individuals, they may not be so effective on a larger scale. Franklin et al (2000) indicated that this may be attributed to the need for acceptance and willingness to comply with treatment.

Another limitation was identified by Burns (2000) who acknowledged that when SDOs were implemented, there was huge variation in interpretation and implementation which was having a negative effect. The consequence of this was that 'Significant variation in practice without either clinical justification or constructive dialogue weakens our profession's position in negotiations about legislation' (Burns, 2000; p.402). Franklin et al (2000) found that SDOs were being used in an attempt to control aspects of patient's lives. For example in fifty-eight percent of patient cases the SDOs were used to improve medication compliance (despite SDOs not having the statutory power to directly enforce medical compliance) (Franklin et al, 2000). Because of this reason the SDOs came under criticisms and were informally referred to as 'psychiatric asbos' (House of Lords, 2007).

The aim of deinstitutionalisation was to limit controlling patients, giving back their liberty and freedom, and providing 'normal' living conditions. However, imposing bail-like conditions in SDOs defies 'ordinary' living. In theory deinstitutionalisation was a good concept with the aim of enabling people to leave in-patient, hospital-based environments. But the lack of support, facilities and resources in the community meant that deinstitutionalisation was widely perceived as a failed strategy (Hudson, 1991). The concept of deinstitutionalisation was also undermined as the introduction of SDOs kept a hold on many patients.

The Local Government Modernisation Agenda (LGMA) derived from a collection of more than twenty policies introduced in White Papers between 1998 and 2001 (Martin and Bovaird, 2005). A meta-evaluation of the LGMA (Martin and Bovaird, 2005) stated that significant improvements had been made in most services since its implementation, which has an important effect on mental health. The importance can be seen in the inclusion of mental health as a national priority for health and social services for the first time, set out in the White Paper *'Modernising Health and Social Services: National Priorities Guidance for 1999/00 - 2001/02'* (DH, 1998b). Further White Papers including *'Modernising Mental Health Services Safe, Sound and Supportive'* (DH, 1998a) and *'Modernising Social Services'* (DH, 1998c) influenced the implementation of the National Service Framework for Mental Health (NSF-MH) (DH, 1999b). The NSF-MH outlined standards and service models in mental health. The NSF-MH outlined ten guiding principles for service delivery in mental health (DH, 1999b; p.4):

- Service user and carer involvement in the planning and delivery of care
- High quality treatment and care
- Non-discriminatory and well-suited services
- Accessible services
- Promotion of safety
- Offer choices which promote independence
- Well co-ordinated services
- Continuity of care
- Empower and support staff
- Be properly accountable

In addition, the NSF-MH also outlined seven national standards set across five areas (DH, 1999b; p.5):

- Mental health promotion
- Primary care and access to services
- Effective services or people with severe mental illness
- Caring about carers
- Preventing suicide

In order to deliver the national standards and guiding principles Primary Care Trusts (PCTs) were developed. The NSF-MH was important for HRS as it acknowledged the previous lack of input from 'users' and carers, patchy services with unclear aims and services, and a lack of financial resources (Thornicroft, 2000). Thornicroft (2000) also indicated the importance of the NSF-MH as it was built upon an evidence base, unlike other previous Government documents. Rather than being simply a vision for mental health, the framework included performance indicators and timeframes for monitoring purposes.

As part of the LGMA and in response to the NSF-MH the CPA framework was reviewed in '*Effective Care Co-ordination in Mental Health Services:*

Modernising the Care Programme Approach - A Policy Booklet' (DH, 1999a). Part of the need for review was given as: 'Professionals have found some aspects of the CPA over-bureaucratic, managers and service users alike have found the lack of consistency confusing. It is they who have been working and living with the CPA for some years now and it is important to take account of their views' (DH, 1999a; p.3). This review was important for people living with mental health problems as it demonstrated that policy implementers were listening to 'service-users', and their input was being used to shape mental health services. This indicates the person living with mental health problems was becoming more active in their mental health care, as opposed to a passive subject which has been widely demonstrated previously.

The 2007 Mental Health Act defined the roles of Supervised Community Treatments (SCT) and Community Treatment Orders (CTOs), which were put into practice in November 2008 (replacing SDOs). Supervised Community Treatment (SCT) allowed the patient to be treated in the community but under a Community Treatment Order (CTO). They were implemented to address the 'revolving door' effect and prevent deterioration and hospital readmission rates (Churchill, Owen, Singh and Hotopf, 2007). SDOs were introduced as aftercare for patients who had been detained and needed further assistance to prevent risk or serious harm/exploitation to themselves or others (Churchill et al, 2007). CTOs require patients to accept clinical monitoring, and included powers to rapidly recall patients for assessment (Burns et al, 2013). These concepts received criticisms around medication compliance (Lawton-Smith, Dawson and Burns, 2008), which arguably made the concept no different to guardianship (Churchill et al, 2007). Furthermore, the initiatives endured criticisms such as

variations in rates and uses of CTOs and a limited research base (Burns and Dawson, 2009). A randomised control trial (RCT) into CTOs has failed to support this. Burns et al (2013) found that CTOs did not reduce the hospital readmission rates for patients who are psychotic. They stated that there was *'No support in terms of any reduction in overall hospital admissions to justify the significant curtailment of patients' personal liberty'* (Burns et al, 2013; p.1). However, whilst they may not reduce admission rates, there is evidence which indicates that CTOs reduce the amount of time spent in hospital when admitted. Kisely et al (2013) found that there was a mean decrease of 5 bed-days in hospital from the CTO group compared to controls. The authors saw this as suggesting that CTOs may reduce the lengths of stay in hospitals (Kisely et al, 2013).

Supporting People

On the 1st April 2003 the 'Supporting People Programme' was launched by the Department for Communities and Local Government (CLG) to provide housing related support for vulnerable people. The definition of vulnerable used in the Supporting People Programme include those who are homeless, older, have learning difficulties, offenders, have mental health problems, young people leaving care, women experiencing domestic violence, vulnerable Gypsies and Travellers, teenagers parents, and refugees (Communities and Local Government, 2009a). Supporting People was launched as the 'government programme for funding, planning and monitoring housing related support services' (Directgov, 2011). The programme arose out of the uncertainty and confusion about funding, so pulled seven funding streams together into one. This included Transitional Housing Benefit (THB); Housing Corporation

Supported Housing Management Grant (SHMG); and the Probation Accommodation Grant Scheme (PAGS) (Audit Commission, 2007). The restructure in funding aligned with the change of housing benefit which, from 2003 could only be used to pay for 'bricks and mortar' (Wilson, 2012; p.2). Unlike the previous support during the 'care in the community' era Supporting People was administered through all local authorities and documented to help around 37,300 people with mental health problems (CLG, 2011).

With this change in funding came a change in housing models. What was once a 'home for life' under care in the community models became a 'stepping stone' to independent living (Warnes and Crane, 2000; Whitley and Siantz, 2012). In America they had implemented a 'continuum of care' under programmes such as 'staircase models' and 'transitional housing' (Ridgway and Zipple, 1990). In the UK under the Supporting People Programme 'tenants' were now given a two year window where they were expected at the end of this period to move on into independent living, or earlier if possible. A reason for this can be the influence of 'reinstitutionalisation' which refers to people who become institutionalised in residential care settings, as they were in hospitals (Priebe and Turner, 2003). Care in the community evidenced that placing individuals straight out of hospitals into the community was unsuccessful, so short term supported housing placements were proposed to bridge that gap and make the conversion more manageable.

However, after the introduction of Supporting People it quickly became apparent that the cost of the programme had been grossly underestimated. The initial estimate for SP was between £350 million and £750 million but the final

allocation in 2003 was £1.8 billion (House of Commons, 2012). The programme was an attempt at transparency and clarifying where monies should come from and what roles/responsibilities are included in that money (similar to the health services reorganisation defining health and social care in 1974). For example, 'wardens' in Supported Housing had undertaken a range of health and social care roles such as checking on tenants, helping with their medication, putting on their socks and managing the building. The introduction of Supporting People discouraged these roles and the 'warden' was replaced with a housing manager, support workers, nurses and other relevant professionals (Wilson, 2012). The warden role came into criticism as it was difficult to monitor and manage, there was confusion/tension over the roles of the wardens, and they are very costly (Scanlon, 2006). The importance of their role was related to funding because; following the reorganisation of services the NHS footed the bill for health, whereas other care would be funded from elsewhere. The wardens were fulfilling a range of these services, so their removal was an attempt to clarify the boundaries of responsibility. Nurses/CPNs employed by the NHS then attended to a person's medication (for example, administering depot injections), whereas the HRS organisation funded roles such as the housing manager and support workers.

Although Supporting People arguably professionalised the service it was then an issue of where the money should come from to fund the extra costs. This was further complicated when the existing money was threatened as the ring fence for Supporting People funding was removed in April 2009 (Communities and Local Government, 2009b). The removal meant that Government were no longer obliged to invest money in supported housing. The funding changed to

allocation through Formula Grant and allocated via the Local Government Finance Report (House of Commons, 2012). Within three months of the ring-fence around the funding being removed five of the thirty-two authorities in Scotland had already disbanded their Supporting People teams and no longer had anyone identified with the core responsibility for HRS (Communities and Local Government, 2009b). This could indicate that HRS was not in local Council priorities. Local authorities identified their priorities in their Local Area Agreement (LAA). A Local Area Agreement composed from a 'national indicators set'. Local authorities chose 35 national indicators (out of a possible 198) to address in their LAA, which is a three year agreement. Of these 198 only two national indicators were directly related to Supporting People services (Communities and Local Government, 2009a). Neither of these indicators were mandatory so there was a high chance of HRS being neglected.

Current Housing and Related Services and the future

The government removed the ring-fence for Supporting People as it sought a movement towards full needs based allocations (Communities and Local Government, 2010). This can be seen as part of the personalisation agenda which involves engaging individuals in assessment of need and development in services in order to bring out the best in staff and satisfy service users (Leadbeater, 2004; p.12). Ideas for this include direct payments, personal budgets and individual budgets. This is a long way from putting people into asylums and much more person-centred than early conditions for people living with mental health problems. In terms of housing new ideas arose in the US in the 90s where there was a trend for 'Housing First' models as an alternative to transitional models. The first one was started by Pathways to Housing in New

York and was founded upon a ‘housing first’ rather than ‘treatment first’ philosophy, (Johnsen and Teixeira, 2010). The idea has taken a long time to catch on elsewhere though, with Finland implementing housing first in 2007 (ahead of their target to end homelessness from 2008-2011) (FEANTSA, 2010) and France in 2010 (French Republic, 2010). Shelter (2008) documented elements of Housing First being used in the UK (for example, properties firstly leased from private landlords, and then rented on to homeless households), but emphasised that ‘no single model of housing and support is likely to be effective for all homeless people with complex needs’ (Shelter, 2008; p.1). Johnsen and Teixeira (2010) documented that the UK shows ‘elements of ‘Housing First-ness’, but these tend to be used with clients who have low or medium support needs’ (p.6). In 2010 The Jury for the European Consensus Conference on Homelessness recommended that ‘housing-led’ approaches were the most effective solution to homelessness (with Housing First being good examples of housing-led approaches) (Pleace, 2012). Despite this statement more recent literature (e.g. Pleace and Bretherton, 2012) has warned that a growing diversity in ‘Housing First’ services may have ‘drifted’ away from the original service design which puts it at risk of ambiguity and confusion in its implementation.

The variation in accommodating people living with mental health problems demonstrates it is a topic which has not yet reached a consensus. The perceptions of people living with mental health problems has improved, but the wide range of housing models (such as transitional, staircase and housing first) indicate that a model of best practice is yet to be found. Furthermore, it has been considered that there may not even be a model of best practice in HRS,

as one single model may not be appropriate or effective for all people (e.g. Shelter, 2008).

Overview of HRS progression

There is ongoing debate and contention about how best to accommodate people living with mental health problems. The issue is complicated as it involves policy, practice and financial implications. The combination of these factors have evolved throughout the history of mental health and Goldman and Morrissey (1985) identified a 'cyclical pattern of institutional reforms' that were 'marked by public support for a new environmental approach to treatment and an innovative type of facility or locus of care' (p.727). They argue that each attempt at reform is not 'new', but it is simply a revised version of the previous effort to accommodate people living with mental health problems. They claimed that in failing to address social problems such as dependency, criminality and poverty the result has been a repeating cycle of policies 'which only partly accomplish the goals of their activist proponents' (p.727). Table 2A integrates the ideas of Goldman and Morrissey (1985) with the addition of the newest 'trend' in housing: individual budgets and 'Housing First' models. Table 2A documents the changes and trends in the evolution of HRS that have been discussed throughout the chapter. In the UK individual budgets are being piloted on staircase/transitional models of housing which are not based on a Housing First principle. This could be due to reservations about the effectiveness of Housing First, which were evaluated by Pleace and Bretherton (2012), and included issues with the fidelity of subsequent attempts at Housing First and trustworthiness of the evidence base.

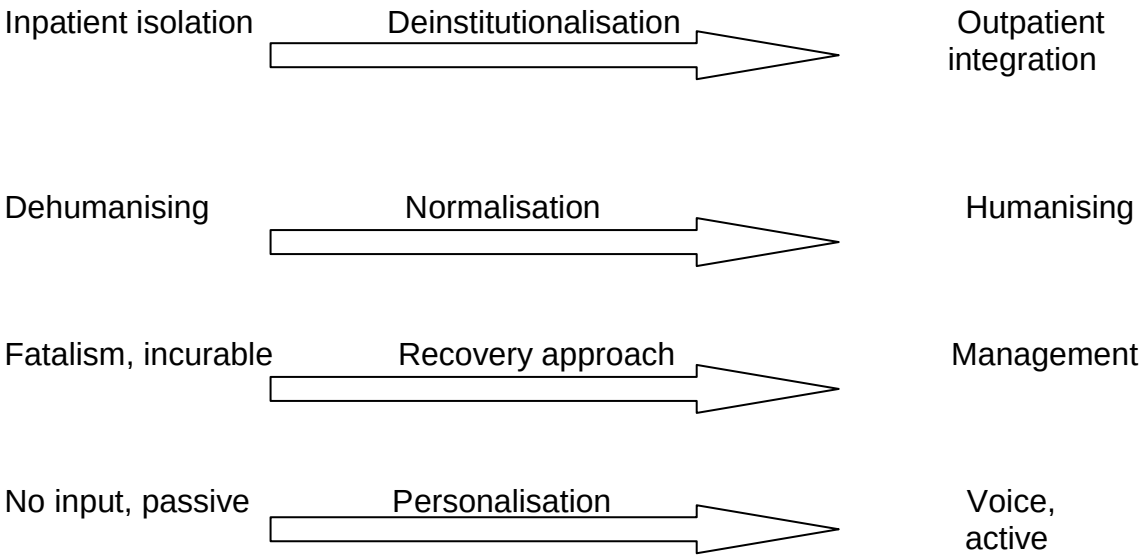
Table 2A.
Ideas for accommodating people living with mental health problems, their funding source and the housing model and principle on which they were implemented
(Cycles 1-4 adapted from Goldman and Morrissey, 1985)

Cycle	Time	Accomm-odation	Funding	Housing model(s)	Principle/ influences	Important policy, Acts, programmes
1	19th C	Asylums	Private	Asylums	Segregation/ Moral movement	Madhouses Act (1774), County Asylums Act (1808), Lunacy Act (1890)
2	Early 20th C	Mental Hospital	Private and state	Hospital based structure	Segregation/ mental hygiene movement	Mental Treatment Act (1930) Mental Health Act (1959)
3	Mid 20th C	Shelters/ homes	Multiple inputs	Care in the community	Home for life/ Community mental health movement	'Health and Welfare: the development of Community Care' (DHSS, 1963), 'Hospital services for the mentally ill' (DHSS, 1971), 'Better services for the mentally ill (DHSS, 1975), National Health Service Reorganisation Act (1973), Mental Health Act (1983), Griffiths report: 'Community Care: Agenda for Action' (1988), National Health Service and Community Act (1990), Mental Health (Patients in the Community) Act (1995), Health and Social Care Act (2008)
4	Late 20th C/ early 21st C	Supported housing	Supporting People	Staircase/ transitional	Continuum of care/ community reform support	Supporting People Programme (2003) Mental Health Act (2007)
5	Early 21st C	Independ-ent living	Government–independent budgets	Housing Led	Housing First	'Pathways to housing' programme (1992)

Throughout this chapter the topic of accommodating people living with mental health problems has been discussed. In determining the best way to accomplish this, a question to be considered is the best way for whom? The ‘the best way’ may not always be established by the tenant/service user, but instead the government/people funding the housing. Goffman (1961) claimed that, rather than the person living with mental health problems themselves, structures suited and served the needs of others such as relatives, police, judges, psychiatrists. Arguably the ‘best way’ has been the most cost effective which conveniences people other than the individual living with mental health problems, for example funding bodies/government. The solution may be a compromise which involves an effective, sustainable and cost-effective programme which is favoured by people living with mental health problems themselves. What that programme looks like is not yet definite but developments throughout history are clear and ‘housing first’ models are a long way from ‘lunatic asylums’.

This chapter has illustrated that the development of mental health services has involved a number of changes as it has evolved over time. It may not be possible to establish cause and effect for all of these variables but recognition of them contextualises HRS and gives a background to how it has developed. Examples of these changes can be found in Figure 2i.

Figure 2i.
Mechanisms of change – theoretical concepts which have affected the evolution of mental health services



Summary

The purpose of this chapter was to provide a historical background of the transition from accommodating to supporting people living with mental health problems in the community. In doing this five themes emerged: (de)institutionalisation, models of health and illness, power relationships, stigma and reform.

The (de)institutionalisation theme developed through the evolution of HRS and was marked by the transition from in-patient isolation to out-patient integration. The development was documented with the progression from asylums, to mental hospitals, to a home for life, to contemporary housing models (staircase, transitional, housing first). This theme was also mirrored in the movement away

from fatalism to recovery. Hope and optimism rose with the belief that people had the ability to change as opposed to accepting a lifetime of ‘lunacy’. Normalisation was a driver for deinstitutionalisation and the concept of community care replaced institutional living arrangements.

In line with (de)institutionalisation the theme models of health and illness arose. This theme was demonstrated in the evolution from mysticism to the medical model to the social model of health/illness/disability. Progressions were made in viewing mental health not as simply illness/cure but as a complex issue where psychological and social factors needed to be considered. The psychopharmacology movement supported the medical model and enabled the possibility of community living but the anti-psychiatry movement opposed this and aligned with the social model arguing that concepts such as mental health were socially constructed so people shouldn’t be segregated in the first place.

The anti-psychiatry movement also aligns with another theme which emerged from this chapter: power relationships. Supporters of anti-psychiatry argue that psychiatry is simply a means to control people, enforce ‘norms’ and label anything which does not conform. The anti-psychiatry and moral treatment movements were examples of challenges to the power dynamic between health professionals and the public/service users. The balance of power has arguably shifted with the service user moving from a passive recipient of treatment/care /services to an active participant who has a voice. This transfer of power has also been mirrored in policy where personalisation has provided service users with choice in addition to their voice.

Stigma emerged as a theme as the concept has plagued mental health with negative stereotypes and labels. However, there have been positive developments which started with the acknowledgement that stigma was an issue in mental health which needed addressing. Perceptions, understanding, attitudes and social reception of mental health have seen improvements with campaigns, education and incidents such as shell shock which challenged previous stereotypes. There was a shift from ideas of possessed sub-humans to humanising people living with mental health problems and supporting their entitlement to a 'normal' life. Terminology has changed through legislation due to the acknowledgement that 'labelling' had occurred and outdated words carried stereotypes and stigma.

The final theme which emerged from this chapter was reform, which has occurred through legislation, policy and Acts. It has been demonstrated that there has been cycles of reform, or perhaps more accurately recycled attempts at the same reform over time. Reform has occurred in response to campaigns and movements (e.g. moral treatment) and to overcome stigma surrounding mental health. Early reforms concentrated on the treatment/conditions and terminology in mental health where the concept of institutional living was not really challenged.

Later reforms addressed this concept through the deinstitutionalisation movement and abolishing old asylums. The later reforms have thus focused on funding/financial issues and defining organisational responsibilities. For example, this chapter referred to the complications of funding HRS programmes in mental health as the topic straddles health care, social care and housing, so

there is debate and contention as to who has ownership and therefore responsibility. With each sector having their own priorities and financial pressures all three areas (social care, health care, and housing) have pushed mental health services back and forth, waiting for one another to pick up the bill.

The evidence suggests that an answer to the ‘best’ way to accommodate/provide services for people living with mental health problems has not been decided with the government piloting new ideas currently in terms of individual budgets. What’s more, the answer may never be decided if it is down to subjective opinions, but what can be concluded is that the situation in terms of welfare and human rights has improved vastly since the conditions of early asylums.

This chapter has provided a greater understanding of the development of HRS. The historical contextualisation provides foundations to build this study. Therefore, the following chapter will present the methodology which guided this study.

Chapter Three: Methodology

Research methodology concerns the assumptions underlying the techniques used in research (Kothari, 2004). It focuses on the 'best means for acquiring knowledge about the world' (Denzin and Lincoln, 2005; p.183). The methodology for this study has been informed by the work of Crotty (1998) on the foundations of social research.

This chapter will be split into two sections: the first will set out the philosophical underpinnings of the research, and the second will outline the research design which guided the study.

3.1. Philosophical Underpinnings of Research

Firstly, methodology needs to be understood within its wider philosophical context. The philosophical underpinnings of research are important as together they compose the approach taken by the researcher to their research. These parameters ‘can influence the way in which the research is undertaken, from design through to conclusions’ (Flowers, 2009; p.1). Therefore, it is important to acknowledge them so that ‘approaches congruent to the nature and aims of the particular inquiry are adopted, and to ensure that researcher biases are understood, exposed, and minimised (Flowers, 2009; p.1). This section will discuss a collection of related concepts which constitute the study’s philosophical underpinnings: ontology, epistemology, research paradigm, and theoretical perspective. These factors have been prepared in a flowchart (Figure 3i.) to illustrate the philosophical underpinnings of research.

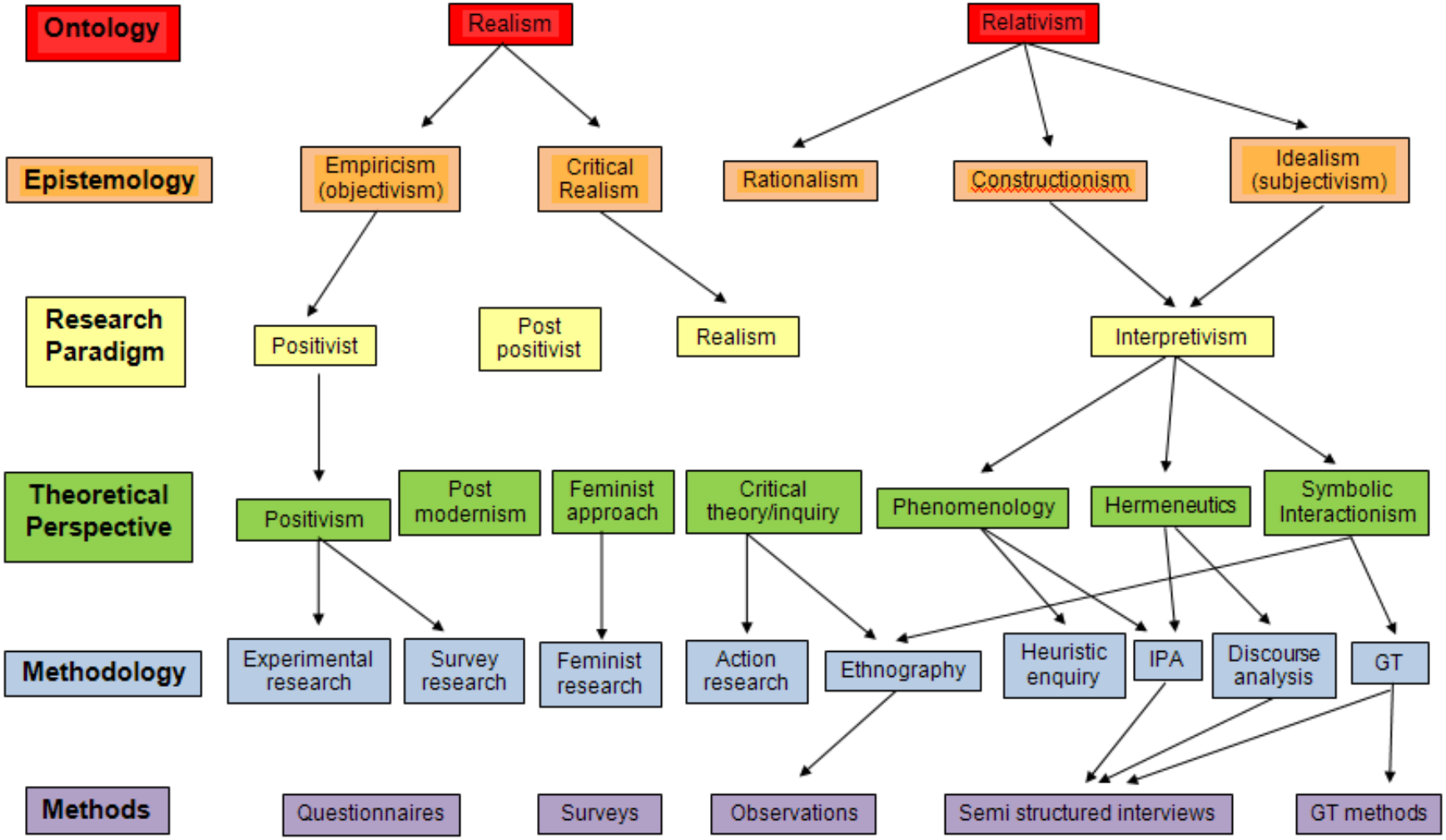


Fig 3i. Philosophical underpinnings of research

Ontology

Ontology refers to the study of what exists (Higgins and Smith, 2013). Ontology 'describes our view (whether claims or assumptions) on the nature of reality, and specifically, is this an objective reality that really exists, or only a subjective reality, created in our minds' (Flowers, 2009; p.1). The former is associated with realism, and the latter is associated with relativism.

Relativism 'is the view that cognitive, moral or aesthetic norms and values are dependent on the social or conceptual systems that underpin them, and consequently a neutral standpoint for evaluating them is not available to us' (Baghramian, 2004; p.1.). Therefore, a person's judgement is not external but instead it is influenced by a number of factors which affects their understanding of object/phenomena. This study aligns with relativist ontology, as HRS is not an objective concept, but one which is open to interpretation. HRS is a concept which has been taken and applied diversely in different situations and contexts. This suggests that HRS is not a true model, but one which relies on the understanding of its implementers.

Epistemology

Epistemology refers to the study of knowledge. It concerns what knowledge is and what it is worth (Neta, 2014). Furthermore epistemology involves the consideration of the degree of knowledge in terms of how much or little we do or can know. Within epistemology there are three main stances: objectivism, constructionism, and subjectivism. Objective epistemology holds that there is a truth, and objects/concepts have intrinsic meaning, which people discover to obtain knowledge (Audi, 2009). Constructionist epistemology embraces the idea

that the world is independent of the mind, but knowledge of that world is socially constructed by people (Crotty, 1998). Subjectivist epistemology promotes the idea that people impose truth onto the world, and that objects/concepts have an acquired meaning which humans have given them (Audi, 2009).

This study aligns most closely with a constructionist epistemology whereby HRS in theory is a specific concept (housing + additional services), but in practice there is variations to its implementations due to different people constructing their interpretations of this concept in their own way.

Research Paradigms

Research paradigms are the basic ontological and (the related) epistemological positions, and have 'developed in both classical and contemporary forms to effectively classify different research approaches' (Flowers, 2009; p.2). They are 'a set of philosophical assumptions about the phenomena to be studied, about how they can be understood, and even about the proper purpose and product of research' (Hammersley, 2012; p.2). Flowers (2009) identified three key paradigms: positivist, interpretivist, and realist.

Positivist assumptions stipulate that 'science is the only reliable source of knowledge', 'science involves logically inferring clearly specified laws about the behaviour of phenomena from evidence', and 'the evidence must be empirically given' (Hammersley, 2012; p.19). Furthermore, there is no room for subjective factors in positivist research, and instead there should be strict control of variables, with the adoption of quantitative measures (Hammersley, 2012).

Positivism is characterised as being deductive where existing theory is used to create and test hypotheses (Flowers, 2009).

Interpretivism on the other hand is inductive and is concerned with theory building (Flowers, 2009).The main aim of interpretivism is ‘understanding the subjective meanings of persons in studied domains’ (Goldkuhl, 2012; p.4). This is achieved by working with ‘these subjective meanings already there in the social world; i.e. to acknowledge their existence, to reconstruct them, to understand them, to avoid distorting them, to use them as building blocks in theorizing’ (Goldkuhl, 2012; p.5). An interpretivist argument is that one cannot understand a person’s actions without grasping how that person makes sense/interprets their world, which requires an understanding of their beliefs, attitudes and perceptions (Hammersley, 2012).

Realism draws from both positivist and interpretivist positions (Flowers, 2009). From positivism realism has adopted the goal of rational, empirically-based science, but in line with interpretivism argues that social reality is pre-interpreted (Flowers, 2009). Krauss (2005) stated that ‘the concept of reality embodied within realism is thus one extending beyond the self or consciousness, but which is not wholly discoverable or knowable (p.761).

An interpretivist paradigm was adopted for this study as the focus is people living with mental health problems. A positivist approach would lose sight of individuals as it rejects subjective factors. A realist approach would concentrate on the wider concept of reality, whereas interpretivism allows the focus to stay on the individuals. This is important in HRS as the history chapter documented

how the priority has revolved around other issues such as housing models and policy, approaches to mental health, and measuring outcomes; not the service-user experience.

Theoretical perspective

Theoretical perspective refers to 'the philosophical basis on which the research takes place, and forms the link between the theoretical aspects and practical components of the investigation' (Mugo, 2013; p.7). Theoretical perspective concerns the underlying assumptions of the approach to research (Crotty, 1998). Crotty (1998) identified a number of theoretical perspectives in research: positivism, postmodernism, feminism, critical enquiry, phenomenology, hermeneutics, and symbolic interactionism.

Positivism 'offers assurance of unambiguous and accurate knowledge of the world' (Crotty, 1998; p.18). It aims to be objective, and based on empiricism (Sim and Wright, 2000). A positivist theoretical perspective would include the development of nomothetic knowledge in the form of universal laws (Punch, 2013).

Postmodernism was borne from the belief that social conditions have changed drastically so previous ways of knowing are no longer applicable (Esterberg, 2002; p.20). Thus, postmodernism holds some 'fundamental dissatisfactions with the scientific world view' (Seale, 1999; p.471). Instead postmodernists would argue that there is not one true reality, instead there are multiple, equally valid realities and ways of knowing (Esterberg, 2002; p.20). This in turn is problematic for qualitative research as it could be argued that explanations or

accounts will always be incomplete or have deficits as knowledge is provisional (Esterberg, 2002).

Feminist perspective ‘recognises the essential importance of examining women’s experience’ and ‘is attentive to issues of difference, the questioning of social power, resistance to scientific opposition, and a commitment to political activism and social justice’ (Hesse-Biber, Leavy and Yaiser, 2004; p.3). However, Harnois (2013) was keen to point out that feminist research requires a feminist perspective but does not necessarily focus on women or gender.

Critical theory is ‘concerned in particular with issues of power and justice and the ways the economy; matters of race, class and gender; ideologies; discourses; education; religion and other social institutions; and cultural dynamics interact to construct a social system’ (Kincheloe and McLaren, 2002; p.90)

Phenomenology, put simply, is the investigation of phenomena, or ‘things’ (Priest, 2004). The aim is to uncover and describe the essence of phenomena (Priest, 2004). Essences refer to essential features of the world (Honderich, 2005). Phenomenology considers bracketing existing understandings of phenomena and re-visiting them in order to capture new meaning, or consolidate/enhance existing meaning (Crotty, 1998). By doing this ‘one suspends judgement about the existence of things around us’ (Honderich, 2005; p.104). A phenomenological theoretical perspective holds that there is ‘a fundamental difference between the objects of the outside perceptual world and the objects of the world of consciousness; the former are never given to us

wholly and completely in single mental acts of perception, and the latter are fully given to us when we attend to them. But the self...is only presented to us indirectly' (Honderich, 2005; p.696).

Hermeneutics concerns interpretation and the phenomena of language (Honderich, 2005). In hermeneutics, the aim of interpretation of phenomena is to uncover hidden meaning (Priest, 2004). In hermeneutics 'pre-existing personal experiences and 'pre-judgements' or prejudices should not be eliminated or suspended, but rather acknowledged as exerting a profound influence on the understanding of phenomena; therefore they are important to interpretation' (Priest, 2004; p.6).

Symbolic interactionism stems from the work of social psychologist George Herbert Mead, but was developed by Herbert Blumer (Crotty, 1998). Blumer (1969; p.2) stated that symbolic interactionism is based on three simple premises:

1. Human beings act towards things based on the meanings they have for them,
2. The meanings of things is derived from social interaction,
3. The meaning of things are handled/modified by an interpretative process by the person dealing with the things they have encountered

These factors illustrate the core principles to symbolic interactionism revolve around meaning, language and thought. For this study a symbolic interactionist theoretical perspective was adopted. In applying symbolic interactionism to HRS it holds that stakeholder meaning of HRS is developed through social interaction with the HRS environment. Additionally, stakeholders will act

towards HRS on the basis of the meaning they have constructed for the concept. Also in line with this perspective, a person's meaning and experience of HRS will be modified through their personal interpretive process.

Methodology

Methodology refers to 'the strategy, plan of action, process, or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes' (Crotty, 1998; p.3). Crotty (1998) identified nine research methodologies: experimental research, survey research, feminist standpoint, action research, discourse analysis, phenomenological research, heuristic inquiry ethnography, grounded theory. The mapping of theoretical perspectives to the associated methodology is illustrated in Table 3A.

Table 3A.
Theoretical perspectives and methodology mapped out

Theoretical perspective	Methodology
Positivism	Experimental research Survey research
Feminism	Feminist standpoint
Critical enquiry	Action research
Hermeneutics	Discourse analysis
Phenomenology	Phenomenological research → IPA Heuristic inquiry
Symbolic Interactionism	Grounded Theory Ethnography

Table 3A demonstrates how the assumptions can inform the strategy of a piece of research. The positioning of a researcher should define the way in which research is implemented. Furthermore, it was important for the methodology to be the appropriate approach to achieving the aims and objectives of this study. In the abstract of this thesis it was stated that the purpose of this study was to re-evaluate the area of HRS. Therefore the starting point for this needed to be grounded in the foundations of HRS. This was reflected in the aim of the study referring to the evolution of HRS and how it has been documented, investigated and experienced. Because of this an action research approach, which relies on the knowledge of the problem/issue to be solved, would be inappropriate. Action research could be useful for future research in HRS but a previous step of investigating the area to uncover the problems/issues was needed. The aims and objectives of this thesis align with this previous step.

The aim of the study emphasised the need to capture the experience of HRS from those who delivered and received it. Therefore, the study was intentionally focused on the stakeholders of HRS. Because of this a heuristic enquiry approach was dismissed for this study. In heuristic enquiry the researcher is seen as a participant in the study and is encouraged to 'pursue the creative path that originates inside of one's being and that discovers its direction and meaning within oneself (Djuraskovic and Arthur, 2010; p.1572). As well as obscuring the focus of the study away from HRS stakeholders, it was felt that researcher bias may occur with heuristic enquiry. This would go against the purpose of the study which was to undertake a critical exploration of HRS.

Superficially, Interpretive Phenomenological Analysis (IPA) could appear to align with the aim and objective of this study. For example. IPA was developed to explore ideographic subjective experiences and social cognitions (Biggerstaff and Thompson, 2008). IPA investigates 'how participants are making sense of their personal and social world and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants' (Smith and Osborn, 2007, p.53). IPA acknowledges the role of interpretation but holds that is possible to 'access an individual's cognitive inner world' (Biggerstaff and Thompson, 2008; p.5). On one hand this approach is fitting with the intention to discover stakeholder experiences of HRS. However, this study aims to move past the descriptive narrative of stakeholders into critiquing the issues which arise and contextualising this alongside the documentation of HRS evolution in literature and research.

Based on Table 3A it is possible to see that in fitting with the philosophical underpinnings guiding this study Grounded Theory (GT) and ethnography align with symbolic interactionism. Adopting a methodology which aligned with the wider philosophical underpinnings of the research was important as well as deciding which approach would best answer the aims and objectives of the study. On a surface level ethnography could achieve this with a central concept being the 'understanding and representation of "experience"' (Willis and Trondman, 2000; p.6). This study aimed to capture the experiences of stakeholders in HRS. However, this approach, which relies on the immersion of the researcher in the research field, is vulnerable to the same criticisms of heuristic enquiry in terms of researcher bias. Furthermore, ethnography is the 'written representation of culture (or selected aspects of culture)' (Van Maanan,

2011; p.1). Whilst this could provide an insight into the culture in a HRS organisation this approach, like IPA could be limited to descriptive information whereas this study aimed to undertake a critical exploration of HRS.

Grounded Theory (GT) aims 'to generate theories regarding social phenomena: that is, to develop higher level understanding that is "grounded" in, or derived from, a systematic analysis of data' (Lingard, Albert and Levinson, 2008; p.459). GT was adopted for this study as a richer understanding of HRS was needed that fully emerged from the data, and was not reliant on researcher interpretations to lead the findings. This was fitting with the aim and objectives of the study as it allowed the researcher to move beyond description of HRS stakeholders experience to critical exploration in the generation of theory. Furthermore, the findings are focused and emerge solely on the participants' experience which was important for this study. A more thorough explanation of GT in relation to this study is presented.

Grounded Theory

Glaser and Strauss (1967) developed Grounded Theory (GT) which concerns 'how the discovery of theory from data – systematically obtained and analysed in social research – can be furthered' (p1). There are three main approaches to GT: Glaserian, Straussian and Constructivist. Each of these approaches brings with it different philosophical underpinnings and a table (Table 3B) has been prepared to illustrate this.

Table 3B.
Distinguishing features of the different approaches to GT

Type	Ontology	Epistemo-logy	Theoretical perspective	Method-ology	Researchers
Glaserian	Realist	Objectivism	Positivist	GT	Glaser & Strauss
Strauss-ian	Critical Realist	Subjectivism	Post positivist	GT	Strauss & Corbin
Construct-ivist	Relativist	Construction-ism	Interpretivism	GT	Charmaz

Table 3B demonstrates that there are a range of factors which have led to the development of three separate perspectives under the umbrella of GT. Walker and Myrick (2006) highlighted that differences lie in 'the researcher's role, activity, and level of intervention in relation to the procedures used within the data analysis process' (p.547).

Glaser's work is seen as the classic approach and it emphasises the emergence of theory from the data without the imposition of the analyst's conceptual categories onto the data (Nolas, 2011). This has strong positivist roots with an objective perception of reality. The researcher was part-funded by the HRS organisation which represents the Case Study and it would be unrealistic to argue there is tabula rasa, or that the researcher's position will not have any effect on the research. Because of this the Glaserian approach to GT was ruled out.

Straussian GT is less positivist and holds that complete objectivity is impossible as every piece of research contains an element of subjectivity. Instead the objectivity is apparent through the willingness to listen and to give voice to respondents (Strauss and Corbin, 1998; p.43). This stance is more fitting with

post-positivism. Walker and Myrick (2006) argued that Straussian GT re-prioritised aspects of original GT, placing more emphasis on their tools, paradigms and matrices. This could potentially over-formalise, and over-complicate the procedure and lead to enforcing quantitative parameters which could restrict the goal to be inductive. Because of this Straussian GT was not adopted for this study.

The most recent of GT theorists is Charmaz (2006) whose approach concerns the emphasis of joint meaning, and is the form of GT used to inform this study. Before proceeding it is important to highlight an inconsistency in the way Charmaz's approach has been described: constructivist and constructionist. The terms have been used interchangeably (Andrews, 2012). McNamee (2004) proposed the two share similarities based on their focus on meaning-making processes. Some authors have indicated a slight difference in that constructivism focuses on the individual and their cognitions, whereas constructionism focuses on the social processes (e.g. Young and Collin, 2004). In this study both the internal processes of the stakeholders making sense of HRS, and the external processes which may affect their understanding of HRS are important. Therefore, this study adopts a constructivist approach to GT which is embedded within a social constructionist epistemology. For the remainder of the thesis the term constructivist will be used to maintain consistency.

Against Glaser's quest for objectivity Charmaz (2006) stated that 'rather than being tabula rasa, constructivists advocate recognising prior knowledge and theoretical preconceptions and subjecting them to rigorous scrutiny' (p.402).

This shows an acknowledgement of the influence of the researcher on a research project, and rather than dismiss it she proposes the researcher should integrate this as part of the research process. This is more realistic for the current study as the researcher was funded by the organisation acting as the Case Study. But explicitly acknowledging this factor and evaluating the researcher's influence as part of the study will help control researcher bias. Also, when discussing experience and lived knowledge this will be approached with a constructivist lens whereby the researcher understands these accounts as multiple constructed realities. Multiple constructed realities are various 'contradictory but equally valid accounts of the same phenomena' (Johnson and Onwuegbuzie, 2004; p.16). This appears to be very fitting with the study as the concept of HRS has been interpreted very differently in numerous HRS models, so constructivist GT accommodates this.

Reflexivity

Constructivist Grounded Theory acknowledges the role of the researcher in the research process. In order to account for this influence the researcher is encouraged to engage in reflexivity throughout the project. Finlay (2002) refers to reflexivity as the examination of how 'the researcher and intersubjective elements impinge on and even transform research' (p.210). The aim of reflexivity is to make the research project 'less esoteric, and more transparent and accountable' (Nolas , 2011; p.20). In order to maintain reflexivity throughout the researcher kept two diaries: a research diary and a field diary. The field diary was specific to the data collection, so documented questions in the interviews, responses, areas in need for further exploration, and ideas to inform the next interview. An extract from the field diary can be found in Appendix 3a.

The research diary is more general and overarches the whole project so documents events, time lining, project decision making (for example concerning methods), changes to circumstances which may affect the project etc. An extract from the research diary can be found in Appendix 3b. The use of these diaries enabled the reflection and evaluation of experiences, and documents decisions, the process, supervision and other incidences. The diaries were updated throughout the research process and revisited to ensure transparency and providing a clear account of how the research was undertaken. To expand the contribution to reflexivity the researcher also created an online blog to be shared with the supervision team. Here anonymous extracts from the interviews and parts of the research diaries were posted to the blog. This allowed the supervision team to comment and facilitated discussion which encouraged further reflection and evaluation. This also promotes transparency and aimed to reduce subjectivity in the research process by gaining the input of two other researchers. Due to confidentiality reasons the blog is not publicly available.

Methods

Specific methods of the study will be discussed in the methods chapter (Chapter four). For this study it was decided that a qualitative approach would be the most appropriate. Previous chapters have demonstrated that there have been many attempts in the field of HRS to apply quantitative parameters in research. However, it has also been illustrated that despite quantitative studies, there still remains questions that are unanswered in the area. It was argued that there is a need to re-evaluate research in HRS and mental health, concentrating on the people's experiences, and exploring the area in depth. A qualitative approach was judged to be the most efficient manner to achieve this.

Summary

This section has outlined the philosophical underpinnings of the study, from ontology to methodology. Understanding this is hugely important as ‘If these underlying assumptions are not identified and considered, the researcher may be blinded to certain aspects of the inquiry or certain phenomena, since they are implicitly assumed, taken for granted and therefore not opened to question, consideration or discussion’ (Flowers, 2009; p.1). Other approaches for this study were dismissed because of limitations such as a superficial level of description/interpretation and/or researcher bias. The selection of GT for this study was to investigate at a deeper level to attain meaning and understanding of the concept (HRS). GT was also chosen due to being the most appropriate approach to address the research aim and objectives. The following section outlines the research design of the study.

3.2. Research design

Research design 'provides a framework for the collection of data and analysis' (Bryman, 2012). The three most common criteria in which social research is evaluated are validity, reliability and replicability (Bryman, 2012). However, Guba and Lincoln (1989) challenged the appropriateness of these criteria in a qualitative context, and instead proposed a more relevant set of principles. These can be found in Table 3C.

Table 3C.
Comparison of conventional criteria with alternative criteria for the evaluation of social research (Adapted from Guba and Lincoln, 1989)

Conventional paradigm	Parallel criteria (trustworthiness)
Internal validity	Credibility
Validity/generalisability	Transferability
Reliability	Dependability
Objectivity	Confirmability

Table 3C demonstrates that qualitative research should consider credibility, transferability, dependability and confirmability in their design. Credibility refers to the accuracy in which the true picture of the concept in question is captured by the study (Shenton, 2004). In this study it means the accuracy in which HRS is accurately captured by the researcher. Transferability concerns the selection of participants that are representative of the sample population, and allow the possibility of making connections from this representative sample at a local and community level (Jensen, 2008). In this study it requires selecting stakeholders of HRS which are representative of the organisation and its tenants, and the extent to which the findings based on these participants are relevant to other

stakeholders in HRS. Dependability relates to the quality of research, and is shown in qualitative research if the 'decision trail' of the researcher can be followed (Thomas and Magilvy, 2011; p.153). In this study this requires transparency in the research and providing an audit so the process of the study can be clearly tracked throughout. Confirmability refers to the ability to establish that findings have emerged from the research data, not the researcher's own hypotheses or influence (Shenton, 2004). In this study this means ensuring the results of the study are completely grounded in the data from the HRS stakeholders, and the researcher has not enforced preconceived ideas to guide the research in a biased manner.

Case Study (CS)

This study adopted a single Case Study design as it is focused on one single unit for the investigation (Mills, Eurepos and Wiebe, 2010). A Case Study is an empirical enquiry that investigates a contemporary phenomenon in depth and within its real life context (Yin, 2009; p.18). It is often used when the intention of the researcher is descriptive and exploratory rather than to test hypotheses and generalise findings[11]. Case study is often used when a case is unique. Studies in HRS frequently compare different models of housing (e.g. Trainor et al, 1993; Nelson, Aubry and LaFrance, 2007). Selected HRS organisation for comparison are often managed by different companies with different set-ups, dynamics and tenants, and implemented in different contexts. However, what has been neglected is the tracking of changes within one organisation. This study is unique in that there are different tenants that have resided with the organisation for different lengths of time, in a range of accommodation types with ranging

[11] Although GT concerns theory the exploratory nature of the CS is fitting with GT as the purpose is to *generate* new theory, not test pre-conceived theory.

levels of support. This is because the organisation was originally founded on a 'home for life' housing model ethos but following the introduction of Supporting People funding in 2004 this model had to be changed into 'Supported Housing' which offered short term support and a housing placement for two years. After the two year period the tenants were expected to move on into independent living which was a vast difference to the previous model. Furthermore, whilst this current study was underway the Supporting People funding was removed from the organisation which caused a further transformation into 'Intensive Housing Management'. This meant that funding came from housing benefit, the services were no longer classified as 'support' but as intensive housing management services, and the timeframe for staying in a property were relaxed. The organisation has therefore endured the changes and evolution which were outlined in Chapter two. Consequently this study was implemented during a transitional period (from one HRS model to another), which enabled the researcher to witness the change as the participants experienced it for the first time so captured the initial reactions/consequences. This is advantageous as novel circumstances provide a rare insight and the potential for new and original data (Yin, 2009).

Case study (CS) design

Yin (2009) discussed Case Study design which facilitates the analysis of data across multiple levels. Firstly the case can be investigated as a whole, whereby its 'global nature' is explored (p.50). Further to this sub-units of analysis can be incorporated to create a more complex design, which can 'add significant opportunities for extensive analysis, enhancing the insights into the single case' (Yin, 2009; pp.52-53). This allows the case to be analysed on three levels:

organisation, group and individual. For this study ‘single case holistic design’ explored the organisational level, ‘single case embedded design’ explored the group level, and ‘single case multiple embedded design’ explored the individual level.

The purpose of adopting three lenses to view the case study is to gain a critical insight into the case in question. By analysing the case in these ways it introduces a longitudinal aspect where participants are interviewed then re-interviewed at a later date in the form of focus groups. An illustration of the study as a single case multiple embedded design can be found in 3D.

Table 3D.
The different approaches to Case Study design

Key 1	
	Focus of study
	Case
	Embedded unit
	Unit within embedded unit

Key 2			
HRS	Housing and related services organisation	T1	Pre SP tenants
S1	Pre SP Staff	T2	SP tenants
S2	SP Staff	T3	Post SP tenants
S3	Post SP Staff	T4	'returner' tenants

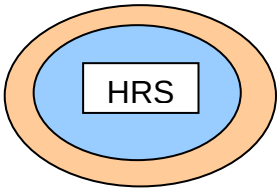
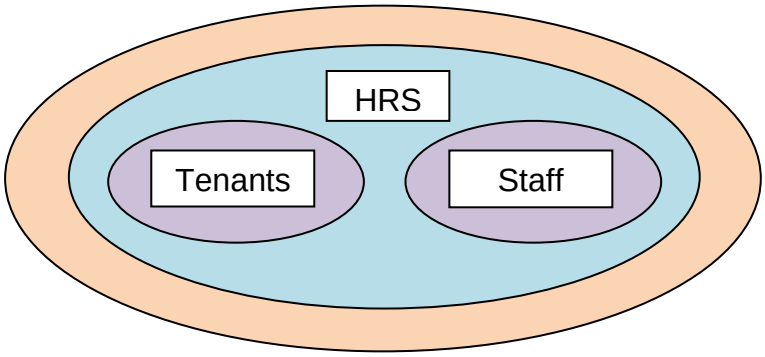
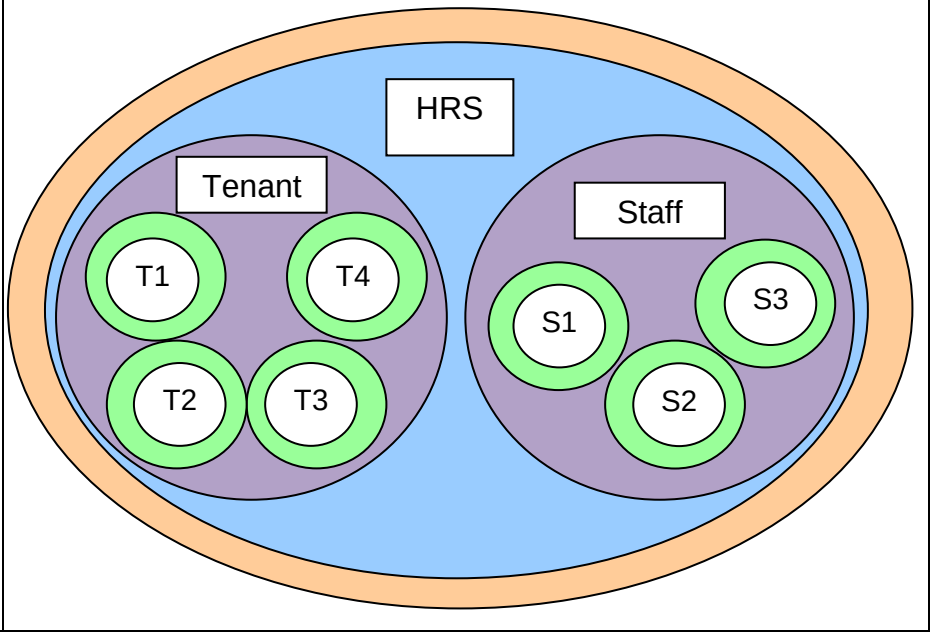
1. Single case holistic design	
2. Single case embedded design	
3. Single case multiple embedded design	

Table 3D illustrates that as part of the analysis the Case Study will be examined as a whole, between participant groups (staff vs. tenants), and within participant groups (tenants vs. tenants and staff vs. staff). This will be undertaken using single case holistic design, single case embedded design, and single case multiple embedded design respectively. By doing this, three perspectives of the CS will be obtained which will provide a rigorous evaluation of the experience of HRS from the individuals involved in the delivery and receipt of HRS. Each approach to CS design is explained in relation to the study. At each stage the researcher was positioned within the outer layer: focus of the study (labelled in pink). This position was adopted in order to be close enough to acknowledge the joint construction of experience between participants and researcher, but not too involved as to negatively impact the results in terms of bias. The inclusion of the researcher in the research design was important in order to recognise that, whilst there was no contribution in terms of data, the process of analysis included the interpretation of someone other than the participants themselves.

1. Single case holistic design

   The single case holistic design treats the case as a whole and looks at it on a meso level. Here data from all participants, regardless of stakeholder position will be integrated and analysed as one. For this study this meant viewing the HRS organisation as one unit, not differentiating between staff and tenants or other roles.

2. Single case embedded design

   The single case embedded design acknowledges the split between stakeholders of staff and tenants. This means looking at the case on a micro

level and aims to uncover between group differences. Here data from staff will be analysed as a group and data from tenants will be analysed as a group before being compared to identify similarities or discrepancies.

3. Single case multiple embedded design

   Single case multiple embedded design is informed by the early data and found through purposive sampling. Like the embedded design it works on a micro level design but in this instance it looks for within group differences. For example, are there any differences between pre Supporting People (SP) staff and post-SP staff? Also, are there any differences between pre-SP and post-SP tenants, and furthermore are those that are still housed different to those that have been moved on?

Summary

This section has provided a description of ‘trustworthiness’ criteria which are more fitting with qualitative research than traditional criteria in predominantly quantitative research. An overview of the research design, which was identified as Case Study, was also provided. The following chapter will outline the methods used for the study.

Chapter Four: Methods

Research methods are the techniques that are used to conduct research (Kothari, 2004). This chapter begins by introducing Grounded Theory (GT) methods which have informed the study. Sample size, participants, sampling, and the study procedure are described. The latter half of the chapter (4.1) concerns ethical considerations discussing safeguarding, potential impacts of being funded by the organisation acting as the Case Study, maintaining a reflexive account and protecting the participants' identities.

Grounded Theory method

This study was guided by a Grounded Theory (GT) framework which holds that an investigation should not be a linear process, but should be on-going and dynamic (Kelle, 2007). In GT there are various components which are important and should be present in the methods. Engward (2013) argued that in order for a study to be identified as GT it must demonstrate the following:

- Openness (theoretical sensitivity)
- Immediate analysis
- Coding and constant comparison
- Memo writing
- Theoretical sampling
- Theoretical saturation
- Production of a substantive theory (generate theory)

This study was guided by all of these components, and each will be discussed in turn.

Openness (Theoretical sensitivity)

Openness in GT refers to the requirement of the researcher to be aware of the ways they (as the researcher), and the research process have shaped data collection and analysis (Engward, 2013). In a GT context openness is synonymous with the term 'theoretical sensitivity' which Holton (2007) claims requires analytic temperament and analytic competence. Analytic temperament refers to the ability to maintain analytic distance from the data; and analytic competence refers to the ability to develop abstract conceptual ideas from the data (Holton, 2007). The importance of openness/theoretical sensitivity is that is linked to the need to be inductive and guided by the data as opposed to pre-conceived ideas. Suddaby (2006) argued that with prior knowledge, instead of observing there is a danger of the researcher being forced into testing hypotheses. This should be avoided as bias can occur by interpreting results which may not give a true reflection of the actual situation.

Strauss and Corbin (1990) identify three main sources from which theoretical sensitivity can be affected: literature, personal experience, and professional experience. Literature concerns theory, research, documents and publications of an area which, by reading one is becoming sensitised to the phenomena being studied (Strauss and Corbin, 1990). Professional experience relates to practice in a field, and personal experience relates to individual, first-hand experience of an issue.

Prior to the study the researcher had no previous professional or personal experience of HRS in mental health. This limited the existing knowledge of the area which may lead to hypothesis testing based on experience. In addition,

research journals were kept throughout the research process, which have been described in the previous chapter, and will be discussed further in the ethical considerations section of this chapter.

In a measure to obtain openness/theoretical sensitivity the literature review for the study was undertaken after the data collection and analysis stages. There has been much debate around literature reviews in GT (e.g. Hickey, 1997; Hallberg, 2010; Dunne, 2011). A positive of completing the literature review after the research stage is that the researcher will avoid forming biases if they have evaluated and made conclusions about an area of research. However, there are potential limitations to this approach, such as unknowingly undertaking a piece of research that has previously been completed, thus affecting the original contribution of the study.

A literature review was not undertaken prior to this study as it could result in the researcher forming hypotheses and preconceptions about what the results might be. However, in order to identify a suitable general area, (very) brief scoping was undertaken by holding informal conversations with stakeholders in HRS to ascertain their interests for research, and a light perusal of literature to certify original contributions. The researcher entered the field with a descriptive and superficial grasp of HRS, but not an understanding or knowledge of findings in HRS (which could then taint the research process). Therefore, the argument here is one of depth, where the differentiation between a blank slate and a blank mind is important. A blank mind suggests the researcher is entering the research field unequipped and empty of knowledge. A blank slate on the other hand suggests the researcher has some previous knowledge which could be

useful in determining the most relevant aspects to focus on in a study, but allows research itself to lead the direction and findings of the study.

Immediate analysis

Immediate analysis refers to the process of the study. Much empirical research follows a linear, step-by-step procedure which involves the collection of all data before commencing with data analysis (Newman and Benz, 1998). In GT this is not the case and the analysis of data occurs as soon as it is collected. The relationship between data collection and analysis is iterative, meaning it is much more dynamic, and they occur in parallel to one another. The study contains 'cycles' where analysis informs the next phase of data collection (Lingard et al, 2008). This approach allows flexibility in the procedure, and for it to be guided by the data. This is important for this study as it will allow an investigation of HRS directed by the participants to discuss topics important to them. Without an iterative process in GT the research cannot adapt and change in accordance to findings as they occur, and opportunities to explore potentially important leads would be missed.

Coding

Coding refers to 'the process of breaking data down into smaller components and labelling these components' (Engward, 2013; p.40). The purpose of coding is to organise data so the researcher can construct themes, essences, descriptions and theories (Walker and Myrick, 2006). Coding is recognised as the core process, and fundamental analytic tool of GT (Holton, 2007; Mills, Bonner and Francis, 2006).There have been various stages of coding proposed (e.g. Glaser, 1978; Strauss and Corbin, 1990; Charmaz, 2006) which can cause

confusion with differences in terminology. This study was guided by the stages identified by Holton (2007), which have been adapted and illustrated in Table 4A.

Table 4A.
The stages of coding in Grounded Theory
(adapted from Holton, 2007)

Stage		Other terms
1. Substantive coding	a. Open Coding	Line-by-line coding, initial coding
	b. Selective Coding	Focused coding
2. Theoretical coding		

Table 4A demonstrates that in this study two stages of coding will be undertaken: substantive followed by theoretical. Furthermore, the substantive coding stage is split into two: open and selective.

Open coding is the first stage of coding, whereby the transcripts of interviews are analysed line-by-line. They are coded in as many ways as possible. An example of open coding of one of the transcripts of this study can be found in Appendix 4a. Selective coding 'allows the researcher to filter and code data which are determined to be more relevant to the emerging concepts' (Jones, Kriflik and Zanko, 2005; p.8). An example of selective coding can be found in Appendix 4b. Theoretical coding 'occurs on the conceptual level, weaving the substantive codes together into a hypothesis and theory' (Walker and Myrick, 2006, p.550).

Axial coding is a stage of coding identified by Strauss and Corbin (1990). It has been omitted from Table 4A as it was not adopted for the current study. Axial coding is 'the process of relating categories to their subcategories' (Strauss and

Corbin, 1990; p.123). The purpose of axial coding is 'reassembling data that were fractured' and taken apart in the earlier stage of open coding (Strauss and Corbin, 1990; p.124). It looks to apply a single coding paradigm including conditions, interactions among the actors, strategies and tactics, and consequences (Urquhart, 2007). Axial coding was not chosen to be used in the current study as it was deemed, in line with other researchers (Urquhart, 2007) as an unnecessary step which complicated the process of analysis. It has also been criticised for forcing data as opposed to allowing it to emerge from the data (Glaser, 1992).

Constant comparison

Constant comparison is the 'inductive process of comparing data with data, data with category, category with category, and category to concept' (Bryant and Charmaz, 2007; p.607). Its purpose is to 'tease out similarities and differences and thereby refine concepts' (Wiener, 2007; p.303). Constant comparison allows a 'higher level of abstraction' to be achieved in creating categories from the data (Dey, 2007). In the present study it was used by comparing the data, themes and theory which was emerging from each stage of the data – from interviews to interviews to revisits.

Memo writing

Memos are analytical and conceptual written records which contain the products of analysis or provide guidance for the researcher (Strauss and Corbin, 1998). The purpose of memos is to 'serve as reminders or sources of information' (Strauss and Corbin, 1998; p.217).

For this study the researcher drew from the approach of Strauss and Corbin (1998), to distinguish between different types of memos. These were:

1. Code notes
2. Operational notes
3. Theoretical notes

Code notes refer to memos concerning the process of coding, and the codes that are emerging from the data. Operational notes refer to procedural aspects of the research, and the practical side of the research process. Theoretical notes refer to emerging theory and related concepts such as theoretical sampling. Examples of this can be found in Table 4B.

Table 4B.
Different types of memo used in the study

Memo type	Description	Example(s)
1. Code note	Categories, concepts etc.	• Potential early themes: goals, service provision, move-on, environment, change, support, organisation, self-efficacy, experience, recovery → these will need to be condensed further in second phase • A lot of talk about goals but are these the same for all tenants? Are the tenants on the same page as the staff? And are the goals of the tenants and staff the same as what is being implemented through the HMSP?
2. Operational note	Sampling, recruitment of participants, place of interview, gatekeepers etc.	• Place of interview may have to be reconsidered – small offices, put in room next door to colleagues and interrupted by phone and colleague needing to access the shredder – potentially disrupting flow of interview, and psychologically could put staff off from speaking truthfully if scared of being overheard.
3.	Theory	• Based on King's (2009) distinction between house and home (or housing policy and

Theoretical note	related to concept being discussed	dwelling) this may have implications on the relationship between government (as the actor enforcing policy), the Housing organisation (the actor having to abide by the policy) and the tenant (as the actor abiding to the housing organisation). The role of the housing organisation may be that of a mediator between house and home. They convert tenant experiences into measurable outcomes for policy, and they convert policy into more practical applications for tenants • The early findings suggest there may be a difference between staff, based on the length of time they have been with the organisation. This split indicates that there may be two groups of people working towards two different things within one organisation • Is deinstitutionalisation out of acute psychiatric hospital or living independently? → two different things

Theoretical sampling

Theoretical saturation occurs when emerging theoretical considerations guide the selection of cases and/or research participants (Bryman, 2012). In theoretical sampling the researcher intentionally seeks out participants who have had an experience which is of interest, and/or participants who have particularly significant links with a concept (Morse, 2007). Its purpose is to 'elaborate and refine the categories constituting your theory' (Charmaz, 2006; p.96).

In this study staff members were interviewed first. The data which emerged indicated that the length of stay that the tenants had been with the service was a relevant factor, and there could be differences between tenants based on this. As a result, tenants who had been with the organisation for varying lengths of time were identified and recruited so this idea could be further explored. The length of time the tenants had been with the organisation could be aligned with

different models that have been used to accommodate people living with mental health problems over history[12]. For this study three models were identified. Model A referred to 'home for life' models where tenants were not expected to leave the organisation and the length of their stay was not defined. Model B referred to 'Supporting People' models whereby tenants were expected to move on after a temporary stay with the organisation, and the length of stay was defined as two years maximum. Model C referred to 'Intensive Housing Management' which represented a post-Supporting People era after the organisation finished their contract with Supporting People and no longer worked within the two year framework. There were also tenants with the organisation that had been service users there more than once. These returning tenants had therefore experienced more than one model and were categorised as 'mixed' model. The distribution of the tenants and their models can be found in Table 4C.

Table 4C.
Study participants

	Model A	Model B	Model C	Mixed
Tenants	2	2	2	3
Staff	3	5	1	-

Table 4C demonstrates that nine tenants and nine staff members were recruited for the study. Two tenants and three staff members had been with the organisation since before the SP contract where HRS was a 'home for life' (which the researcher labelled Model A).Two tenants and five staff members entered the HRS organisation as the SP contract was implemented (which the researcher labelled Model B). Two tenants and one staff member recently

[12] See chapter 2 for more details

joined the HRS organisation since the termination of the SP contract (which the researcher labelled Model C). Finally, three tenants were currently residing with the HRS organisation which had previously been residents, left and had then returned (which the researcher labelled Mixed Model).

Theoretical saturation

Theoretical saturation refers to the collection of data until there are no new conceptual insights being generated (Bloor and Wood, 2006). Often researchers (e.g. Mason, 2010) have discussed saturation in terms of sample size, and the number of participants needed to recruit before the emergence of new concepts subsides. However, this is a false assumption as additional people do not guarantee additional information. Furthermore, this assumption could lead to breadth, rather than depth of a topic being explored. As the purpose of this study was to obtain a rich understanding of HRS in mental health the focus was certainly depth over breadth. Theoretical saturation was sought in this study by revisiting participants and undertaking further exploration in the form of follow up interviews and a focus group. However, there are no formal rules or guidelines for when theoretical saturation is reached, which relies on the researcher's judgement (Holloway and Wheeler, 2013).

What's more, 'often there are time constraints and other barriers to sample saturation; hence it is not always appropriate to confirm saturation' (Holloway and Wheeler, 2013; p.147). In this study the practical issue of completing research in the timeframe allowed by research ethics was a factor to be considered. Another barrier was the turnover of participants due to the temporary nature of the HRS which meant follow up data collection was not

always possible. Because of these issues the researcher completed two phases of data collection iteratively where the responses shaped a substantive theory (described next), which signalled a robust exploration of HRS, and indicated a thorough attempt of theoretical saturation (even if the concept can never truly be achieved).

Production of a substantive theory

A goal of GT is to produce substantive theory. This is a set of concepts that are related to one another in a cohesive way (Engward, 2013). The theory is constructed through the process of analysis, where similarities and differences are identified within contextualised instances, patterns or themes (Adelman, 2010). In this study this was achieved following data collection, constructing the findings to demonstrate the relationships between variables.

Glaser and Strauss (1967) distinguished between substantive and formal theory. Substantive theory is developed from an empirical area of enquiry (in this case HRS), whereas formal theory is developed from a conceptual area of enquiry (e.g. stigma). The difference could therefore be identified in the level of abstractness, with substantive theory being specific and formal theory being more general.

Glaser (2007) admitted that the lack of attention to formal theory was due to it not fitting with typical qualitative approaches. For this reason, and the focus on HRS as opposed to wider social concepts, formal theory was not aspired to for this study.

In this study the substantive theory was formed as a product of the iterative data collection and analysis process. Clusters of characteristics which could define different models of HRS were identified. The practical applications of this are discussed in later chapters.

A Basic Social Process (BSP) 'is a core category that has two or more emergent phases which resolve the main concern of the group under study' (Artinian, 2009; p.77). Put simply, the main concern of participants is the Basic Social Problem, and the Basic Social Process (BSP) explains how to resolve it (Polit and Beck, 2010). A BSP can be seen as a fundamental theme which connects all categories and is able to explain the majority of variation in data. This is arguably reductionist and positivist in trying to condense a range of participant experiences into one, all-encompassing theme. It is a concept which aligns with objective GT that is criticised for its tendency to 'oversimplify, erase differences, overlook variation, and assume neutrality throughout inquiry' (Charmaz , 2008; p.408). Additionally, the quest for a BSP can 'mislead the researcher or mask many processes' (Charmaz, 2008; pp.409-410). For these reasons this study did not pursue the development of a BSP.

Models of GT method

To further demonstrate the methods of data collection and analysis, a model from previous research have been selected to illustrate utilising Grounded Theory. Figure 4i shows a representation of this.

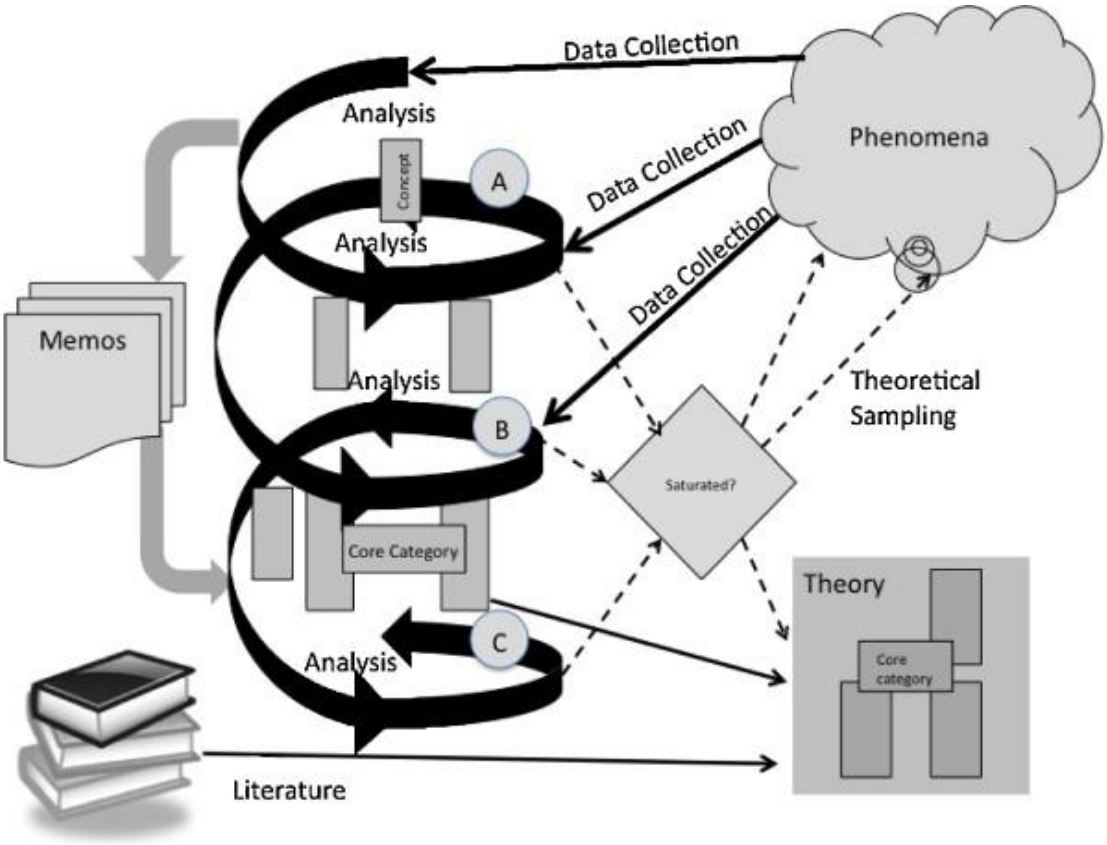


Figure 4i. The Grounded Theory Method (Adolph and Krutchen, 2011)

Figure 4i demonstrates the dynamic and ongoing process of GT. Visually it is possible to see its iterative nature which is not a concrete, step-by-step procedure where one stage has to be fully completed before the next stage is started.

The process of GT starts with a phenomena (illustrated in a thought bubble to demonstrate its iinitial stage as a notion/idea). In this study this is the experience of HRS in mental health. Because of the inductive nature of GT the next stage is data collection, which, due to the iterative nature of GT is a back and forth process between analysis. In this study the iterative process was the undertaking of interviews, and the immediate analysis before the process of data collection had finished.

Alonside the analysis memos were taken by the researcher. During the analysis the process was evaluated to see if saturation has occured. If not the phenomena was revisited through theoretical sampling and further data collection and analysis took place.

In this study, following the staff interviews, the findings suggested there may be differences in experiences based on length of time people had been involved with the organisation. Because of this tenants were theoretically sampled to explore these ideas further and data collection by way of one-to-one interviews were undertaken. Furthermore, following the tenant interviews the researcher felt that saturation had not occurred so the phenomena of experience was revisited and further data collection (one-to-one interviews, joint interviews and a focus group) was completed.

Throughout the analysis stage themes and core concepts were identified that were grounded in the data. These findings are presented in later chapters. Following the completion of data collection (when the nearest state to saturation has occured), core concepts and themes were developed further where a substantive theory was developed. This study followed this process, the results of which are presented in Chapter five (specifically 5.3).

Finally, due to the inductive nature of GT the Critical Interpretive Synthesis was undertaken last (as opposed to a traditional literature review being completed beforehand) and then introduced to the study findings to inform further analysis. In this study the combination of the Critical Interpretive Synthesis and study

findings created a conceptual framework of HRS, which is discussed in Chapter seven (specifically 7.3).

Sample size

The purpose of the study was to gain a critical insight and deeper understanding of a particular sample and not intended to generalise findings on a large scale. Even in qualitative literature it may be hard to find specific practical guidance on sample size as many researchers 'shy away' from suggesting a precise number of participants for qualitative studies (Mason, 2010). This is because 'an appropriate sample size for a qualitative study is one that adequately answers the research question' (Marshall, 1996; p.523). As each research question is different, this means a potentially different number for every study.

Therefore, in qualitative studies with an inductive approach the amount of participants should not be pre-determined as the data should indicate when enough participants have been used. Instead the guiding principle should be saturation (Mason, 2010), and data should be collected until theoretical saturation is reached (Flick, 2009). Theoretical saturation is achieved when 'research concerns are clear and your theoretical framework no longer changes...you are simply confirming the theory that you have already developed, rather than modifying or elaborating it' (Auerbach and Silverstein, 2003). However, as previously mentioned, new people do not guarantee new information so theoretical saturation aims for depth of knowledge not breadth. Nevertheless, in practical terms a pre-determined number of participants is required by ethical committees.

Therefore, as the organisation was small in size (12 staff members), all were originally recruited. The same number were attempted to be recruited in the tenant group in an effort to gain a balanced view of stakeholders.

It could be argued that such a small sample size is a criticism. However, the purpose of this study was not to generalise findings on a broad scale, but to investigate a particular case in depth. The sample of a study should be representative of the group which is focus for a study. In this study the sample needed to represent the experience of people living with mental health problems receiving housing and related services. As the study selected all members of the HRS organisation and the same amount of tenants then a robust documentation of stakeholder experience in HRS was captured.

Sampling

This study initially used purposive sampling, and then theoretical sampling. Purposive sampling is 'where people from a pre-specified group are purposively sought out and sampled' (Procter, Allan and Lacey, 2010; p.149). Theoretical sampling is 'the process of choosing a research sample in order to extend and refine a theory' (Auerbach and Silverstein, 2003; p.92). The two terms have been used interchangeably in the past (Coyne, 1997) but are distinguishable as all theoretical sampling is purposive, but not all purposive sampling is theoretical (Hood, 2007; p.158).

Purposive sampling

Initial sampling for the study was purposive as participants were recruited because they were identified as stakeholders of a HRS organisation. In order to

grasp a well-rounded understanding of the whole organisation stakeholders were recruited from all staff groups, e.g. executives from the board of trustees, housing staff and support staff. Likewise, the tenant group were recruited as they were also identified as stakeholders of a HRS organisation.

Theoretical sampling

In line with the GT method previously described the study adopted theoretical sampling. Here, participants were specifically chosen to test and develop ideas which had emerged from the data. A more detailed account of which tenants were theoretically sampled was documented previously (see Table 4E).

Participants

The participants of the study were stakeholders from one organisation which provides housing and related services (HRS) for adults living with mental health problems. 'Stakeholders' here refers to those directly or indirectly involved in the HRS organisation. The participants represented two main groups: staff and tenants. The staff group was made up from executives from the board of trustees, housing staff and support staff.

Inclusion and exclusion criteria

The inclusion criteria for the study required the participants to be aged 18 or older, English speaking, and a Stakeholder of the HRS organisation that was being used as the Case Study. This meant that staff participants had to be an executive on the board of trustees, housing staff or support staff; and tenant participants had to be residents at one of the HRS organisation's properties. Another criteria that was put in place as a safeguarding measure was that only

those with capacity to give informed consent at the time of the study were to be included.

Staff

Originally 12 staff members were identified for the study. This figure represented all members of the HRS organisation so further recruitment from this group was not possible. From the initial stage of identifying participants for recruitment the staff group consisted of three executives from the board of trustees, four members of housing staff, and five members of support staff. Due to staff turnover, 8 staff members took part in interviews. Five staff members took part in the follow-up phase: two individual interviews and one focus group. The two executives participated in individual interviews, and the two members of Housing Staff and one member of Support Staff participated in a focus group. A more detailed outline of this can be found in Table 4D.

Table 4D.
Identification and recruitment of staff members

Stage	Description	Staff
1	Identify staff members for inclusion in study	**12 identified**: 3 Executives 4 Housing staff 5 Support staff
↓	Staff turnover: 1 executive, 1 Housing staff and 2 support staff leave	
2	Recruit staff members to study	**8 identified**: 2 Executives 3 Housing staff 3 Support staff
↓	1 member of support staff unavailable at time of interviews, 1 new member of staff recruited	
3	Undertake interviews	**8 interviews undertaken:** 2 Executives 3 Housing staff 3 Support staff
↓	Staff turnover: 3 Support staff and 1 Housing staff leave, 1 Support staff returns	
4	Undertake follow ups: Interviews → Focus group →	**5 included in follow-ups:** 2 Executives 2 Housing staff 1 Support staff

Tenants

Originally 12 tenants were identified for the study. This was to reflect the same amount of staff members identified. Two participants left (moved on) from the service before being recruited to the study, which meant ten participants were recruited. Eight interviews were undertaken as one tenant was unavailable at the time of interviewing and one tenant passed away. After the interviews one participant declined the invitation to take part in a follow up. One tenant moved on after interview so was unavailable for the follow up. With six remaining participants two focus groups (2x 3 participants) were organised. Two further tenants were unavailable at the follow ups which resulted in two joint interviews

(2x 2 participants) being undertaken. A more detailed outline of the identification and recruitment of tenants can be found in Table 4E.

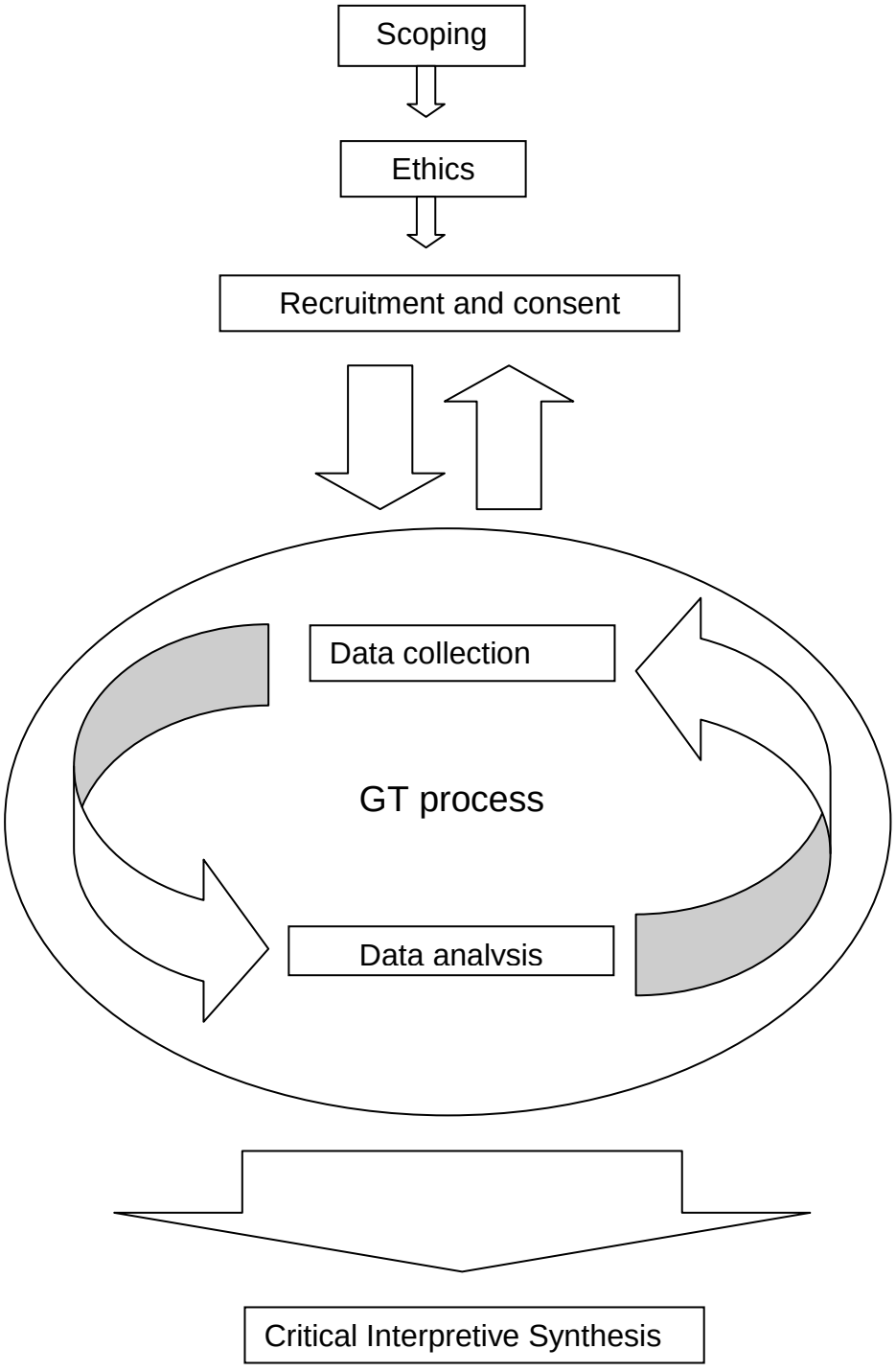
Table 4E.
Identification and recruitment of tenants

Stage	Description	Tenants
1	Identify tenants for inclusion in study	**12 identified**
↓	tenant turnover: 2 tenants left service	
2	Recruit tenants to study	**10 recruited**
↓	Unforeseen circumstances: 1 tenant passed away, 1 tenant unavailable at time of interview	
3	Undertake interviews	**8 interviews undertaken**
↓	Unforeseen circumstances: 1 tenant left service 1 tenant declined invitation for follow up, 2 tenants unavailable at time of follow ups	
4	Undertake follow ups: 2 joint interviews	**4 included in follow-ups**

Procedure

After initial scoping of the research area and informal meetings with the HRS organisation the study was planned. The study contained a number of stages including gaining ethical approval, recruiting participants, data collection and data analysis. Each aspect is described below, and an illustration of the procedure can be found in Figure 4ii.

Fig 4ii.
A flowchart of the procedure of the study



Ethics and timescale

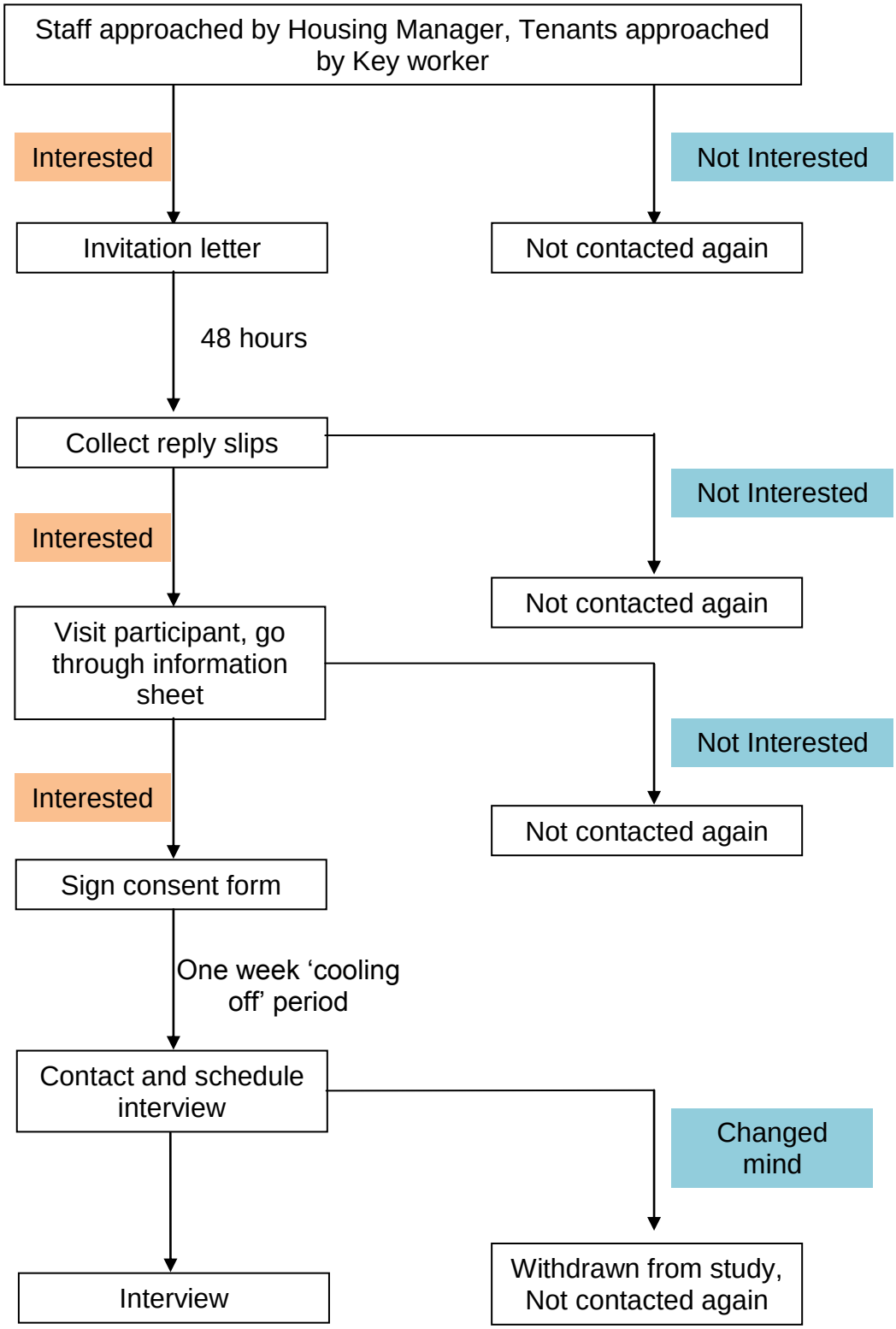
The study firstly gained ethical approval from the Staffordshire University peer review system. Following this the study gained a favourable ethical opinion on

07th October 2011 by a UK NRES committee. The letter of access for research was received on 28th November 2011. The right of access to conduct research was granted from 14th November 2011 to 13th November 2013. Therefore data collection was undertaken within these dates.

Recruitment and consent

Figure 4iii. shows a flowchart of the recruitment and consent procedure. Identification of the study sample was undertaken by the Housing Manager at the HRS organisation. Following this the participants were approached and asked if they would be interested in taking part in the study. To avoid potential researcher bias or duress the staff were approached by the Housing Manager and the tenants were approached by their Support Worker. If the participants were interested in taking part the same person (Housing Manager/Support Worker) provided an invitation letter (Appendix 4c). After 48 hours the reply slips were collected by the person that provided them and the researcher organised a consent visit with the participant. In the consent visit the researcher went through the information sheet (Appendix 4d) and then asked the participant to sign a consent form (Appendix 4e). The participants were given a one week 'cooling off' period to allow extra time to consider their involvement in the study. After one week the participants were contacted to arrange an interview and this was then undertaken on the agreed date. The participants were fully informed about the nature and purpose of the study, and reminded of their right to withdraw at any point at each stage.

Figure 4iii.
Flowchart of the recruitment and consent procedure



Methods of data collection – Phase one

The main source of data collection for the study was semi-structured interviews. Each participant took part in a one-to-one interview with the researcher which lasted approximately one hour. Examples of the types of questions that were asked in the interviews can be found in Table 4F. A more detailed example of the interview schedule can be found in Appendix 4f. The interview schedule was compiled following informal interviews with staff members at the HRS organisation and very brief scoping of the background literature.

Table 4F.
An extract of the Phase one interview schedule

Area of interest	**Example questions**
Success	• What do you believe makes a successful HRS? • How do you think 'success' should be measured?
Goals	• What would you like to achieve from the HRS? • Are you aware of what goals are in the support plans?
Move on	• What are your thoughts on the 2 year time frame? • What are the chances of someone being able to move on?
Future	• What are you working towards? • What are your plans for the future?

Methods of data analysis – Phase one

Following the completion of the interview the interviews were transcribed using an Olympus AS-2400 transcription kit. The researcher also created a project in NVivo 9 to document and audit the process. The researcher completed notes in a research and field diary, which were attached to NVivo 9. The transcripts were

printed and line by line coding was undertaken by hand as the first round of analysis (Appendix 4g). The interviews were then scanned onto the researcher's computer and attached to NVivo 9.

The researcher then used NVivo to undertake line by line coding on each transcript, creating 'nodes' (codes) which later developed into themes as the theory progressed. Following the initial coding, as more data was collected focused coding was undertaken. This involved creating 'memos' which further documented emerging themes from the data.

As with the data collection, the analysis was undertaken in keeping with Grounded Theory and Case Study approaches, with constant comparison and theoretical sensitivity guiding the analysis. Constant comparison involves repeatedly comparing and contrasting instances in order to elucidate the meanings and processes that shape the phenomena being studied (Nolas, 2011; p.19). This sees the progression of instances to codes, to categories, to memos to theory. Theoretical sensitivity is the ability for researchers to be analytic, seeing what is being studied in theoretical terms and go beyond the entities themselves and to identify characteristics of these entities (Oktay, 2012). Put simply it means that the researcher becomes aware of important concepts or issues that arise from the data (Holloway and Todres, 2010). In order to retain theoretical sensitivity Strauss and Corbin (1990) outlined four techniques:

i. Basic questioning of the data,
ii. Analysis of the multiple meanings and assumptions of a single word, phrase or sentence,

iii. Making novel comparisons to promote non-standard ways of looking at the data and providing for a more dense conceptualisation,
iv. Probing absolute terms such as never and always.

Methods of data collection – Phase two

As outlined in the methodology chapter the study was inductive and led by the data. Data collection was not a linear process but one that was circular and dynamic, which allowed early findings to influence the future direction of the study. Following the one-to-one interviews there were themes and theory emerging from the data which required further exploration, and so a second phase of data collection was necessary. A summary of key issues which had arisen from phase one was compiled by the researcher and given to the participants prior to the second phase. This can be found in Appendix 4h. Based on the data which had emerged a new interview schedule was constructed. Examples of the questions asked can be found in Table 4G.

Table 4G.
Phase two questions

Early theme/ subtheme	Questions for staff	Questions for tenants
Goals	Some tenants said they didn't have any goals	Were you involved in the creation of your support plan and goals
Service provision	Plans for the future	
Move on	What is the purpose of moving people on?	What does the term move on mean to you
Move on/ readiness	How do you know when a tenant is ready to move on?	Are you all encouraged to move on?
Move on/ Ability	For those who may never be able to move on and live independently, what does their recovery look like?	

Environment	How does the organisation fit in with other services and the tenants' network?	Who else other than here do you see/ What role do they play?
Change	The model has changed to Intensive Housing Management. How, if at all will this impact the tenants and their recovery	The organisation has changed what they are doing from Supported housing to intensive housing management, have you noticed any differences
Support	What areas of support are the organisation's responsibilities/ What doesn't the organisation cover?	What areas of support are the organisation's responsibilities/ What doesn't the organisation cover?
Organisation	Where does the organisation fit in with deinstitutionalisation?	
Self-efficacy	Is it possible to allow tenants to make their own decisions on their readiness and capability to move on?	Do you think you will be able to move on and live independently – why/why not?
Self-efficacy/ time perspective	Tenants tend to 'take each day as it comes' rather than planning for the future	
Experience	What is the staff's conceptualisation of the properties?	
Recovery	What is the organisation's role in a person's recovery	What does recovery mean to you

Initially focus groups were proposed as a means to obtain further data. However, as previously mentioned there was a need to be flexible and pragmatic when the thorough plan which had been created a-priori was not able to be carried out in practice. The reality of undertaking research in an evolving HRS organisation meant there was turnover of both staff and tenants. The consequence of this was staff and tenants which left were no longer stakeholders of the HRS organisation so did not meet the inclusion criteria, and

were not able to be located and contacted to take part in the second phase of the study. In between the data collection phases four staff members, and two tenants left. The remaining participants were approached and asked if they would still be interested in taking place in a follow up meeting. All staff members agreed; with the addition of a support worker who was unavailable in phase one. One tenant participant declined the invitation to take part in phase two, but one new tenant who was unavailable in phase one was recruited. Therefore, there were five staff members and six tenants identified for follow up at phase two.

It was decided that staff and tenants would be kept separate in phase two in case the dynamic between groups affected the responses, e.g. tenants not wanting to say certain things in the presence of staff and vice versa. It was acknowledged that this may also happen with the staff group where participants may have felt restricted in expressing their opinions in the presence of senior members of the organisation. As a result the executives on the board of trustees were not grouped with the other staff members.

In the executives' group one participant left, and this left two participants remaining. Initially a joint interview was proposed but due to unforeseen circumstances this was not possible so the two participants were interviewed separately. A focus group with the remaining staff members was undertaken. In the tenant group two focus groups were proposed. The researcher liaised with the Housing Manager to group participants appropriately, but no problems (e.g. disagreements/hostility) between participants were identified. Originally six tenants were invited to participate (two focus groups of three tenants). On the

days of the focus groups one participant was unavailable from each group, which left two participants on two occasions. The pragmatic approach allowed the adaption of data collection to two joint interviews, and allowed the follow up to be completed.

Overall phase two comprised of two follow-up interviews, two joint interviews and one focus group. As in phase one, the follow-up interviews, joint interviews and focus group were recorded using an Olympus DM-550 digital voice recorder.

Methods of data analysis – Phase two

As previously mentioned, the process of the study was inductive, dynamic and circular. Therefore data collection of phase two was analysed in the same way as data collection in phase one. Line-by-line coding was undertaken both by hand and on NVivo 9, catagorising the data within the 'nodes' identified in phase one, or creating new nodes if new data emerged. The focused coding reinforced the 'memos' and theory that had been developing throughout the study.

Summary

This section provided an overview of the methods adopted for this study. Key aspects of Grounded Theory were identified and described in relation to this study. Choices around the selection of participants for the study were identified, including sample size and sampling. Finally the procedure for the study was outlined in order to demonstrate transparency. The following section will discuss the ethical considerations of the study.

4.1 Ethical considerations

Ethical considerations are hugely important in research as ‘every researcher has a responsibility to protect the participants in the investigation’ (Drew, Hardman and Hosp, 2008; p.56). The Social Research Association (SRA) (2002) outlined four core principles regarding ethics in social research which should be upheld:

1. Obligations to society – researchers must work responsibly and in line with moral and legal order of society, maintaining high standards ‘in the collection and analysis of data and the impartial assessment and dissemination of findings’ (SRA, 2002; p.13).
2. Obligations to funders and employers – researchers should maintain a clear and balanced relationship with funding bodies/organisations and employers. However, these ‘should not compromise a commitment to morality and to the law and to the maintenance of standards commensurate with professional integrity” (SRA, 2002; p.13).
3. Obligations to colleagues – researchers should maintain standards of appropriate professional behaviour, and consider the safety and security of colleagues. There is also a requirement for ‘methods, procedures and findings to be open to collegial review’ (SRA, 2002; p.13).
4. Obligations to subjects – researchers ‘must strive to protect subjects from undue harm arising as a consequence of their participation in research’ (SRA, 2002; p.14). Considerations for this include: informed consent which is entirely voluntary and ‘no group should be disadvantaged by routinely being excluded from consideration’ (SRA, 2002; p.14).

Likewise, the Economic and Social Research Council (ESRC) compiled a Framework for Research Ethics (FRE) which maintains six principles for ethical research (ESRC, 2012; pp.2-3):

1. Integrity, quality and transparency in research
2. Full disclosure of the purpose, methods, uses of research, and details of any risks
3. Confidentiality and anonymity respected
4. Voluntary participation free from coercion
5. Avoidance of harm
6. Clear independence of research and any conflicts of interest or partiality made explicit

The researcher planned and conducted this study in accordance to these standards, and in compliance with the study protocol that was approved by a UK Research Ethics Committee. Research ethics were especially important for this study as the participant was adults living with mental health problems, which are identified as a vulnerable group by Supporting people (CLG 2009a, 2009b). A vulnerable group refers to population groups which 'encounter discriminatory treatment or need special attention to avoid potential exploitation' (Reichert, 2006; p.78).

For this study there were a number of ethical issues which needed to be considered. This section will firstly address safeguarding as this was the principal concern of the research project. Following this the impact of being funded by the organisation being investigated and used as the Case Study will be explored. More specifically, the potential for researcher coercion and researcher bias will be discussed. Additional ethical considerations will then be highlighted, including maintaining a reflexive account and protecting the participants' identity.

Safeguarding

In line with the SRA (2002) fourth core category (obligations to subjects), measures of safeguarding were considered in this study. Safeguarding can be defined as ‘a range of activities that organisations should have in place to protect people (both children and adults, unless stated otherwise) whose circumstances make them particularly vulnerable to abuse, neglect or harm’ (Care Quality Commission, 2013; p.2).

Safeguarding is a requirement within the Health and Social Care Act (2008), and is an issue which has been built around concerns for human rights and data protection (SRA, 2002). Three issues of safeguarding which will be expanded upon here are informed consent, risk assessments, and participant led approach.

Informed consent

Informed consent is important as ‘competent individuals are entitled to choose freely whether to participate in research and to make decisions based on an adequate understanding of what the research entails’ (WHO, 2011; p.16). The inclusion criteria for this study were clear that only those with capacity to give informed consent at the time of the study would be approached to take part. In this study the participants received a participant information sheet about the study and had the opportunity to ask the researcher any questions they may have had. There was no deception involved in the study, and the participants were fully informed about its full nature and purpose Participants were also given a ‘cooling off period’ after receiving the participant information sheet to consider their Involvement. Furthermore, the participants were also required to

sign a consent form to demonstrate that they understood the purpose of the study and were willing to take part. The participants were also informed verbally, on the participant information sheet and consent form that they were free to withdraw from the study at any time without their reasons being challenged or questioned.

Risk assessments

The SRA (2001) outlined a number of dimensions of risk in social research including: physical threat/abuse, psychological trauma, being in a compromising situation, everyday life risks, and causing physical or psychological harm to others. The final dimension is important as it acknowledges that the researcher is not the only person who is potentially at risk from the research process. It recognises that there is a possibility that taking part in research may have a negative or detrimental effect on the participants (e.g. psychological distress if asked sensitive questions about a trauma they had experienced).

Close relationships between the researcher and staff based within the organisation were important to ascertain any potential risk, for participants or the researcher. In this study the tenant participants had already undertaken a number of risk assessments prior to the research commencing as this was standard practice for the HRS organisation.

The researcher adhered to the University lone working policy, which states ‘persons are to be considered working alone if they have neither visual nor audible communication with someone who can summon assistance in the event of an accident or illness’ (Staffordshire University, 2014; p.1). Safe working

arrangements included ensuring the researcher was not exposed to significantly higher risk than if the research was being undertaken as part of a group, avoiding illegally prohibited situations, and ensuring safe access and exit for the researcher. The researcher's PhD supervisors were informed of the research schedule so the whereabouts and time scale of meetings were known. Furthermore, in line with Research and Development (R&D) ethics the researcher provided details of each visit to the R&D trust before commencing, and rang both immediately before and after entering the property. For measures to avoid participant harm in the study a participant-centred approach was adopted.

Participant-centred approach

The semi-structured interview schedule was designed to focus on participant experience of HRS, avoiding personal questions that may be uncomfortable, upsetting or intrusive. The interviews were open and flexible to allow the participants to speak freely and guide the process within their own comfort zone. All participants were offered a choice of venue for their interviews, the organisation's offices were offered as a familiar environment (as opposed to University premises), and on some occasions interviews were conducted in participants' (tenants) residencies (when requested). The interviews were undertaken at tenant residencies for practical reasons (for example, no access to transport), or for personal preference of the tenant (e.g. stated that they would feel more comfortable at home, felt it would be less formal).

Impact of being funded by the Case Study

The PhD was match-funded by the University and the organisation acting as the Case Study. Due to this arrangement, there were a number of issues which needed to be considered. Potential issues could include researcher coercion and researcher bias. Researcher coercion refers to influences 'that may impair the ability to choose voluntarily to participate (or not) in research' (Magyar, Edens, Epstein, Stiles and Poythress, 2012; p.69). Researcher bias on the other hand refers to 'a form of systematic error that can affect scientific investigations and distort the measurement process' (Sica, 2006; p.780). Each will be discussed in turn.

Researcher coercion

The participation rate for this study was high, with 100% staff members agreeing to take part. Baruch (1999) found an average response rate to questionnaires of 55.6% in research studies which confirms the current study as well responded. Because of the high participation rate it was important to reflect on this to ensure recruitment was not due to researcher coercion. This could have happened due to the researcher being based within the organisation being studied so the participants may have felt more need to take part.

To reflect on researcher coercion factors influencing recruitment were considered. Newington and Metcalfe (2014) identified four themes of factors influencing recruitment to clinical research: infrastructure, nature of the research, recruiter characteristics and participant characteristics. Infrastructure referred to good access to potentially relevant participant, and good collaboration with GPs and other health professionals. This study had good

access to relevant participants (being match funded by the organisation acting as the Case Study). Nature of research referred to the type of research study in question. It was noted that clinical trials were harder to recruit to due to the requirement of greater commitment from the participants. The researcher required a maximum of two meetings with the participants for data collection so was not onerous on commitment. Also, the appeal of the research itself was a factor. The appeal for participants in this study as it allowed them to voice their opinions and gave them an opportunity to provide anonymous feedback about the organisation. With regards to recruiter characteristics Newington and Metcalfe (2014) found that professional role, personality, and knowledge of the research project were influential on participant recruitment. The researcher had in-depth knowledge of the research project (having designed it personally), and the professional association with a University could have had a positive impact on recruitment. This is supported by a study by Fox, Crask and Kim, 1998) who demonstrated that University sponsorship of a study produced a significant increase in response rate in mail surveys. Participant characteristics arose as a theme as it was believed that ‘certain patients were more likely to agree to participate in clinically focused research than others’ (Newington and Metcalfe, 2014; p.6). Staff members who acted as gate keepers were familiar with the tenants in the organisation so would have approached those who they believed were more likely to participate based on their personal experience and knowledge of those participants.

In an attempt to avoid researcher coercion the use of gatekeepers for both staff and tenants was introduced. This measure meant that the researcher did not initially approach potential participants personally. The purpose of the

gatekeeper(s) in this project was to avoid any potential pressure and limit the influence of the researcher on the individuals' decision on whether or not to participate in the study. Furthermore, the information sheet and consent form made it clear that participation was entirely voluntary, and that their decision to withdraw would be accepted and respected without question.

Researcher Bias

The issue of researcher bias can be related to emic/etic debate. Chapman and Routledge (2009) distinguished the two terms:

> *'Emic refers to categorising behaviour from the perspective of the insider in ways that are meaningful to the people producing this behaviour, while etic refers to categorising behaviour from the perspective of an outsider in ways that are applicable to different systems and can be used to compare them'* (p.66).

With the researcher being match funded by the organisation, this questions their positioning as an 'insider' or 'outsider'. There have been a number of measures adopted in the study to overcome potential researcher bias. The Grounded Theory approach was selected to account for researcher influences. As described in previous chapters the researcher maintained two research diaries and engaged in reflexivity to acknowledge and evaluate the potential influence they could be having on the results. The data was collected inductively to prevent contamination from pre-conceived ideas and avoid the researcher guiding the study based on previously held beliefs. Furthermore, the analysis of interviews was documented in a blog which was shared with supervisors to ensure a neutral input was being considered in an attempt to avoid biased interpretation of data. As another measure to check for researcher bias the theory emerging from the interviews was taken and presented to the participants during the follow ups to test their credibility. Following phase one of

data collection the researcher drew from the study's memos and analysis to produce a summary of early ideas/themes concepts which had emerged from the data. This information was word processed and sent to the participants electronically, or in hard copy (by the gatekeepers of the study) prior to the phase two data collection and analysis. This then gave the participant to confirm, contest and/or expand on certain concepts which had been identified.

Further ethical considerations

Ethical considerations for this study did not end with safeguarding and potential being funded by the organisation acting as the Case Study. Two further issues were maintaining a reflexive account to address the issue of transparency, and protecting the participants' identities.

Maintaining a reflexive account

Transparency is a central constituent of qualitative research. Reflexive accounts are commonly applied as a mechanism by which to ensure transparency and rigour through the analytic process. Taking into account the emic/etic debate, transparency is of particular importance for this study and a reflexive account was a core feature. The field diary contained inserts about the interviews themselves, so included questions asked in interviews, notes made during the interviews, and general feelings arising during the interview. The main research diary had inserts about the whole research process, including sampling, informal meetings with the organisation, consent visits, ideas about data analysis, potential themes and the emergence of links between the data and existing literature. The field diary was used to reflect upon each interview and these reflections were used to inform the next interview in terms of areas to

explore and questions to ask. The main research diary documented the development of ideas and theory from the data in a clear and concise way to maintain transparency. By using the research diaries an outsider would be able to follow the procedure of the study and make connections between preparation for data collection, data collection and data analysis. The field diary and main research diary in this study collectively constituted a reflexive journal. This differs from a traditional research diary in that instead of simply noting what has occurred the researcher is actively engaging in evaluating and scrutinising the process at each stage. In reflexivity, 'rather than attempting to control researcher values through method or by bracketing assumptions, the aim is to consciously acknowledge those values' (Ortlipp, 2008; p.695).

Protecting the participants' identity

It is acknowledged that the organisation is one that is small in size so measures to ensure anonymity and confidentiality amongst participants will be outlined in the thesis. The researcher undertook the study adhering to the Caldicott principles (DH, 1997). These are:

1. Justify the purpose(s) for using patient data
2. Don't use patient-identifiable information unless it is absolutely necessary
3. Use the minimum necessary patient-identifiable information
4. Access to patient-identifiable information should be on a strict need to know basis
5. Everyone should be aware of their responsibilities to maintain confidentiality
6. Understand and comply with the law, in particular the Data Protection Act

In this study the researcher used a code to refer to patients to ensure anonymity. Furthermore, any patient identifiable information mentioned in

transcripts (e.g. names, addresses, places of work) was removed. As measures of confidentiality the researcher was the only person who listened to the recorded interviews, and transcripts were only seen by the researcher (except partial, anonymised sections shared only with two PhD supervisors to combat researcher bias).

Summary

Following on from the methods this section provided an overview of the ethical considerations of this study. The study was conceptualised within SRA and ESRC general research ethics principles. Secondly issues surrounding safeguarding were highlighted followed by a discussion of the potential impact of being funded by the research study. Finally, two further additional ethical issues were highlighted. The methodology and methods chapters have outlined the approach to the study. The following chapter presents the study findings.

Chapter Five: Results

The previous chapter documented how the study was undertaken. This chapter presents the results of the study and will be split into five sections: experiences of change in HRS, consequences of change in HRS, important factors in HRS, a conceptual model of HRS, and informing the Critical Interpretive Synthesis.

As outlined in previous chapters the study was an inductive exploration into stakeholder experiences of HRS. This meant that the participants were free to discuss HRS openly and there was interest in discovering how HRS was delivered and received by those directly involved. Upon analysis of the results two sets of results emerged: change in HRS and important factors in HRS. These results will form parts one to three of this chapter. The fourth part of this chapter emerged from the further analysis of issues which arose in parts one and two. A conceptual model was created which captures a number of themes which were discovered from the data and represents a cluster of characteristics which are typically present in different HRS models. These findings form the basis of substantive theory, which was described in Chapter four. Part five of this chapter summarises the results before explaining how they informed the Critical Interpretive Synthesis.

5.1. Experiences of Change in HRS

This study allowed the exploration of change in HRS from first-hand experience by staff and tenants in HRS. From the interviews it was possible to gain an understanding of where the organisation had come from, which provides the context of how it has developed into the service it is today. A staff member identified the beginning of the organisation:

> *S6: "it was at a time when hospitals, psychiatric hospitals were actually er putting people out into the community"*

Since then, and as documented in Chapter two, the concept of HRS has undergone a range of changes, references to which can be found in Table 5A.

Table 5A.
Areas of change in HRS.

Area of change	Participant Quotes
Funding change	*S6: "we're in contract with Supporting People and the goal posts have changed within that contract considerably"* *S7: "we made a decision that we were not religiously going to stick to that [Supporting People contract]"*
Model change	*S1: "Originally...it was kind of sold as a, as a home for life"* *S2: "that's another thing that's changed...in the last, last few years all this moving on'* *S2: "it was when people came in, as I say they were mainly elderly then, forties and fifty year olds, it was sort of a house for life...You know if you're happy here this is your house for life"* *S4: "I think it worked a lot differently back then...the tenancies and stuff were a lot different back then the agreements and stuff so now like we-we sign people to short hold tenancies whereas back then I-I don't know what they signed them to you know so, I-I suppose it's just all changed really over the years"*

'related services' change	*T3: "before there wasn't doing that they just left you..."I wasn't getting any one week sessions or not like what we do here now"* *S2: "I don't deal with much paperwork with the residents, I used to at one time...Before, I mean when I first started there was only me...I used to do everything....I used to do the decorating, in the summer I used to do the gardens...used to do all the er collect rent....I used to do all the housing benefits".* *S5: "In the service I worked before...they'd be helping people to put their socks on and you know, giving them breakfast...that's not what they-there are people paid there are organisations who should have taken the responsibility for ensuring that happened....it [supporting people] made the role more professional"* *S6: "the newer staff that I've had have erm they've been a different type of staff they've probably got far far more experience erm they've come from erm appropriate backgrounds f-for the work"*

Table 5A demonstrates that the organisation has endured changes in their funding, the HRS model they have implemented, and the related services connected to the accommodation provided. In terms of how the changes have been received, a staff member indicated they have not necessarily been welcomed:

> *S3: "people don't like change, I know change has to happen but they don't like change do they a lot of people"*

The negativity towards change could be due to associated uncertainty which staff members made reference to:

> *S4: "it's just been so up in the air"*
>
> *S4: "it is really hard to get a grasp of everything what's going on because everyone's kind of stressing about this and that and oh God like, so it's a bit-it's a bit of a hard one but I'm not too sure to be honest at the moment"*
>
> *S5: "you can't run a business too well with a lot of uncertainty"*

> *S5: "we are in quite a state of flux at the moment because some of the houses have been lost and you know we've not got anything to replace it with at the moment, there's lots of various projects that are being spoken of"*
>
> *S7: "it's a very grey area in terms of where that funding would come from. At the moment the trust don't know where to apply for that money or then they're not sure they could maybe apply there but they're not sure"*

In history (as documented in chapter two), the progression of HRS has been neatly boxed into HRS models as clear, separate chapters. For example: home for life, Supported Housing, Intensive Housing Management. However, the previous quotes from participants indicate that in practice this change was not such a smooth process without resistance, and instead caused periods of uncertainty which were uncomfortable for the staff and tenants involved in HRS. Arguably, the evolution of HRS can be implemented more easily if different organisations were to provide different models in different contexts. For example, a residential home in one single shared building providing a home-for-life model which is delivered by wardens and similar care staff would be easily distinguishable from temporary accommodation in a collection of individual properties in different locations which is delivered by key workers and health professionals. The comparisons between HRS organisations would be more obvious such as physical building type, staff roles and different tenants (e.g., all people from a residential home would be unlikely to all move to the same supported housing services). However, the HRS organisation which has been drawn from in this Case Study has experienced the development first-hand. The organisation has had to adapt within itself, which could account for the feelings of uncertainty where the boundaries and differences between HRS models have been blurred. This has implications for model fidelity which will be discussed later.

Despite these potential criticisms the situation of the Case Study organisation could arguably provide important conditions for research as the same staff, tenants, organisation and buildings can be tracked throughout the process. The HRS organisation is in a rare position which may provide unique insights into the experience of HRS due to being able to document change *within* an organisation rather than *between* organisations. What's more, the interviews were undertaken during the process of the HRS organisation losing their Supporting People funding, and transforming from Supported Housing to Intensive Housing Management. This allowed the experiences of the transition to be captured in real time, rather than retrospectively.

This section substantiates the changes in HRS which were outlined in Chapter two. Stakeholders' discussion of the experience of transformations in HRS provides confirmation that change was occurring in practice. The next step was to explore the personal experiences of change in HRS which is described in the following section.

5.2. Consequences of change in HRS

In investigating the impact or consequence of change in HRS practice, and in line with the Grounded Theory approach five themes emerged from the data. These were: economic issues, duration, progress, boundaries and independence. Themes relate to the subjects that respondents discussed when interviewed about HRS. During the data analysis patterns started to emerge around topics which were categorised and grouped as themes. Here, each theme represented an issue related to change, and provided information about the experience of HRS in practice and the impacts this has on implementation. A table of the themes and subthemes can be found in Table 5B. Each theme will be discussed in turn.

Table 5B.
Themes and subthemes which emerged from the data

Themes	Subthemes	
	HRS in practice	**Impact/consequence**
Economic issues	• Funding	• Auditing
Duration	• Move on • Timeframe (length of stay)	• Model
Progress	• Goals	• Capturing goals
Boundaries	• Areas of support	• Role
Independence	• General support	• Institutionalisation

Table 5B demonstrates that changes in HRS had a number of impacts which the staff and tenants discussed in their interviews. In addition to providing confirmation of the changes documented in Chapter two, the results could provide knowledge about the consequences changes had on HRS practice. This provides a deeper level of understanding than superficially identifying change as it could suggest reasons as to why previous models of HRS were not successful. This in turn could affect future implementation of HRS as a clearer idea of what issues need to be acknowledged and overcome could improve HRS.

Theme 1 – Economic issues

The first theme concerned economic issues, which emerged from staff references to funding the HRS. A staff member identified that seeking funding was something that the organisation needed to address:

> *S6 – "we've got a-a situation where we need some money"*
>
> *S6: "think the priorities for us now...is that we look for outside funding pretty quickly"*

The need for funding appeared to be exacerbated by the availability of funding, and staff members showed concerns:

> *S2: "they're [Government] always trying to cut back on money and stuff but obviously we need money at the moment...they're just trying to cut back"*
>
> *S5 – "you know funding's lost through supporting people, added pressure is that erm a number of our houses rented...have got to be given back...So we're losing money, straight away we're losing money 'cause we've got no properties to rent out"*
>
> *S7 – "services are starting to reduce the level of funding the Supporting People funding is no longer ring-fenced"*
>
> *S8: "even the recent work now on supporting people that's targeted at cutting back"*

The financial situation was causing funding to become a stressor to the staff members who spoke about the pressure it brought:

> *S1 – "money is always in the back of your mind...are concerned about finances and about where the money's going to come from for properties and er you know to support these people properly"*
>
> *S1: "it is really difficult when you're obviously constantly under pressure of funding for this and funding for that"*
>
> *S2: "we need to make money to-to survive, to have a job in the first place"*

The evidence shows that the organisation were in a financially vulnerable position, with unstable funding streams (SP funding had recently been removed). The staff members saw themselves as casualties of the funding cuts and securing funding became a priority for the organisation. A potential implication of this is funding taking priority over the service users. If the main concern is financial as opposed to people then there is a risk of the service-user voice being lost. This could have a negative impact on satisfaction or effectiveness of the HRS.

Impact: Auditing

From the interviews there were references to measuring and documenting success, recognition, and feedback. Together these issues formed a theme concerning auditing. Auditing was the consequence of the unstable financial situation of the HRS organisation, which meant it became important to demonstrate the outcomes of the HRS as this could affect whether funding was received.

The first part of the problem was that staff found the current methods for documenting their success through auditing complex and felt as though it did not work in practice:

> *S5 – "do a self-assessment every year and you have to say against all of the standards and how I've always done it is we actually record the evidence against each of those standards so we're continually putting evidence against it which is an absolute nightmare"*

> *S6 –"I think over the years it's got harder and harder and harder we've got the quality assessment framework which we use erm to-to monitor actually and document what we do for Supporting People"*

> *S7 – "Supporting People have become more and more rigorous in looking at what we're doing, checking erm the processes...checking on the processes in place for gathering the information, actually measuring the outcomes"*

Because of the issues with the prescribed system for auditing staff members felt the process did not effectively capture their work:

> *S1 – "for every failure there's a success as well and I don't think those successes are recognised"*

> *S3 – "It shouldn't be ticking boxes, erm I don't know how it should be measured...I think there's a lot of organisations that they just tick boxes and we don't do that"*

> *S5 –" I don't know how best we could capture that really but, the SP wise by measuring outcomes, but that doesn't always give a true reflection of what you've actually done for that individual"*

The staff members indicated that the current system could be too reductionist, only judging 'success' on one outcome (people moving on from the HRS), which may not give justice to the tenants' progression whilst with the organisation:

> *S6 – "Supporting People base successes on people moving on"*

S8 –" I think success can only be measured by the pathway of the individual have they developed or not, have they been able to achieve the objectives that we've agreed with them that we should reach and if we have and all the boxes are ticked and then they can go on to independent living and remain"

S8 –" I think facts and figures can help with your turnover and so forth but I mean if you're turning people through your accommodation who ain't quite ready then the statistics ain't going to show that so I think the success is the length of people once they've moved on, that they continue to stay in independent living, and not having to fall back"

The staff indicated that, rather than perceiving success in the same light as the funding organisation, they judged their success based on feedback received from tenants and partner organisations:

S3 – "we've had a couple of meetings recently and the feedback's been brilliant off everybody"

S4 – "a lot of the feedback from the tenants is always good"

S5 – "we've had letters in from-from various partners erm strategic partners and from the tenants saying how well erm the service-how good the service and how it's helped this that and the other"

S6 – "We've got letters endorsing from he-from prison in reach and probation to say how we've kept people out of prison"

Theme one has demonstrated that the evolution of HRS produced an economical issue whereby unstable funding has caused uncertainty and a focus on auditing in practice. Whilst funding processes such as Supporting People may have been useful in theory for measuring the success of HRS, in practice staff members found it labour some, and efforts to audit the service drew focus away from the service users. In addition, staff members do not feel the current approaches to auditing (which is also what their success is based upon) captures everything they do for the tenants. The staff members saw the audit process as a task to maintain funding but their real measure of success was

satisfaction which they gained from feedback from tenants and strategic partners. Staff members feel as though their service is successful, but the tools measuring ‘success’ do not capture this. This has meant the organisation has struggled to meet the demands and criteria of Supporting People, which in turn has led to the termination of their financial contract. These findings not only evidence that maintaining funding is a hard task for HRS organisations, but it suggests reasons as to why this is, by exposing a difference between theory and practice.

Theme 2 – Duration

The second theme concerned two related subthemes: timeframe and move on. Timeframe refers to the length of stay a tenant is expected to remain with the HRS organisation. Move on refers to the process of leaving the HRS organisation, usually to independent living arrangements (a tenancy without the ‘related services’ of HRS). Recommended duration has varied with different HRS models. For example, in home for life models, as the title suggests there is no timeframe enforced or expectations to move on into different accommodation. However, Supported Housing under Supporting People included a timeframe of 24 months, with an expectation to move on into independent living arrangements after this period. Staff and tenant responses to move on and timeframes can be found in Tables 5C and 5D respectively.

Table 5C.
Staff and tenant attitudes towards move on in HRS

Staff		Tenants	
For	**Against**	**For**	**Against**
S4: "they don't need to be stable with us eventually they can be stable somewhere else" *S6: "You can't leave people to stagnate"*	*S7: "We want them to stay it's appropriate with them"* *S8: "(Prefer to) keep them"* *S8: "you're only adding to their instability"*	*T1: "I do want eventually do want my own flat, everyone does doesn't they really I-I don't want to be sharing with people for the rest of my life"* *T2:" I'll be happy to move on in two years"* *T5: "I want to move into a private place"*	*T3: "I feel safe and I know that's there-there's always staff around 'cause if I lived by myself there'd be nobody around"* *T4: "No didn't want to move I thought it was my home"* *T6: "it's so stressful it is...confusing, very very confusing you know"*

Table 5D.
Staff and tenant attitudes towards a timeframe for HRS

Staff		Tenants	
For	**Against**	**For**	**Against**
S3: "I do think the two years is okay" *S5: "it's ideal for others, I mean there are some that could move on quite easily within 6 month"* *S6: "you can move them on it-it's not a problem...you don't have to keep them forever...that's not-that's not the right way to do things...I don't think you can leave people to stagnate"*	*S2: "some people who are still not capable after two years"* *S7: "we wouldn't desert them and say well you've got to go anyway, because you've passed the time that you should be with us"* *S8: "It's too much pressure...I don't agree with it"*	*T1: "This time next year I-I I hope I'm not with these, not for no other reason but I wanna be on d'ya know what I mean I want to start my life on my own"* *T5: "It's probably good because err nobody wants to be here any longer than that"*	*T3: "I'm not happy with the timeframe"* *T6: "A bit, sickly feeling really thinking I'd got to start again"* *T8: "A bad thing"*

Tables 5C and 5D show that there are differences of opinion both between and within staff and tenants with regards to HRS duration. With differing opinions on move on and time-frame the compromise that the organisation reached was retaining the concept of move on but removing the timeframe. This compromise they encompassed in an 'Intensive Housing Management' model.

The differences evidenced may reflect the length of time the staff/tenants have been part of the organisation. For example, some staff members and tenants have been with the organisation since the home for life model where there was

no timeframe or pressure to move on, whereas other staff and tenants have only been with the organisation since the introduction of Supporting People (and the associated two year time frame and expectation to move on).

Impact: Model

A potential impact of this issue is that there could be a number of different models being implemented at the same time. The consequences of this are twofold; it could cause confusion and it indicates that model fidelity is not being upheld. Staff members acknowledged that in practice they did not fulfil the requirements stipulated in the Supporting People guidelines with regards to duration:

> *S4: "if they're not ready to move on in two years we're not going to kick them out, it's just, that's just the general you know frame that we say".*
>
> *S4: "it's not strict, where you know if they're not ready then they're not ready".*
>
> *S7: "made a decision that we were not religiously going to stick to that you know and and we would face the consequences if that happened but if we felt that somebody wasn't ready to move on and they'd been ready for two years or two and a half years or three years we wouldn't move them on just because we were trying to meet a certain criteria or a certain percentage of moving in within a period of time".*

As well as identifying model infidelity staff interviews gave reasons for this, indicating that the Supporting People framework put the organisations and tenants under too much pressure:

> *S1: "I do feel under pressure with the move on process, the fact that everything's having to work within a time scale".*
>
> *S7: "there is a lot of pressure to er to move those people through the process within two years to be-to get independent living".*
> *S8: "This two year turn around erm and I think that's one of the reasons why we considered not to go for it, it's too pressure on*

us, on the individual who's always got .a load of pressure on board anyway....it ain't fair on them"

Furthermore, staff members proposed justification for their decision not to enforce strict parameters around duration, as they believed it had negative consequences on the tenants:

S5: "you can be forced to be moving somebody on at the end of two years when you know that they're not really ready to move on"

S7: "people were trying to meet that two year target and er people were moving on when they weren't quite ready"

The evidence demonstrates that the organisation took a decision to remove parameters around duration as it put too much pressure on both the organisation and tenants. Staff members believed duration restrictions could negatively affect tenants if they were moved prematurely. Because of this model fidelity was affected, and in turn attaining Supporting People outcomes (e.g. number of tenants moved on to independent living) was affected. Inability to implement a SH model and/or attain SP outcomes led to SP funding being removed. This could have implications for the debate between evidence based practice and policy based evidence, which will be explored further in the discussion.

The differences between and within the staff and tenants towards duration could mean that different people are working towards different goals and this could cause friction. The organisation needs clear vision and unison in what model and its elements are being implemented, but this is not possible if some staff members do not support the concept of move on when others do.

Implementing a range of different HRS models or a hybrid of features from different models could demonstrate a tenant-centred approach revolving around an individual's circumstances. On the other hand there is danger of this being construed as 'one rule for one, one rule for another' amongst tenants. Likewise, if a tenant is looking to move on to independent living but a staff member feels as though that process would add to the tenants' instability they may not feel fully supported in reaching their goal. 'Flexibility' in a timeframe (i.e. allowing a tenant to stay with an organisation longer than is stipulated by SP) could encourage dependence and therefore discourage a tenant to attempt to move on from the HRS. These findings demonstrate the problems (and their reasons) in implementing HRS models in practice.

Theme 3 – Progress

The third theme related to the tenants' progress whilst they were with the HRS organisation. This referred to the targets/goals they had set themselves, or what they wanted to achieve from their time in HRS. The goals identified by staff and tenants can be found in Table 5E.

Table 5E. **Staff and tenant direct references to goals whilst receiving HRS.**	
Staff	**Tenants**
Move on	
Independent living	
Day to day activities (e.g. catch a bus, shopping, have a shave)	
Voluntary work (e.g. attend day centre)	
Social networks (e.g. family relationships)	
Address substance misuse (e.g. stop drinking, get drug free)	
Get a job	
Maintaining a person	
Keep in the community	
Better life	Normal life
Maintain mental health	NO GOALS
Happiness	
Independence	
Finances (budgeting, money management, benefits etc.)	
Eat healthy	

Table 5E shows that there was shared identification of some goals and some goals that were not identified by both groups. Examples of shared goals were move on and independent living, which referred to the aim to leave the organisation and maintain a tenancy unsupported. This was illustrated in the staff interviews:

> *S5: "To eventually...move on into independent permanent accommodation so that they could stay in a tenancy and live independently".*

Equally, when the tenants were asked directly about their goals one tenant replied:

T7: "erm eventually move out of here, get my own place, erm try on my own".

Another example of shared goals was day to day activities. This referred to simple, potentially underestimated tasks which staff and tenants recognised as a goal when achieved. An example of the staff acknowledging day-to-day activities as a goal is:

S3: "I've got one particular person and it's just getting him out of his bed".

Likewise the tenants viewed day-to-day activities as important goals:

T6: "I got so many goals to do with washing, laundry, and then from, after that I've got to put it on the line to dry around the back".

A third example of shared goals between staff and tenants was addressing substance misuse. This acknowledges that people receiving HRS often have complex needs whereby mental health issues are not the only concerns.

S4: "it can be anything from not drinking as much".

For one tenant, addressing alcohol misuse was so important that when asked what the priority and number one goal was, the answer was:

T7: "Stop drinking".

However, there were also goals that were not shared. An example of this was keeping the tenants within the community. This is linked to offender behaviour which was frequently an issue, with the organisation accepting referrals to the HRS from prison in-reach and probation. A staff member highlighted the issue:

S3: "I've got a lot of people that are on probation so my main goal is keeping them out of trouble and keeping them in the community and not in prison".

In the tenant interviews some tenants stated that they didn't have any goals for themselves. When asked specifically if they had any goals one tenant replied:

T2: "At the moment no"

The evidence demonstrated that the staff and tenants shared some goals, and the staff members named a few goals that were not identified by the tenants. Differences between staff and tenant goals could be problematic as it could indicate that they are not working cohesively towards shared outcomes. However, the apparent differences may simply have been respondents listing their most important goals, but if tenants had been presented with the goals identified by the staff (e.g. happiness, managing their finances) they may have agreed that they were in fact working towards this.

As an organisation working towards a support plan and measuring outcomes, tenants stating that they did not have any goals could be problematic. The organisation uses a recovery tool which assesses the tenants' progression in various aspects of their life (e.g. substance misuse, budgeting), so if a tenant is not working towards achieving these issues then this could affect their development/recovery. However, despite its thirty year history, documenting progression and setting goals are relatively new concepts for the Case Study. Some of the stakeholders (both staff and tenants) would have experienced HRS when it was a home-for-life model with no expectations to meet targets or goals. This could explain the diversity in responses in regards to goals.

<u>Impact: Capturing goals</u>

In terms of progress, informal (and arguably subjective) staff/tenant opinions on tenant progress have not been an acceptable form of evidence for funding.

Therefore, progress can only be assessed if tenant goals are recorded and monitored. Capturing goals formally is important in evidencing progression as it can also be related to measuring success if the organisation is helping people to achieve their goals. Currently, to document tenant goals the HRS organisation use a recovery measure called a 'Housing Management and Support Plan (HMSP). This is used to measure tenants' progressions in various areas of their life. There are core categories which every tenant has in their plan, and additional areas which are tailored to each individual. The areas for assessment on the Housing Management and Support Plan can be found in Table 5F.

Table 5F.
Areas explored in the Housing Management and Support Plan

Core areas	**Additional areas**	
Housing	Children	Offending behaviours
Finance	Domestic abuse	Violence/aggression
Meaningful use of time	Alcohol misuse	Substance misuse
Physical health and well-being	Mental wellbeing	Self-harm
Support networks, family, friends	Disability	My choice
	Legal matters	Diversity

Table 5F demonstrates the core areas which should be evident in all HMSPs. These are: housing, finance, meaningful use of time, physical health and wellbeing, and support networks (e.g. family and friends). It is important to compare stakeholder responses to the HMSP (Table 5F) so it can be established whether what is proposed in theory is being implemented in

practice. To do this each of the core categories of the HMSP will be highlighted in relation to this study's results.

With regards to maintaining housing a staff member highlighted the commitment to this as a goal of the organisation:

> *S7: "to prevent people from living on the streets or sofa surfing or being somewhere they you know without any sort of structure".*

This was mirrored in the tenant interviews, where a tenant identified housing as a goal:

> *T7: "Yeah I have to move on s-sometime".*

Managing finances was also identified in the staff interviews. A staff member referred to a goal tenants may have:

> *S4: "some people it would be to sort out their debts, sort out their finances you know".*

Likewise, a tenant acknowledged that finances were an important goal, and something which needed work on:

> *T8: "I'll probably need help paying my rent and my bills so erm that's what happened last time I moved on and I wasn't paying my rent and my bills".*

Meaningful use of time is an overarching term which could refer to a range of things such as securing employment in either paid or voluntary work, undertaking an educational or vocational course, or taking up a hobby. A staff member identified this as a goal for tenants:

> *S1: "whether it's to be able to go and do you know voluntary work".*

Some tenants were receptive to making meaningful use of their time, for example:

> *T8: "I'm doing all this voluntary work at the moment which is keeping busy, like a church".*

Although the organisation provides HRS for people living with mental health problems, the importance of physical health and wellbeing was acknowledged. A staff member said that an aim was:

> *S2: "have a better life and er hopefully to move on, you know, you know make their lives better".*

The tenants also acknowledged the role HRS can play outside of mental health:

> *T3: "that's why I moved in here t-to so I can build my confidence up and get my health back on track".*

The final core category is support networks, which refers to relationships and interactions with others, for example family and friends. A staff member stressed the importance of this as they identified it as a goal for tenants:

> *S8: "interpersonal relationships and skills that they must have to-to get on and deal with other people".*

This topic also appeared in tenant interviews:

> *T1: "building up my family relationships is a-is a goal"*

The evidence shows that both staff and tenants made reference to all of the core areas on the Housing Management and Support Plan. This indicates that the framework for a recovery measure the organisation has adopted is being successfully recognised and implemented in practice.

The 'Housing Management and Support Plan' (HMSP) is a tool which the organisation tailored for their tenants. However, in order to explore the concept

of progress on a wider scale, the goals identified by the participants were compared to The Outcomes Star™, and related versions of the Outcomes Star™: The Homelessness Star™ and The Recovery Star™. This comparison can be found in Table 5G.

Table 5G.
A comparison of the goals identified by the participants with outcomes in The Outcomes Star™ and related tools.

Outcome Star™/ Homelessness Star™	The Recovery star™	Participant Goals
Managing tenancy/ accommodation		Independent living, move on, community living, keep in community, independence
Motivation/ taking responsibility	Responsibilities	Attend appointments, benefits
Self-care, living skills	Living skills	Shopping, catch a bus
Social networks/ relationships	Social networks	Family links
	Relationships	
Managing money		Finances, budgeting, money managing
Drug and alcohol misuse	Addictive behaviours	Drug free, not drinking
Physical health	Physical health and self-care	Eat healthy
Emotional and mental health	Managing mental health	Maintain mental health
Meaningful use of time		Volunteering
Offending		
	Work	Get a job
	Identity and self-esteem	Happiness
	Trust and hope	Normal/better life

Table 5G shows that the HRS organisation is working closely to The Outcomes Star and The Recovery Star model, and the difference lies in the terminology used to describe the tools. One additional area which is not explicitly represented in The Recovery Star but was identified by the HRS was housing specific items such as independent living and 'moving on (from HRS onto independent living without the need for support). An explanation of this difference could be that The Recovery Star is a tool to be administered in a wide range of contexts and services, whereas the HRS organisation focuses on recovery adopted from a mental health context through the use of housing. These findings have demonstrated that the HMSP has been a useful tool to document a tenants' progress.

A positive finding when comparing staff with tenants was that there were many shared goals identified which could suggest the process of progression is a shared vision. Whilst previous issues regarding change have highlighted problems such as implementation in practice (e.g. economic issues, and model issues such as duration), new methods for measuring tenant progress (HMSPs) have been well received and are suitable for use in practice.

The progression of tenants is an important concept as a measurement of the number of tenants which leave the HRS organisation does not capture the development which occurs during/within their time with the HRS organisation. If success is only measured by the number of people who have left the organisation, this does not credit a tenant who may have vastly improved their daily living skills or substance misuse issue.

Theme 4 – Boundaries

The concept of boundaries emerged following the exploration of the areas of 'related services' provided by the HRS organisation. Eight areas were identified by staff and tenants: Money/finance, Health, Appointments/other services, Paperwork, Guidance/signposting, General, Care/practical issues, and Medication. Each of these will be mentioned in turn.

Both staff and tenants identified that the HRS organisation assisted with issues surrounding money or their finances:

> *S2: "he had problems with his bills, he was way behind paying his bills 'cause he'd been you know he'd just got into a lot of debt"*
>
> *T8: "they help you out...if you get behind with your rent"*

The organisation provides HRS to people living with mental health problems, however, the physical health and wellbeing of the tenants was also acknowledged as being important, and so these issues were supported by the organisation:

> *S5: "attend their health appointments because without those their health's going to dip"*
>
> *T1: "we talk about my emotional like how my i-is it emotional wellbeing..."*

The organisation were part of a wider network in supporting the tenants, and so provided assistance in ensuring tenants kept appointments, and/or were on track with other services:

> *S3: "just like simple things like turning up to a doctor's appointment or getting a sick note or...ringing the benefits agency"*
>
> *T5: "I use them for my benefits...I use them for my solicitor"*

Another area of assistance that the organisation was seen to provide was with paperwork, and helping with correspondence from other organisations which may be confusing or hard to understand (for example, if jargon or medical terminology is used):

> *S2: "we've helped them out and showed them how to do things you know and paperwork"*

> *T3: "any other issues, any kind of government whatever...any kind of letter what you have through the post"*

The HRS organisation did not have endless resources so provided guidance and signposting to other services or support which falls outside of their means:

> *S1: "you know situations erm offering them a lot of guidance, a lot of reassurance"*

> *T2: "these will help you out and dig in and get the information that you need"*

The tenants identified that the staff from the HRS organisation helped them with practical issues, for example:

> *T6: "She'll say to me you need a shave I had some razor blades but I can't find my shaver erm you know they make decisions like that like you know, put clean clothes on...they take me out...they brought me here to you today"*

Also, it was stated in the tenant interviews that the staff members assisted with the tenants' medication:

> *T3: "come and checked my tablets...make sure that I'm taking them properly..."*

Further references to areas of related services can be found in Table 5H.

Table 5H.
Areas of related services provided by the organisation
(as identified by staff and tenants)

Area	Quotes
Money/ finance	*S2: "we deal with some of the bills and things at the moment, the gas and that"* *T1: "my budgeting, my money, you know if I'm spending my money properly"* *T8: "They ask you if you're coping alright at the flat and erm co-ask you if you're coping with your money and all that, err which I'm managing at the moment 'cause I did have a gambling addiction a long time ago"*
Health	*T7: "my drinking and I'll call into SW* I've got a few mental health issues"*
Appointments/ other services	*T2: "it could be anything from doing forms up until or-or like phone calls and stuff like that, err like for like benefits or various bits and pieces, doctors, hospitals whatever else"* *T7: It's just like things like appointments and things like that...Just seeing if I'm sticking to them"*
Paperwork	*T2: "I get a lot of support...make sure I'm coping and not struggling with anything...I need help with my DLA form"* *T4: "they see to...complicated letters"*
Guidance/ signposting	*T8: "They gave me some advice...They really help me out a lot"*
practical issues	*T4: "...if I want anything moving, she's supposed to be going-coming with me to get some furn-new furniture"* *T6: "I'm going to have to get SW* to take me to Asda one of the days to buy some jeans"*
Medication	*T3: "I'm on that medication and the staff know what I'm on the medication"* *T6: "I shown it to her today my medication she's good you know, she knows them pills"*

The evidence shows that there is a lot of overlap with the areas that staff and tenants identified. This could indicate that there is a shared understanding of

what the organisation should be providing. However, there were some areas that were only identified by the tenants and not the staff, e.g. practical issues and medication. This could be because generally checking medication, personal hygiene issues, physical jobs etc are not covered under what the organisation terms ‘related services’ so should be carried out by other organisations, e.g. organisational health, care workers, CPNs etc. This could therefore demonstrate that the boundaries between what the organisation should and shouldn’t provide are quite blurred and often they end up doing more than they are required to cover.

Impact: Role

Boundaries are important to establish and define the organisation’s role. Understanding the areas which the staff and tenants identify as being provided by the organisation is important as it indicates how the HRS is delivered and received in practice. A comparison of the areas of related services with the HMSP can be found in Table 5I.

Table 5I.
A comparison of related services identified by staff and tenants with the HMSP core areas.

Identified related services	**HMSP (core areas)**
Money/finance	Finance
Health	Physical Health and Wellbeing
Appointments/other services	Housing
Paperwork	Meaningful use of time
Guidance/signposting	Support networks, family, friends
Practical issues	
Medication	

Table 5I shows that whilst there is some overlap between the related services provided by the HRS organisation and the HMSP tool (highlighted in blue) there are others which are not identified in both. The additional core areas of the HMSP are housing, meaningful use of time, and support networks. However, the related services identified were appointments/other services, paperwork, guidance/signposting, practical issues and medication. This could demonstrate that the organisation's role is more expansive than is measured and recorded in the recovery tool being implemented (HMSP). This could be because issues such as financial status and physical health are more easily measured than a person's ability to complete their own paperwork, or confidence to make and attend appointments with other services. The measurement of HRS will be further explored in the discussion chapter.

The identification of practical issues and medication as areas which the organisation assists with also has implications for the organisation's role. This

could suggest that the boundary between care and support is still not clear. In Chapter two it was shown that HRS arguably sits uncomfortably between health care and social care, and defining the functions and responsibilities of each are important for issues such as funding. A number of comments made by the staff highlight the difficulty and perhaps grey area of labelling what they provide:

> *S1: "making sure they're in a property that they feel safe and secure in"*
>
> *S2: "making sure people are comfortable"*
>
> *S6: "Caring, it isn't caring...It's support"*
>
> *S7: "provide support and housing for people with enduring mental illness to enable them to live independent lives"*

The above comments demonstrate how important the terminology used in HRS is. The word 'caring' has specific connotations which explain why the latter two quotes refer to 'support', but the first two quotes suggest there is a caring attitude from staff.

Finally, when exploring the role of the HRS organisation, staff members indicated that they saw themselves as a mediator between the government and service users (tenants). Here the staff stated that the Government do not understand tenants and what happens in practice so it is their role to turn practice into measurable outcomes for policy. For example:

> *S1: "I don't think the Government pick up on those minor goals at the moment"*
>
> *S2: "I don't think they realise the sort of people we're dealing with"*

Likewise, staff members claimed that tenants do not understand the government policy/framework so it is the HRS organisation's role to turn the

strict outcomes/policy into usable measures which can be understood and implemented in practice. For example:

> *S1: "I don't 100% believe that the tenants fully understand the goals that the government sets...I don't, I think a lot of them struggle to get their head round why they have to do certain things"*

> *S5: "SP doesn't really mean anything to them (tenants) because, SP don't set goals for them, we do...well we don't, we deal with them, tenant and us set the goals, supporting people set the standards that we have to work within"*

The evidence demonstrates that a role of the HRS organisation is to facilitate the relationships between theory and practice, manipulating the evidence to suit different audiences. This will be explored further in the discussion.

Issue 5 – Independence

Seven specific areas of support were identified in the results of this study. An additional finding was numerous vague references to support, and this was termed 'general' support. This is where tenants identified that the organisation provided support, but did not articulate with what. For example:

> *T2: "I get a lot of support...make sure I'm coping and not struggling with anything"*

> *T3: "just to check up just to make sure that I'm alright I-I've got any problems with anything or whatever"*

> *T6: "they're very supporting...if you've got a problem they'll sort it"*

> *T7: "they help you, if you have any, if you need any help they'll help you, they'll do their best to help you"*

> *T8: "sort problems out for you, do ev-everything-everything that if I'd have asked them to do they'd do it for me"*

Further references to general support which did not specifically identify what the tenants were receiving help with can be found in Table 5J.

Table 5J.
Tenant references to general help.

T1: "help you in any way they can possible"

T2: "they've helped me with that's all I can say they've helped, they've always had an answer for me or if not they've got a solution for me"

T3: "I know that any kind of help that they would help you"

T4: "Well they see to complicated things"

T6: "She just comes to check on me err she about everything really you know if there's any problems"

T7: "She helps me with everything"

T8: "They really help me out a lot"

Furthermore, the tenants expressed that they felt that the organisation were always there for them. For example:

> *T1: "if y-you've got any problems all you've got to do is speak to them, they're always there d'ya know what I mean, don't matter whatever the problem is they'll always-they'll always there to speak to you, about anything"*
>
> *T2: "So they're always here for you basically, they're always here for you they're always willing to help"*
>
> *T3: "there's always help off the staff if you ever need it"*
>
> *T8: "they're always there to talk to you if there's anything wrong"*

Further examples of tenants making reference to the organisation 'always being there' can be found in Table 5K.

Table 5K.
Tenant references to the organisation always being there

T1: "There's nothing they don't miss out and that's once a week like, or i-i-if say if it's not my key meeting day and I need to speak to someone I just go through them I could go knock on the door and they'll always listen to-d'ya know what I mean they won't say go away come back on your key meeting day"

T2: "the door is always open but if you need to talk to somebody without an appointment or whatever else there is always somebody here that you can talk to"

T3: "there's always somebody over the phone"

T4: "Well they're there to turn to if I've got any-any problems most of the time"

T8: "it's only-only a phone call away, if you need to speak to someone"

Together Tables 5J and 5K illustrate that the organisation were perceived as a source of comfort to some tenants. They were regarded as being there for general assistance and could be related to social exclusion.

Impact: Institutionalisation

The evidence demonstrates that the organisation is perceived as a constant source of support for the tenants which could have implications for their independence. Staff members made indirect references to institutionalisation with concerns about over-reliance and dependence on the organisation:

> *S4: "these guys have been here a long time...they're kind of just they've kind of become part of the [*organisation] now"*
>
> *S5: "A lot of them w-we weren't needing to give a lot of support to them you know we just it becomes habit and comfortable...and then they don't want to move on"*

Some of the tenant group recognised that they were attached to the organisation, For example, when T2 was asked if they felt they relied on the

organisation the answer was *'yes I do yes'*. There were similar examples of this recognition:

> *T1: "I do depend on them, but not as much as some people I've met"*
>
> *T4: "when I first moved in I-I didn't really want them there, wanted anybody to come...and I feel I need them...Got used to them now and made me feel obligated I feel obligated now"*
>
> *T4: "I've come to rely on with them now before I wasn't when I first moved in...Come to rely on them"*

Furthermore, as well as assessing their own attachment to the organisation the tenants also remarked on other tenants' situations in relation to institutionalisation:

> *T1: "some people will live with them (organisation) are completely and utterly dependent on them"*
>
> *T2: "they [other tenants] can take advantage and they're abuse the system a little bit too much"*
>
> *T5: "It's [timeframe] probably good because err nobody wants to be here any longer than that, d'ya know what I mean you get in-inst-intuti what's that word* [institutionalised]"

Linked to the idea of institutionalisation and the organisation providing a constant source of support was the organisation acting as a safety net to tenants:

> *T3: "even when I come here at night time when I've been really low and I'm doing it (self-harming) but I've rang up instead of doing it and I know the staff are here the next morning"*
>
> *T6: "it is really (reassuring) 'cause you never know what I'm going to get through the post and letters I can't understand"*
>
> *T8: "I'd have somebody up here or always here so I could talk to them or just a phone call away"*
>
> *T8: "it's only-only a phone call away, if you need to speak to someone"*

This could impede their independence by preventing move on and therefore there is a danger of institutionalisation. A related concept to institutionalisation which was evident in the data was revolving door. Staff members made references to this issue:

> *S2: "they might be okay but once you, some of the people y-you move them out, th-the mental problems could dip...so they could end up back in square one where they-where they started"*

> *S4: "within mental health it's kind of like a cycle isn't it, you get stages where you're up and down and, sometimes it's kind of a bit like being in a revolving door and you just kind of your mental health dips and then you can find yourself back in hospital or and then end up you know coming back through again"*

There was also evidence that a revolving door had occurred to tenants specifically involved in the HRS organisation:

> *S5: "it is quite possible that some people that you move on their tenancies may fail, they may end up back in prison they may go back to old ways...just a vicious circle you know and some of it can be-be caused through mental health issues"*

> *S7: "they've ended up back in hospital and er a small number of them are coming have come back to us"*

> *S7: "ultimately they may find their way back to us if you know if they have a deterioration"*

Further exploration of the issue unearthed potential reasons for the revolving door occurring with tenants, and the consequences this had on the tenants:

> *S1: "basically like making them start all over again because you've got to do all that work all over again with them"*

> *S1: "every time they fail it knocks them back"*

> *S7: "they may fit their requirements to move on, and they may move on, but from our point of view, they might not have been quite ready to move on at that stage and subsequently they-they come ill again and revert back to where they were, er and sometimes revert back to a worse position than where they were"*

S8: "If you're discharged from hospital too soon then the person gets re-admitted err the first admission ain't been dealt with properly"

The evidence implies that the revolving door occurs when tenants are moved on from HRS too prematurely, which could suggest why they chose to remove the restraints of a time frame in the model they implement. There is danger of institutionalisation whereby the tenant cannot sustain their own tenancy and end up re-residing with the HRS organisation. This issue also questions what is meant by the term independence, and whether this is solely judged by whether or not someone is a HRS tenant. This will be explored further in the discussion.

Summary

This section began by confirming the findings of Chapter two, and demonstrating that the changes documented in literature were experienced by the HRS organisation in practice. Five issues which emerged from the data (economic, duration, progress, boundaries and independence) were then explored in turn. It was found that funding pressures led to a focus on auditing HRS which moved focus away from the service users, and the auditing tool in theory did not translate well in practice. Secondly there were differences between and within staff and tenant groups with regards to the duration of HRS, which had implications for model fidelity. In turn this had a negative consequence where the organisation had their funding removed. It was found that the HMSP tool is useful in capturing a tenant's progress, and that measuring success should take into account a person's journey within the organisation as opposed to simply counting the number of people moving on. The findings also demonstrated that there is still an issue concerning

boundaries between staff and tenants which has implications for the organisation's role. The staff's role is arguably more complex than can be captured on the HMSP as additional tasks are difficult to measure. Finally, vagueness around defining independence was uncovered whereby the organisation was identified as a foundation for many people which could have consequences on institutionalisation and contribute to a revolving door. The findings of this section will be explored further in the discussion chapter. The next section will explore important factors identified in HRS.

5.3. Important Factors in HRS

The previous section investigated the impact of change on HRS. This section will explore the stakeholder experience of HRS by identifying factors which are important in HRS. Like section 5.2, and in fitting with the Grounded Theory the findings are grounded in the data. Themes emerged from the data which identified factors in HRS and these were grouped into processes and outcomes. This can be found in Table 5L.

Table 5L.
Important factors identified in HRS.

Processes	Both process and outcome	Outcomes
• Time perspective • Conceptualisation of property • Internal (Self) efficacy • External efficacy • Staff-tenant relationship • Trust	• Autonomy • Independence • Coping skills • Medication	• Mental Health • Quality of life • Substance use • Community living • Confidence • Meaningfulness • Safety • Stability

Table 5L demonstrates that ten processes and twelve outcomes were identified from the research study. The middle column of Table 5L highlights the overlap of these factors where four factors were categorised as both a process and an outcome (autonomy, independence, coping skills, and medication). The processes will be discussed first, followed by the outcomes and then the factors

which could be categorised as both a process and an outcome will be discussed.

Processes

In this context processes referred to the collection of factors which directly or indirectly affect experiences of HRS.

Time perspective

Time perspective refers to 'the individual's construal of the flow of personal experiences into the temporal phases of past, present, or future' (Epel, Bandura and Zimbardo, 1999). This emerged from the tenant interviews when exploring their plans for the future. It was found that some tenants had plans set for the future, for example:

> *T1: "I do want eventually do want my own flat, everyone does doesn't they really I-I don't want to be sharing with people for the rest of my life"*

> *T8: "plans for the future is err I-I hopefully to move on in the next 12 to 2 years...that's my plan erm"*

However, the majority of tenants struggled to identify a future path for themselves:

> *T3: "to be honest with you I can't look towards the future I can never look towards the future I can't"*

> *T7: "I find that if you plan something and it doesn't always work out...so take each day as it comes"*

Further examples of time perspective can be found in Table 5M.

Table 5M.
Tenant responses relatable to time perspective.

T2: "Do you want the truth I don't know yet sweetheart, I can't tell you"

T3: "I can't see the future be honest but I like having my own place but I'm frightened of living by myself"

T4: "I haven't got much of a future ...you could die at any time (laughs)"

T5: "Me, a plan, now that's a good question that is, couldn't even tell you, with what's happened to me I couldn't even tell you"

T6: "I don't know, it all depends how life takes it as it comes isn't it really"

The evidence indicates that many tenants demonstrated an avoidance of planning for the future. This could mean they have limited future time perspective so may be more likely to 'live for the moment' rather than spending time planning long term prospects. In turn this could have an impact on the motivation of tenants as Bandura (1997) proposed that motivation is influenced by cognitive representations of future states. A potential implication of this is that if tenants cannot picture their future, or if it is perceived negatively, then this will have a detrimental effect on their motivation. Tenants with low future-orientation could have less goals in HRS and show low motivation to move on, and so instead just concentrate on the present day to day living. Therefore improvements to tenants' conceptualisation of their future need to be achieved in order to positively motivate them.

Conceptualisation of property

Recent housing theory literature (e.g. King, 2009) proposed that housing (housing policy) should be distinguished from dwelling (home). The organisation

provides HRS whereby the tenants are given a residency in one of the organisation's properties. The tenants' experiences therefore provide an insight into how they perceived the property. The results demonstrated that some tenants viewed the property as simply a place to sleep, for example:

> *T1: "*[Town name] is home if you know what I mean"*
>
> *T5: "that's [property] classed as your home, well it's supposed to be...but it's not...Just a place to put your head down"*
>
> *T7: "I'd say it was somewhere to start off".*

Some tenants however viewed the property as their own, for example:

> *T2: "It's my home...It's my home, I've got nowhere else it's a roof over my head that I'd class as my home"*
>
> *T3: "I do class it as my home"*
>
> *T4: "I thought it was my home and I thought I could stay in it"*

There was also some uncertainty:

> *T1: "I don't think I could call it home at the minute...because I-I've only been here two weeks overall but I suppose say in six months time then I might be able to call it home"*
>
> *T7: "it is my home but it's not my home if you know what I mean because like your own will be your own place won't it"*

The evidence shows there is a divide between tenants on what the property represents. Some see the property as their home whilst others see it as a temporary place (house) until they move on. There are also some tenants that acknowledge it as both or are unsure what it means to them. A potential implication of this is that if the property is seen as their home they may settle and be less likely to move on, and therefore not attain independent housing. If a tenant has an emotional attachment to their property they may be harder to motivate to find alternative accommodation. This issue has the potential to impact the concept of (de)institutionalisation.

Internal (Self) efficacy

Internal, or self-efficacy refers to one's perceived competence to reach a goal (Epel, Bandura and Zimbardo, 1999). Self-efficacy beliefs affect how people think, motivate themselves and make decisions (Epel et al, 1999). This concept developed from staff and tenant references to ability, capability, competency, and readiness to move on.

Some of the tenants displayed confidence in achieving independent living, which indicates high self-efficacy:

> *T1: "Err if a flat come in the right place now then yeah I think I would be ready to go"*
>
> *T2: "fingers crossed I should be ready within twelve months to start moving or think about moving on"*

However, some of the tenants expressed a lack of belief in themselves to move on to independent living:

> *T3: "I can't manage myself...that's why my head's in a mess I can't cope with life sometimes, I seriously can't and the staff know that".*
>
> *T6: "I'd start and then I'd end up in hospital...I doubt if I could cope without support"*
>
> *T8: "They want me to move on but I'm just not ready for it yet"*

One tenant was indecisive about their ability to move on into independent living, initially asserting that he would capable, and then showing signs of self-doubt:

> *T7: "I've still got a few issues I've got to sort out but I reckon I could do it"*
>
> *T7: "I thought about having my own place but I don't know it's like half of me if is ready but the other half ain't"*

The tenant interviews demonstrate that there are mixed levels of self-efficacy, with some tenants having a lot of self-belief, and others lacking. There were also signs of uncertainty, so at some points having self-belief, but also hesitation, as if questioning their self-belief. Low self-efficacy needs to be addressed in HRS as tenants who do not believe they are capable of achieving their goals are at risk of 'stagnating', or worse, having a detrimental effect on their recovery and an increased level of dependency on staff/organisation. This concept is important as it has the potential to impact tenants' progress and (de)institutionalisation.

External efficacy

External efficacy refers to a person's belief of someone else's competency/ability to reach a goal. For example, a staff member's beliefs about a tenants' ability to obtain independent living. Like internal efficacy this concept emerged from references to ability, capability, competency and readiness to move on.

In the staff interviews, some indicated high external efficacy, believing that tenants were capable of moving on and attaining independent living:

> *S4: "I think that everyone's capable of moving on"*

> *S6: "people with mental illness can live on their own...hundreds and hundreds and do out in the community, and they're fine"*

However, there were also examples of staff members demonstrating low external efficacy, whereby they did not have belief in the capabilities of the tenants:

S1: "some people will never ever be able to live independently"
S3: "Some people will never get there...we've got a high number of people that'll never [move on]"

S5: "some of the long term, the men particularly they don't cope well on their own so they wouldn't want a tenancy of their own"

S7: "And they some-they may fit their requirements to move on, and they may move on, but from our point of view, they might not have been quite ready to move on at that stage and subsequently they-they come ill again and revert back to where they were, er and sometimes revert back to a worse position than where they were"

S8: "there comes some-a group of people who no matter where you put them err if you go for total independent living they ain't going to cope"

The results show that, like in the tenant group, there were mixed levels of external efficacy, with some staff having high belief in tenants, and some staff having low beliefs in tenants' ability to live independently. Although cause and effect cannot be established here, it is important to consider that staff opinions of a tenant may affect the tenants' self-efficacy. Equally, a tenant's self-efficacy may affect the level of confidence staff members have in their ability to move on from HRS.

External efficacy could be linked to the way in which staff members perceive the tenants. Indications of this were found in the staff interviews when discussing the tenants' backgrounds:

Some of the staff made references to the tenants' history:

S1:" a lot of them come to us with nothing"

S1: "*some people will come to us erm with quite bad histories which have never actually been addressed, never been dealt"*

S2: "a lot of them have had really poor lives to start with"

S2: "you know some of the stories they tell you and you know what problems they've had, living rough and you know they've been in prison and er they've had some terrible lives some of them"

Staff also made reference to the complexity of some of the issues surrounding the tenants, such as having to deal with more than mental health issues alone:

S3: "he's got a history of drug abuse he's never been clean for this length of time, he's never been out of prison for this length of time either, mental health dips all the time"

S3: "You know if they fit the criteria, so a lot of the people that we've got have got dual diagnosis anyway...So they've either got alcohol or drug problems or they've been in prison"

These examples may demonstrate empathy on behalf of the staff members, but could indicate a potential for staff to pity the tenants because of their previous history, or their complicated background (e.g. dual diagnosis). This could affect the staff perceptions and judge tenants as less capable to overcome their issues. In turn this could affect their perceived competency of the tenant to reach goals, and therefore affects their external efficacy, which could have a knock on effect on the tenant's own self-efficacy. Therefore, staff need to engage in evaluation and reflexivity in their own perceptions of tenants and the different ways this may affect the tenant (e.g. perception or self, dependency).

<u>Staff-tenant relationship</u>

The staff members highlighted the importance of a positive relationship between staff and tenants:

S1: "got to have a good rapport with your clients"

S1: "we build a rapport with these people, erm and then when they start to talk to us and open up to us"

S3: "you build up a relationship with that person, you know they trust you"

S4: "at the moment I'm just kind of trying to build up a good rapport with them all"

Feedback from the tenants indicated the staff's awareness and attempt to achieve good working relationships with the tenants were successful:

T1:"the staff are-are brilliant"

T1: "Good [relationship with staff] v-very good I-I like to think so anyway"

T3: "Good [relationship with staff], I've got no problems at all, not with one of them...I haven't had a serious problem with them"

T7: "Okay...I think they're alright"

T8: "quite alright...They're very good I'd say"

The previous comments indicate that the staff were perceived positively by the tenants. Staff acknowledged the importance of rapport and identified it was a relationship that was constructed and built rather than automatically obtained. From the results of the interviews two types of relationships between staff and tenants emerged: formal and informal. Formal referred to strict boundaries being in place, and a distance between staff and tenants. Informal referred to the relationship being more relaxed, with less strict boundaries which allowed the perception of friendship between staff and tenants. Examples of references towards the staff-tenant relationships can be found in Table 5N.

Table 5N.
Responses regarding the relationship between staff and tenants in the HRS organisation

Relation-ship	**STAFF**	**TENANTS**
Formal	*S1: "you have to be careful of erm you know tenants becoming too dependant...But that's obviously where your boundaries come in"* *S6: "that's been a bit of an issue in the past has-has been the boundaries...because you're not people's best friend...so boundaries have been erm have been a bit blurred"*	*T3: "some the staff are strict with you and everybody has got to stick to everything"* *T3: "it's fantastic place round here there's decent nice staff, they're always polite, there's not one that's nasty against you...you've got to stick to the rules, if there wasn't any rules like I said before, people just do what they want and it'd be hell"*
Informal	*S1:"I suppose personally I enjoy the fact that they've got somebody to turn to"* *S2: "they treat me as I say a friend"* *S2:"some of the older people...they treated me as-as a son"*	*T6: "pretty good [relationship with staff] really 'cause they always say hello to me, make me a cup of tea and a cup of coffee"* *T6: "they're pretty good really are the staff here really...very supporting"* *T8: "[The staff are] more like of a family"*

Table 5N illustrates that people have different perceptions of the relationship between staff and tenants. Some perceive the relationship as a strict one with clear boundaries in place, whereas others perceive it as more of a caring relationship where they are friends, or even like family. This could be linked to professionalisation where in recent HRS staff enforce clear boundaries and move away from 'friendship' style relationships. However, there are still signs of these informal relationships, which could be associated with the length of time staff and tenants had been part of the organisation and the HRS model being

implemented. For example, staff members and tenants who had been with the organisation since the home-for-life model could still hold informal relationships which do not have as clear boundaries as later models. Despite SH and IHM being implemented since the home-for-life model the relationships had not evolved or progressed in line with professionalisation.

Although causal factors cannot be established from these results, the staff-tenant relationship could be related to self-efficacy. For example, a caring relationship could encourage dependence and therefore low self-efficacy as the tenants see themselves as incapable of move on and rely of the organisation. On the other hand a tenant with low self-efficacy could encourage the staff to adopt a 'caring' role where they feel the need to 'look after' the tenant as they are seen as incapable to move on and be independent. These concepts could again impair tenant progress and reinforce institutionalisation. Therefore, the staff-tenant relationships should promote empowerment of tenants which can positively affect self-efficacy.

Trust

Trust was an issue related to the relationship between staff and tenants, and a lack of it would prevent openness and honesty. The staff members acknowledged the importance of trust to tenants:

> *S1: "some people have got erm you know horrendous histories and trust is a massive thing"*
>
> *S2: "they get used to a certain face... it's trust as well...you know it's trust"*
>
> *S3: "if is someone doesn't trust you they're not going work with you and they have to be open and honest"*

S3: "A lot of the people they haven't been able to trust anybody...they've either had bad upbringings and you know they've been to prison they don't trust anybody, that is a major issue, trust, they don't disclose they don't open up, never had to"

The tenant interviewees highlighted that trust is a reciprocal relationship between staff and tenants. Trust was seen as an issue for tenants, and it was something that the tenants acknowledged they received from the staff.

T2: "there's a lot of trust in, there's a lot of trust in this place...A hell of a lot of trust, that's what I like about it, with the hostel that I was at I hardly come out my room"

T3: "we trust each other you see"

T7: "I'm getting a bit of leeway here, like they put their trust in you"

The evidence shows that trust was seen as a two way relationship between staff and tenants. The organisation was promoting the idea of instilling their trust in the tenants in the hope that it would help the tenants with their own trust issues and trust would be reciprocated. This issue is important as it affects co-operation between staff and tenants. Poor trust and consequently poor co-operation could have a negative effect on tenants' progression within HRS. Therefore, trust is needed between staff and tenants to promote positive working relationships and allow progress to be made with the HMSP.

Outcomes

Staff and tenant experiences of HRS allowed the exploration of the areas which HRS impacts. The outcomes refer to the products or results of the HRS, which can be used to assess what effects HRS has on tenants. The HRS was identified as having a role in the tenants' recovery generally:

S7: "part of the-the therapeutic recovery is to-is to have good housing, good support"

T3: "the psychiatrist said right we'll get you into one of these places and see if we can get your life back you know on track and you know"

T7: "it's [HRS] erm part of my erm rehabilitation"

More specific examples will be discussed in turn with the outcomes identified from staff and tenant interviews.

Mental Health

The role HRS plays in a person's mental health was identified, whereby providing HRS could be perceived as helping to maintain a person's mental health.

S1: "It [premature move on] can be detrimental 'cause it can really have a-a knock on effect on their mental health they can take a step backwards you know they can have a, have a dip in their mental health and you know i-it's basically like making them start all over again"

S2: "they might be okay but once you, some of the people y-you move them out, th-the mental problems could dip"

T6: "I don't know how I'd go on if I hadn't got support, I'd just crack that's all"

Likewise, a negative experience with HRS can have a detrimental effect on mental health:

S1: "if we've you know if we've got somebody on mental health, it you know giving them a set date to achieve something by can create an awful amount of anxiety, erm cause a lot of stress and it can make them quite poorly"

Therefore, the tenants need a good experience whilst residing in HRS as it could affect their progress and recovery, which in turn could affect their ability to maintain their own tenancy independently.

Quality of life

Another area which HRS was reported to impact is quality of life. WHO (1997) define quality of life as 'individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.' (p.1). Staff interview contained references to tenant quality of life:

> *S1: "we might be able to maintain you know a decent standard of life for them"*
>
> *S6: "they're happy with what they've got quality of life's good"*
>
> *S7: "So we would judge ourselves on the fact that if we're providing a-a good quality of er of housing, improving their quality of life"*
>
> *S7: "by giving the right level of support he he felt he was comfortable in where he was living he's managed to control his life and have a reasonable quality of life"*

This illustrates that recovery in mental health is more complex than simply addressing clinical symptomology. The tenants need to be in a position whereby moving into independent living will not have a negative effect on quality of life as this will dissuade tenants from wanting to move on. If a tenant believes their quality of life will reduce if they leave HRS (for example fears of becoming isolated if HRS provides them with a social network), it will only motivate them to stay. This in turn could have implications for (de)institutionalisation.

Substance use

The HRS organisation held a strict policy in relation to substances, and the tenants explained how they received the relevant support and HRS had a positive impact on their substance misuse:

> *T1: "I've always had a problem with speed like and she [key worker] caught me red-handed, well she didn't catch me with it...so they sent me straight to *[drug and alcohol service] and gave me a final warning here"*
>
> *T2: "there's a no drug policy which is a good thing... here you have got a strict policy and that's what I like about it, keeps you in order then"*
>
> *T2: "my drug habit has basically been sliced, and I mean seriously 'cause I used-I-I was quite bad on err cocaine and cannabis, I don't touch cocaine no more cannabis I rarely use any more as well plus I don't drink (laughs) err so yeah this has actually helped me a lot"*
>
> *T2: "I was slowly dragging myself down and down into a little spiral again and err just went out of control and messed up, I'd had enough and that's when I basically I seen that *[name removed] and she managed to get me into here and these have offered me a hell of a lot more support than what they'd done"*
>
> *T3: "make sure that you don't smoke and er-erm or cannabis or any drugs or any drink, y-as long as you stick to the rules and don't break them then you know, I'm finding it no problem"*

The HRS organisation does not provide specific services for substance misuse which indicates that the improvement is also down to other aspects of the tenants' lives. A strict intolerance to such behaviour with the potential to lose their placement with HRS appeared to act as an effective deterrent.

Community living

Staff members identified that a measurable end goal, or outcome for tenants was to live in the community.

S1: "as long as you know we can help erm create social networks you know erm live within the community as you and I would where it's not just hospital based"

S3: "To see somebody live independently in the community"

The implementation of the HMSP attempts to progress the tenants and with key working sessions equip them with the skills required to maintain their own tenancy. Therefore the experience of HRS could enable a tenant to reach this goal/outcome. Community living is an outcome as it is the desired end product of a HRS placement.

Confidence

Another outcome which emerged from the data was confidence. Staff members identified that confidence could be an issue for tenants, and they showed awareness that a person's experiences in HRS can affect their confidence:

S1: "every time they fail it knocks them back whereas every time they achieve it brings them back up doesn't it"

S1: "we don't set unrealistic goals, because we need to build these people's confidence"

S2: "they've had more confidence I suppose to move out and move in on their own, 'cause that's what they need confidence

S4: "some people have...no confidence"

S5: "some of them fly it just increases their confidence and they think oh I've done that"

Tenants also indicated that being with the HRS had had a positive effect on their confidence:

T3: "that's why I moved in here t-to so I can build my confidence up"

T6: (I am) "Much confident and happy now"

T8: "I'm maybe more confident"

Confidence could be related to self-efficacy whereby if a tenant's confidence improved this could have a positive effect on their self-belief to achieve their goals and make progress within HRS. Confidence could therefore have a direct or indirect effect on motivation which could be the difference between moving on and staying with the organisation. Tenant confidence needs to be addressed as a lack of it could be reinforcing dependency on the organisation and impeding tenant progress.

Meaningfulness

Meaningfulness was an outcome which developed from references to a sense of purpose, belonging, and/or importance; and making life meaningful with meaningful use of time:

> *S1: "we all try and make that person's life as meaningful as possible"*
>
> *S2: "they need something...I know other people that go and see them, they get them out and about"*
>
> *S4: "if there's any possibilities that we can you know maybe get him on a course or get him to do something, just to make more...use of his-useful time to be honest"*
>
> *S7: "that they're getting the right level of support from the housing association that they need to fulfil a useful life"*
>
> *S8: "people deserve to feel that they belong and erm that's what we do"*
>
> *T3: "they don't like you staying in all day and not doing nothing, you know being a lay about in other words and not doing nothing, nothing with your life you've got to do something in the day"*

Meaningfulness is important as it can effect a person's motivation. If a person feels as though they have no purpose then they will have no goals or anything to work towards. This needs to be addressed in HRS as a purpose/goal can

have a positive effect on a tenant's progress. What's more, instilling a sense of purpose/importance in a person can have a positive effect on their confidence. In HRS this could be achieved by participating in voluntary work.

Safety

The staff members indicated that a goal of HRS is to implement a safe environment for tenants:

> *S7: "that they're comfortable and they feel safe"*
>
> *S8: "I think the safe warm and pleasant environment that we have to provide for the home"*

Responses from tenants suggest that the outcome of safety is being achieved. Tenants described previous housing arrangements, and after explaining a bad experience one tenant (T6) was asked if they felt they were safer at the current HRS organisation, to which they replied '*yes I do yes'*. This was reinforced by other references to safety:

> *T3: "I've had people running me down and down to the ground and I've been attacked that many times and I've give myself up, at least I've come to somewhere wh-where it's safe and I know it's safe and the people are safe what am around me 'cause people wasn't safe around me I wouldn't be here"*
>
> *T3: "I feel safe and I know that's there-there's always staff around 'cause if I lived by myself there'd be nobody around"*
>
> *T6: "pleased really 'cause I've got a roof over my head 'cause sometimes years ago in the 80s and 70s I used to sleep outside"*
>
> *T8: "Yeah, much more environment then the err bad hostel... a hostel's where people pick on you and they used to beat you up"*

This shows that in comparison to other HRS received by the tenants the organisation provides them with a feeling of safety which they did not have

previously. This is important as not feeling safe can have a negative impact on a person's health, which in turn could affect a tenants' recovery.

Stability

A final outcome identified from the data was stability. This developed from direct references to stability, and discussions around the organisation's role in the prevention of prison and hospital. Firstly the staff made general references to stability, attributing the HRS to stabilising tenants, and linking problems with HRS with instability:

> *S3: "I think having properties it gives tenants stability"*
>
> *S8: "many times (with move on) you're only adding to their instability and I don't think that's right"*

The tenants indicated instability in references to moving around, which they perceived negatively:

> *T4: "I moved out and lived somewhere nearby then in a flat...he sold the flat so I had to move again...and then I ended up here eventually, keep moving on"*
>
> *T4: "I don't like moving-keep moving about"*
>
> *T6: "A bit, sickly feeling really thinking I'd got to start again like erm move on again"*

After making connections between HRS and stability, and the negative impact excessive moving about can have on a tenant the staff members provided examples of tenants which they believed had gained more stability from being involved with the HRS:

> *S3: "this is the longest he's ever been out of prison...and he's been discharged now from the mental health team so even though we don't do a lot with him he does a lot his self...the stability of the house or a home...has kept him out of hospital"*

S4: "if that's what they're looking for is stability then we'll work with them on that"

*S7: "I know one particular person and one consultant that would say erm that the support and the housing provided by the *organisation has kept that person out of hospital for 15 years...Whereas before they were a revolving patient... the consultant would say...that is the primary reason that that person is not in and out of hospital anymore because they've got they're getting regular support they're comfortable where they're living"*

S7: "he was again a revolving patient very ill er but by giving the right level of support he he felt he was comfortable in where he was living he's managed to control his life and have a reasonable quality of life"

This was seconded by tenants who also made references to the organisation providing stability:

T1: "they would be a lot of homeless people...a lad that was in the B&B had to move out of the B&B and he had nowhere else to go, he would have been homeless and I brought him up here and they've give him a place...if it weren't for these he'd be sleeping under some bridge somewhere now"

T3: "if it wasn't for these kind of places...then some-you know some people would be stuck on the mental health"

*T3:" if it wasn't for this kind of place I would be stuck and I seriously don't want to go back into *[hospital] ever again"*

T7: "Well it [the organisation] means a lot really I mean I could be out in the streets drinking every day getting into trouble but I'm not"

The evidence indicates that both staff and tenants perceive the HRS as providing stability to tenants' lives. Without HRS disruptions to stability were reported which can have a detrimental effect on people's health. Providing order and routine could help to calm what otherwise could be a chaotic lifestyle.

Processes and outcomes

There were a number of factors relating to HRS which were identified as being both a process and an outcome. These were autonomy, independence, medication and coping skills which will be discussed in turn.

Autonomy

A philosophy of HRS is to promote independence and encourage tenants to take responsibility and make their own decisions without relying on others. In the context of HRS decision making/autonomy was discussed in reference to moving on and readiness to live independently. This concept developed from references to choice, decision making, move on and readiness. Autonomy could be perceived as a process as it could affect other outcomes in HRS. For example, a person with little autonomy may be unhappy with the decisions which are being made for them:

> *S7: "some people have actually moved on and been quite cross with us that they didn't want to go"*
>
> *S7: "So there are people that we know that aren't happy with them moving on"*
>
> *T4: "when I had to move up here I didn't get much of a choice"*
>
> *T5: "They want to say what you can do, not what you want to do, what they want to tell you to do...I want to choose"*
>
> *T6: "Well sometimes they're* [decisions] *made for me like you know...that's why I've got support workers....my decision like my support worker made decisions for me to have that flat...because he knew himself in his own common sense that that flat was not helping enough for me"*

However, autonomy could be an outcome if the experience of HRS has affected a person's decision making:

S1: "realistically, ultimately the tenant should be the one to decide whether they're going to actually move out into the big wide world"

S3: "I think...the tenants if they could have a decision of what sort of service they wanted"

S8: "you can't tell people what they're going to do...I mean you can take your horse to water but you can't make it drink can you"

T1: "I think my decision is the main one"

T1: "we'd work together" [on decisions]

T3: "People have got choices obviously you know"

T8: "it would be err both of our choices" [move on]

In terms of reaction to lack of autonomy responses were mixed. Tenant T5 answered "no" when asked if he was involved in decisions concerning himself, and found this was a problem because he wanted to have a choice (for example where to live next). However, Tenant T6 also answered "no" when asked if he was involved in decisions about himself, but expressed that he was happy for this to be the case. This shows that some tenants were happy to have decisions made for them, whilst others were not.

Although cause and effect cannot be established caution needs to be taken as low expectations (low external efficacy) of tenants could relate to high input (from staff) in decisions, which could reinforce low internal (self) efficacy in tenants. Likewise, staff with high expectations of tenants could display high external efficacy which could be related to low input (from staff) in decisions, and reinforce high internal (self) efficacy of tenants. This will be explored further in the discussion.

Independence

Linked to autonomy was the concept of independence which refers to the functioning of tenants without the heavy guidance of the related services provided in HRS.

> *S3: "it [HRS] enables people to live independently in the end"*
>
> *S4: "we'd be with you and help you along and eventually try and you know, encouraging you to, be independent"*
>
> *S5: "I think it's about promoting, again encouraging and helping people regain some of that independence"*

Independence was proposed as a process because a tenant with a high amount of independence when they join the organisation may have different outcomes compared to a tenant who has a low amount of independence. However, the experience of HRS may lead to improved independence which therefore classifies it as an outcome.

Medication

Tenants made references to the effects taking medication had, which meant it could be categorised as a process:

> *T2: "I can relax more, I can settle in, I can sit down err it's mainly because of my medication when my medication comes in I need to relax you see"*
>
> *T3: "I wasn't safe around the area I didn't feel safe with me on loads of medication"*
>
> *T3: "but it's the medication you see, makes me so tired"*

However, tenants also explained that being with the HRS organisation had a positive impact on medication compliance due to supportive staff members, which means it is also an outcome:

T3: ”she’s always come and checked my tablets, she’s always make sure that I’m taking them properly”

T6: “I shown it to her [support worker] today my medication she’s good you know, she knows them pills”

So being on medication could have an effect on HRS experience and being in HRS could affect compliance with medication (e.g. staff members reminding tenants to take medication which they might not do if living alone). This in turn could have wider implications for a person’s recovery.

Coping skills

Coping skills were identified as a process as poor coping skills can lead to negative outcomes such as stress and struggling to maintain a tenancy:

S3: “last time he moved on thought he was ready for move on, he didn’t have no floating support, couldn’t cope and came back”

S4: “some people just can’t cope with certain things and there’s just so much stress and worry going on inside”

S5: “some of the long term, the men particularly they don’t cope well on their own so they wouldn’t want a tenancy of their own, they-they cope because there are others in the house it’s a shared house”

S8: “a group of people who no matter where you put them err if you go for total independent living they ain’t going to cope”

However, the tenants identified that improved coping skills occurred as a result of receiving support from the HRS organisation and was therefore an outcome:

T3: “I can’t cope with life sometimes, I seriously can’t and the staff know that”

T6: “I doubt if I could cope without support like you know”

T8: "I thought I could cope-cope by myself...I did move on and which was a big mistake moving on, 'cause I couldn't cope at all"

Whether it is a process or an outcome (or both), coping skills are important because they would be needed for a tenant to be able to manage their own tenancy. Being able to deal with various stressors the tenants may have in their lives is an important skill. The organisation may act as a support network to assist in the tenants' coping, but if HRS is not permanent the tenants need to be able to manage their own lives independently without 'related services'.

Summary

This section has highlighted important factors in HRS. Processes, outcomes, and factors which act as both have been explored. This section is important as it identified the mechanisms and course of action which occurs in HRS practice. The findings produced eighteen factors (six processes, eight outcomes and four overlapping). This emphasises that the measurement of HRS is difficult due to the complex relationships between a number of variables, and it is hard to establish cause and effect. However, this section moved past a superficial identification of HRS model being implemented and explored components within the model which can affect the experience of HRS. The following section contains further analysis of the data which led to the construction of a model.

5.4. Conceptual model

The preceding sections explored the consequences of change in HRS, and important factors in HRS. As it has previously been acknowledged, the Case Study was an example of a HRS organisation which had evolved over time in response to the developing models of HRS. This meant it was possible to capture a range of HRS model features just by investigating one organisation. During the analysis of the results patterns emerged which were relatable to the different HRS models. These patterns represented themes which created core categories. This was in keeping with the GT framework adopted for this study. Core categories 'account for most of the variation in a pattern of behaviour' (Glaser and Holton, 2005; p.2). Clusters of characteristics surfaced which were related to concepts that had emerged from the data, and these aligned with three HRS models. The core categories along with the clusters of characteristics which aligned with different HRS models formed the basis of substantive theory in HRS. Again, the presence of this feature demonstrates the study's accomplishment of a GT framework. The conceptual model can be found in Table 5O.

Table 5O.
Clusters of characteristics aligning with different HRS models which were implemented within the same HRS organisation over time

Concepts		HRS Model		
Core categories	**Themes/ subthemes**	**A**	**B**	**C**
Economic issue	Funding	Private	Supporting People	Government
Duration	Length of time with HRS	Pre Supporting People	Supporting People	Post Supporting People
	Move on	Against	For, planning with time frame	For eventually, but not working to time frame
Progress	Goals	None	Support plan, star chart	Not strict, some goals, ad-hoc key sessions
	Recovery status	Recovered	Recovering	Not a priority
Boundaries and independ-ence	Institution-alisation	Reliant on staff	Not dependent, aware of institutionali sation	Not dependent, not hugely involved
External factors	Staff-tenant relationship	Good neighbour, like family	Firm but fair, professional	Professional
	External efficacy	Staff do not think they capable	Staff also confident in their ability	Some people will move on but some will always need support
Intrinsic factors	Self-efficacy	Do not believe in themselves	Believe in themselves	Believe in themselves
	Independence	Already achieved	Not yet achieved	Not a priority
	Concept-ualisation of property	Home	House	Home
	Autonomy	Happy for staff to make decisions	Lead decisions	Joint decisions

Table 5O demonstrates that six core categories were developed from twelve themes/subthemes which emerged from the study data. The core categories were economic issues, duration, progress, boundaries and independence, external factors, and intrinsic factors. Together the core categories formed clusters of characteristics which defined features of different HRS models. As aforementioned, in previous literature and research HRS models have been distinguished by prominent, obvious, and often physical features such as building and staff titles. However, when an organisation like this Case Study had to evolve their model of HRS their experience indicates the lines are not as clear. This suggested that deeper, more abstract features which revolved around culture and beliefs were also underpinning the models.

Whilst the analysis confirmed obvious differences such as funding and measurable criteria such as goals and move on, there was also the identification of more conceptual aspects. These were recovery status, staff-tenant relationship, external efficacy, self-efficacy, independence, conceptualisation of property and autonomy.

One reason for the omission of these factors is due to the difficulty in their measurement. Measuring the length of time a tenant has been with HRS is quick, simple and not open to interpretation. Determining a person's independence or calculating their autonomy is far less clear. What's more the subjective judgement involved in assessing these factors could also be a reason for their oversight. Assessing the staff-tenant relationship relies on the records of the staff and/or tenants so there could be bias. The currently omitted factors are entwined into the culture of the organisation so would not be

apparent at a superficial or surface level. In other words researchers would have had to dig much deeper in order to discover this. However, as it has previously been demonstrated, the area of HRS has not been able to afford an abundance of rich in-depth study.

The core categories and clusters of characteristics of the conceptual model form the basis of the substantive theory as it is able to provide explanations for variances in behaviour (or in this case HRS models). This is in keeping with the GT approach adopted for this study but also has implications for HRS in practice. Educating the HRS organisation of the importance of these factors and the impacts it can have on tenants' experience of HRS could help shape constructive behaviour which will work towards positive outcomes in HRS. For example, if staff members are made aware that treating tenants like family may make them reliant on the organisation; or awareness that low external efficacy from staff is found alongside low self-efficacy of tenants, then it may encourage the staff to evaluate their own approach to HRS.

Whilst the conceptual model and substantive theory of HRS cannot establish cause and effect or strength between the clusters of characteristics it still provides a valuable insight into underlying features of HRS which have previously been unnoticed or overlooked. The HRS organisation could use the conceptual model as an evaluative tool to reflect upon the current status of their model and how this may have implication in practice.

Summary

This section has described the conceptual model of HRS which informs the substantive theory of HRS. The importance of this and implications for HRS in practice have been discussed. The following section outlines the findings of the study and how this has informed the literature review.

5.5. Informing the literature review (CIS)

This section will summarise the findings of the results chapter before moving on to outline how these findings were used to inform the literature.

This chapter has presented the results of the study which was informed by a Grounded Theory approach. Sections 5.1 and 5.2 explored change in HRS, which also confirmed the findings of Chapter two. These findings are important as it allowed the researcher to move beyond the superficial identification of issues in HRS and investigated why previous implementation of HRS had not been successful. Furthermore, it offered suggestions for why previously proposed models did not work in practice which provides a deeper level of understanding of the topic. The findings indicated that the HRS organisation has had to be reactive to developments in policy and procedures in HRS, transforming itself to keep afloat and maintain funding.

Section 5.3 investigated important factors in HRS which uncovered processes and outcomes. This provided a richer insight into the complexity of measuring HRS, as multiple factors are involved. However, there are still some gaps. For example, the findings were only based on one Case study and cause and effect of factors could not be established. Section 5.2 and the conceptual model in section 5.3 highlighted further issues as problems occurred in practice when top-down approaches were adopted. Because of this it has previously not been possible to establish what a successful HRS organisation looks like.

Section 5.4 presented a conceptual model whereby clusters of characteristics allowed the identification of components within three HRS models. This work formed a conceptual model of HRS which comprised of core categories and themes which emerged from the data. In doing this the methodology and methods were strengthened as the findings were able to produce outcomes in line with the GT framework. The findings also strengthen the work in previous sections (such as Chapter two) as it provides reasons for problems which could have occurred when implementing HRS in practice. For example, a home for life model could be in danger of creating an environment whereby tenants are reliant on staff, which could have consequences for institutionalisation. This chapter has also demonstrated the complexity of HRS models. It has been shown that differences between models do not simply lie with easily measured aspects such as the number of people living in a building; but the relationships and culture within an environment which may or may not encourage dependency and institutionalisation.

Whilst this study has made significant findings to grasp a rich understanding of HRS from the perspectives of the staff and tenants, it is not all encompassing. Therefore, in order to gain an even further understanding of HRS a literature review was needed. The purpose of the literature review was to address the following points:

1. What research has been undertaken in HRS?
2. How has HRS developed in research?
3. What important factors in HRS have already been identified?
4. How do the findings from the literature review enhance the findings from a historical background of HRS and primary Case Study?

Undertaking the literature review after the study is fitting with the inductive Grounded Theory approach as prior knowledge does not then contaminate the data analysis. Following the CIS the results will be discussed in relation to the research findings. It will be possible to contextualise the research study within the wider literature base, and examine whether there are shared findings or discrepancies between the two. The following chapter therefore is a literature review in HRS.

Chapter Six: Literature review

This chapter is presented in three sections. Part I will introduce Critical Interpretive Synthesis (CIS), comparing and differentiating it from other approaches, and justify how its framework will be applied in the area of HRS and mental health. Part II is the undertaking of the synthesis, which includes outlining methods and identifying relevant research. Part III presents the results of the CIS, and concludes the findings with suggestions for future directions in the area of HRS and mental health.

6.1. Introduction to Critical Interpretive Synthesis

Introduction

Critical Interpretive Synthesis (CIS) was developed by Dixon-Woods et al (2006) as an alternative to traditional systematic reviews. A systematic review aims to 'identify, evaluate, combine and summarise the findings of all relevant individual studies' (NIHR, 2012; p.2). Meta-analysis is an example of a traditional systematic review which is suited to quantitative data (Wolf, 1986). The terms systematic review and meta-analysis have often been used interchangeably however Bown and Sutton (2010) highlighted the distinction; that meta-analyses 'involve the mathematical combination of the results from the source data whilst a systematic review does not' (Bown and Sutton, 2010; p670).The rejection of qualitative research is a criticism of traditional systematic reviews such as meta-analysis as it could lead to the omission of potentially important qualitative evidence (Card, 2012). In contrast, CIS encourages the inclusion of multiple types of evidence (e.g. qualitative, quantitative) and can be applied to a large and/or diverse body of evidence (Dixon-Woods et al, 2006). To illustrate the differences between CIS and a traditional systematic review a table of comparison has been compiled (Table 6A).

Table 6A.
The differences between features of Systematic Review and Critical Interpretive Synthesis
(Adapted from Dixon-Woods et al, 2006)

Feature	Systematic Review	Critical Interpretive Synthesis
Formulating review question	Precisely formulated, tight parameters, selection criteria in advance, a priori	Iterative, modify question in response to results,
Searching literature	Explicit search strategy, relies heavily on electronic databases	Number of strategies: electronic database search, website search, reference chaining (snowballing), contact with experts
Sampling	Limited through tightly specified inclusion criteria, specific boundaries	Ill-defined boundaries, shifts as the review progresses
Determination of quality	Hierarchy of evidence, structured quality check list	Prioritise 'signal' (likely relevance) over 'noise' (the inverse of methodological quality), low threshold, only totally flawed excluded

Table 6A highlights the rigid, strict strategy that characterise systematic reviews. Critical Interpretive Synthesis, in comparison, is much more inductive and allows the data and findings to lead the process, rather than *a-priori* parameters.

As opposed to concentrating on the qualitative vs. quantitative divide in evidence Dixon-Woods et al (2005a, 2006) highlighted the disparity between integrative/aggregative reviews and interpretive reviews. This differentiation moved the focus away from the methods of included studies to the *purpose* of

the review. Aggregative reviews aim to assemble, combine, pool and then summarise data. They include tight, well-defined parameters with *a-priori* definitions, categories and/or questions to be addressed. Interpretive reviews however, are inductive and concern the development of concepts. Dixon-Woods et al (2006) favoured interpretive reviews where the goal is to generate theory and has strong explanatory power. Dixon-Woods et al (2005a) reiterated the importance of prioritising purpose of review over methods of included studies by stating the need to avoid tying approaches to an 'empirical anchor' (for example, linking integrative reviews with positivism and/or quantitative approaches) (Dixon-Woods et al, 2005a; p.46). Dixon-Woods et al (2005a) moved beyond the question of *what data* to include in a synthesis (e.g. qualitative/quantitative), and concentrated on addressing *how to synthesise* the data. The authors identified a number of methods for synthesising qualitative and quantitative data. These were: narrative review, thematic analysis, grounded theory, meta-ethnography, realist synthesis, Miles and Huberman's data analysis techniques, content analysis, case survey, qualitative comparative analysis, and Bayesian meta-analysis. Following this synthesis, and not content with the current approaches available Dixon-Woods et al (2006) developed CIS.

Influence of meta-ethnography

The development of CIS was influenced by meta-ethnography. Meta-ethnography was originally proposed as an alternative to meta-analysis (Noblit and Hare, 1988). Following the criticisms of meta-analysis of only including quantitative evidence meta-ethnography was created specifically for synthesising qualitative studies (Andersen, Nielsen and Brinkmann, 2012).

Barnett-Page and Thomas (2009) outlined the three methods which characterise Meta-ethnography:

1. **Reciprocal Translational Analysis (RTA)** - where key themes/concepts from each paper are identified and then translated to following papers. The outcome is creating overarching outcomes or metaphors.
2. **Refutational Synthesis** – the process of identifying, exploring and explaining contradictions between studies.
3. **Lines-of-argument Synthesis (LOA)** – the process of building up a picture of the whole, from studies of its parts

Originally Dixon-Woods et al (2006) aimed to draw heavily from meta-ethnography with CIS being a compromise, or middle ground between quantitative meta-analysis and qualitative meta-ethnography. The importance of utilising both qualitative and quantitative evidence bases is that in doing so a 'higher order understanding' is achieved (Andersen et al, 2012; p.95). However, Dixon-Woods et al (2005b, 2006) struggled with some of the concepts of meta-ethnography. For example, the authors found that RTA was difficult to apply to large amounts of papers and diverse data sets. In relation to Refutational Synthesis the authors recommended that rather than including contradictions as part of the process, a more critical and reflexive approach should be adopted. Because of these draw-backs Dixon-Woods et al (2006) chose not to integrate RTA or Refutational Synthesis into their approach. CIS does however draw from Lines-of-argument synthesis (LOA).

<u>Lines-of-argument synthesis</u>

Noblit and Hare (1988) stated that LOA concerned 'inference: What can we say of the whole (organization, culture, etc.), based on selective studies of the parts?' (p.23). The authors also highlighted that LOA could be synonymously

conceptualised as ‘grounded theorizing’ (p.23). Dixon-Woods et al (2005b) acknowledged the resemblance between LOA and GT, noting its similarity with Glaser and Strauss’ (1967) ‘comparative method’. Dixon-Woods et al (2005a, 2005b) additionally likened LOA to Guba and Lincoln’s (1994) ‘dialectic synthesis’ (which refers to comparing and contrasting original findings to generate new interpretations).

Orders of construct

Dixon-Woods et al (2006) identified that LOA was built from ‘orders of construct’ proposed by Schutz (1962). This involved the differentiation of ‘first-order constructs’ and ‘second-order constructs’. First-order constructs refer to a person making sense of their world. These are captured in the empirical material that is gathered in research (Aspers, 2004). Second-order constructs refer to researchers attempting to interpret that person/people making sense of their world. It is where the researcher ‘connects the “common sense” world with the scientific world of theories’ (Aspers, 2004; p.4). Britten et al (2002) expanded on this work by introducing the concept of third-order constructs/interpretations. This involves going beyond individual studies, and synthesising a collection of studies in an area.

Dixon-Woods et al (2006) make a clear analogy of third order constructs to their term ‘synthetic constructs’, which they argue is more useful as ‘it is more explicit’[13] (p.6). Synthetic constructs are ‘the result of a transformation of the underlying evidence into a new conceptual form’ (Dixon-Woods et al, 2006; p.5). This means they are ‘grounded in evidence...and allow the possibility of

[13] Dixon-Woods et al (2006) also emphasised that a synthesising argument might link synthetic constructs and second order constructs, so CIS does not make a precise distinction between second order and third order constructs (p.6)

several disparate aspects of a phenomenon being unified in a more useful and explanatory way' (p.5). The development of orders of construct can be found in Table 6B.

Table 6B.
Orders of constructs

Construct	Origin/Influence	Description
First-order	Phenomenology	People making sense of their own world
Second order		Researchers' interpretations of people trying to make sense of their world
Third order	Ethnography	Build on explanations and interpretations of the constituent studies
'Synthetic' constructs	Attempts to be free from an 'empirical anchor'	Transformation of evidence into a new conceptual form, grounded in evidence, Doesn't distinguish between second and third order constructs

Table 6B demonstrates that synthetic constructs is a distinguishable concept that is not attached to empirical groundings which aims to take existing evidence and convert it into new findings.

This study draws from LOA and order of constructs (specifically adopting synthetic constructs to explore third order constructs) as it aims to create theory which is grounded in evidence, transform existing evidence into new forms (orders of construct) and explore the concept (HRS) as a whole, which has been produced by studies of its parts (LOA).

Summary

This section has introduced Critical Interpretive Synthesis as an approach to reviewing research evidence. It has compared and differentiated CIS to other approaches such as systematic review and meta-ethnography. CIS can be seen as pragmatic and middle-range[14] between systematic review and meta-ethnography as it accommodates all types of research so a fuller representation of the big picture can be obtained. Critical Interpretive Synthesis explores data that has been constructed from participants' experiences to generate new theory and fill gaps which were left unanswered by the studies on their own. The remainder of this section demonstrates the relevance of CIS in HRS and why it was adopted for this study.

Justification for applying a CIS framework

CIS is appropriate for use within this investigation as the evidence base for housing and related services (HRS) in mental health is vast and diverse. There have been qualitative, quantitative, theory based, and policy based papers on the topic, from a number of disciplines, for a number of purposes (for example policy, to secure funding, to provide evidence for HRS organisations).

The distinction that was made between aggregated and interpretive reviews is important. To date research in the area of HRS in mental health could be categorised as aggregated, where there has been pooling of information on HRS models and interventions in order to test hypotheses (for example health or housing related outcomes). However, there are still gaps in the area which provides an opportunity to develop theory inductively in an interpretive review,

[14] Merton (1949) coined the term 'Middle-range theory' which compromises between the strict and empirical observation, and abstract theory

Proposal

There has been a vast amount of primary data (second order construct) in HRS which covers a number of aspects, for example cost-effectiveness of the interventions (e.g. Rosenheck, Kasprow, Frisman and Liu-Mares, 2003), impact on quality of life (e.g. Oliver and Mohamed, 1992), and comparison of housing models (e.g. Tsai et al, 2010). There have also been considerable attempts to review/evaluate this primary data (third order construct) in HRS and mental health (e.g. Ogilvie, 1997; Fakhoury et al, 2002; Rog, 2004). Despite this research it is still uncertain what the best way to accommodate people living with mental health problems is. Therefore the proposal is to adapt 'synthetic constructs' from CIS in order to investigate third order construct research in HRS in mental health. As the approach is inductive, and will allow the evidence to lead the synthesis specific outcomes of the synthesis will not be hypothesised prior to its conduction. Instead, the CIS will be guided by the questions which emerged from the results of the study. Table 6C illustrates the identification of the gap for the current study.

Table 6C.
Identification of the gap for the current study

Theory	**Purpose**	**How**	**Criticisms**	
Second-order constructs	Capture people making sense of their world	Previous primary research	May not be transferable,	Attempted to address by undertaking
Third-order constructs	Aggregate a number of primary studies	Previous reviews in HRS	Still gaps/ unanswered questions in the area	
Synthetic constructs	Synthesise reviews in HRS	This study		Will address by undertaking

Table 6C identifies space for the CIS. By providing an overarching critical synthesis of what reviews have been undertaken concerning HRS and mental health the aim is to generate new theory which can direct future research in the area.

6.2. Undertaking Critical Interpretive Synthesis

This section describes how a synthesis of research was undertaken in the area of housing and related services (HRS) and mental health. The approach draws heavily from Critical Interpretive Synthesis (CIS) and its related concepts (e.g. synthetic constructs), which have been outlined in Part I.

This review contains the same components for synthesising and reporting research that were used by Dixon-Woods et al (2006) in their original paper on CIS:

- Sampling
- Determination of quality
- Formulating a review question
- Searching literature
- Data extraction
- Conducting the analysis

Each component will be discussed in turn.

Sampling

Traditional systematic reviews include strict parameters for what should be included in the review. Critical Interpretive Synthesis does not support this approach and instead sees the boundaries as 'ill-defined', liable to shift as the review progresses, and overlapping with other fields (Dixon-Woods et al, 2006; p.3). This notion is more fitting for the topic area of the current synthesis. As previously highlighted (see Chapter two), HRS in mental health is a contentious issue in terms of categorising and establishing responsibility. It straddles health

care, social care and housing; so it is difficult to apply strict parameters without the risk of losing potentially valuable data. Therefore, the inclusion of studies was not restricted to only those that specifically addressed HRS and mental health. For example, a review concerning people with concurrent disorders[15] in HRS was included[16], and a review of the broader categories of housing and health was also included[17]. The inclusion and exclusion criteria were broad and inclusion was a judgement of relevance for the specific purpose of being useful in addressing the review questions, rather than simply meeting a set of rigid criteria. However, inclusion being a 'judgement' by the researcher could be a limitation as this relies on subjective interpretation of a study's relevance. To overcome potential bias 'PICOTS' criteria could be adopted, which are: Population, Intervention, Comparator, Outcome, Timeframe, and Setting (Riva, Malik. Burnie, Endicott and Busse, 2012). PICOTS applied to this study can be found in Table 6D.

Table 6D
PICOTS applied to the current study

P	People living with mental health problems
I	Housing and related services
C	Evaluative/review articles relating to HRS and mental health
O	*multiple – to be explored in review itself*
T	Relevant articles from any time frame (no parameters applied)
S	HRS interventions

[15] Concurrent disorders: O'Campo et al (2009) use this term to refer to substance misuse and mental health
[16] O'Campo et al (2009)
[17] Foster et al (2011)

By acknowledging PICOTS the inclusion criteria for studies can be constructed. The inclusion and exclusion criteria are set out below in Table 6E.

Table 6E.
Inclusion and exclusion criteria for the synthesis

Inclusion criteria	Exclusion criteria
• Evaluative/review articles relating to housing and related services and mental health • Articles printed in English • Relevant articles from any time frame (no parameters applied)	• Primary (second-order constructs) studies • Studies with no application to housing and related services and mental health • Studies unable to access due to copyright restrictions

Determination of quality

Systematic reviews typically involve strict criteria for quality judgement and control (Bown and Sutton, 2010). Critical Interpretive Synthesis goes against this approach and instead argues for the priority of likely relevance over methodological standards[18]. It could be argued that a lack of quality control is a limitation as the studies which are included in a review affect the reliability and validly of the results; and can result in bias (CRD, 2009). On the other hand, not enforcing stringent quality controls may provide some valuable insights into the topic which strict measures may not have captured. Furthermore, the articles in this study were review articles, meaning the studies would have already been subject to quality control procedures in selecting appropriate studies, and so repeating this would be unnecessary.

[18] Dixon-Woods et al (2006) likened this to Edwards et al's (2000) concept of 'signal' (relevance) over 'noise' (the inverse of methodological quality) in judging quality in qualitative evidence

Methods

Formulate the review question(s)

The review questions for this synthesis were quite broad at the outset, with the aim of refining it as the synthesis progresses. The questions were informed by the results of this study and have already been outlined. However, to recap these were:

I. What evaluative/review research has been undertaken in the areas of housing and related services and mental health?
II. How has HRS developed in research?
III. What has been learnt from the research?[19] – What important factors in HRS have already been identified?
IV. How do the findings from the literature review fit with/enhance the findings from the study and the historical background of HRS?

By addressing this issue the review will provide guidance for the question of 'what is the best way to accommodate people living with mental health problems?'

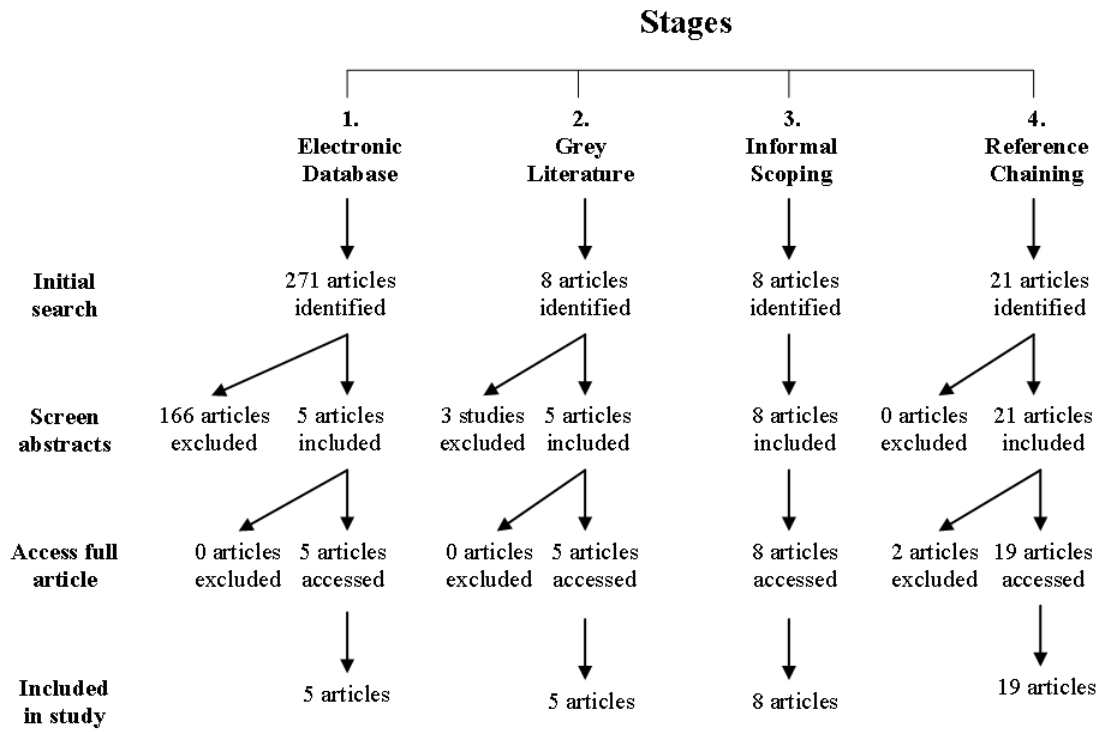
Searching the literature

The literature search was structured but flexible and pragmatic, adopting a number of strategies to identify relevant empirical studies. These included electronic database searches, speaking to HRS practitioners (to inform a search for more grey literature), informal scoping of the internet, and reference chaining[20].

[19] Equally, by investigating what has been found/learnt from the research the gaps of what is still left to be addressed will also be highlighted.

Fig. 6i below outlines the process of searching the literature over the four stages: electronic databases, grey literature, informal scoping, and reference chaining. Each of these stages will be discussed in turn.

Fig. 6i. Process of searching the literature



1. Electronic database search

A structured search of electronic databases was conducted to identify relevant literature. Unlike a systematic review which aims to provide a comprehensive overview of all relevant literature, CIS is more concerned with the relevance of papers. For this reason a senior subject librarian was contacted who provided advice for the most suitable search strategies to address HRS and mental health. Bown and Sutton (2010) recommend that 'the services of a clinical librarian or information specialist should be employed to enhance the quality of

[20] Reference chaining: term used by Dixon-Woods et al (2006), also known as 'snowballing'. It refers to searching the references of an important piece of research to identify other relevant sources.

the literature search' (p.671). The senior subject librarian identified four databases: CINAHL, MEDLINE, PsycINFO and Social Care Online.

In systematic reviews the search terms are standardised across databases, and the same terms are used throughout. For example, the term 'assisted living' would be entered into every database in an attempt to capture relevant studies. However, each database has their own 'thesaurus', and categorise topics differently to one another. Therefore, a term that is used in one database might not be the most appropriate term to use in a second database. For example, 'Assisted Living' is the term used in the CINAHL database to refer to support with living, whereas the term used by the Social Care Online database is 'Supported Housing'. Bown and Sutton (2010) claimed that the use of multiple searches using multiple search terms, different combinations of search terms and search term synonyms also improves the effectiveness of an electronic literature search (p.671). To identify the most relevant search terms the 'topic tree' or 'thesaurus' was explored in each database by the researcher and senior subject librarian. This was done by undertaking three searches: one for housing terms, a second for support terms and a third for mental health terms. The terms 'Housing', 'Support', and 'Mental Health' were entered into the thesaurus/topic trees and the tool indicated the most appropriate related terms to use in order to capture the most relevant studies. For example, for the support term 'assisted living' was the preferred label in CINAHL and PsycINFO, but MEDLINE used 'residential facilities' and Social Care Online used 'supported housing'. The preferred search terms from each databases were tested in the other databases to ensure no data was being omitted because of this strategy but this was not found to be the case. A tailored approach to each

database is more inclusive than set search terms as relevant papers which are not coded according to one databases' preferred system could be lost in the search process because of a difference in terminology. After scoping all of the databases the relevant search terms were identified, which are shown in Table 6F.

Table 6F
Databases and relevant search terms

Database	Housing terms	Support term	Mental health terms
CINAHL	Housing	Assisted living	Homeless persons Mental disorders Mental health Mental health services
MEDLINE	Housing	Residential facilities	Homeless persons Mental health Mental health services
PsycINFO	Housing	Assisted living	Homeless mentally ill Mental disorders Mental health Mental health programs Mental health program evaluation Mental health services Psychiatric patients
Social Care Online	Housing	Supported housing	Mental health Mental health care Mental health problems Mental health services

After searching all of the databases 271 studies were identified that fit the inclusion criteria. The second step was screening of abstracts. This was

undertaken according to the parameters set out in the sampling section previously. After this stage five studies remained which fitted the inclusion criteria. The next step was to access the full articles, All of the articles were obtained, so a total of five studies were included from the electronic databases which can be found in Stage 1 of Table 6G. A more detailed version of the electronic databases search can be found in Appendix 6a.

2. Speaking to professionals and grey literature

As well as published data in journals, databases, and easily accessed articles found through informal internet searches, there is often a body of grey literature which is relevant to an area of research. In HRS in mental health there are many charities and third sector organisation who are involved in providing services. It was therefore identified that in addition to empirical research it would be appropriate to broaden the literature search. Dixon-Woods et al (2006) used 'contact with experts' as a search strategy, which was replicated here. The staff at the third sector organisation which part funded the PhD were contacted and asked to identify any charities/organisations/reports/literature/research they were familiar with that informed their practice. The organisation identified: Sitra[21], Rethink[22], Shelter[23], Midland Heart[24], MIND[25], and Carr Gomm[26]. In addition to these the senior subject librarian assisted in identifying: HSCP, UKHCA, DH, NICE, WHO, and NIHR. SCIE was identified, however the 'Social Care Online' database is affiliated with SCIE so was already captured in the previous round of searching. The websites of each of these sources were

[21] Sitra: is based in the UK, partially funded by CLG and provides housing with health care and support
[22] Rethink: A UK Mental health charity which provides advice, guidance, mental health services, and support groups
[23] Shelter: A UK housing and homelessness charity
[24] Midland Heart: A UK housing and care organisation
[25] MIND: a UK mmental health charity
[26] Carr-Gomm: A UK charity which provides supported living and support services

scanned for research and publications relevant to HRS and mental health. The results can be found in Table 6H.

Table 6H.
Grey literature

Source	Found	Ex-cluded	Studies	Total included
Sitra	0	-	-	0
Rethink	0	-	-	0
Shelter	0	-	-	0
Midland Heart	0	-	-	0
MIND	0	-	-	0
Carr-gomm	0	-	-	0
HSCP	0	-	-	0
UKHCA	0	-	-	0
DH	0	-	-	0
NICE	7	2	*Included:* Kyle and Dunn (2008); Brunette, Mueser and Drake (2004); NICE (2005); Johnson (2013); Kane, Chan and Kane (2007). *Excluded:* Chilvers et al (2006); Pleace and Wallace (2011) -duplicates (already identified in Stage 1)	5
WHO	0	0	-	0
NIHR	1	1	*Excluded*: Chilvers et al (2006) – duplicate (already identified in Stage 1)	0
SCIE	0[27]	-	-	0
Total				**5**

Table 6H shows that initially eight studies were identified which fitted the inclusion criteria. After checking for duplications three studies were removed

[27] SCIE have an affiliated database for research: Social Care Online, which was searched in Stage 1

which left five studies. The full articles of all five studies were obtained. The process of this search can be found in stage 2 of Table 6G.

3. Informal Scoping

Traditional systematic reviews rely heavily on electronic databases to identify literature and research. However, this is not the only place to locate research and so an informal search was undertaken to locate any studies which might have been missed by the electronic search. The search terms identified with the senior subject librarian were used in Google and Google Scholar. From this nine further studies were identified which can be found in Stage 3 of Table 6G.

4. Reference chaining

Following the database and informal searches reference chaining, or 'snowballing' was used to further search for relevant studies. Here the reference sections of already included studies were searched to identify any studies missed by the first searches. The same process was then applied to the new studies, where the reference sections were explored until saturation was reached and no new relevant studies were identified. The process of snowballing studies was the same as the informal searches. Originally 21 studies were identified. The next step was to access the full articles, 2 could not be obtained, despite attempting to access it through the British Library, and 19 were accessed. After screening the introductions all 19 articles were included in the study.

In the second round of snowballing the reference sections of the 19 new studies were explored and 0 studies were identified. The snowballing had therefore

reached saturation and marked the completion of this stage. Overall 19 studies were identified through snowballing, which can be found in Stage 4 of Table 6G. The process of snowballing can be found in Appendix 6b.

After Stages 1-4 were completed a total of 37 articles were identified for inclusion, which are shown in Table 6G. Table 6G documents the stage of searching the articles were found, author(s), title of article and the source where the article originated (e.g. journal/report). A further table with more details of the included studies (including location of review, methodology and methods) can be found in Part III of the synthesis.

Table 6G.
Articles included in synthesis

Stage	Author	Title	Source – e.g. Journal/report
STAGE 1. Electronic Database Search	Carling (1993)	Housing and Supports for Persons with Mental Illness: Emerging Approaches to Practice.	Hospital and Community psychiatry
	Rog (2004)	The Evidence on Supported Housing.	Psychiatric Rehabilitation Journal
	Chilvers et al (2006)	Supported Housing for People with Severe Mental Disorders.	Cochrane Collaboration
	Johnsen and Teixeira (2010)	'Housing First' and Other Housing Models for Homeless People with Complex Needs.	Crisis report
	Pleace and Wallace (2011)	Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review.	National Housing Federation report
STAGE 2. Grey Literature	Brunette et al (2004)	A review of Research on Residential Programs for People with Severe Mental Illness and Co-occurring Substance use Disorders.	Drugs and Alcohol Review
	NICE (2005)	Housing and Public Health: A Review of Reviews of Interventions for Improving Health.	NICE report
	Kane et al (2007)	Assisted Living Literature Through May 2004: Taking Stock.	The Gerontologist
	Kyle and Dunn (2008)	Effects of Housing Circumstances on Health, Quality of Life, and Healthcare use for People with Severe Mental Illness: A Review.	Health and Social Care in the Community
	Johnson (2013)	A Purposive Review, with Methodological Observations, on the Impact of Housing Circumstances and Housing Interventions on Adult Mental Health and Well-being.	Housing, Care and Support

STAGE 3. Informal Scoping	Brown (2004)	Supported Housing Programs for the Homeless Mentally Ill: A Survival Analysis.	Unpublished thesis
	Kirsh et al (2009)	Critical Characteristics of Supported Housing: Findings from the Literature, Residents and Service Providers.	WellesleyInstitute report
	Leff et al (2009)	Deos One Size Fit All? What We Can and Can't Learn From a Meta-analysis of Housing Models for Persons with Mental Illness.	Psychiatric Services
	Rogers et al (2009)	Systematic Review of Supported Housing Literature 1993-2008.	Center for Psychiatric Rehabilitation
	Nelson (2010)	Housing for People with Serious Mentall Illness: Approaches, Evidence and Transformative Change.	Journal of Sociology and Social Welfare
	Schiff et al (2010)	Housing for the Disabled Mentally Ill: Moving Beyond Homogeneity.	Canadian Journal of Urban Research
	Tabol et al (2010)	Studies of “Supported” and “Supportive” Housing: A Comprehensive Review of Model Descriptions and Measurement.	Evaluation and Program Planning
	Foster et al (2011)	Precarious Housing and Health: Research Synthesis.	Hanover Welfare Services report

STAGE 4. Reference Chaining	Rog and Raush (1975)	The Impact of Housing on Health: Examining Supportive Housing for Individuals with Mental Illness	Community Mental Health Journal
	Carpenter (1978)	Residential Placement for the Chronic Psychiatric Patient: A Review and Evaluation of the Literature	Schizophrenia Bulletin
	Colton (1979)	Community Residential Treatment Strategies	Community Mental Health Review
	Cometa, Morrison and Ziskoven (1979)	Halfway to where? A Critique of Research on Psychiatric Halfway Houses	Journal of Community Psychology
	Nelson and Smith-Fowler (1987)	Housing for the Chronically Mentally Disabled: Part II Process and Outcome	Canadian Journal of Community Mental Health
	Rog, Holupka and Brito (1996)	The Impact of Housing on Health: Examining Supportive Housing for Individuals with Mental Illness.	Current Issues in Public Health
	Ogilvie (1997)	The State of Supported Housing for Mental Health Consumers: A Literature Review.	Psychiatric Rehabilitation Journal
	Barrow and Zimmer (1999)	Transitional Housing and Services: A Synthesis.	Report - US departments: HUD and HHS
	Parkinson, Nelson and Horgan (1999)	From Housing to Homes: A Review of the Literature on Housing Approaches for Psychiatric Consumer/survivors.	Canadian Journal of Community Mental Health
	Rosenheck (2000)	Cost-effectiveness of Services for Mentally Ill People: The Application of Research to Policy and Practice	American Journal of Psychiatry
	Newman (2001b)	Housing Attributes and Serious Mental Illness: Implications for Research and Practice.	Psychiatric Services
	Fakhoury et al (2002)	Research in Supported Housing.	Social Psychiatry and Psychiatric Epidemiology
	Page (2002)	Poor Housing and Mental Health in the United Kingdom: Changing the Focus for Intervention.	Journal of Environmental Health Research

STAGE 4. Reference Chaining (cont.)	Evans et al (2003)	Housing and Mental Health: A Review of the Evidence and a Methodological and Conceptual Critique.	Journal of Social Issues
	Frankish, Hwang and Quartz (2005)	Homelessness and Health in Canada	Canadian Journal of Public Health
	Hwang, Tolomiczenko, Kouyoumdijan and Garner (2005)	Interventions to Improve the Health of the Homeless: A Systematic Review	American Journal of Preventative Medicine
	O'Malley and Croucher (2005)	Supported Housing Services for People with Mental Health Problems: A Scoping Study.	Housing Studies
	Nelson, Aubry and Lafrance (2007)	A Review of the Literature on the Effectiveness of Housing and Support, Assertive Community Treatment, and Intensive Case Management Interventions for Persons with Mental Illness who have been Homeless	American Journal of Orthopsychiatry
	O'Campo et al (2009)	Community-based Services for Homeless Adults Experiencing Concurrent Mental Health and Substance Use Disorders: A Realist Approach to Synthesizing Evidence.	Journal of Urban Health: Bulletin of the New York Academy of Medicine

Table 6G demonstrates that in the literature search five studies were identified through electronic database searches, five studies were located by searching grey literature and speaking to professionals, eight studies were found by informal scoping, and nineteen studies were identified by reference chaining studies which were included in earlier stages. This demonstrates that the largest numbers of studies were found by methods which are not adopted in traditional approaches such as a systematic review (informal scoping and reference chaining). This is a major strength of the CIS approach as it has enabled the incorporation of potentially valuable studies, which otherwise may have been missed if alternative approaches were adopted.

Data extraction

With the 37 relevant articles for the Critical Interpretive Synthesis identified the next stage was data extraction. Dixon-Woods et al (2006) recalled their unsuccessful attempt to apply a data extraction pro-forma to compare features of the studies included in the synthesis (for example, characteristics of research participants and key findings). The authors attributed practical reasons for this failure, which suggests the application of a pre-set framework on a group of studies can be problematic when the dataset is large and/or diverse. The proposed alternative for this was an informal summary of documents, which was the approach adopted for this study. General features of the approach taken in each article (e.g. area and population studied) were summarised in a table which can be found in part III.

Critique of articles

Following the summary of each paper in the data extraction stage, the next step was to compare the content of each article. The purpose of the comprehensive inspection of papers was to identify themes and explore them in a critique. This was undertaken as themes offer further knowledge of phenomena which had been previously researched in HRS.

The critique was undertaken by uploading the articles into NVivo 9. Each article was explored in turn, its contents being analysed and themes identified. Once all of the articles had been analysed separately the themes were critiqued to explore the findings in more depth. Dixon-Woods et al (2006) advised the use of constant comparison of theoretical structures against data in the articles, and attempting to identify categories of analysis and comprehend the relationships between them. The results can be found in the next section.

Dixons-Woods et al (2006) also acknowledged that in the process of CIS and qualitative approaches it is not possible to obtain full transparency because of the interpretive elements which are involved. Transparency in research refers to ‘the need to be explicit, clear and open about the assumptions made and the methods and procedures used’ (Hiles and Cermak, 2007; p.2).

6.3. Results of Critical Interpretive Synthesis

This section presents the findings of the Critical Interpretive Synthesis.

Data extraction

The previous section highlighted that an in-depth pro-forma of articles covering features such as key findings and characteristics of participants was not practically possible with such a large and diverse data set. Instead general features of the approaches used in the study were drawn out and summarised. The Table in Appendix 6c identifies the area of the review, population from which the participants were drawn, years which the review covered when searching for literature, types of articles which were included in the review, and any details provided about the methodology and methods used for the review.

The table in Appendix 6c presents a large amount of information about the review articles. This will be broken down further to discuss the information that has been provided in the data extraction exercise. The articles were intentionally placed in numerical order in Appendix 6c to illustrate the trends for reviewing HRS over time. From this Table 6I outlines the number of articles per decade.

Table 6I.
Number of HRS reviews per decade

Decade	1970s	1980s	1990s	2000s	2010s
No. of reviews	4	1	5	20	7

Table 6I demonstrates that the movement of HRS gained momentum from the 1970s, which is fitting with deinstitutionalisation and Care in the Community literature. Table 6I also documents a sharp increase in the number of reviews since the year 2000. In UK literature this could reflect the development and introduction of Supporting People in HRS, where a new framework prompted more reviews in the area.

Appendix 6c also demonstrates the change in language used concerning both HRS and mental health. A clearer illustration of this can be found in Table 6J.

Table 6J
Housing and mental health terms in the HRS review articles by decade

Decade	Housing term	Mental health term
1970s	Psychiatric halfway house, Residential placement, Community residential treatment	Psychiatric clients, Chronic psychiatric patient, Handicapped individuals, Half-way house residents
1980s	Community housing programmes	Chronically mentally disabled
1990s	Housing and Supports. Supportive housing, Supported Housing, Transitional housing and services, Housing approaches	Persons/individuals with mental illness, Mental health consumers, Mentally ill individuals, Psychiatric consumers/ survivors
2000s	Services, Housing attributes, Supported housing , Housing , Supportive housing programmes, Residential	Mentally ill homeless people, Homeless mentally ill, People/ persons with mental illness, Mental ill health, Mental health, Serious/severe Mental illness,

	programmes, Homelessness, Interventions for homeless people, Housing interventions, Supported Housing Services, Assisted Living, Housing and support interventions, Housing circumstance, Housing models, Community based services	People with mental health problems, Homeless people with mental illness, People with severe mental illness and co-occuring substance use disorders, Severe Mental Disorders, People with severe mental illness, mental health disorders
2010s	Housing models, Housing, Supported and supportive housing, Precarious housing , Housing Support Services, Housing interventions	Adult mental health, Serious mental illness, Disabled mentally ill, Psychiatric disabilities, People with mental health problems, Homeless people with 'complex support needs'

Table 6J illustrates the development of terms used to describe people residing in HRS. Tenants, as they are identified in this study, have also been described as patients, clients, consumers, and survivors. The mental health terms associated with the HRS have also endured change of terms, including 'handicapped', 'serious mental illnesses', and 'mental health problems'. These changes mirror the progressions documented in the history chapter, whereby policy and social movements to tackle stigma surrounding mental health influenced terminology and labelling of related terms.

The variance in housing terms used in HRS reflects the development of new HRS models, which is seen in early references to 'residential placement' followed by references to 'Supported Housing', and most recently references to

‘housing interventions’. The wide range of labels attached to HRS could explain the ambiguity and confusion which has often been cited as a problem in HRS due to inconsistent labelling of models. This has had a negative impact on the area as it has been documented as compounding comparisons and affecting model fidelity, which will be discussed further on in more detail.

Appendix 6c documented the years which the articles covered in searching for literature when undertaking the HRS review. Each year between 1975 and 2009 was included in the timeframe searched by at least three reviews, and 2010 was included in the timeframe of two reviews. These figures are likely to be much higher because in twenty reviews the timeframe was not stipulated. One review alone may not be able to capture all of the HRS literature, but undertaking a CIS on review articles allows the combination of reviews to encompass a comprehensive coverage of the history of HRS. The CIS included reviews undertaken from 1975 to 2013, which included literature from 1975 to 2010[28].

Appendix 6c illustrates that 17 articles made no reference to the types of studies which were included in the review. The remainder of articles varied in describing the data included. Some articles emphasised a general approach, stating that ‘all literature’ or ‘published articles/literature’ were included. Some articles made reference to the source of the papers included in the review, e.g. peer-reviewed journals, grey literature, and academic literature. The inclusion and exclusion criteria of papers for the reviews were identified in a number of articles, such as: quantitative studies only, must have a comparison group;

general reports excluded, eliminated qualitative reviews. Several articles made reference to the types of study included in the review, for example experimental or observational studies, statistical reports, randomised or quasi-randomised trials, controlled outcome evaluations. Gaps, ambiguity and/or unclear aspects of reviews are problematic as it compounds comparisons. If evaluations are not transparent in how they are conducted, what the process has been and exactly what is being reviewed then this could affect reliability and validity of the results.

The methodologies guiding the reviews contained more variance, which can be found in Table 6K.

Table 6K.
Methodology of review articles

Methodology	No	Authors
Not specified – 'survey of the literature', 'evaluative approach', 'critical review', 'review' 'synthesis', 'systematic approach', 'comprehensive review', 'review of international literature'	25	Carling (1993), Rog (2004), Johnsen and Teixeira (2010), Brunette et al (2004), Kane et al (2007), Brown (2004), Kirsch et al (2009), Nelson (2010), Schiff et al (2010), Tabol et al (2010), Rog and Raush (1975), Carpenter (1978), Colton (1979), Cometa (1979), Nelson and Smith-Fowler (1987), Rog et al (1996), Barrow and Zimmer (1999), Parkinson et al (1999), Rosenheck (2000), Newman (2001b), Fakhoury et al (2002), Page (2002), Evans et al (2003), Frankish et al (2005), Nelson et al (2007)
Systematic review	4	Ogilvie (1997), Hwang et al (2005), Chilvers et al (2006), Kyle and Dunn (2008)

[28] The literature included could have been dated earlier than 1975, or later than 2010, but because some reviews did not disclose the timeframe it is not certain.

Realist synthesis/methodology	2	O'Campo (2009), Foster et al (2011)
Narrative synthesis	2	NICE (2005), Rogers et al (2009)
Meta-analysis	1	Leff et al (2009)
Rapid Evidence Assessment	1	Pleace and Wallace (2011)
Purposive review	1	Johnson (2013)
Scoping study technique	1	O'Malley and Croucher (2005)

Table 6K demonstrates that four systematic reviews have been undertaken in HRS, and other approaches such as realist synthesis and narrative synthesis have also been adopted. However, the majority of articles did not align with a specific approach, and instead used more general terminology such as review, systematic approach and synthesis. The difference between structured reviews (e.g. systematic review, meta-analysis) and unstructured reviews (e.g. 'review', 'synthesis') is that structured reviews follow a clear protocol or procedure of a recognised methodology which is clearly laid out beforehand, and followed throughout the review. It must be noted that the unstructured reviews may in fact be structured, but without clear labelling of methodology or procedure it cannot be classed as such. Structured reviews are good practice as they attempt to achieve transparency and reliability, and should be an objective, unbiased review of an area. Twenty five unstructured reviews compared to twelve structured reviews suggests that the quality of reviews in HRS have not always been consistent. If two-thirds of the reviews have been built on methodologically flawed foundations this may have implications for the results of the reviews.

Critique of articles

Following the data extraction a detailed inspection of papers was undertaken. As aforementioned the articles were uploaded onto NVivo 9 where they were critically explored in turn, with the content of each paper analysed and themed. From the articles the results were categorised into four sections: descriptive information, black-box evaluations, ambiguity in HRS, and theory-driven evaluations. The results of the critique can be found in Table 6L.

Table 6L.
Themes and subthemes/findings from the HRS literature split into five sections

Section	Theme	Sub-themes/Findings
Descriptive/ contextual information	History/ development of HRS	
	Change	
	Government input/Policy	
	Funding	
	Underlying theory	
	Focus of previous research	
Black-box evaluations	HRS general research	
	Single model research	
	Comparative models research	
Ambiguity in HRS	Measurement	Programmes measured
		Methodological approach
		Tools/ instruments
		Variables and Outcomes
	Model fidelity	Outlining HRS models
	Intensity of services	
	Length of stay	
	Related services	

Theory-driven evaluations	Important features	Attrition/retention
		Characteristics of tenants
		Preferences
	Relationships between variables	Mediators
		Moderators
		Intrinsic factors
		Organisational factors
		Environmental factors
		Housing factors
	Outcomes	Behavioural/ psychological
		Clinical
		Self-sufficiency
		Cost
		Service outcomes
	Mapping variables and outcomes	

Table 6L documents an overarching view of the information established from the HRS literature. This is important as it allows the bigger picture to be viewed, and provides a rich insight into what findings and knowledge have been discovered in the area of HRS. Each section will be discussed in turn.

Descriptive information

Descriptive information referred to the contextual embedding that was present in the HRS articles. This aspect contained six themes: history/development of HRS, change, Government input/policy, funding, underlying theory, and focus of previous literature.

History/development of HRS

Information regarding the history/development of HRS was a common feature in the review articles. The deinstitutionalisation movement has been acknowledged as being involved in the birth of HRS (Colton, 1979; Chilvers et al, 2006; Leff et al, 2009; Nelson, 2010). Potential reasons for the development of HRS which have been offered include financial motives (Fakhoury et al, 2002; Pleace and Wallace, 2011); concern for treatment of patients and conditions of HRS (Fakhoury et al, 2002); consumer preference to live independently (Tabol et al, 2010); revolving door syndrome (Pleace and Wallace, 2011); and medication and changing social attitudes (Fakhoury et al, 2002). The evolution of HRS models has also been documented in HRS reviews. For example, from Continuum of Care to Housing First (Kyle and Dunn, 2008); long stay wards to community (Nelson, 2010); and highly supervised to low supervision (Schiff et al, 2010). It was acknowledged that the early models of HRS (e.g. residential care) were implemented with very little supporting evidence (Fakhoury et al, 2002). Finally, in the development of HRS the issue of professional boundaries arose, emphasising the importance of creating a clear distinction between HRS and NHS services (Pleace and Wallace, 2011). These findings are important as they allow the placement of HRS in its historical context. The findings also support the developments of HRS which were outlined in the history chapter.

Change

In the history chapter change was identified in the HRS models being implemented. The HRS literature used theory to further explore these changes. For example, Nelson (2010) adopted the terms ameliorative and transformative

which he had outlined in another paper (Nelson and Prilleltensky, 2010) to describe different types of change. Ameliorative change refers to arguably superficial change within a system which does not question fundamental underlying values or structures, and the objective is improvement of an existing system. In contrast, transformative change refers to a change in the values/structures of the system, which involves a fundamental revision of the system's operation (Nelson, 2010). Nelson (2010) argued that some HRS models have displayed ameliorative change (such as custodial housing), whereas others have entailed transformative change (e.g. supported housing). It has been proposed that there needs to be transformative change in HRS as this advocates the person as tenant not patient; focus is on recovery not illness; and the tenant is perceived and treated as an active participant with voice, choice and control (Nelson, 2010). Furthermore, it was acknowledged that additional change needs to occur in the area of HRS whereby misconceptions about mental illness (e.g. people are dangerous and unpredictable) need to be challenged, and that education and advocacy is needed to confront stigma (Nelson, 2010). The distinction of types of change is important as the lack of focus on transformative change could explain why researchers and practitioners are arguably no closer to implementing successful HRS.

Government input/Policy

References were commonly made to Government input/policy of HRS. Nelson (2010) argued that relevant policy is important as without it there is danger of supports being compromised; and inappropriate, unacceptable, and inadequate supports may be delivered. NICE (2005) outlined the factors which could impact HRS in the UK, and these have been collated in Table 6M.

Table 6M. Identification of Government/policy factors which could impact HRS in the UK (drawn from NICE, 2005)	
Frameworks/ programmes	• Communities Plan (Sustainable Communities: Building for the future) (ODPM, 2003b) • Tackling Health Inequalities: a programme for action (Department of Health, 2003). • The Housing Health and Safety Rating System (HHSRS) • A new commitment to neighbourhood renewal: national strategy action plan (Social Exclusion Unit, 2001) • Supporting People programme • Communities: Homes for All (ODPM, 2005a) • Communities: People, Places, Prosperity (ODPM, 2005b)
Resources	• Office of the Deputy Prime Minister - Social Exclusion Unit
Services	• NHS Modernisation Agency - The National Enhanced Services (NES)
Publications	• Housing and public health: a review of reviews of interventions for improving health Evidence briefing (NICE, 2005)
Acts of parliament	• Housing Act (2004)

Table 6M demonstrates that various Government/policy factors could have an impact on HRS. These are apparent through frameworks/programmes, resources, services, publications and acts of parliament. Table 6M also shows that HRS is not addressed by one programme, but has relevance in a number. This could mean efforts are being diluted, or stretched if the organisation is trying to adhere to conflicting frameworks, which could have a negative impact on service implementation.

Funding

In the contextual information provided in HRS evaluations there have been references to the funding stream/policy. This has included Supporting People in the UK, HUD in the US, and SAAP in Australia. This is important because different funding streams are associated with different policies, which can affect the HRS being implemented. Implications of this issue are discussed later on.

Underlying theory

Also present in the contextual information of HRS evaluations were references to associated theory. For example, the drift hypothesis and psychosocial rehabilitative model have been applied to the area of HRS (Johnson, 2013; Curley, 1994). Scarce references to theory are typical of HRS literature. Previous literature has struggled to certify whether housing is a stand-alone theory by its own merits, or whether housing is a passive topic to which existing theory should be applied. The ambiguity of whether there is theory *of* housing, or theory *and* housing even warranted a special edition in Housing, Theory and Society journal (2009). The authors (Bengtsson, 2009; King, 2009; Allen, 2009; Clapham, 2009; and Gibb, 2009) acknowledged the theoretical deficit in housing literature. The deficit was attributed to limited appeal/interest in investigating theory in the area (Bengtsson, 2009; Gibb, 2009), which in turn could have been due to funding issues. For example, 'policy-oriented contract research is not always the best way to develop theories, but at least it provides funding in harsh times' (Bengtsson, 2009; p.18). This statement supports the findings of the history chapter where the priorities of HRS organisations has been to secure funding, not investigate theory.

The unsuccessful attempt to apply theory in housing could be due to the incompatibility of theory in the area. Allen (2009) highlighted the risks of trying to construct a worldview as this violates the lived experience and understanding of people in the houses (tenants). Clapham (2009) also noted problems with attempting a unified theoretical framework by using a top down approach, and instead King (2009) proposed that research should question how readily the concepts fit into housing. Thus, the application of a conceptual framework could prove more successful than the search for a potentially elusive and unattainable grand theory of housing. A distinction of theoretical and conceptual framework has been provided by Rocco and Plakhotnik (2009):

> *"A theoretical framework synthesizes existing theories and related concepts and empirical research, to develop a foundation for new theory development" (p.127).*
>
> *"A conceptual framework relates concepts, empirical research, and relevant theories to advance and systematize knowledge about related concepts or issues" (p.128).*

To date existing literature in HRS has not identified a strong conceptual framework for the topic, so investigation of this could inform the area and uncover new findings.

Focus of previous research

When providing contextual information in HRS research there has been references to the focus of previous literature in the area. From this it has been identified that the setting for HRS research is commonly urban and suburban (Barrow and Zimmer, 1999), the participants are often single adults (Schiff et al, 2010), and the groups which have received a lot of attention have been families, people living with mental health problems and people who have been involved in substance misuse (Barrow and Zimmer, 1999). In terms of ability of tenants a

potential for ‘cherry picking’ was uncovered where HRS organisations accept those who they believe are most likely to succeed in the programme, which makes the intervention appear more favourable (O’Malley and Croucher, 2005). This information is useful to see where previous efforts to investigate HRS have been concentrated. Understanding the participant groups is important as it might have an effect on the outcomes so is a factor which needs to be considered.

Contextual information summary

The evidence shows that HRS reviews commonly contain useful contextual information from which valuable lessons could be learnt. It has been acknowledged that there is a clear lack of theory guiding work in the area of HRS (Newman, 2001b). There have been few attempts to apply different theories to HRS, and there are many gaps. This could be due to uncertainty as to whether there are theories of housing itself, or whether the two are separate and theories can be applied to housing. There is a strong basis for arguing that the area of HRS could be captured more thoroughly in a conceptual framework as opposed to a theoretical framework as existing research has proved unsuccessful in identifying a unified theory to explain HRS.

Cultural differences were highlighted including funding, policy, and government input. Difficulties in comparison have resulted when drawing conclusions about HRS in one context with different welfare regimes, scales of homelessness, client characteristics, service networks and housing stock (Johnsen and Teixeira, 2010); and applying it to a different context. There are complications when an intervention is de-contextualised in an attempt to relate findings

elsewhere (Johnsen and Teixeira, 2010). This evidence could suggest that extracting HRS from context for the purpose of comparisons should not be exercised as valuable information about the intervention is lost when this happens. Context is clearly an important factor which should be integrated/explored further in research as opposed to being disregarded in comparative studies.

Investigating the focus of previous research in HRS indicated that certain groups have received more research than others. The consequence of this has been an absence of information of some sub-populations, especially those who may have unique housing needs (Nelson, 2010). For example, research is lacking on youths (including run-away youths), conditions other than substance misuse and mental health (Hwang et al, 2005); 'aged mentally ill', 'people with multiple disabilities', and 'people discharged from correctional facilities' (Nelson et al, 2010). This is important as it has been argued that different populations may result in different outcomes (Carpenter, 1978).

As a result of these findings, and in line with previous reviews, in order to further understanding of HRS researchers have called for a stronger theoretical base (Kane et al, 2007), consideration of context in evaluations (Barrow and Zimmer, 1999), the effect of culture (Schiff et al, 2010; Pleace and Wallace, 2011), and the investigation of different populations in different locations (Parkinson et al, 1999; Tabol et al, 2010).

Black-box evaluations

Black-box evaluations refer to evaluations which focus on the outcomes of the study. For example, before and after an intervention in the same group, or one outcome measured and compared between two groups. What is captured in a black-box evaluation is the "empirical determination of the presence or absence of effects" (Grimshaw et al, 2007; p.5). These types of evaluation are useful in demonstrating whether or not an intervention works, and are less concerned with what happens during the programme process, or why the intervention worked (Green and McAllister, 1998). Black box evaluations can be especially apparent in 'Shoestring' approaches whereby there are financial, political and/or methodological constraints such as a tight budget and deadline (Bamberger, Rugh, Church and Fort, 2004). Shoestring black box evaluations dominated HRS in early research, which will be demonstrated in general HRS research, single model evaluation and comparisons between HRS models.

HRS general

In line with the deinstitutionalisation movement there was a shift towards housing related accommodations in contrast to traditional hospital environments. The philosophy driving this move included the belief that housing matters for psychological health (Evans et al, 2003). This philosophy has been supported by research indicating that housing leads to improved outcomes (Rosenheck, 2000), including more residential stability (Rog et al, 1996; Rogers et al, 2009); less hospitalisation and improved quality of life (Rog et al, 1996); enhanced continuity of care and long term treatment success (Brown, 2004); and greater housing satisfaction (Newman, 2001b). HRS has been documented to significantly improve residential status for people living with mental health

problems, those who are homeless/at risk of homelessness, and people who have had issues with substance misuse (Rogers et al, 2009). Research has also indicated that it is the related services aspect of HRS which is important as opposed to housing alone. For example, it has been shown that in a comparison, all modelled housing achieved significantly greater housing stability than non-model housing (Leff et al, 2009). There has been variation in the ways in which the services in addition to providing accommodation have been conceptualised and delivered in practice, which is where different HRS models have developed.

HRS single model evaluations

The discrepancies in HRS model implementation have led to the investigation of different HRS models in research. For example, research has demonstrated that Supportive Housing is associated with positive outcomes for people with 'serious mental illness' (Nelson, 2010). Supported Housing is linked with having a big impact on people living with 'serious mental illness' (Kirsh et al, 2009), through a positive effect on mental and social health (Fakhoury et al, 2002). More specifically Supported Housing has been associated with housing stability, living situation, quality of life (Rogers et al, 2009); satisfaction (Rogers et al, 2009; Nelson, 2010); housing choice, housing quality, hospitalisation, substance and alcohol misuse (Nelson, 2010); and empowerment, independence, and community integration (Parkinson et al, 1999). Case Management has been shown to improve psychiatric symptoms (Hwang et al, 2005) and decrease use of psychiatric services (Rogers et al, 2009). Assertive Case Management has demonstrated decreased psychiatric hospitalisations and increased outpatient contact (Hwang et al, 2005). Half way Houses have

been associated with reduced hospitalisation rates and adjustment to community living (Rog and Raush, 1975), and it has been concluded that some clients, in some programmes improve to some extent (Cometa, 1979). Finally, it has been recorded that permanent housing has the potential to improve mental health and quality of life of people living with mental health problems (Kyle and Dunn, 2008). Whilst these findings are important, and could be used as evidence to secure funding, the limitation is that it is not known what features of the models are responsible for producing the positive outcomes.

Comparative models research

As the different models of HRS emerged, the research moved towards comparisons in an attempt to establish the best model for practice. Examples of findings can be found in Table 6N.

Table 6N.
Comparisons of HRS models through outcome-based research

Models	Outcome
Supported Housing vs. Conventional hospital care	Supported Housing = improved functioning, social integration and satisfaction[29]
Case management Vs. Usual care	Case management = decreased substance use[30]
Co-ordinated treatment programmes vs. Usual care	Co-ordinated treatment = usually better health outcomes[31]
Community-based accommodation vs. Hospital	Community-based accommodation = higher levels of satisfaction, improved quality of life, maintenance of social functioning and psychiatric symptomology[32]

[29] Fakhoury et al (2002)
[30] Hwang et al (2005)
[31] ibid
[32] O'Malley and Croucher (2005)

Intensive case management vs. traditional case management	Intensive case management = better housing outcomes[33]
Apartments, group homes and half-way houses Vs. Board-and-care homes or nursing facilities	Apartments, group homes and half-way houses = better outcomes[34]

Table 6N suggests that some models provide better outcomes in a range of areas than others. However, in contrast to these comparative results, some evaluative research has indicated that there is no significant difference within housing models (Leff et al, 2009), and that no single approach has been found to be more successful that others (Chilvers et al, 2006). Again, whilst a comparison of models may be useful for funding (if multiple interventions are competing for funding and organisations want to demonstrate they have better outcomes), it still does not help in understanding how or why one model is better than another.

Black-box evaluations summary

The main issues with early HRS research were the ambiguity in design, definition and operation of HRS (Pleace and Wallace, 2011); and inconsistent use of terminology (Fakhoury et al, 2002; Tabol et al, 2010). The impact has been difficulties in making comparisons, categorisations and evaluations (Fakhoury et al, 2002; Kane et al, 2007; Tabol et al, 2010; Pleace and Wallace, 2011). Nelson and Smith-Fowler (1987) specifically identified that the majority of HRS research suffers from a 'black-box' effect. A black-box piece of research makes assumptions about an intervention causing a certain effect or creating particular outcomes. Black-box research has been used in HRS to 'prove' one

[33] Rogers et al (2009)

model is ‘better’ or ‘more successful’ than another as this helps with funding. However, black-box studies do not allow the identification of what features of HRS specifically are important for success in HRS. This has meant that many studies in HRS have been criticised for being descriptive (Carpenter, 1978; Rog et al, 1996; Fakhoury et al, 2002), and lack meaningful critique as the causal factors are uncertain. Black-box evaluations have provided superficial knowledge about HRS, suitable for funding organisations who may only be interested in which model has the best outcomes out of a selection, rather than picking apart why this might be.

Ambiguity in HRS

Following the implementation of evaluations in HRS It became apparent that the research was not being approached or undertaken in a consistent way, and ambiguity was compounding comparisons. Areas identified as containing ambiguity which will be discussed here are: measurement, programme fidelity, variation (in length of stay and intensity of services), and related services.

Measurement of HRS

The evidence indicated that there has been wide variation in approaches to measuring HRS (Kane et al, 2007; Kyle and Dunn, 2008; Tabol et al, 2010).

The first difference concerns the programmes being measured. Examples of the differences in programmes included for evaluation were:

[34] Nelson and Smith-Fowler (1987)

- A collection of HRS providers in one area/region
- Different HRS models/providers compared to one another
- A single HRS model set across multiple contexts
- A single HRS service tested before, during and after implementation

A second difference lies in the methods/methodology adopted for evaluation (Leff et al, 2009; Johnson, 2013). These can be found in Table 6O.

Table 6O.
Methodological approaches to HRS evaluation – drawn from the Magenta book (HM Treasury, 2011)

Type of evaluation	**Definition**
Summative	Asks questions about the impact of policies in comparison with 'doing nothing' or in comparison with another type of intervention
Formative	How a policy intervention works, who it benefits, and under what circumstances do they benefit, mostly qualitative
Goal based	Explores whether policy objectives have been achieved by looking at the actual effects of an intervention and whether there have been any unintended consequences.
Experimental and quasi-experimental	Evaluation that tests policy interventions using robust models, either comparing the intervention with other interventions and/or with doing nothing. Uses statistical analysis
Economic appraisal – looks at relative benefits of an intervention	**Cost effectiveness' assessments -** Compare relative costs between services.
	Cost utility' analysis - Examines whether or not there are different outcomes from an intervention for different groups (i.e. is a service better value for money when it works with one group of people than when it works with another group of people)

	Cost benefit analysis - Often used to describe assessments that are actually exercises in cost effectiveness. A real cost benefit analysis‘ is a highly elaborate exercise that is only rarely conducted because it is both complex and expensive. ‘ not only looks at what an intervention costs, it also considers the alternative uses to which the money could have been put and the opportunity cost

It has been noted that the UK evidence base does not solely align with one of these methods, and is mostly fitting with formative and goal based evaluations, whereas the US evidence base adopts experimental and cost effective evaluations (Pleace and Wallace, 2011).

A third variation in HRS evaluations is the tools/instruments which are used to measure the success of HRS. The measures adopted have been split into five broad categories: health management tools, service user goals, standardised definitions of interventions, validated housing outcomes and quality of life measures (Pleace and Wallace, 2011). This complicates model comparisons as one service could be basing success on the attainment of service user goals whilst another service could be judging success based on effective health management. Because of these differences it is hard to transfer the results of these studies to each other and compare them in a comprehensive way.

A final area of discrepancy is the variables and outcomes which are measured in assessing HRS (Leff et al, 2009). This issue could have arisen from the inconsistencies in the way HRS has been viewed, for it has been used as an input, output, or both in previous literature (Fakhoury et al, 2002). The

relationships between variables and outcomes are such large issues they will be explored and discussed in the theory-driven evaluations section. For now it will be highlighted that, along with other features of measuring HRS, there has been a wide amount of variation. It has already been noted that model comparisons are complicated if different tools/instruments have been adopted (e.g. service user goals vs. effective health management). Even when the same outcome has been measured, it might have been in different ways. For example, two evaluations may have stated 'improving health' as an outcome, but one evaluation may measure this based on hospital admissions, whilst the other may measure it based on the number of GP visits a person makes. Furthermore, even when standardised measures are used for an outcome, this does not guarantee that evaluations can be compared. For example, 'improved health' could be measured through a 'Hospital Anxiety and Depression Scale' (Hiscock et al, 2000), or through 'The Demoralization Index of the Psychiatric Epidemiology Research Instrument' (Evans, Wells, Chan and Saltzman, 2000).

It has been highlighted that in HRS there has been variation in the programmes which are evaluated, the methodological approaches to evaluation, the tools/instrument used to measure effectiveness, and the outcomes which are measured. The large amount of variation in measuring and evaluating HRS complicates model comparisons and has implications for transferability of results. Another potential issue in measuring HRS is in bias of reporting. There is danger of this if the HRS staff member is both providing support and reporting outcomes. Judgement by a HRS staff member could be subjective and inconsistent, and they may 'sugar-coat' problems whereby they under-report poor outcomes and/or over-exaggerate positive outcomes.

Programme fidelity

In research fidelity refers to “the extent to which delivery of an intervention adheres to the protocol or program model originally developed” (Mowbray, Holter, Teague and Bybee, 2003; p.315). Within HRS this has been identified as an issue, and it has been acknowledged on a number of occasions that HRS programmes vary (Carling, 1993; Barrow and Zimmer, 1999; Pleace and Wallace, 2011). There has been no consensus in definitions (Kane et al, 2007), and components and features of models have not been explicitly explained so have been unclear (Brunette et al, 2004). As well as the ambiguity of ill-defined interventions it has also been documented that some interventions have been labelled as a particular model, despite not adhering to its elements (Tabol et al, 2010). The problem of programme fidelity is a large one in HRS but it has rarely been addressed in HRS research (Tabol et al, 2010). An impact of programme fidelity is that it makes it difficult to compare schemes, processes and outcomes (Fakhoury et al, 2002). Research could even be inaccurate, if an evaluation claims to report results on a specific programme/model of HRS when that was not what was actually implemented in practice. For example, an intervention labelled as Housing First could be associated with a range of health outcomes when in actual fact the intervention in question demands treatment adherence (which goes against the Housing First model), and this could be causing the positive effects. Therefore, the features of an intervention must be clear, unambiguous and transparent in order for accurate measurement and evaluation to take place.

Despite the potential confusion with HRS model descriptions, when programmes have been clearly defined and models were critiqued in a large

number, a range of distinguishing features were able to be identified. In an attempt to build up a picture of HRS models, a table was compiled to highlight the key differences. The results can be found in Table 6P.

Table 6P.
HRS models grouped according to time frame (early vs. contemporary) and length of stay (permanent vs. linear)

	Early permanent housing	**Contemporary permanent housing**	**Early Linear models**	**Contemporary linear models**
Examples	• Custodial housing • Residential care/treatment model housing • Board and care homes • Boarding homes • Co-operative apartments • Nursing homes	• Housing first	• Residential continuum • Supportive housing • Staircase model • Halfway houses	• Supported housing
Service user	Ex-patient, client		• Resident	• Tenant
Philosophy	• Home for life	• Housing first	• Treatment first	• Stepping stone
Housing	• Shared housing	• Independent housing – scatter site, private rented	• Continuum of residential facilities, different housing models	• Independent housing – regular/normal on-site
Treatment	• Treatment required	• Treatment not required	• Treatment required	• Treatment not a requirement
Goal	• Clinical stability	• Housing stability	• Housing readiness	• Independence and integration, enhanced quality of life
Levels	• No levels	• No levels	• Progress/'graduate through various levels of housing	• Usually one level – middle way between hospital and community
Length of stay	• Permanent	• Permanent	• Short term – expected to move through continuum	• Limited – expected to move on

Cont.	**Early permanent housing**	**Contemporary permanent housing**	**Early Linear models**	**Contemporary linear models**
Services	• Food, medication, cleaning, NOT rehabilitative services • Services not routinely provided	• Wrap around, floating services • Non-compulsory • Non-time limited support • Community based support through ACTs	• Varying levels of supervision and social support	• Flexible support – often provided by external agencies • Community based support and services
Staff	Housing staff often live in, care provider	Staff do not live in	Limited staff presence, assist with rehabilitation	Facilitators – On site, available in office hours
Framework/ approach	• Focus on medical related needs of people • High demand for sobriety	• Housing is a basic human right – should not be a reward for sobriety/treatment • Harm reduction approach • Consumer choice • Moving is de-stabilising, adds unnecessary stress • Low demand, few rules	• Link housing with support services • Consumer participation • Decision making • Hope to move on to normal living • Transitional in nature • Bridge the gap between hospital and community • Should not supervise medications • Prepares people for own tenancy • High demand • rehabilitation	• Client goals and preferences • Individualised and flexible rehabilitation • work and social network • Client **choice** of own living situation • Empowerment, community integration • Psychiatric rehabilitation framework: choose-get-keep • Inter-agency collaboration

Table 6P demonstrates that there have been two main differences between HRS models: permanent vs. linear models, and early vs. contemporary trends. These will be discussed in turn.

Variation – length of stay

The length of stay in HRS, i.e. whether it should be permanent or transitional, has been a key point of contention (O'Malley and Croucher, 2005). Permanent models advocate a housing first philosophy whereas linear models support the concept of treatment first. The primary goal in permanent models has been stability – whether clinical or housing; whereas the primary goal for linear models is housing readiness. Housing readiness is the process of changing behaviour and life circumstances through the experience of HRS (Rog et al, 1996). There have been criticisms of this concept. For example, there have been variations in the way HRS programmes define, approach and measure 'housing readiness; the HRS provider ultimately decides a person's housing readiness, which has implications for choice and service-user involvement in services; the screening of potential tenants may be biased where those most likely to achieve housing readiness are accepted to the HRS service (cherry picking); and lastly the duration of a person's stay is related to availability of permanent housing, so housing readiness may be irrelevant anyway (Rog et al, 1996). The last point is important as a person may progress to a point where they are 'housing ready', but if housing is unavailable then this prevents them from further development and they are forced to stay where they are. This can be compared to unintentional 'bed blocking' which occurs in inpatient services.

Evaluations in HRS have proposed that discharge from HRS needs to be a semi-permeable boundary (Brunette et al, 2004) which suggests avoiding setting strict timeframe parameters. Despite transitional models dominating in the UK (Pleace and Wallace, 2011) research has proposed a need for permanent/unlimited provisions (Parkinson et al, 1999; O'Malley and Croucher 2005; Kyle and Dunn, 2008), with longer stay/fully completed programmes demonstrating better outcomes (Brunette et al, 2004; Leff et al, 2009). This indicates a discrepancy between policy, research and practice.

Variation – intensity of services

A comparison of early and contemporary trends of HRS reveals differences in the intensity of services. This refers to the level of demand which is the 'expectations and requirements for service participation that transitional programs impose on residents and the ways in which they enforce these expectations' (Barrow and Zimmer, 1999; p.10). For example, in home for life models there was little involvement of housing staff, and they would generally check up on residents, rather than actively working towards psychiatric rehabilitation which is common practice in more contemporary models.

It can be hard to identify intensity of services as there is limited evidence which can serve as a measure of this, and there has been no common way of describing it (Pleace and Wallace, 2011). The lack of evidence of intensity of services explains why it is absent as a factor in Table 6P, and the impact of absence is that it compounds model comparisons. It has been offered that the intensity of services should be assessed on the amount of time workers spend with service users and the range of support that is offered (Pleace and Wallace,

2011). Incorporating this into practice could help define the HRS model being implemented. This is important as two different services may state that they provide key working sessions to tenants, but one service may provide sessions for one hour once a fortnight, whereas the other service may provide sessions for one hour three times a week. The difference in allocated time (intensity of services) may have an impact on recovery and outcomes so is a variable that needs to be considered.

‘Related services’ of HRS

Linked to the intensity of services are the additional parts of the package that are provided alongside the housing, the ‘related services’ of HRS. This is important to identify as without it a programme is purely housing, and there would be little difference between a social housing landlord, and a HRS service. The related services are another factor which varies among interventions that could compound programme comparisons. What’s more, when the reviews are examined together like in this instance, it is possible to see that over time the related services have changed. Services have increasingly expanded from housing to services involving welfare, health and education, and training and employment (Pleace and Wallace, 2011). For example, early permanent housing models demonstrated a range of services with a focus on clinical and domiciliary tasks such as medication, cooking, cleaning, and care needs. Rehabilitation services were not a priority for the HRS organisation to provide. The introduction of Supporting People in the UK changed the approach to related services, and set out a defined list of areas which could be provided by a HRS organisation:

1. Accommodation - Finding appropriate housing/moving
2. Practical assistance - setting up/maintaining a home
3. Daily living skills - Training and support
4. Health, care and other services - help with access
5. Benefits - help with access
6. Choice and control
7. Social support, skills and networks - support in development
8. Emotional support and counselling services- facilitating access

This framework completely contrasted the earlier approach, with a new focus on rehabilitation, where physical health and care responsibilities were passed to relevant health and social care organisations (as demonstrated in the history chapter). This issue also validates the use of the term 'services' rather than 'support' to describe additional aspects to the housing, as the term support could have specific meanings and connotations for responsibilities and funding streams in this area. Table 6Q maps the Supporting People areas against areas identified in research.

Table 6Q.
Supporting People areas of 'related services' in HRS along with areas identified in HRS literature

Supporting People area	Areas identified in HRS literature	Reference
Accommodation	Accommodation – help searching for an apartment /moving	Carling (1993)
	Working with landlords	Kirsh et al (2009)
	Housing and support goals	Carling (1993)
Practical assistance - setting up/maintaining a home	Tenancy sustainment	Pleace and Wallace (2011)
	Adaptations	Pleace and Wallace (2011)

Daily living skills – training and support	Skills for independent living: Home care skills (cooking/cleaning) Budgeting/financing/ managing debt	 Kirsh et al (2009); Rogers et al (2009) Carling (1993); Kirsh et al (2009); Pleace and Wallace (2011)
Health care and other services – help with access	Physical health	Kirsh et al (2009), Pleace and Wallace (2011)
Benefits – help with access	Accessing other resources	Kirsh et al (2009)
Choice and control	Enhancing choice and control	Pleace and Wallace (2011)
Social support, skills and networks – support in development	Access to social support groups/family/friends	Carling (1993); Kirsh et al (2009); Pleace and Wallace (2011)
Emotional support and counselling services – facilitating access	Preventing and managing a crisis	Carling (1993)
	Mental health	Pleace and Wallace (2011)
	Drugs and alcohol	Pleace and Wallace (2011)
	Leisure/culture/faith/learning activities	Pleace and Wallace (2011)
	Training and education	Kirsh et al (2009); Pleace and Wallace (2011)
	Work like activities	Pleace and Wallace (2011)
	Paid work	Pleace and Wallace (2011)
	Harm from others	Pleace and Wallace (2011)
	Self -harm	Pleace and Wallace (2011)
	Harm to others	Pleace and Wallace (2011)
	Compliance with statutory orders	Pleace and Wallace (2011)
	Medication	Carling (1993)
	Ongoing monitoring of need	Carling (1993)

Table 6Q demonstrates that, along with the Supporting People areas that were identified, HRS organisations have provided additional related services. This

could be due to the funding issues where there was great flexibility in what could be delivered by a HRS organisation, and what constitutes ‘related services’. This flexibility could be perceived as a lack of boundaries, which is problematic as it compounds comparisons in evaluations, caused by a lack of transparency of the services.

Different types of HRS that have different services, programme goals and philosophies could be evaluated together when they were never in competition in the first place. As highlighted in the history chapter, the absence of boundaries in early models also met criticism for preventing independence and reinforcing institutionalisation. Despite Supporting People introducing clear areas of additional services, there have still been gaps in the reporting of additional services. For example, ‘helping with access to benefits’ could mean passing on the phone number of the relevant department to a tenant, ringing up on behalf of a tenant to request a form, or as far as filling in the form for the tenant and returning it to the benefits department. Likewise, stating a programme goal for HRS of ‘improving the lives of people living with mental health problems’ is clear in identifying what it wants to achieve, but there needs to be clarity in how this will be accomplished, in terms of methods and measurement. This relates back to the intensity of services that was highlighted previously. Simply identifying an area of potential assistance does not clarify the extent to which a person has been helped. Similarly, stating a goal, without further information to how it is to be achieved can lead to vagueness and uncertainty.

Ambiguity in HRS summary

In terms of measurement of HRS, much of the criticism is based around methods and methodological issues (Newman, 2001b; Nelson et al, 2007). For example, inconsistencies and problems identified include research design (Cometa, 1979; O'Campo et al, 2009), researcher bias (Newman, 2001b; Evans et al, 2003; Pleace and Wallace, 2011), and sample size (Fakhoury et al, 2002; NICE, 2005). Another criticism identified is that, as opposed to the characteristics of housing, researchers have focused on types of housing (Nelson and Smith-Fowler, 1987). This is linked to the black-box issue that was highlighted previously. More generally, actually what is being measured in HRS has caused confusion as there has been uncertainties and variance in independent and dependent variables (Carpenter, 1978; Evans et al, 2003; Kane et al, 2007).

The problem of programme/model fidelity was identified and this issue has been widely acknowledged in HRS (Leff et al, 2009; Johnsen and Teixeira, 2010; Nelson, 2010; Tabol et al, 2010). Critics claimed there was no fidelity assessment (Nelson et al, 2007) and the differences between housing conditions have been presumed, instead of being measured explicitly (Evans et al, 2003). The impact can again be applied to black-box evaluations as the outcomes studies will not be able to distinguish what 'core ingredients' are responsible for, or can contribute to positive outcomes (Nelson, 2010).

Theory-driven evaluations

Theory-driven evaluations attempt to move beyond black box evaluations by investigating the processes that occur within an intervention. The aim is to

provide a more robust understanding of what factors are responsible for the successful/unsuccessful implementation of a programme. Unlike black-box evaluations which concentrate on *if* an intervention works or not, theory driven evaluations investigate at a deeper level by focusing on *why* programmes work or not, and acknowledge situational factors such as context and people. Theory-driven evaluations began to surface in HRS following the limitations of black-box evaluations and related criticisms in ambiguity which had complicated comparisons between models. Building on existing results of theory driven evaluations it was possible to draw out important features of HRS, relationships between variables, mediators, moderators, other variables and outcomes from the review articles. Further analysis mapped the variables to outcomes in order to demonstrate potential relationships highlighted in previous research. These findings are presented in turn.

Important features

When exploring ‘what works for whom’, the ‘whom’ aspect refers to the tenants themselves. This has led some researchers to investigate the characteristics of tenants, and the types of people who use HRS. It has been documented that people living in Supported Housing were more likely to be older, less educated, and unemployed than clients living independently or in semi-supervised settings (Fakhoury et al, 2002). Furthermore, those living independently have been reported by other studies to be of younger age, of female gender, and to have had shorter duration of hospital care (Fakhoury et al, 2002). These findings were only highlighted from one evaluation, perhaps due to the inconsistent reporting of tenant characteristics which has been observed in HRS (Carpenter, 1978). Therefore, there is a need for more clarity in identifying the participant

groups in HRS research if tenant characteristics could affect outcomes.

Another approach to addressing the 'for whom' question has been through assessing attrition and retention rates in HRS. However, there has been mixed results. Some evaluations have identified predictors for poor outcomes such as severity of illness (Rogers et al, 2009), predictors of exclusion from HRS such as behavioural problems (Rogers et al, 2009), and reasons for attrition, such as 'inability' to follow programme rules (Brown, 2004). On the other hand it has also been proposed that the issue hasn't been explored properly in research (Brown, 2004), and that it has not been possible to establish predictors using tenant factors (Brunette et al, 2004). The first step would be to identify *who* seem to 'drop out' of HRS followed by further research into *why* certain people 'drop out'.

In terms of tenant preferences it has been found that tenants prefer HRS to hospital based accommodation (Carpenter, 1978; Carling, 1993), and that particularly tenants prefer independent living arrangements (Ogilvie, 1997; Fakhoury et al, 2002; Brunette et al, 2004). This is important as it has implications for service user voice, choice and control in healthcare.

Theory-driven evaluations – Relationships between variables

A criticism of previous HRS literature is that much of it has been based on black box evaluations. This has meant comparing two different HRS models, and concluding that differences in results are due to the programme itself. It has since been acknowledged that it is not enough to say one HRS model is better than another, and it should be identified what specific features of the HRS

model created the successful result when evaluated. This is related to the concept of Realist Synthesis which attempts to answer ‘what works for whom in what circumstances and in what respects, and how?’(Pawson and Tilley, 2004; p.2). An illustration of this can be found in Table 6R.

Table 6R.
The variables which must be identified in an evaluation process.
Adapted from Pawson and Tilley (2004), and Foster et al (2011)

Mechanism (M)		Context (C)		
Mediator	+	Moderator	=	Outcome (O)
Causal factor		Strength factor		
What works and why		For who and what circumstances		

Mediators

Mediators are ‘what it is about programmes and interventions that bring about any effects’ (Pawson and Tilley, 2004; p.6). Mediators, in a HRS context refer to the causal links between housing and health, accounting for the relationships between the two factors (Foster et al, 2011). In the literature eight mediators were found (Evans et al, 2003; Foster et al, 2011):

1. Stigma
2. Community/social support
3. Parenting
4. Control/autonomy
5. Stability/tenure
6. Safety/security (fear of crime)

7. Indoor environment/housing hardware (temperature, noise level, air quality)
8. Living practices (personal hygiene, washing, preparing food)

Moderators

Moderators, on the other hand are the context which facilitates the change, and factors which influence the strength of the relationship (Foster et al, 2011). Two moderators were identified from the literature (Foster et al, 2011):

1. Personal (demographic) characteristics
2. Circumstances (access to a car, resources)

Other variables

In addition to the mediators and moderators explicitly identified in the literature, there was a range of other factors which emerged as being involved in the process of HRS. These factors appeared to have some form of effect, impact, or involvement in the situation/environment in HRS. These variables could be mediators, moderators, or even outcomes; but cause and effect could not be established which meant they are yet to be classified. The results can be found in Table 6S, where the researcher has categorised the factors into: intrinsic, organisational, environmental, and housing.

Table 6S
Important variables identified from the HRS review literature

Intrinsic factors	Organisational factors	Environmental factors	Housing factors
• Consumer preference, • Self-efficacy, • Isolation, • Ontological security • Resident characteristics	• Staff training • Staff-tenant relationship • Service providers/ services • Intensity of services • Staff character-istics	• Monthly income • Neighbourhood • Other resident characteristics • Social climate	• Living environment (place, context, location of services) • Poor quality housing • Privacy • Space (overcrowding) • Affordability • Number of residents

Table 6S demonstrates that previous literature in HRS has adopted, investigated and found a number of important variables which may have an effect. The mediators, moderators, and other factors were collated to provide an overview of the important variables identified from the HRS literature. The results can be found in Table 6T.

Table 6T.
Mediators, moderators, and other important variables identified from the HRS review literature.

	Intrinsic factors	Organisational factors	Environmental factors	Housing factors
Mediators	• Autonomy/control (Perceived choice, sense of mastery)		• Stigma/lack of acceptance • Community/ social support/network (including friends/family) • Safety/security • Parenting • Living practices	• Indoor environment/ Housing hardware (physical conditions), • Tenure/stability
Moderators	• Personal/demographic characteristics (including gender, age, culture and ethnicity)		• Circumstances (e.g. access to car)	
Other factors	• Self-efficacy • Isolation • Ontological security • Consumer preference	• Staff training, • Staff-tenant relationship, • Service providers/services • Intensity of services • Staff characteristics • Management practices	• Monthly income • Neighbourhood • Other resident characteristics • Social climate	• Living environment (place, context, location of services) • Poor quality housing • Privacy, • Space (overcrowding), • Affordability • Number of tenants

Table 6T illustrates the complexity of investigating HRS. There are multiple causal, strength and other variables across a number of domains which may or may not interact to produce effects. Categorising the potential processes in Table 6T is a novel way to provide an overview of the previously identified factors in HRS, which is easier to digest then simply one full list. The next task is to investigate what variables lead to what outcomes.

Theory-driven evaluations – Outcomes

Outcomes in HRS refer to the consequence/end results. The previous section identified the processes involved whereas the outcomes are what is caused by the variables. The review papers were explored and the outcomes varied vastly. Because of the scale of variance in outcomes the results were grouped for ease of reference into six domains: behavioural/psychological, social/environmental, clinical, self-sufficiency, economic, and service outcomes. The results can be found in Table 6U.

Table 6U.
Outcomes in HRS

Behavioural/ psychological (intrinsic)	Social/ environmental	Clinical	Self-sufficiency	Economic	Housing (organisational/ service)
• Self-esteem/ confidence • Quality of life/ wellbeing • Personal empowerment • Happiness • Life satisfaction • Ontological security • Psychological stability/ wellbeing • Motivation • Maladaptive behaviour • Control/ Autonomy • Sense of freedom • Childhood distress	• Community integration • Participation in social activities • Social connectedness • Engagement with children • Isolation • Safety • security	• Mental status (Psychiatric symptoms) • Health problems • Medication adherence • Substance use/ abstinence • Level of functioning/ functional status • Imprisonment • Death • Neuro-psychological/ cognitive functioning (attention, verbal memory, general intellectual functioning)	• Employment • Global functioning (including Independent and community) • ADL (bathing, feeding, dressing, personal hygiene) • Instrumental ADLs (shopping, housekeeping, money management, food prep, medications, transport) • Coping skills/managing stress	• Capital expenditure • Total cost of care • Total health costs	• Housing obtained/tenure • Quality of housing • Residential/ Housing stability • Utilisation of services • Hospitalisation/ admissions • Homelessness/ No. of days homeless • Resident/housing satisfaction • Residential success • Staff turnover • Quality of services • Privacy • Housing hardware

Table 6U exhibits the wide range of outcomes which have been explored in HRS. Table 6U also illustrates how there has been such a large amount of variance in comparisons of HRS. In addition, Table 6U demonstrates the large amount of information which is lost when outcomes are only focused in one area. For example, if a programme is only measured on the effect it has on hospital admissions (housing outcome) and total health costs (economic) then the impact the HRS has on arguably other important factors such as community integration (social outcomes) and self-esteem (behavioural/psychological outcomes) have not been considered. Therefore a robust measure of outcomes should incorporate a range drawn across multiple categories which have been developed in Table 6U.

Mapping variables and outcomes

From the HRS evaluations mediators, moderators, other variables, and outcomes were identified. The processes/variables were themed into intrinsic factors, organisational factors, environmental factors and housing factors. The outcomes were themed into behavioural/psychological (intrinsic), social/environmental, clinical, self-sufficiency, economic and housing. The HRS reviews identified multiple relationships between the variables and outcomes. An overview of this can be found in Fig. 6iii. More detailed maps for each variable can be found in Appendix 6d.

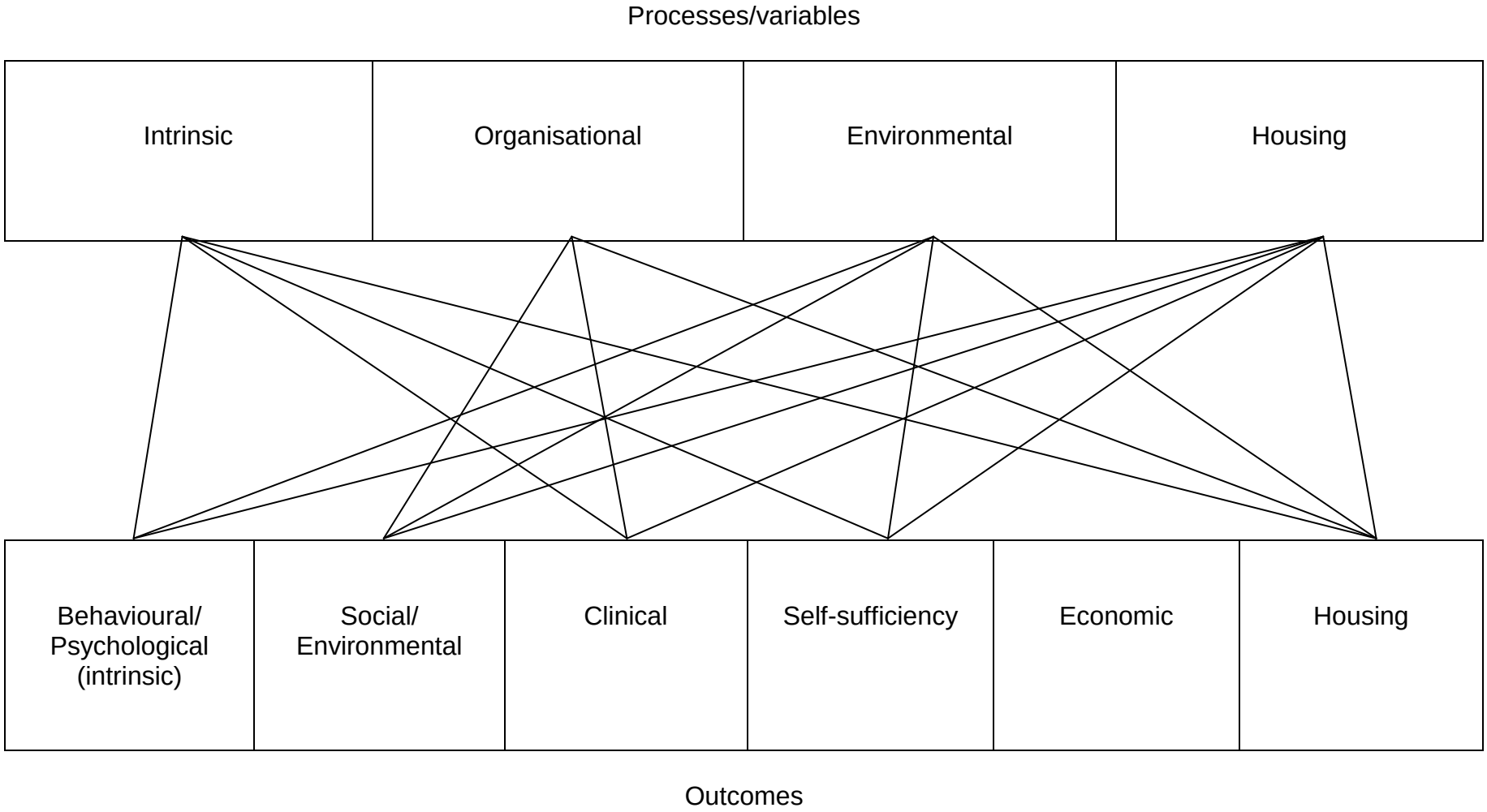


Fig. 6iii. Overview of the relationships between processes/variables and outcomes in HRS

Fig 6iii illustrates the complexity of the relationships between processes and outcomes in HRS. Intrinsic factors were linked to intrinsic outcomes (e.g. self-esteem, motivation), clinical outcomes (e.g. mental status, health problems), a self-sufficiency outcomes (global functioning), and housing outcomes (e.g. quality of housing and residential stability). Organisational factors were linked to a social outcome (social connectedness), a clinical outcome (hospitalisation), and housing outcomes (e.g. housing stability, staff turnover). Environmental factors were linked to intrinsic outcomes (e.g. quality of life, sense of freedom), social outcomes (e.g. community integration, isolation), clinical outcomes (e.g. mental status, cognitive functioning), a self-sufficiency outcome (coping skills), and housing outcomes (housing stability, residential satisfaction). Housing factors were linked to intrinsic outcomes (e.g. autonomy, quality of life), social factors (e.g. safety, security), clinical outcomes (e.g. mental status, hospitalisation), a self-sufficiency outcome (global functioning), and housing outcomes (e.g. privacy, housing hardware). Although economic outcomes emerged from the findings these were not directly related to any of the processes, hence the omission of links in Fig 6iii.

As with the substantive theory presented in Chapter five, the relationships of these factors can be used to inform HRS practice. The process and outcome domains can be likened to core variables of GT whereby they explain variances in behaviour. Fig 6iii gives a richer understanding to *how* HRS works, and what factors shape experience of HRS. If the HRS organisation is made aware of the variables which can have a positive or negative effect on a number of aspects of the tenants' lives, through reflexivity and evaluation this could improve practice.

Theory-driven evaluations summary

The aim of theory-driven evaluation has been to identify what factors are related to positive outcomes in HRS. The rationale behind this was the failings of previous literature to identify the 'active ingredients' which lead to success or failure (Carpenter, 1978; Newman, 2001b; Nelson, 2010; Johnson, 2013), or which type of HRS is best (Newman, 2001b; Foster et al, 2011). A main criticism of this work is that it has been correlational research (Nelson and Smith-Fowler, 1987; Parkinson et al, 1999) where causality has not been established (Parkinson et al, 1999; Fakhoury et al, 2002; Foster et al, 2011). A major issue with existing literature is that it did not encompass the diversity of individual factors which affect HRS (Kyle and Dunn, 2008), and in turn there have been weak/poorly defined relationships between HRS/housing and health/clinical outcomes (Barrow and Zimmer, 1999; NICE, 2005).

The problems with current research gave grounds for attempting to identify mediators, moderators, other variable and outcomes (Tables 6S, 6T, and 6U); and then map these potential relationships onto one another in order to grasp the bigger picture of HRS (Appendix 6d). These processes and outcomes could provide the foundations for a conceptual model of HRS which has been absent in previous research and literature.

CIS Discussion

Adopting a Critical Interpretive Synthesis approach allowed the comparison of multiple attempts to review/evaluate the area of HRS. Taking a step away from the primary literature to critique how the secondary literature has been constructed enabled the previous patterns of evaluation to be discovered, and

to make sense of the area as a whole. The results demonstrate that HRS reviews typically contain general contextual information to set the scene. Following this, researchers have attempted to prove the success of one model in particular, or compared different types of models in black-box evaluations. Researchers began to acknowledge that in making black-box evaluations it was impossible to identify the processes that were responsible for positive effects, or what was causing one model to be perceived as more successful than another. This led to more contemporary attempts to investigate causal mechanisms. A number of mediators, moderators, and other processes/variables have been identified in isolation, or a small amount in reviews. This CIS drew from all of the review articles to map the connections of variables to outcomes. Plotting the processes and outcomes in this way represents the first time the exercise has been undertaken.

It is surprising that this study is the first attempt to map processes and outcomes across evaluative HRS reviews considering that calls for theoretically-driven evaluations started over twenty-five years ago with Nelson and Smith-Fowler (1987) asking “What are the characteristics of programmes that are most effective on what type of criteria for what types of clients?” (p.87). An explanation for why this still hasn’t been answered could be due to funding worries dominating HRS practice, so organisations have arguably only had to try to prove they are more successful than another model or intervention they are in competition against (shoe-string evaluations). The financial conditions of HRS organisations have caused them to focus and prioritise meeting funding criteria and not afforded the luxury of researching HRS at a deeper level. An additional or exacerbating reason could be that lessons are not being learnt in

HRS, or that new research is not effectively being informed by previous literature. The CIS demonstrated that a wealth of primary research has been undertaken in HRS which has been documented in a substantial number of reviews/evaluations, yet there are still large gaps in understanding. This could suggest that prior research has not productively used existing knowledge to build and strengthen the design and implementation of HRS. This observation is seconded by Newman (2001b) who stated 'It is not much of an exaggeration to say that, with few exceptions, each study appears to be starting over. As a result, much remains unknown' (Newman, 2001b; p.1315). This study could be seen as a positive step towards critically evaluating previous literature in HRS and building on prior knowledge and understanding of the area.

The findings of the CIS demonstrated that despite a large number of black box evaluations being undertaken in HRS there was still no consensus as to which HRS model was the most successful. This result aligned with previous evaluations who agreed that there had been no concrete evidence to support one particular HRS model (Brown, 2004; Hwang et al, 2005; O'Malley and Croucher, 2005; Chilvers et al, 2006). However, not identifying a best practice model in HRS does not necessarily signify poor research. It could indicate that there is in fact no such thing as a 'best model' as this suggests a 'one size fits all' mentality and could not accommodate individual differences. This realisation is not a new one. The recommendation of the implementation of a range of HRS model with choice and flexibility has been advised for over thirty years (e.g. Colton, 1979; Parkinson et al, 1999; Kirsh et al, 2009; Foster et al, 2011). Possible reasons for this recommendation not coming to fruition could include the previously aforementioned factors of financial conditions and not learning

from previous literature. Additionally, as well as funding leading the focus of research, meeting funding criteria also led HRS practice. This standardisation of practice in order to consistently make comparisons, and measurements in HRS also meant that it was hard to deviate to accommodate for individual differences. It could be argued that standardising HRS models was a matter of convenience. This supports the findings of Chapter two whereby people living with mental health problems have not been the centre focus of services/organisations, but other priorities have led decisions in HRS. If it has not been possible to find success by developing HRS and then trying to apply it to tenants, an inductive approach to start with tenants and then develop HRS around their needs should be considered. This recommendation has been mirrored in previous reviews evaluations which have called for tenant/stakeholder voice and input in HRS (Ogilvie, 1997; Barrow and Zimmer, 1999; Frankish et al, 2005; Pleace and Wallace, 2011).

Implementing an inductive approach to HRS requires a movement away from deductive, policy driven methods. Despite the previously mentioned barriers to tenant-centred HRS (funding criteria, ineffective use of literature/research, convenience), there was also criticisms of HRS which could arguably provide the conditions for change which promotes the idea of prioritising tenants. Firstly, the HRS literature/evidence base has been criticised for a lack of quality research (NICE, 2005). Secondly, it has been claimed that interventions and policy making has been based on ‘assumption and conjecture’ (Johnsen and Teixeira, 2010) or ‘intelligence’ (Johnson, 2013) instead of evidence (O’Malley and Croucher, 2005). These claims refer to developing services based on policy and then judging evidence based on the ability to meet said policy. This issue

will be expanded upon in the discussion chapter. Contemporary findings indicate that grey literature has offered new understandings of HRS that has not been captured in formal approaches such as meta-analyses (Johnson, 2013). New suggestions are that there is “no need for continual, robust evaluation of housing support services nor is it the case that all services have to be thoroughly evaluated” (Pleace and Wallace, 2011; p.50), and this could be replaced by experience of tenants or “local knowledge” as a “legitimate basis for policy and commissioning (Johnson, 2013: p.32). These contemporary findings suggest a place for stakeholders’ voices and the welcoming of tenant-centred approaches in HRS.

To create a tenant-centred HRS two issues need to be further established: cause and effect of processes and outcomes in HRS, and a robust measure of HRS. The CIS is valuable in identifying potential relationships and starting to line up potential answers to that question. However, the CIS is limited in that it is not possible to establish which factors cause what effects. Additionally, the strength of the effects or the combinations of variable relationships are not clear. The multidirectional links in HRS were also identified by NICE (2005) who stated that there is probably a two way relationship between housing and health (NICE, 2005). This illustrates the complexity of HRS, and could suggest that previous attempts to evaluate HRS have been unsuccessful due to being too reductionist or simplistic.

In order to address this issue further research must explore which variables are responsible for what effects. This will be useful for HRS organisation as they will be able to tailor a service around tenants which is both aware of factors which

can positively affect tenants, and also mindful of factors which could exacerbate or be detrimental to tenants' health and wellbeing.

In line with improving the understanding of processes and outcomes in HRS is the need to capture the success of HRS. Previous evaluations have appealed for the ascertainment of HRS effectiveness (Rog and Raush, 1975; Ogilvie, 1997; Brunette et al, 2004; Pleace and Wallace, 2011). However, as demonstrated in this chapter the effectiveness of HRS has been negatively affected by issues with between and within (fidelity) model comparisons, and inconsistent measurement in HRS. A more robust measurement of HRS is needed which is flexible but thorough. The previous attempts to measure CIS have been shown to be reductionist, over simplistic and/or superficial in capturing a tenant's experience and progression in HRS. The findings which identified a range of factors involved in HRS aligned with researchers advising that no single outcome measure should be relied on (Pleace and Wallace, 2011). A proposal for this which is grounded in this study's results and the CIS is proposed in the discussion chapter.

The issues of cause and effect and measurement in HRS which were identified in the CIS were also evident in a number of HRS reviews/evaluations. Recommendations in HRS research can be found in table 6V.

Table 6V.
Recommendations in HRS research

	Recommendation	Source(s)
Measurement of HRS	Need to research cost effectiveness	Carling (1993); NICE (2005); Kyle and Dunn (2008); Johnsen and Teixeira (2010); Pleace and Wallace (2011)
	Long term follow ups/longitudinal	Carpenter (1978); Nelson and Smith-Fowler (1987); Barrow and Zimmer (1999); Evans et al (2003); Brown (2004); Kyle and Dunn (2008); Johnsen and Teixeira (2010); Pleace and Wallace (2011)
	More in-depth qualitative studies	Ogilvie (1997); Fakhoury et al (2002); Kyle and Dunn (2008)
	Use control groups	Carpenter (1978); Hwang et al (2005); Kyle and Dunn (2008); Pleace and Wallace (2011)
	Need RCT	Brunette et al (2004); NICE (2005); Pleace and Wallace (2011)
	Valid standardised instruments	Fakhoury et al (2002); Kane et al (2007); Kyle and Dunn (2008)
	Uniform set of measures of housing as input and outcome	Newman (2001b)
Relationships between variables and outcomes	Clarify links between housing and outcomes	Nelson and Smith-Fowler (1987); Kyle and Dunn (2008)
	Should report multiple outcomes for robustness	Hwang et al (2005): Leff et al (2009)

Relationships between variables and outcomes Cont.	Consensus on primary and secondary outcomes	Rogers et al (2009)
	Need more research on processes and outcomes	Ogilvie (1997); Parkinson et al (1999)
	Relationships between housing interventions and outcomes must be clear	Pleace and Wallace (2011)
	Features that relate to outcomes	Fakhoury et al (2002)

Despite this study being conducted inductively there has still been shared ideas between the thesis and previous HRS literature. In relation to measurement in HRS this study represents an in-depth qualitative study which was called for (see table 6V). With regards to relationships between variables this thesis has discovered features that relate to outcomes, undertaken work on processes and outcomes, and agreed with the need for multiple outcomes for robustness (see table 6V). Furthermore, the discussion presents a uniform set of measures which can be used in HRS which was identified as a need from this study and previous literature. The common findings of this study to previous literature confirm prior research and strengthen the results of this study. Attempts to address these issues also represent original contributions to the HRS area. What's more, potential processes and outcomes have been identified from the data so RCTs could now test these factors in order to further establish cause and effect. Appeals have been made for RCTs by previous researchers (see Table 6V), and this study has provided foundations on which RCTs could be built.

Summary

This section provided a brief overview of the CIS results and suggested reasons for shortcomings in previous HRS research and literature. The lack of evidence promoting one HRS model and the need for flexibility and a tailor made model with an inductive approach were discussed. The issues of cause and effect and robust measurement in HRS were examined, also relating these issues to previous research to highlight similarities. To conclude, the challenge in HRS now is to establish cause and effect between HRS processes and outcomes is needed, along with designing tenant-centred HRS. The following chapter is the discussion which will further explore the findings of this thesis.

Chapter Seven: Discussion

The previous chapter undertook a Critical Interpretive Synthesis of the HRS literature base. The CIS, study results, and the overview of the development of mental health services provide a broad insight into HRS in the literature, research and practice. In this chapter these three aspects will be integrated, and discussed and strengthened with theoretical foundations. This chapter will be split into two sections:

1. Critique
2. Recommendations

The chapter will be structured this way to present the issues which were identified from this research and offer recommendations which demonstrate how these findings can also be used and applied to HRS in practice.

The issues which will be discussed in the critique and recommendations are change, HRS and measurement in HRS. These issues emerged following the amalgamation of findings from the history (chapter two), results (chapter five), and literature review (chapter six). The identification of issues for discussion from the findings of this thesis can be found in Table 7a.

Table 7a.
Issues for discussion based upon findings from the history, results, and literature review chapters of the thesis.

	Issue for discussion	History	Results	Literature review
1.	Change	*Throughout chapter* – e.g. Overview of HRS progression	Consequences of change	*Throughout chapter* - e.g. Descriptive information, black box evaluations
2.	HRS in practice	*Throughout chapter* – e.g. Supporting People	Consequences of change	Ambiguity in HRS
3.	Measure-ment in HRS		Important factors in HRS	Theory driven evaluations

Table 7a demonstrates that the issues for discussion are fully grounded in the findings of the thesis. Despite the study being undertaken inductively Table 7a indicates that there are shared commonalities between HRS in practice and literature.

7.1 Critique

From this research four issues in HRS were identified: subjective interpretation in measurement of HRS, deductive change in HRS development, model infidelity in HRS practice, and uncertainties of what to measure in HRS. Each will be discussed in turn.

Subjective interpretation in measurement

A potential reason for the problems around measuring HRS is in people's subjective interpretation of related terms such as independence and institutionalisation. For example, policy makers may acknowledge a tenant as 'independent' only after they have moved on from HRS and are managing their own tenancy. However, the tenancy may be a trivial aspect of a tenant's progress to some staff and tenants, who judge independence on a person's ability to complete activities of daily living and managing their own finances. Two tenants living in the same HRS accommodation may lead completely separate lives, both undertaking voluntary work, shopping and cooking for themselves and paying bills. However, to avoid social isolation and loneliness they may both prefer to live with a 'house mate'. To the tenants and the staff they could perceive these people as hugely independent, but this would not be reflected in the outcome measures if the criterion was living alone in one's own residency. Therefore, what is counted ('independent' living) is not necessarily the most important, or accurate measure of that factor.

This topic can also be related to the concept of deinstitutionalisation. The process of deinstitutionalisation concerned integrating people from the asylums

into the community. However, it has been argued, including by participants from this study, that HRS can be perceived to be an institution as the person is not regarded as ‘independent’. This suggests that deinstitutionalisation could be a two-step process. However, some people, again including participants from this study, believe that this second phase of deinstitutionalisation is unnecessary. The argument is that further movement can cause disruption as the success is maintaining health outside of an inpatient environment.

In previous chapters it was demonstrated how the same term, with the same meaning has been labelled differently over time. For example PTSD has also been referred to as soldiers’ heart and combat fatigue. A second example would be service users previously being referred to as patients, clients or customers. However, here the difference lies in the meaning attached to a word which remains constant. The findings of the study demonstrate that independence to some people indicates a person’s ability to complete daily living skills competently whereas others would interpret independence as the ability of a person to manage their own tenancy. Likewise some people would attach the physical context of a hospital, inpatient environment to deinstitutionalisation, whereas other people would associate a structured supported environment, and the process of moving into one’s own tenancy with the same term.

This lexical ambiguity occurs when the subjective interpretation of a word (which informs the meaning they attach to it) is different between people. The consequence in HRS is that tenants, organisations and policy-makers may expect and work towards different things, based on their own interpretations. This could lead to frustration if a group believe they have achieved

deinstitutionalisation but others are judging this on different parameters so believe the goal has not successfully been achieved. The acknowledgement of subjective interpretations is an important factor in HRS as this has previously not been addressed despite clearly having an impact on HRS practice. A recommendation to help overcome this issue is described in the following section.

Change

Change has been a prominent feature of this thesis. It has been documented in the history and development of mental health (Chapter two), HRS practice (Chapter five), and in HRS literature (Chapter six). This thesis has attempted to explore change in terms of its causes, influences and effects. Change is important in HRS as it has been stated that 'a company's longer term viability depends to a large extent on its ability to make organization-wide change happen – fast' (Holbeche, 2006; p.ix). This means that in order for the HRS organisation to continue it must be able to adapt to the context and change happening around them, and evolve with it.

Change theory

Theory can be used to 'frame the development of strategies and interventions to achieve change in behaviours' (Riekert, Ockene and Pbert , 2013; p.1). In this thesis change theory was drawn from to analyse the HRS organisation's situation and better explain how the process of change was being experienced in practice. This is relevant for the current study as the organisation had experienced a number of different trends and policies guiding HRS which had

required transformation, adaption, evolution and progression in managing change. Lewin ’s (1947) change theory will be used to illustrate these changes.

Lewin’s (1947) change theory has been used as it explains the process of change in the most basic, three step process which is a suitable starting point. The three stage process involves unfreezing, moving, and freezing (Lewin, 1947). A visual representation of this with an example of HRS can be found in Fig. 7i.

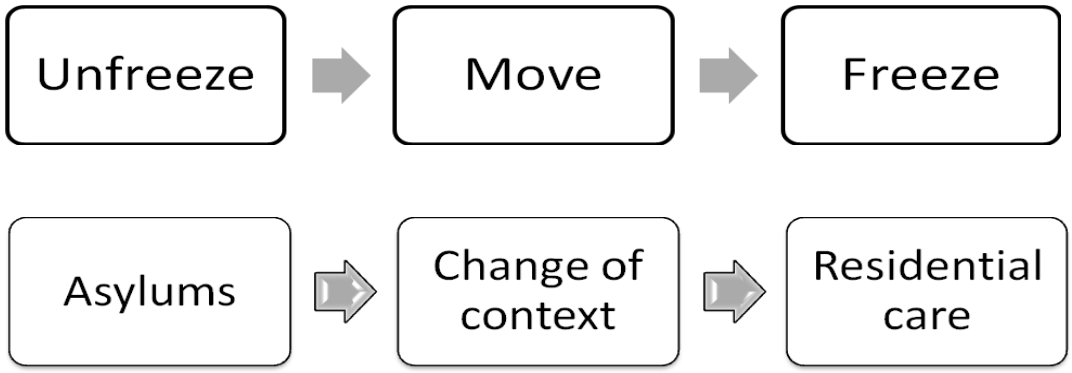


Fig. 7i. Visual representation of Lewin’s (1947) model of change with a HRS example.

Fig. 7i illustrates that in order for change to take place there must be ‘unfreezing’ of current practices, movement whereby the change(s) are implemented, and then a final freeze stage which is where new practices are reinforced/solidified to become the norm. An example using HRS would be the discontinuation of asylums where those practices cease to exist, movement in the form of deinstitutionalisation and the introduction of non-hospital environments with residential care, and the continuation of practices as residential care are strengthened by familiarity, and perseverance with the model. However, whilst Fig. 7i illustrates the process of change this thesis has

demonstrated that HRS has changed in a number of ways, which indicates a complexity deeper than can be explained by simply ‘unfreeze, move, freeze’. Watzlawick, Weakland and Fisch (1974) proposed a distinction between first order and second order change which is useful in gaining a better understanding of *how* something has changed. First order change involves a change which attempts to improve an existing system, without challenging its foundations; whereas second order change attempts to challenge the foundational beliefs or behaviours underpinning a system. Nelson and Prilleltensky (2010) applied the terms ameliorative and transformative to first and second order change; distinguishing between improvement (ameliorative) and structural change (transformative). Nelson (2010) proposed that custodial model housing demonstrated ameliorative (first order) change as despite the context being moved from institution based there was still a focus on care and many features of the new model mirrored that of the old model (e.g. unlimited length of stay). However, Nelson (2010) proposed that Supported Housing represents transformative (second order) change as the underlying system, that of service user as patient/resident, is challenged and instead the service user is viewed as a tenant. The focus shifted from managing patients to encouraging recovery.

The HRS organisation of this study endured two main model changes: Home for life to Supporting Housing (under Supporting People), and Supported Housing to Intensive Housing Management. Arguably this first stage is transformative as the underlying system of retaining service users was replaced by a belief that placements must not be permanent. The second stage however, is arguably ameliorative as the underlying structure of recovery focus, service user as

tenant and temporary placements was retained; but changes were made in funding and period of placement. Supported Housing and Intensive Housing Management assume the progression of tenants to leave the organisation which requires another transition from HRS to independent living. This arguably requires transformative change as it challenges the need for HRS accommodation and replaces this with the service user maintaining their own tenancy.

In theory, the HRS organisation should now represent an Intensive Housing Management model as it should have already endured the changes outlined above. However, this was not the case as the results of this study suggest that the final 'freeze' step of Lewin's (1947) change model has not been reached. If the final freeze stage had occurred and the HRS organisation was implementing IHM then this would be the clear direction and model that the stakeholders would be familiar with. However, this was not the case. Instead the findings of the study illustrated that there was uncertainty towards change from the stakeholders. For example, staff members made comments about being in 'a state of flux', and things being 'so up in the air'. Gersick (1991) stated that uncertainty occurs when members are no longer directed by old structures (in this case a certain HRS model – supported housing), yet are lacking future direction (of the future HRS model – Intensive Housing Management). Thus, the process of change within the organisation is incomplete. Indications of what the stakeholders in HRS were uncertain about were highlighted in the results with differences between and within staff and tenant groups (e.g. towards programme elements and model fidelity).

A distinction between ameliorative (first order) and transformative (second order) change is useful in understanding how an organisation *should* change. However, top-down driven fundamental changes to the system are limited if they are not implemented in practice.

The next step was to investigate *why* the process of change has not been successfully completed. Lewin (1947) proposed that in order to ignite actual change the total circumstances or social/force field needs to be considered; not just one factor. In this study this means being open-minded to the issues which may affect current HRS implementation, change in HRS and future HRS implementation. Rather than focusing on one issue (such as deinstitutionalisation) the whole picture needs to be assessed (evaluating a number of potential variables/factors which may have an impact on HRS implementation). Lewin (1947) used the term quasi-stationary[35] social equilibria to describe the status quo of a situation's present state. In order to change into a new desired state there needs to be an imbalance of driving and restraining factors that are within the force field. A visual representation of this can be found in Figure 7ii.

[35] The term quasi-stationary is used as Lewin (1947) argues that change and constancy are relative concepts, and that a situation is never static, but there are instead differences in the amount, level or type of change that occurs.

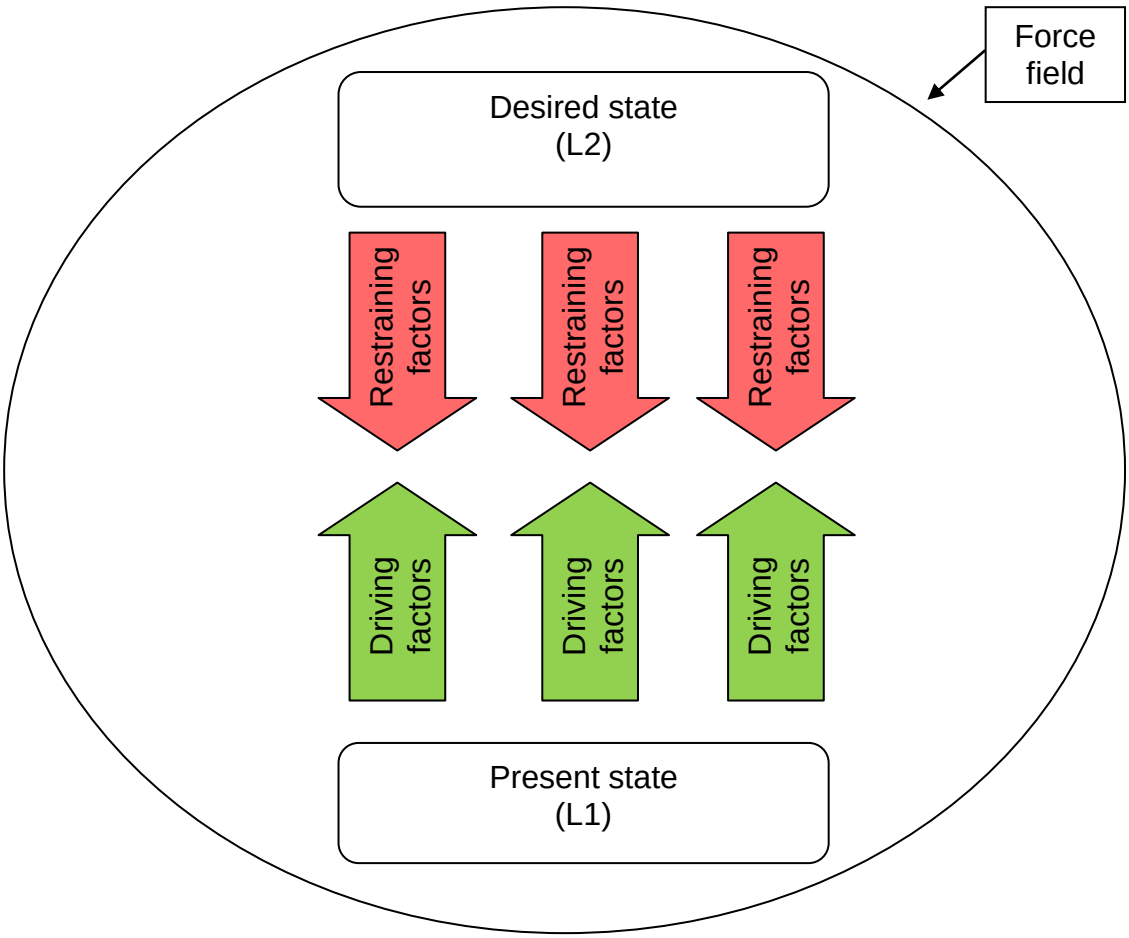


Fig. 7ii. Driving and restraining factors in force field analysis (adapted from Lewin, 1947).

In Fig. 7ii the present state of HRS is a mixture of models (SH, IHM, home for life) and the desired state is IHM. The particular driving and restraining factors in HRS will be identified later on in the chapter. In order to apply force field analysis to the HRS organisation two issues regarding the quasi-stationary social equilibria need to be addressed:

1. Why does the HRS organisation proceed with its current model?
2. What are the conditions (e.g. driving and restraining factors) for changing the current HRS model (current state)?

To answer the first part, the HRS organisation proceeds with its current model as the driving factors do not outweigh the restraining factors which are acting as a barrier to change (specific example from this study which have emerged from

the data will be provided under deductive and inductive change). Therefore, the HRS organisation are stuck in their present state and are unable to reach their desired state (where they could freeze/reinforce this change) unless the driving and restraining factors are addressed. The quasi-stationary social equilibria is maintained as an increase in driving factors occurring in parallel to a decrease in restraining factors is needed to alter the status quo of HRS, which will result in change (specific examples of this in relation to this study will be provided later on).

The second part can be answered through the amalgamation of information acquired around change in the history literature, results of the study and literature review. However, it will be argued here that there are two types of change: that which allowed top-down changes to occur on a theoretical level, but more importantly inductive changes which could occur on a practical level. Corrigan and Boyle (2003) stated that change must occur on a number of levels of human capital: agency leadership, staff (line level), and consumer level. This distinction is important as the argument here is that change has only occurred at the agency leadership level, which is deductive. Inductive change at staff and tenant levels in HRS has not occurred which is why in practice the process of change is incomplete.

Deductive change

This thesis has identified the following driving factors in HRS: changing social attitudes/perceptions, funding/financial motives, government/policy change, deinstitutionalisation, personalisation, normalisation, the recovery approach, and the psychopharmacology movement. Restraining factors were: stigma,

revolving door syndrome, problems measuring HRS, uncertainty around the psychopharmacology movement. Together these create a force field which has been depicted in Figure 7iii.

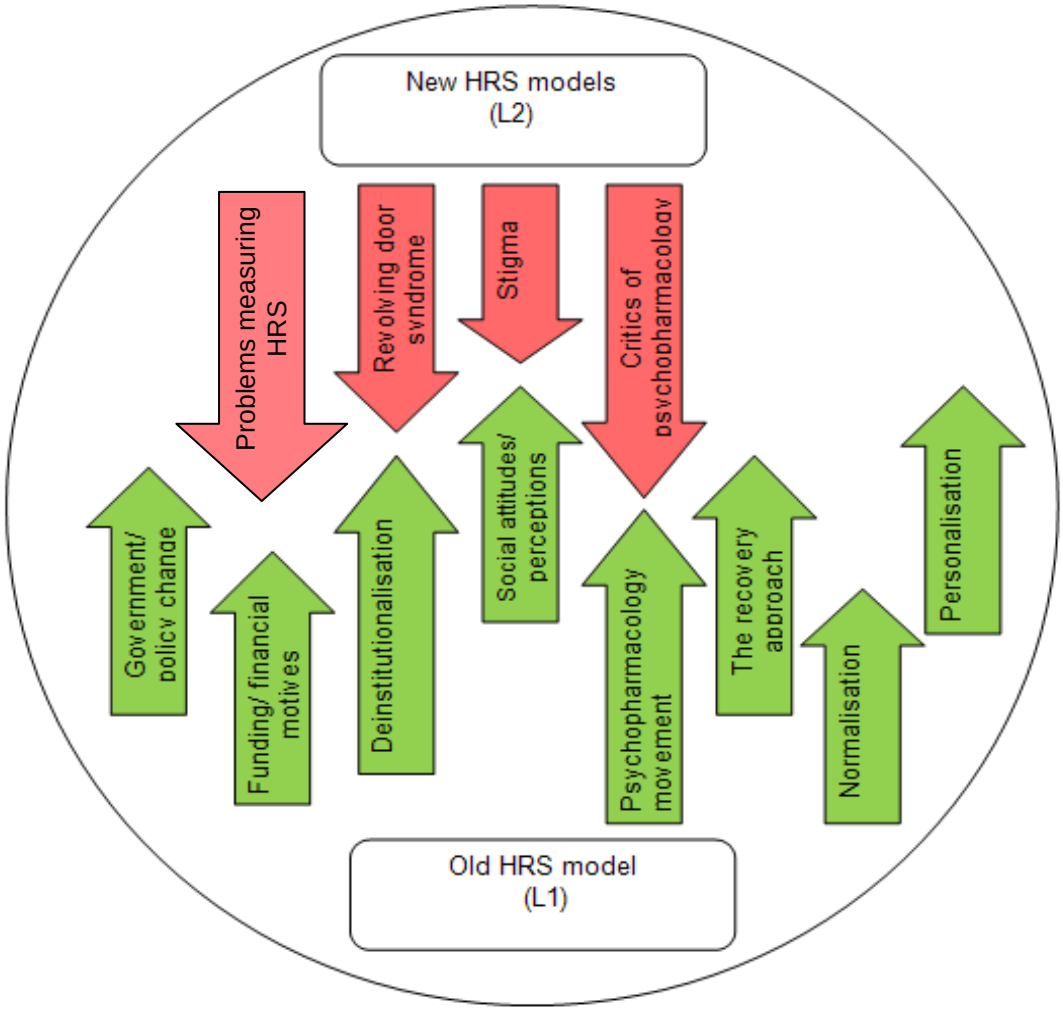


Fig. 7iii. Driving and restraining factors in HRS which led to the deductive change from old HRS models to new HRS models.

Fig. 7iii Illustrates that in the organisational level force field of HRS the conditions enabled deductive change to occur. The driving factors away from old models of HRS (asylums, residential care, Supported Housing) such as deinstitutionalisation, and driving factors towards new models of HRS (IHM, independent living), such as psychopharmacology and the recovery approach; outweighed the restraining factors acting as a barrier to the new models, such as criticisms of psychopharmacology and concerns about the revolving door.

This increase in driving forces occurring simultaneously with a decrease in restraining factors caused an imbalance in the quasi-stationary social equilibria. The consequence was that the HRS model was able to move from its present state to its desired state. This change at the agency leadership level has deductively created the conditions to implement an Intensive Housing Management HRS model, but without the change occurring at staff and tenant levels the model will not successful transpire into practice.

Model infidelity

An important finding in this thesis was that there were many issues with model fidelity[36], primarily with:

1. Length of stay
2a. Related services
2b. Intensity of services

Model infidelity arose because aspects of HRS which were proposed in theory/policy did not translate well into practice. For example, the Supporting People contract stipulated that tenants should stay for a maximum of two years with the organisation. In reality however, the organisation found this was premature for some of their tenants which led them to keeping them within the organisation. A second example would be that although it is not named as an area of related services staff members may undertake a practical task such as move a piece of furniture for a tenant as this is more time efficient and convenient than contacting another agency, making an appointment and having someone called out. Finally, a staff member responsible solely for maintenance may stay and have a cup of tea with a tenant after finishing their job. This

[36] Definition provided on p.240

questions the boundaries of the staff and tenants, as well as the related services of the HRS as it is not stipulated in policy. However, the HRS organisation may feel that in practice this is a beneficial social interaction for the tenants, which addresses isolation and loneliness.

Jansen, Van Oers, Kok and De Vries (2010) argued that policy, practice and research do not converge easily as they derive from three separate niches. The authors claim each domain holds its own norms, ideologies, codes of behaviour and communications. Some of the problems this causes are outlined in Table 7b.

Table 7b.
Problems with integrating policy, practice and research
(Adapted from Jansen et al, 2010; p8)

Issue	Policy	Practice	Research
Agenda setting	Much influence	Little influence	Very limited influence
Formal power in policy	Much influence	Sometimes indirect influence	Usually no influence
Evidence	Policy based evidence	Practice based evidence	Research based evidence
Legitimacy	Focus on environmental approach	Focus on individual behaviour approach	Insufficient focus on environmental approach

The power and agenda setting in favour of policy indicates a top-down deductive implementation of an intervention, in this case HRS. This is supported by the types of evidence drawn from, where policy uses policy-based evidence concerning legitimacy or acceptability; practice-based evidence concerns

applicability and feasibility; and research-based evidence concerns rationality and empirical validity (Jensen, 2008).

Chapter two demonstrated that the development of HRS occurred initially without a strong evidence base. Without this 'policy makers must fall back on intuition, ideology, or conventional wisdom – or, at best, theory alone'. (Banks, 2009; p.5). Banks (2009) went on to warn that such policies can end up going 'seriously astray' (p.5), which could account for the model infidelities present in HRS. Policy-based evidence refers to the implementation of a framework (in a HRS context based on a weak evidence base) and then collating evidence to inform/support it. This arguably happened with Supporting People whereby HRS organisations were told to adhere to SP guidelines and provide information about outcome measures they had prescribed. This has implications for the measurement of HRS (which will be discussed in the next section), but a goal would be to work towards evidence based policy which is inductive as opposed to deductive. Whilst policy based evidence is a criticism of policy makers, it could be argued that inductive approach is difficult when there is an 'overwhelming volume of research literature' to find the evidence, and there is a 'lack of monitoring and evaluation of public health policy that uses clear outcomes and performance indicators' (Jansen et al, 2010; p.2). Thus, there needs to be a clearer idea of what needs to be measured before evidence-based practice can be implemented.

As policy and practice are two very different concepts, the process of translating one into the other is undertaken by the HRS organisation who acts as a mediator. In HRS this involved converting policies into understandable,

achievable targets for tenants; and likewise mapping tenant experiences into measurable, meaningful data for policy makers to collect. An example of this is the Housing Management and Support Plan which, at a policy level is used to determine an organisation's success, and at an individual level used to track a tenant's progress. Originally objective measures such as number of tenants moved on in a given time period was assessed, but this arguably did not capture the actual work of HRS organisations robustly enough. Instead this was replaced by assessment of tenants' progression. However, a problem with this is that it relies on self-reporting by both staff and tenants. This could be a potential problem as the organisation will want to present positive results to the policy makers as this has important effects with regards to funding. Therefore, report bias may occur which would have a negative effect on the tenants. Over-scoring tenants' progression to satisfy funding bodies would give them a false representation of their actual progression, which may in turn have a negative effect on their recovery.

Another issue is that model fidelity can be hidden when the organisation is in control of both implementing HRS in practice and feeding back to policy makers. For example, the organisation may use Supporting People criteria as an auditing tool in order to 'tick a box' and satisfy funding conditions, but this may not be what they use in practice. They may implement what they see fit and then transfer this onto the requirements for policy makers. This demonstrates why policy-based evidence is undesirable; the organisation could manipulate their results in order to fit what the policy makers have stipulated. The problem with this is that the policy makers will receive positive results from the organisation, which will reinforce their implementation of a certain model,

whereas the successful model in practice could look completely different. But, as shown in Table 7A the power to change policy lies with the policy makers not practitioners so the HRS organisation will continue to mediate the relationship in this way. In order to break this cycle a shift is needed towards evidence based policy and practice, but as previously mentioned there needs to be a clearer understanding of measurement in HRS.

What to measure in HRS

> *"Not everything that counts can be counted; not everything that can be counted counts"* – William Bruce Cameron

A second problem in the measurement of HRS is knowing *what* to measure. To apply the above quote to HRS; not everything that is important in HRS is currently measured, and not everything that is currently measured in HRS is important. McKee (2004) noted that 'systems capture only a tiny amount of the overall work of a healthcare provider' (p.153).

The literature review demonstrated that outcomes have been used sporadically and inconsistently in HRS, so making comparisons has been difficult, which has further compounded attempts at evidence based policy and practice. However, in both the results of the study and literature review important factors in HRS were identified which could provide a rich understanding of HRS and capturing a robust measurement of the HRS organisation. The combined findings of study and literature review can be found in Tables 7C and 7D.

Table 7C.
Processes involved in HRS identified by the research study and literature review.

	Intrinsic	Clinical	Organisational	Environmental	Housing
Research study	• Time perspective • Trust • Conceptualisation of property • Coping skills • Independence	• Medication	• External efficacy		
Research study and literature	• Autonomy/control • Self-efficacy		• Staff-tenant relationship	• Safety/security	
Literature	• Personal/ demographic characteristics • Isolation • Ontological security • Consumer preference		• Staff training, • Service providers/services • Intensity of services • Staff characteristics • Management practices	• Stigma/lack of acceptance • Community/ social support/network • Parenting • Living practices • Circumstances • Monthly income • Neighbourhood • Other resident characteristics • Social climate	• Indoor environment/ Housing hardware (physical conditions), • Tenure/stability • Living environment (place, context, location of services) • Quality of housing • Privacy • Space (overcrowding) • Affordability • Number of tenants

Mediators | Moderators

Table 7D.
Outcomes involved in HRS identified by the research study and literature review

	Intrinsic	Self-sufficiency	Clinical	Social/ environmental	Services (organisational)	Economic
Research study	• Meaningfulness	• Independ-ence				
Research study and literature review	• Self-esteem/ confidence • Quality of life/ wellbeing • Autonomy/ control	• Coping skills/ managing stress	• Medication adherence • Substance use/ abstinence • Mental status (Psychiatric symptoms)	• Community integration • Safety/ security	• Residential/ Housing stability	
Literature review	• Personal empowerment • Happiness • Life satisfaction • Ontological security • Psychological stability/ wellbeing • Motivation • Maladaptive behaviour • Sense of freedom • Childhood distress	• Employment • Global functioning • ADL (bathing, feeding, dressing) • Instrumental ADLs	• Health problems • Level of functioning/ functional status • Imprisonment • Death • Neuro-psychological / cognitive functioning	• Participation in social activities • Social connected-ness • Engagement with children • Isolation	• Housing obtained/tenure • Quality of housing • Utilisation of services • Hospitalisation/ admissions • Homelessness • Resident/housing satisfaction • Residential success • Staff turnover • Quality of services • Privacy • Housing hardware	• Capital expendi-ture • Total cost of care • Total health costs

In summary, tables 7C and 7D show that the results and the literature review of this research combined identified HRS processes over five domains (intrinsic, clinical, organisational, environmental and housing) and HRS outcomes over six domains (intrinsic, self-sufficiency, clinical, social/environmental, services/organisational, and economic).

Table 7C and Table 7D identify a number of factors from HRS literature that are important in HRS. Although these are not original findings from the study, this is the first time the factors have been collated and themed. As aforementioned, previous literature has used processes and outcomes sporadically, and, as shown in the literature review, previous research has tended to start again rather than build on what has already been found. The presence of these factors only in the literature review and not in the results could be due to the Case Study approach adopted for this study. A study on a wider scale may have captured more of the factors identified in literature. Additionally, this research was undertaken to capture the experiences of stakeholders involved in HRS in practice. Therefore, the study did not capture issues such as capital expenditure or total cost of care as this was not the focus.

Table 7C demonstrates that the following processes were identified in both the research and the literature review: autonomy, self-efficacy, staff-tenant relationship and safety/security. Likewise, Table 7D demonstrates the following outcomes were identified in both the research and the literature review: self-esteem/confidence, quality of life, autonomy, coping skills, medication, substance use, mental status, community integration, safety/security, and housing stability. As the study was conducted inductively, prior to the literature

review the results were independent and not informed by the previous research undertaken. The results therefore give support to previous findings that these aspects are important in HRS.

The research study also made original findings in addition to results which provided support to existing literature. As shown in Table 7C there were a number of intrinsic, clinical and organisational factors that were processes in HRS. These were: time perspective, trust, conceptualisation of property, coping skills, independence, medication and external efficacy. Similarly, Table 7D shows the findings of meaningfulness and independence as important outcomes in HRS. These factors are predominantly individual, as opposed to organisational or policy based, which could explain why they have not been previously identified in research. This study aimed to capture the individuals' experience as opposed to a deductive organisational or policy driven evaluation. However, it is important to acknowledge that the results have emerged from a small Case Study which questions its generalisability. Therefore, in order to apply these findings elsewhere further research into the new factors would have to be undertaken.

Summary

First, this section has critiqued the findings which emerged from the research undertaken for this study. It has been acknowledged that problems have surfaced in HRS due to subjective interpretation of concepts such as independence and institutionalisation. The consequence of this is that it has affected the measurement of HRS.

Second, it has been highlighted that change in HRS is not a simple fluid process but one which involves restraining and driving factors. The process of change in HRS for this case study was noted to be incomplete and the consequence being a current mixture of models due to being in a transitional period. Deductive change at the organisational level has created the social conditions for HRS models to be implemented but further change is needed for this to successfully transpire into practice.

Third, this research has demonstrated that there have been issues with model fidelity in HRS with deviations occurring in length of stay, related services and intensity of services. Subjective interpretations of policy have meant discrepancies when attempting to translate into practice. This complicates comparisons and could result in report bias.

The final issue to be critiqued in this section was uncertainties of what to measure in HRS. It was demonstrated that there has been no standardisation of measurement which has impeded comparisons due to different processes and outcomes being measured. This research synthesised the results from this research and the HRS literature to identify shared themes of processes and outcomes in HRS.

In summary, this section has critiqued the main findings which have emerged from this research. The following section will build on these findings to offer recommendations to demonstrate the application and importance of this research in HRS practice.

7.2 Recommendations

This section provides recommendations for HRS which are grounded in the findings of this research. The main recommendations are: standardisation of terminology, inductive change, the implementation of Psychologically Informed Environments (PIEs), and the implementation of the conceptual framework which was developed from this research in HRS practice. Each will be discussed in turn.

Standardisation of terminology

HRS is arguably a socially constructed concept which means different things to different people. This is difficult when objective measures are implemented in order to evaluate an organisation. In order to address this ambiguous terms need to be identified and defined in a process that includes stakeholders at all levels to include a variety of opinions. It has been shown in this study that terminology of the HRS models themselves has been ambiguous. This thesis has found support for these findings but also found evidence for ambiguity of terms within HRS which need to be standardised and used in a consistent way to avoid confusion. Future work therefore needs to be undertaken concerning terms such as independence, deinstitutionalisation, housing readiness. This could include developing a definition, tools for means testing, and/or specific ways to measure these concepts.

Inductive change

To build on deductive change the second set of conditions are needed for inductive change at staff and tenant levels, and will complete the process of

change in practice. These conditions were primarily identified in the results section, and formed the substantive theory. The cluster concepts which were discovered inform the type of HRS model being adhered to, and therefore these underlying concepts need to be addressed in order for change to take place (for example, independence, self efficacy and goals). These factors represent what Lewin (1947) termed 'social habits', which are formed through the value system/ethos of a group. Social habits cause an 'inner resistance' which can act as a barrier to change and require additional force to 'unfreeze' (Lewin, 1947; p.32). The social habits which form the inductive change conditions that were identified in this study were: consumer preferences, conceptualisation of property, self-efficacy, external efficacy, goals, autonomy, independence, recovery status, staff roles, staff-tenant relationship, boundaries, duration (length of stay), and move on.

As internal factors the social habits have the potential to act as a driving factor or resistance factor, depending whether it is positive or negative. For example, if a tenant has high self-efficacy this could act as a driving force to attain the desired state (e.g. independent living). However, if a tenant has low self-efficacy this could act as a resistance factor to change and the tenant will not reach the desired state. The inductive change conditions translated into a social force field can be found in Figure 7iv.

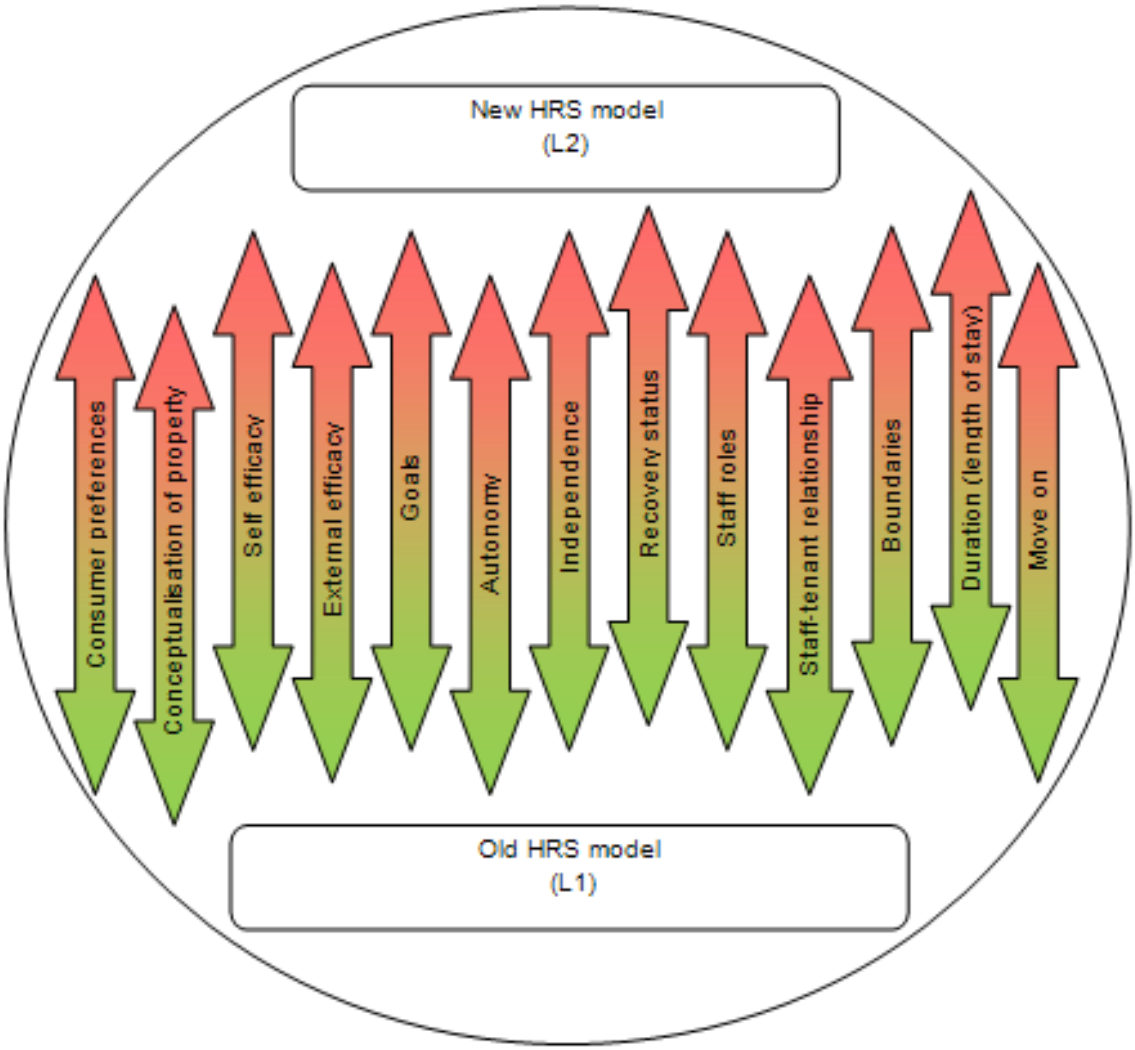


Fig. 7iv. Social habits which could act as driving or resistance factors and lead to inductive change in HRS.

Fig. 7iv is important because it illustrates the complexity of the force field which needs to undergo change. Addressing only one of these issues may not be enough to affect the status quo of the situation, which reinforces the necessity of addressing the issue as a whole.

The Reasoned Action Approach (RAA) (Fishbein and Ajzen, 2010) can be applied to the inductive change force field to further explore the relationships between social habits involved in enabling or disabling change. The RAA is a framework which has been developed from earlier works by Fishbein and Ajzen (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1980; Ajzen, 1985, 1991). The

approach functions on a human social behaviour level which is fitting with the inductive change required in HRS. The basic premise is that people's beliefs underpin attitudes, subjective norms and control, which informs their intentions, which in turn informs their behaviour. In a HRS context attitudes include consumer preferences, independence and recovery status. The social habits which constituted subjective norms included goals, move on, conceptualisation of property, external efficacy and boundaries. Control factors consisted of self-efficacy, autonomy, duration (length of stay), staff role and staff and tenant relationship. For example, a tenant may believe that the norm in HRS is to stay long term, and this is what ought to be done so they will have low motivation to comply with a new model which involves them moving on to independent living. This could mean they have no intention on finding alternative accommodation and their subsequent behaviour does not change. A simplified visual representation of the RAA principles applied to the social habits can be found in Appendix 6h.

In order for change to occur interventions are needed which challenge a person's attitudes, norms, control and beliefs (Fishbein and Ajzen, 2010). Therefore the previously listed social norms could be perceived as barriers to change. NICE (2014) have created a set of guidelines addressing individual approaches to behaviour change, which include the provision of training for health and social care practitioners, professionals and workers. Techniques offered for behaviour change included needs assessments, goals and planning, feedback and monitoring, motivational interviewing, social support and comparisons of behaviour (NICE, 2014). Furthermore, Michie et al (2013) identified 93 behavioural change techniques (BCT) and synthesised these into

16 clusters in a BCT taxonomy. Examples include: material rewards, self-monitoring of behaviour, behavioural practice/rehearsal and social comparison. The HRS organisation could adopt some of these methods in order to stimulate change. For example, the organisation could promote 'model' examples of tenants who have successfully moved on into independent living where they successfully manage their own tenancy. A potential issue of confidentiality with this suggestion could be addressed by treating the case as an anonymous case study whereby names and specific details of names, addresses and identifiable information is omitted. This could elicit social comparisons which would challenge beliefs, subjective norms, affect motivation and consequently intention and behaviour.

Psychologically Informed Environment (PIE)

As there have been many issues with implementing previous models of HRS for reasons already discussed, a proposal would be to implement a Psychologically Informed Environment (PIE). This concept was developed by Johnson and Haigh (2010) and also appeared in a CLG (2010) Mental Health Good Practice Guide. Psychologically Informed Environments were borne out of the Royal College of Psychiatrists Enabling Environments (EE) initiative. Therefore, in order to conceptualise Psychologically Informed Environments, EEs will be defined first before moving onto PIEs in more detail.

Enabling Environments

'Enabling environments' (EE) is a general term to identify an approach to best practice in 'creating and sustaining a positive and effective environment' (Royal College of Psychiatrists, 2013; p.3). The priority is high quality relationships in

all activities (Royal College of Psychiatrist, 2012). The setting for an EE is not prescribed so could be implemented in various working and social situations such as day centres or voluntary groups.

Enabling Environments (EE) were developed from work that was originally tailored for modern Therapeutic Communities (TCs). Chapter two demonstrated how the first attempts to implement housing related provisions following deinstitutionalisation were not very successful. Reasons for this included a lack of resources and large deficits in the prediction of financial support needed to fund such projects. However, from 2002 the Royal College of Psychiatrists developed the Community of Communities quality network, which agreed a set of standards for TCs to operate within (Johnson and Haigh, 2011). This provided core values needed to be obtained and maintained to use the title Therapeutic Community; clear, measurable criteria; annual peer and self-review process (including a neutral reviewer visit to discuss performance), and aggregation of an annual TC report (compiled from nearly 100 UK and a small number of overseas TCs) (Haigh and Van Hartog, 2012). Whilst this work was positive for TCs, there was recognition that its principles had further applications, and there was risk of valuable organisations/groups that did not fit the TC definition to be omitted with a lack of guidance/framework for development (Johnson and Haigh, 2011). Therefore, an equivalent process was undertaken to identify criteria suitable for non-TC settings, and this formed the basis of EEs. In this process, the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) developed ten core values/standards which must be obtained in order to receive the EE award (Royal College of Psychiatrists, 2013). These can be found in Table 7E.

Table 7E. CCQI Core Standards for the EE award	
• Belonging	• Boundaries
• Communication	• Development
• Involvement	• Safety
• Structure	• Empowerment
• Leadership	• Openness

The concept of EEs, and their related values laid the foundations upon which PIEs were built.

PIEs

A PIE can be described as an EE grounded in psychological thinking/theory. The term 'psychologically informed' is intentionally general as PIEs are not specifically prescribed by a particular approach, belief or paradigm. The underpinnings of a PIE could derive from any psychological theory, 'from psychodynamics to behaviourism, from Gestalt to evolutionary psychology' (CLG, 2010; p.88). Instead, a PIE is 'any attempt to identify, adapt and consciously use those features of the managed environment which would allow the resources and functioning of the service to be focused on addressing the psychological needs and emotional issues thrown up by the residents' (Johnson and Haigh, 2011; p.31). An important indicator which distinguishes a PIE is: 'if asked why the unit is run in such-and-such a way, the staff would give an answer couched in terms of the emotional and psychological needs of the service users, rather than giving some more logistical or practical rationale, such as convenience, costs, contracts or regulations' (CLG, 2010; p.88). This is important in HRS as the findings of this thesis have shown that the

requirements of funding organisations have previously led practice, and there is a need for a more inductive approach. The implementation of a PIE in HRS would support the need to prioritise tenants in efforts to achieve this inductive approach.

Evaluation in PIEs: Reflective practice

The findings of this study have shown that a preoccupation of auditing the HRS service in order to meet the criteria for funding organisation have led to policy-based evidence in HRS. Instead of a labour-some auditing process to evaluate HRS, a PIE would emphasise the exercise of reflective practice as an important component. This demonstrates a move away from deductive, policy driven evaluation towards an inductive approach.

Reflective practice can be defined as 'the process of thinking about the work we undertake – that is, we reflect on our actions either at the time (reflection-in-action) or at a suitable opportunity thereafter (reflection on-action) (Thompson and Pascal, 2012; p.319). The benefits of engaging in reflective practice in PIEs are threefold (CLG, 2010; p.90):

1. Aims to recognise people's difficulties
2. Enables staff to acknowledge the emotional challenges of their work which can lead to distancing which could reduce the risk of burnout
3. Enables shared learning cycles

Reflective practice in HRS would support an inductive approach as staff members would be able to critique their roles and the organisation in relation to the tenants, as opposed to funding and policy processes.

Choosing a paradigm in PIE

As previously mentioned there is no prescribed psychological theory which should underpin a PIE. In a 'Psychologically informed services for homeless people Good Practice Guide' (Keats, Maguire, Johnson and Cockersell, 2012) three paradigms were outlined as examples: psychodynamic, cognitive and behavioural, and humanistic. Important applications of a psychodynamic approach in HRS are the dynamics of relationships and the ability for people to change (Keats et al, 2012).

The findings of this thesis have shown that the relationship between staff and tenants is important, and that there is a need for behavioural change at the individual level in order to move towards a different model of HRS. Cognitive and behavioural paradigms concern the associations between thoughts, feelings and behaviours/actions. This could be applicable in HRS if a tenant has negative beliefs about themselves which reinforces their need for HRS and prevents them from moving on. These maladaptive beliefs need to be addressed and overcome in order to achieve behaviour change, i.e. independent living. Humanism gives attention to features which are distinctly human, such as love, choice and personal responsibility (Vasconsellos, 2014). Humanism is holistic in approach, concentrating on the 'centrality of the personal' (Vasconsellos, 2014; p.xix).This approach can be seen as supporting the biopsychosocial model of mental health whereby a person's whole situation is considered, not simply their clinical symptomology. The results of this study demonstrated that a wide range of aspects of a tenant's life are identified and included in their recovery tool. Therefore, in practice a tenant's whole situation,

not just their mental health, is taken into consideration. The following provides a more specific example of how a humanistic approach could be used in HRS.

Applying the PIE to HRS: Structure in Goals

As well as adopting a psychological paradigm to guide the implementation of a PIE, more explicit applications could also be made. It has been stated that 'A PIE will aim to use the potential for change that resides in all human beings in the pursuit of some wider or future goal" (CLG, 2010; p.19). This statement is important for two reasons: firstly it supports the need for change which has been demonstrated previously. Secondly, it refers to humans in relation to goal-achieving behaviour. Progression and goals in HRS has been discussed in previous sections such as consequences of change in the results chapter. Here it will be argued that a psychological framework, especially one drawing from Humanism, can be used to structure goals more effectively in HRS.

Originally the priority for measurement was the turnover of tenants moving into independent accommodation; however this did not capture the complexity of the tenants' situation. For example, somebody may improve vastly in their competence in self-care and daily living activities but they may have a poor social network which could leave them isolated and lonely if they were to move into their own accommodation (as opposed to having company if they currently reside in a shared house). Because of these issues recovery tools were introduced. Housing Management and Support Plans (HMSP) were implemented in the Case Study's HRS. This tool split a person's progress into various aspects of their life such as finances and employment.

A potential criticism of the recovery tools are that there is limited structure to the order in which the items of the plan are worked towards. Currently a tenant's subjective judgement of what they are competent at and what they need to develop is used to prioritise areas. Also, in the case of the HMSP 'core areas' are identified based on those most commonly occurring, and then other more specific areas are included. In the HMSP this could mean working on seventeen different aspects of one's life, which could be overwhelming. A more efficient way of structuring a person's progression could be to implement a humanistic framework drawing from Maslow's hierarchy of needs.

Maslow's (1943) Hierarchy of needs

The hierarchy of needs is based on Maslow's (1943) 'theory of human motivation', where five sets of needs are proposed which a person works towards in order to achieve the highest level: self-actualisation. Maslow (1943) loosely termed his work 'general-dynamic theory', based on its influence from functionalism[37], holism[38], Gestalt psychology[39] and dynamicism[40] (p.371).

The premise of the theory is that classifications of motivations should be goal based (Maslow, 1943; p.370). This is applicable to HRS as achieving independent accommodation is not a goal but an outcome, and instead requires

[37] Fuctionalism concerns the 'broad roles' of psychological states, and claims 'it is the nature of the role, not the nature of the occupant of the role, that matters (Jackson and Pettit, 1988; p.381)
[38] Holism concerns viewing phenomena in its whole state as opposed to breaking it down into the 'separate mechanical activities of the parts (Smuts, 1926; p.118)
[39] Gestalt psychology treats phenomena as a whole, behaviours are not determined by individual elements, rather the processes are determined by the 'intrinsic nature of the whole' (Wertheimer, 1938; p.4).
[40] Dynamicism 'emphasises the interaction between a cognitive agent and its environment...and apply a more holistic stance' (Dorffner, 1999; p.23)

the accomplishment of a potentially large number of smaller, gradual goals in order to be attained.

A proposal is to align these smaller goals with all five areas of needs: physiological, safety, love/belonging, esteem, and self-actualisation. Physiological needs are the starting point in the hierarchy. At the most basic level these refer to survival needs. In HRS this could mean tenant's ability to look after their self-care which is related to completing activities of daily living (ADLs). These include tasks related to physiological needs such as feeding themselves and bathing. Without competency in ADLs there is risk of self-neglect which can have a negative effect on a person's health. Therefore a tenant's priority should be to address the basic factors which, if disregarded, could cause a number of physiological problems.

Safety needs concern the seeking of security and comfort. Maslow (1943) referred to a number of different types of safety including physical, financial, health and employment. In HRS tenants could have goals to address all of the types of safety. For example physical safety could include domestic abuse and violence/aggression; financial safety could include paying bills on time and managing their own money; health safety could include addressing their mental health and substance use; and employment safety could include finding a job.

Maslow (1943) also makes reference to 'preference for the familiar' in 'abnormal cases' (p.380). This could encompass the introduction of a routine and habitual customs to avoid the insecurities of the unknown or unfamiliar. In HRS this can be translated into the introduction of some form of order and everyday regularity

to what could be a very chaotic lifestyle. For a tenant in HRS who has recently left prison and are surrounded by unfamiliarity this could be very unsettling. Assisting them to adapt and structure their own day outside of prison could help to ease their insecurities.

Love/belonging needs are the third stage of the hierarchy. The first two stages were very intrinsic whereas the love/belonging needs concern a person's relationship with other people. The love aspect refers to a desire for reciprocal affection with others, and belongingness refers to a desire to feel as though they fit in and have a place in society. In HRS this could mean re-establishing ties with family members or old friends.

Esteem needs consist of two subsidiary sets: the first revolves around the 'desire for strength, for achievement, for adequacy, for confidence in the face of the world, and for independence and freedom'; whilst the second revolves around the 'desire for reputation or prestige (defining it as respect or esteem from other people), recognition, attention, importance or appreciation' (Maslow, 1943; pp.381-382). In HRS the first set of esteem needs could develop through the completion of tasks without assistance, which would instil a belief in their own independence and sense of adequacy. The second set could develop from a reciprocal relationship of trust between the organisation and tenant. The tenant would achieve esteem from the staff members if they have confidence in the tenant's ability to complete tasks independently, without the need for related services.

Self-actualisation needs refer to the ‘desire for self-fulfilment’, and to ‘become everything that one is capable of being’ (Maslow, 1943; p.382). The requirements for this vary between individuals as it is a very personal concept. However, a similar feeling of happiness and contentment is shared amongst those experiencing self-actualisation. In HRS the attainment of independent living could be seeing as fulfilling self-actualisation as all of the prior factors have been managed in order to allow a tenant to progress to the stage of leaving the organisation and no longer requiring HRS.

Each of Maslow’s (1943) hierarchy of needs have been explained in turn and related to HRS. A visual representation of the hierarchy with goals and areas of progress in HRS can be found in Fig. 7v.

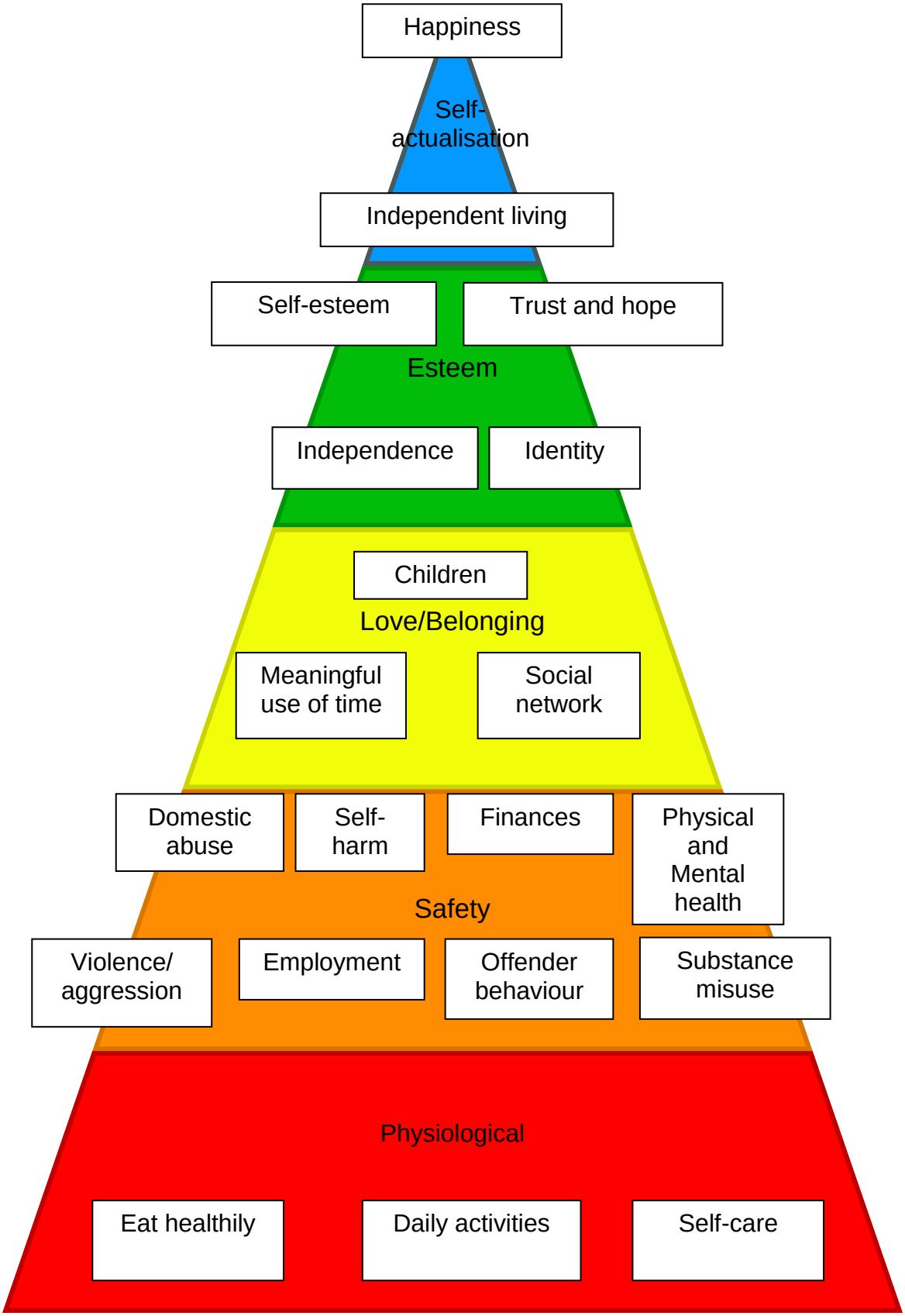


Fig. 7v. Goals and areas of progression in HRS mapped onto Maslow's (1943) hierarchy of needs.

Figure 7v demonstrates how a tenant could move up the pyramid in succession in order to achieve independent living. Although they have previously been described separately in this section, the following extracts from Maslow (1943) support the use of the needs as a sequential (hierarchical) process. In order to achieve one level the previous stages must be satisfied. Without this there will be fixations on previous needs which will prevent progression. However, once these needs have been met a person is able to aspire to new things, where a new level of need emerges:

> *'Human needs arrange themselves in hierarchies of prepotency. That is to say, the appearance of one need usually rests on the prior satisfaction of another, more pre-potent need. Man is a perpetually wanting animal. Also no need or drive can be treated as if it were isolated or discrete; every drive is related to the state of satisfaction or dissatisfaction of other drives'.* (Maslow, 1943; p.370).

> *'But what happens to man's desires when there is plenty of bread and when his belly is chronically filled? At once other (and 'higher') needs emerge and these, rather than physiological hungers, dominate the organism. And when these in turn are satisfied, again new (and still 'higher') needs emerge and so on. This is what we mean by saying that the basic human needs are organized into a hierarchy of relative prepotency'.* (Maslow, 1943; p.375).

In HRS this means that a tenant will not be interested in finding and obtaining an independent tenancy if they have concerns about their finances and ability to achieve the daily activities needed to be able to manage a tenancy (e.g. bill paying). The results of this study indicated that recovery requires an incremental process which is fitting with the hierarchy of needs. For example:

> *S1: "if the goal is too unrealistic or if they're asking us to set a goal which is too unrealistic instead of saying no we'll break it down and try and do it in small parts"*

> *S3: "well th-their end goal is independence"*

> *S5: "So there could be a lot of steps to reach their end goal"*

The results of the study also supported the need to work from the basic up to more complex needs:

> *S8: "I would have thought that the main goals are their ability to be domestic so that they can look after their own environment"*

Additionally, the hierarchy of needs promotes the idea that stages are addressed and fulfilled before progressing to the next:

> *"A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else. If all the needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background"*. (Maslow, 1943; p.373).

This means a tenant should not be pressured into higher level goals which they are not ready to process. It would be counter-productive to expend time on an activity (e.g. finding employment) when a tenant needs to first fulfil basic needs (e.g. self-care). This aligns with the findings of the study whereby tenants could not consider 'higher' order goals such as independent living until other priorities had been addressed. For example:

> *T3: "goals at the moment is-is-is sticking to Q* [day centre]...that's my goal at the moment to be honest with you I can't look towards the future"*

> *T2: "I've been concentrated about getting my back sorted...so we've been concentrating on that first...as soon as we can sort that out I think from what you've just said about the support plan, we can start working on that properly as well...if I can get that one problem sorted that will start lifting my depression off me a little bit I think...it'll give me a bit more motivation to start doing a lot more things...basically my physical health is very important because basically if my physical health's down my depression's down my lifestyle's down...there's no way I can pick myself up from any of those three until I get that one thing sorted"*

Structuring a tenant's goals according to Maslow's (1943) hierarchy of needs could be a more successful way of achieving independent living as opposed to

expecting them to simultaneously attempt to progress in an unmanageable number of areas. Implementing this Humanistic framework in HRS could be beneficial for their progress. The person-centred approach aims to develop a tenant's skills in a structured way is a combination of theory (Maslow's hierarchy of needs) and practice (HMSP) which could produce positive outcomes for tenants.

Conceptual framework of HRS

The findings of this thesis could be used to address the problem of HRS factors involved in measurement. In Chapter three a distinction was made between theoretical and conceptual frameworks. It was argued that the unsuccessful application of a theoretical framework was due to its incompatibility to the area of HRS. Instead, a conceptual framework was proposed as needed, which is what has been developed from the integration of research and literature that has related concepts and theory to further knowledge about HRS. The conceptual framework of this study encompasses the conceptual model (Table 5O, p.185) and the conceptual theory which were developed in this thesis. A visual representation of the conceptual theory of HRS which has been developed from this thesis can be found in Figure. 7vi.

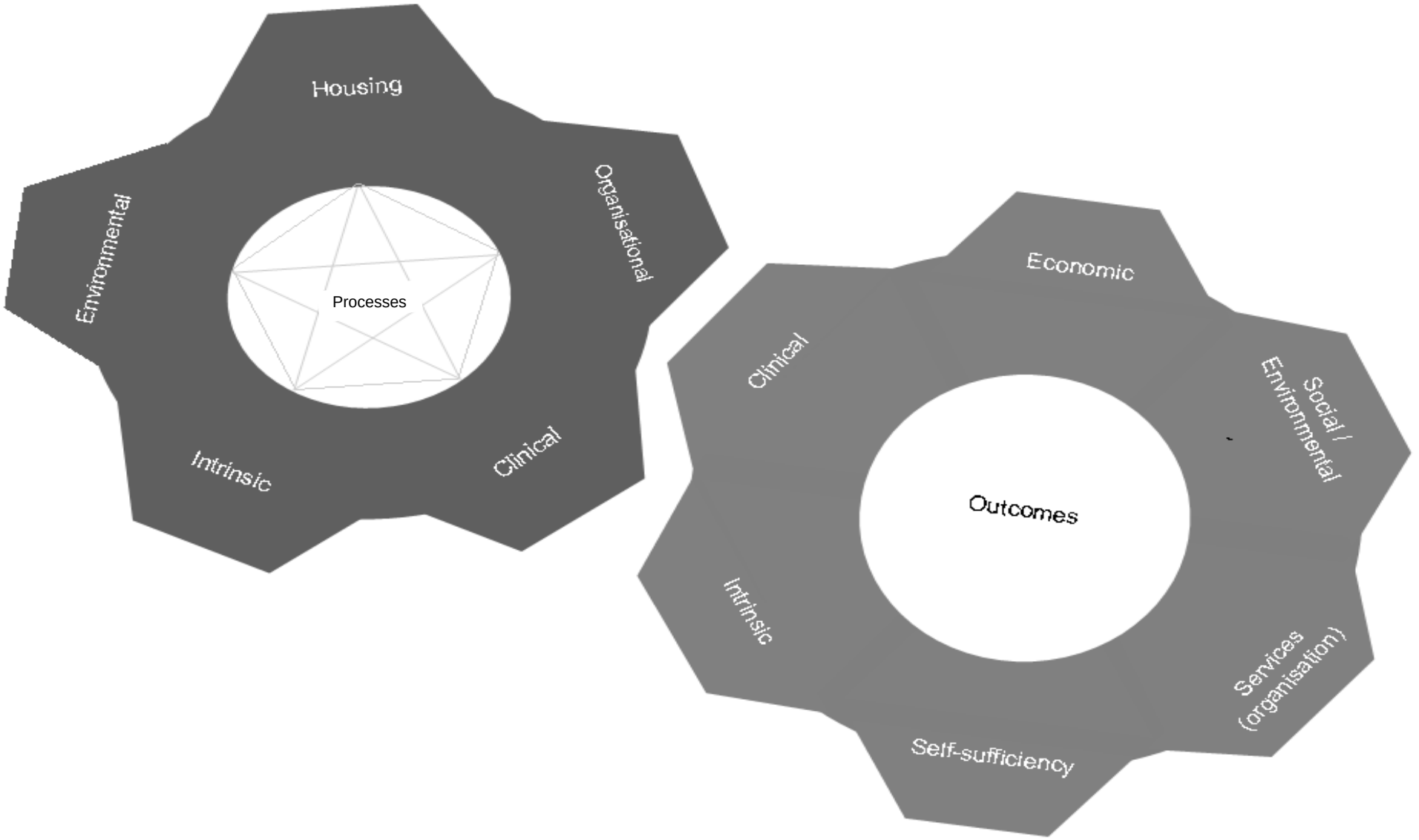


Fig. 7vi. Conceptual theory of HRS

Figure. 7vi. consists of two cogwheels representing the processes and outcomes in HRS. The processes span five domains: housing, organisational, environmental, intrinsic and clinical. The constituent variables of the processes cogwheel can be found in Table 7C. The inner pentagon and pentagram represent the associations between variables which act as mediating and moderating forces, which can subsequently affect outcomes. The outcomes cogwheel spans six domains: economic, social/environmental, services, self-sufficiency, intrinsic, and clinical. The constituent variables of the outcomes cogwheel can be found in Table 7D. The conceptual theory is illustrated as cogs because there are multiple fits of processes with outcomes. It is a product of this thesis so it is completely grounded in and relevant to HRS in mental health.

The conceptual theory can be used as a reflexivity tool for HRS organisations in practice. This would be fitting with the PIE framework recommended for implementation. Instead of prescribed top-down outcomes for organisations to work towards, PIEs promote person centred approach. The conceptual theory captures the HRS experience which is fully grounded in HRS literature and most importantly research with tenants of HRS. The conceptual theory is based on HRS tenants' beliefs and attitudes so has more depth than policy driven, arguably superficial outcomes (such as number of tenants moving on). The multiple domains of both processes and outcomes demonstrate the holistic approach taken which considers the whole person, not judging them on the basis of a limited number of outcomes. This is arguably a fairer way to evaluate a person's progress as judging a number of tenants on one single outcome from one single domain (e.g. substance use), does not account for individual differences, and is reductionist (if for example a tenant has made significant

progress in other areas of their life which are not measured). The conceptual theory is also important in raising staff awareness of the complexity of factors which can affect the tenants' experience of HRS and outcomes. For example, obvious, easily identifiable/measurable aspects (such as number of people living in a house, or location of house) of HRS should not overshadow the intrinsic, personal, but more abstract aspects (e.g. self-efficacy, autonomy) which this thesis has shown are important.

Also, the conceptual theory could be used as a framework for evaluation in HRS. The literature review demonstrated that previous outcome measures have been used inconsistently and sporadically. This study themed the previous approaches to outcome measures, and therefore has identified a robust way to capture HRS. Rather than a selection of outcome measure based on convenience, or picked at random, a rigorous evaluation would draw from each of the domains identified to capture the outcomes thoroughly. For example, researchers could select self esteem (intrinsic), coping skills (self-sufficiency), substance use (clinical), security (social/environmental), housing stability (services/organisational) and capital expenditure as processes to evaluate HRS on; and evaluate how the HRS was affecting tenants' self-efficacy (intrinsic), medication adherence (clinical), staff-tenant relationships (organisational), social network (environmental), and space (housing) outcomes.

Summary

First, this section has proposed four recommendations which have been grounded in the work undertaken in this thesis. A standardisation of terminology

was requested due to ambiguity causing complications with model fidelity and comparisons.

Second, inductive change was recommended in order to complete the transition process from old HRS models to new, and to prepare tenants for change from HRS to independent living. Working on social habits as driving factors of change at an individual level is needed. The Reasoned Action Approach is a behavioural change model which could be used in practice to assist in facilitating this change. Currently (as seen in deductive change) the emphasis has been on change at an organisational level whereas what is needed is change of people's attitudes, beliefs and behaviours.

Third, a recommendation was to implement PIEs as a new HRS model. This movement would allow the focus to shift onto the service users (tenants) and their psychological and emotional needs. PIEs would support the inductive approach of change, and the adoption of Maslow's hierarchy of needs would provide structuring goals in the HMSPs and HRS.

The final recommendation was to implement the conceptual framework developed from this thesis into the proposed PIEs in HRS practice. The conceptual framework could be used as a reflection tool for HRS organisations in evaluating their own approach, and a holistic evaluation of tenants' progression. The conceptual theory could also provide a more robust and consistent measurement of HRS, when previously it has been limited.

Chapter Eight: Conclusion

The purpose of this thesis was to gain a rich understanding of HRS from the perspectives of the stakeholders who deliver and receive it. To establish if this was accomplished, along with the aim and objectives of the study, this chapter will revisit the study findings and consider the implications, limitations and future HRS implementation.

Addressing the aims and objectives

The aim of this study was to explore how the evolution of HRS has been documented in literature, how HRS has been investigated in research, and how HRS has been experienced (both delivered and received) in practice. This was captured by completing a historical overview of accommodating people living with mental health problems, conducting a qualitative piece of research with HRS staff and tenants, and undertaking a literature review of HRS. From these exercises factors which contributed to HRS evolution were identified as well as gaps/criticisms in previous HRS literature/research. Therefore, as was stated in the aim, a critique of these issues contributed and expanded on existing knowledge of HRS. To help ascertain if/how the aim and objectives of this study were achieved the findings and contributions of the thesis can be found in Table 8A.

Table 8A.
Overview of the thesis findings and contributions

Aspect of thesis	**Finding(s)**	**Contribution/ significance**
Background	Development of HRS	Contextualised HRS in history, identified factors which contributed to its development
Results – experience and consequences of change	Outlined issues in HRS practice and their impacts	Richer understanding of *how* HRS works in practice, indications of *why* previous models did not work
Results – conceptual model	Identified conceptual model, core categories, clusters of characteristics which formed substantive theory of HRS	Gained a richer understanding of deeper, cultural beliefs which affect, Can be used in practice for evaluation and reflexivity
Literature review - black box to theory driven evaluations	Identified progression of literature in HRS	Highlighted gaps/ criticisms of the current HRS literature
Literature review - ambiguity	Identified aspects of HRS which have experienced ambiguity	Deeper understanding of *why* there is ambiguity, not just identifying where there is ambiguity
Discussion – change	Inductive and deductive change	Demonstrated the importance of underlying values and beliefs in affecting experience and outcomes in HRS
Discussion – HRS in practice	PIEs	Offered approach to structuring goals which could be used in practice. Recommended overall framework to HRS which is person-centred and better fitting with what they implement in practice
Discussion – measurement in HRS	Integrated findings from the results (important factors in HRS) and literature review (theory driven evaluations) to develop a conceptual framework of GT	Can be used in practice to evaluate HRS and improve HRS experience

Table 8A demonstrates that the thesis was able to capture the rich understanding of HRS which it aimed for, in terms of contextualising HRS, how HRS works and why previous models were not very successful. This moved beyond the identification of ambiguity into a deeper understanding of why this might be.

The findings of the study demonstrated a link between the first two study objectives. The objectives were: to explore how staff members and tenants experience HRS, and whether there were similarities and/or differences in these experiences; and to explore HRS in practice to confirm what model (if any) was being implemented. The findings showed that there were differences in experiences and perceptions of HRS both between groups (staff and tenants) and within groups (tenants and tenants). These perceptions and experiences appeared to be linked to the HRS model that stakeholders were adhering to. The findings outlined the changes in HRS models that the HRS organisation had endured, and the consequences this had on model infidelity. The findings suggested that despite attempting to adhere to a specific model (e.g. IHM), in practice the HRS model was more of a combination of different models. The consequences of these findings will be discussed further under the implications of the study.

The third objective of this study was to investigate the concepts of success and/or goals in HRS from a stakeholder perspective. This was linked to the fourth objective which was to investigate stakeholder perspectives on the measurement and evidencing of HRS. The findings demonstrated that the stakeholder perceptions of what constituted success in HRS did not always

align with policy criteria for success. The consequences of this were discussed whereby policy instruments were used as a tick-box exercise and the HRS organisation judged their success on feedback and response from tenants. The recommendation therefore was to implement a PIE which would allow the tenants to be prioritised. The findings demonstrated that the HRS organisation's recovery tool (HMSP) was being used in practice with staff and tenants identifying shared goals. However, the implementation of PIEs could improve this process by structuring goals more effectively (e.g. Maslow's hierarchy of needs was applied in this study). Furthermore, the CIS of the study illustrated how success had been investigated in previous HRS literature by mapping the progression of HRS research. The results showed that originally black box evaluations were undertaken to try and state that one HRS model was better than another in order to secure funding. However, this was accepted as a short-sighted approach to capturing success in HRS so theory-driven evaluations emerged. These evaluations attempted to identify the causal mechanisms in HRS, which is still a work in progress. A more robust way to capture success and measure/evidence success was proposed in the conceptual framework which was developed through this thesis. This will be discussed further in the implications of the study.

Implications of the study

The thesis has implications for HRS in practice. A conceptual model and substantive theory of HRS was developed which can be used to inform practice of clusters of characteristics which are associated with different HRS models. In doing this the deeper, cultural beliefs which can affect HRS are brought to light. The conceptual model and substantive theory can be used in HRS practice for

evaluation and reflexivity. Increasing HRS organisations' knowledge of combinations (clusters) of characteristics which could be associated with particular HRS models could be beneficial. The organisations could tailor their services towards or away from particular characteristics and therefore make improvements to HRS in practice.

A second finding which has implications for HRS in practice is that of inductive and deductive change. This finding demonstrated the importance of underlying beliefs and values in affecting experience and outcomes in HRS. The results indicated that change had occurred on an organisational change and provided the conditions for social change to occur, but inductive change at the individual level needed to occur to affect outcomes in HRS. This could suggest that previous attempts to implement changes in HRS has focused on altering aspects of the HRS model itself, but not the beliefs and attitudes held by the people implementing the HRS model. This has meant that change has not successfully occurred as some stakeholders have not 'bought into' the new model and so features of the old model are still present. It was demonstrated how this causes issues such as model infidelity and in turn affects funding. Instead, the identification of change needed at an individual level could have a positive influence of a person's beliefs and attitudes, which may help them engage in the process of change.

The third finding which has implications for HRS in practice concerns the measurement of HRS. A conceptual framework of HRS was developed which illustrates important factors in the experience of HRS. This was achieved by integrating the findings of the study and the literature review in line with the GT

approach that guided the study. This can be used as a reflexivity tool for HRS organisations to build knowledge and awareness of the processes and outcomes in HRS. Understanding which practices cause/influence certain behaviours/outcomes can, like the substantive theory, shape HRS in practice.

Finally, a PIE framework was recommended to be implemented in HRS as this person-centred approach focuses on the tenants as opposed to being policy and target driven. An example of applying Maslow's hierarchy of needs to structure goals in HRS was provided to illustrate the applicability of implementing a PIE in a HRS context.

In terms of policy an implication of these findings is that the inductive approach of PIEs fit more readily with contemporary services such as personal budgets in line with the personalisation agenda. This supports the concept of placing the 'service-user' at the heart of services and allowing them to have autonomy in decisions involving themselves. The future for HRS could constitute PIEs which are funded by personal budgets where tenants are in the driving seat of the services they receive. This picture in comparison to early asylums described in chapter two illustrates the evolution of HRS models, policy, and stakeholder roles in HRS. The shift in power over time has progressively favoured the person receiving HRS.

Limitations

A limitation of this study is that it is based upon one Case Study. However, as it was argued in the methodology chapter, the purpose of this study was not to generalise findings. The conceptual model and theory are applicable to the

Case Study in question but may have transferability if other organisations believe it is a fair representation of their tenant group. Likewise, organisations could use the conceptual theory as a guideline to tailor their own holistic, person centred tool. A second limitation was that cause and effect could not be established from the variables identified in the conceptual model or theory. Because of this it was not known whether factors affected outcomes directly or indirectly. Therefore further researcher needs to be undertaken to establish more precise relationships between processes and outcomes, especially mediators and moderators. PIEs are relatively recent concepts, having only been developed in 2010 (Johnson and Haigh, 2010). Because of this more evidence needs to be collected on their success.

Future HRS

This thesis has demonstrated that policy has not been well translated in practice, and this has negative consequences for the people involved in HRS (e.g. tenants if they are moved on prematurely and experience the 'revolving door', and organisations that lose their funding if they do not follow the prescribed HRS model). A person-centred approach is recommended which is flexible to the tenant needs and built inductively. This could be unpopular with HRS funders because in doing this it would be very difficult to set standardised parameters for evaluation. However, this reinforces the earlier argument that not everything that is important in HRS is currently being measured (the conceptual model and conceptual theory identify gaps), and not everything that is currently measured in HRS is important (overall number of tenants moving on is a very short-sighted measure of the success of a HRS organisation). Further work in HRS is needed to establish the strength and direction of relationships

between processes and outcomes in HRS. As PIEs are a new concept the evidence base needs to be strengthened to demonstrate the impact it has on people living with mental health problems.

Summary

Overall this study has documented the evolution of HRS from asylums to PIEs. An inductive critical exploration of stakeholder experiences of HRS in mental health has been undertaken along with a CIS of reviews/evaluations of HRS. The findings of the thesis concern change, HRS in practice, development of evaluations, and measurement of HRS. The products of the thesis, which are completely grounded in the data, are a conceptual model of HRS, substantive theory of HRS, and a conceptual framework of HRS. Together these findings represent original contributions to the HRS literature which are useful and relevant in HRS in practice.

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Appendices

Note: the appendices are formatted by chapter number and in alphabetical order. E.g. 1a = the first appendix item in chapter one.

1a. List of abbreviations

1b. List of tables and figures

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4h. Summary of key issues given to participants prior to phase two

6a. Detailed database search

6b. Process of snowballing

6c. Data extraction summary table

6d. Mapping variables

6e. HRS mapped onto RAA

Appendix 1a - List of abbreviations

Abb.	Term
ADL	Activities of Daily Living
BCT	Behaviour Change Techniques
BSP	Basic Social Process
CCQI	College Centre for Quality Improvement
CIH	Chartered Institute of Housing
CIS	Critical Interpretive Synthesis
CLG	Communities and Local Government (Department of)
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CO	Conscientious Objector
CRD	Centre for Reviews and Dissemination (University of York)
CS	Case Study
CTO	Community Treatment Orders
DH	Department of Health
DHSS	Department of Health and Social Security
ECT	Electric Convulsive Therapy
EE	Enabling Environments
ESRC	Economic and Social Research Council
EU	European Union
FEANTSA	European Federation of National Organisations working with the Homeless
FRE	Framework for Research Ethics
GP	General Practitioner
GT	Grounded Theory
HHS	Health and Human Services (US Department of)
HHSRS	Housing Health and Safety Rating System
HMSP	Housing Management and Support Plan
HRS	Housing and Related Services
HSCP	Health and Social Care Partnership
HUD	Housing and Urban Development (US Department of)
ICESR	International Covenant on Economic, Social and Cultural Rights
IPA	Interpretative Phenomenological Analysis
LAA	Local Area Agreement
LGMA	Local Government Modernisation Agenda
LOA	Lines-of-argument (synthesis)
NES	National Enhanced Services
NICE	National Institute of Health and Clinical Excellence
NIHR	National Institute of Health Research
NHS	National Health Service
NRES	National Research Ethics Service
NSF-MH	National Service Framework for Mental Health
ODPM	Office of the Deputy Prime Minister
PAGS	Probation Accommodation Grant Scheme
PCT	Primary Care Trust

PhD	Doctor of Philosophy
PIE	Psychologically Informed Environment
PTSD	Posttraumatic stress disorder
RAA	Reasoned Action Approach
RCT	Randomised Control Trial
R&D	Research and Development
RTA	Reciprocal Translational Analysis
SAAP	Supported Accommodation Assistance Programme
SCIE	Social Care Institute for Excellence
SCT	Supervised Community Treatments
SDO	Supervised Discharge Orders
SHMG	Housing Corporation Supported Housing Management Grant
SP	Supporting People
SRA	Social Research Association
SRV	Social Role Valorization
TC	Therapeutic Communities
THB	Transitional Housing Benefit
UK	United Kingdom
UKHCA	United Kingdom Health Care Association
UN	United Nations
US(A)	United States (of America)
WHO	World Health Organisation
WWI	World War One
WWII	World War Two

Appendix 1b - List of tables and figures

Note: The labelling system for tables in this thesis consists of a number (which refers to the chapter in which it is written) followed by a letter (in alphabetical order). Likewise, the labelling system for figures consists of a number (chapter number) followed by roman numerals (in ascending order).

6A	The differences between features of Systematic Review and Critical Interpretive Synthesis
6B	Orders of constructs
6C	Identification of the gap for the current study
6D	PICOTS applied to the current study
6E	Inclusion and exclusion criteria for the synthesis
6F	Databases and relevant search terms
6G	Articles included in synthesis
6H	Grey literature
6I	Number of HRS reviews per decade
6J	Housing and mental health terms in the HRS review articles by decade
6K	Methodology of review articles
6L	Themes and subthemes/findings from the HRS literature split into five sections
6M	Identification of Government/policy factors which could impact HRS in the UK
6N	Comparisons of HRS models through outcome-based research
6O	Methodological approaches to HRS evaluation
6P	HRS models grouped according to time frame (early vs. contemporary) and length of stay (permanent vs. linear)
6Q	Supporting People areas of ‘related services’ in HRS along with areas identified in HRS literature
6R	The variables which must be identified in an evaluation process.
6S	Important variables indentified from the HRS review literature
6T	Mediators, moderators, and other important variables indentified from the HRS review literature.
6U	Outcomes in HRS
6V	Repetitive recommendations in HRS research
7A	Issues for discussion based upon findings from the history, results, and literature review chapters of the thesis
7B	Problems with integrating policy, practice and research
7C	Processes involved in HRS identified by the research study and literature review.
7D	Outcomes involved in HRS identified by the research study and literature review
7E	CCQI core standards for EE award
8A	Overview of the thesis findings and contributions

Appendix 2a – Service User Voice pre-WWI

Pre WW1 – where are the people?
Bedlam: *'Petition of the poor distracted people in the house of Bedlam'* – presented to the House of Lords in 1620[41] **Samuel Bruckshaw:** ex-patient, in 1774 attempted (but failed) legal proceedings after being detained in a private madhouse in Lancashire for almost a year. Produced pamphlets '*One more proof*' and '*The case, petition and address of Samuel Bruckshaw*'[42]. **Jean Baptiste Pussin** (1745-1811): ex-patient became 'governor' of the ward for incurable psychiatric patients. Pinel credits Pussin for liberating the insane and acknowledges his debt to both Pussin and his wife in influencing his own work[43]. **William Belcher**: spent 1778-1795 in a madhouse in Hackey. He published widely, including his *'Address to Humanity'* which contained *'a letter to Dr Munro'* (physician at Bethlem), *'an approved receipt, to make a lunatic and seize his estate'*, and a sketch of a smiling hyena[44]. **John Perceval**: son of Prime Minister Spencer Perceval, spent 3 years in two expensive private asylums in England (Brislington House and Ticehurst). Wrote about his experiences and founded the 'Alleged Lunatics' Friends Society in 1845[45]. **'The Opal'**: Journal produced from 1851-1860 by the patients of Utica State Lunatic Asylum. Contained, amongst other things, poetry, fiction, sketches, open letters. Contents arguably 'sugar-coated' so questionable whether the realistically represent the true patient experience[46]. **Elizabeth Packard**: published books and pamphlets (1868) describing her experiences in the Jacksonville (Illinois) Insane asylum after being committed there by her husband[47]. **Clifford Beers**: ex-patient published autobiography '*a mind that found itself'* in 1908, and founded the National Committee for Mental Hygiene in 1909[48].

[41] Fawcett and Karban (2005)
[42] Ingram (1998)
[43] Schuster, Hoertel, and Limosin (2011)
[44] Ingram (1998)
[45] Fawcett and Karban (2005)
[46] Reiss (2004)
[47] Chamberlin (1990)
[48] Dain (1989)

Appendix 3a – Field diary extract

Field Diary – Interview 1: Staff 1

Notes during interview
• Honest, open, individual • Good understanding, strong team • Are the Government realistic about the move on process?

Notes during transcription
• Very modern views on housing, switched on to the input the gov has even if she doesn't know details of the policies • Not convinced the Gov have a true understanding of everything • Full involvement with tenants, understood success and goals by views of tenants • Success and goals were terms the interviewee was clearly familiar with and meant something to her • Stressed the importance of the individual • Appears that SP are pressuring for 'move-ons' but they don't realise that the tenants are not ready, and some might never be ready/able • Government possibly seeing 'success' as results based such as 'move-ons' whereas org. see maintenance as 'success' - conflicting ideas • Moving on too early seen as detrimental - disrupts tenants (maybe housing first model needed) • Beginning of the emergence as org. as mediators between SP and tenants, the two are perhaps incompatible so it's the org. role to translate for each other • Emergence of discrepancy between what in theory they are supposed to provide and in practice what happens - should be short term (2 years) but had people for 20 years + • The concept of 'move on' she agrees with, just not the timeframe • Successes not recognised by SP, problem with attitudes or evaluation criteria/tools? • Thinks the goals are the same but how they reach them is different

Reflection
• The interview schedule needed expanding as there wasn't enough data generated from the questions to last the full hour • Need to be more open, was too eager and don't want to lead the interview • Conscious of not forcing any preconceptions into the interview • This participant certainly one to consider if re-interviewing is required • Overall impression was that she was very 'switched on' and 'clued up' about the whole area • I have met this staff member a few times so built up a rapport, need to think about how this may impact the interview

Appendix 3b – Research diary extracts

Research Diary - Event
• Organisation suffered fire in one of the shared houses – tenants all moving out to temporary B&B accommodation, not able to access them until back in HRS – too disruptive at the moment to try and get on with research

Research Diary - Event
• Organisation moving office premises – potential disruption for study as staff members will not want to undertake research whilst still setting in to new offices – Overcome this by offering neutral meeting place for interviews or delay further commencement until settled into the new offices

Research diary - Circumstances
• Staff and tenant turnover a potential issue for recruitment – if no longer part of HRS then will no longer meet inclusion criteria so cannot be included in study – potential worry for sample size if people leave and are not replaced by new participants

Appendix 4a – Open Coding example (screen shot of NVivo)

Nodes

Name	Sources	References
Support and support plans	15	78
Difference - new vs old models	10	62
Goals	15	59
Changes	14	55
Length of stay	15	51
Move on	10	50
Time frame	15	42
Inter-tenants differences	10	39
Areas of support	12	39
Ability or capability	10	38
Financial situation	8	37
Ideas for the future	11	33
Other services	11	32
Decision making	14	31
Personal opinion of League and success	15	30
Staff-tenant relationship	11	29
Coping	10	29
Policy reference	8	28
Understanding	7	27
Achievement	6	27
Setting goals	11	26
General support	8	26
Individuality	10	25
Floating support	11	24
Independence	10	24
Government understanding	5	23
Comparison with previous housing	6	23
Team characteristics	7	22
Motivation	10	22
'Our type of tenant' unpopular, not high on agenda	8	22

Appendix 4b – Selective coding example

Revisit 1

Theme 1 - Goals
• Tailor the goals to suit that person • Goals could be phased in – initial goals, short, medium and long term goals • Some people want to be independent straight away, others want a stick to lean on and want others to sort stuff out for them

Theme 2 – Service Provision
• Two issues, crisis points – one was SP where we lost the funding forever, the other was that the Housing association wanted properties back • We can still provide the same level of support to the tenants using that method rather than using the SP funding • We've seen it in the past where people have moved on and it hasn't worked, we still use the SP frameworks around it because it's good governance

Theme 3 – Move on
• As a caring organisation we have always said we will not move people on for the sake of it • We have great pleasure seeing people move on, ultimately that is our goal but it's a balance. It isn't our aim to move people on for the sake of moving on. If someone stays with us for 5-6 years that's fine • Move on has been very bad for people's recovery, from the start they can be concerned, nervous 'how long can I stay?', so emphasise not having a strict move on policy. • Having a move on philosophy is fine but a rigid move on policy can be very detrimental • They (staff) would get a 'sense' (that they're ready)

Theme 4 - Environment
• If you look at us as a business, in some ways they are our customers, in other ways they are our partners – need relationship that tells them what we do, and have close working relationship in selecting the right people to come into our tenancies • Regular rapport, we meet with them occasionally, more often they push us and we've not got enough space

Theme 5 - Change
• Houses handed back had a big change on tenants – it was a struggle, one has come back • Tried to make change as minimal as possible, meetings and discussed with tenants what changes and effects it would have – 50% stayed with us

Theme 6 - Support
• Medication – we don't administer or supervise medication, when they come to us they need to be able to self medicate, we're not there to check that they take it, we constantly remind them to take it

Theme 7 - Organisation
• I don't like to think of ourselves as being institutionalised, one of the risks of coming here (new offices) was that, if there's too many people on one site does it feel more of an institutionalised organisation but it seems to have worked quite well. We're not the NHS and we make clear to people we're not part of the hospital and I think we're small enough to keep that independence and not become institutionalised

Theme 8 – Self efficacy
• In terms of readiness to move on I think quite a number of the tenants we have got think they are ready to move on sooner than they do, they'll say they're ready and maybe we don't think they are, we'd talk them through the process, find out what they're looking for, maybe we could accommodate them with a change but still look after them, or help them move somewhere else. Sometimes we think that's not right and if they leave here they will go downhill • A lot of people that do have mental illness, sometimes they think they are more able than they actually can – sometimes they feel that their capabilities are more than perhaps reality

Theme 9 - Experience
• My view is that when they come it is their home, it's where they're going to live. • Some have good family networks with the intention that they will move home, so there they would see it as a temporary arrangement, but whilst they are here it's their home and that's how I'd like to look at it, once they're here it's their home, they're not coming for a specific period of time, they're coming here to live, 6 weeks, 6 months, 6 years so be it.

Theme 10 - Recovery
• People want somewhere nice to live, friends, a job or a stable income • Trust can be a barrier if you don't have it, trust could be a mediator • To stop a revolving door you have to end up in somewhere you feel safe and secure so in a way that's an outcome. If you stop the revolving door, even if they're with us for 10 years, so that's a positive outcome • After 2 years they may still be poorly but they are able to cope on their own and manage things in the right way, taking their medication, gaining confidence, learning to live with the illness they've got because sometimes they'll never be cured

Appendix 4c – Invitation letter

[redacted]

Title of project:	Stakeholder Perceptions of Success and Goals in Supported Housing: A UK Case Study

Date: 23th November 2012

Dear Sir/Madam,

You are invited to take part in a research study which is ran by [redacted] and supported by [redacted]. The study is called *'Stakeholder Perceptions of Success and Goals in Supported Housing: A UK Case Study'*.

If you register your interest with [redacted] then over the next couple of days a researcher will contact you to organise a visit to see you. On this visit the researcher will discuss the study with you, provide you with an information sheet, and give you the opportunity to ask any questions you may have. If you would then still like to take part the researcher will ask you to sign a consent form and you will be given a week 'cooling off' period before interviews are arranged to start.

To register your interest, or disinterest in the study please complete the reply slip on the following page.

Yours faithfully,

Leanne Rimmer
(PhD student, [redacted])

Researcher contact details

Miss Leanne Rimmer
[redacted]

E-mail: [redacted]
Telephone: [redacted]

Reply slip

Title of project:	Stakeholder Perceptions of Success and Goals in Supported Housing: A UK Case Study
Researcher Details:	Leanne Rimmer - PhD student at [redacted] Address: [redacted] E-mail: [redacted] Telephone: [redacted]

Please give your name and tick one box:

Name: .....

I would like to take part in the study ☐

I am not interested in taking part in this study ☐

Appendix 4d – Participant information sheet

Title of project:	Stakeholder Perceptions of Success and Goals in Supported Housing: A UK Case Study

Participant Information Sheet

This sheet is split into two parts. Part one will give you key information about the study, and part two will give you additional/further information. This sheet may not provide all the answers to your queries so please do not hesitate to ask any questions you may have.

Part 1

Introduction

My name is Leanne Rimmer and I am currently undertaking a PhD at [redacted]. My study will investigate the role of Supported Housing in mental health, with the aim of getting an inside view from the people who are involved in the housing service. I would like to invite you to take part in my study, so this information sheet has been put together to give you a better understanding of the project before deciding whether to participate. Please read the following information, and ask any other questions you may have that are not covered by the sheet.

What is the purpose of the study?

The project aims to look at Supported Housing from the view of the 'stakeholder'. A stakeholder is anyone with a direct or indirect association with the Supported Housing organisation; so both staff and tenants of [redacted] service. The goals that people have and what people see as 'successful' in Supported Housing has not been researched before so this study aims to investigate this. Also the study wants to use the information collected and views from the staff and tenants to explore new models of Supported Housing.

Why have I been invited?

You have been identified as a 'stakeholder'. This means you have been recognised as someone directly involved with a Supported Housing organisation and so will be able to give a personal insight into the service.

Do I have to take part?

No, it is up to you to decide to join the study. The study will be described and the information sheet will be explained. If you agree to take part, you will then be asked to sign a consent form. Participation is entirely voluntary and you have the right to withdraw at any time. Your wish to withdraw will be respected without question and the information you provided (for example if withdrawal after interview) will not be used in the study and destroyed.

What will happen to me if I take part?

You will be invited to take part in a one-to-one interview with the researcher to discuss your experiences of the Supported Housing service. It is expected that the interview will last no longer than sixty minutes. For convenience staff will be interviewed at [redacted] and tenants will be interviewed in their own home. Following individual interviews you will be invited to take part in a 'focus group'. Here you will have the opportunity to join other people involved with the service and discuss Supported Housing. It is expected the focus group will last no longer than ninety minutes. At the end of both the interview and the focus group you will be given the opportunity to ask any questions you may have, and discuss your participation and any thoughts or other comments you may have with the researcher.

What are the possible disadvantages of taking part?

You may perceive taking part in this study as a disadvantage as it may be a slight inconvenience due to it taking up some of your time. Risk assessments will be carried out before the study begins as a measure to reduce the risk of any potential harm or discomfort.

What are the possible benefits of taking part?

A potential benefit of taking part is that you will be able to express your opinions about Supported Housing and it is hoped that more can be learnt about what the people involved in the organisation think. Your opinions will be used to explore new models of Supported Housing and possibly implemented in future service provisions.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

All information gathered during the study will remain strictly confidential. Data collected (e.g. tape-recorded interviews and transcripts) will be filed in locked storage at the [redacted] University. Participants will be referred to using a coding system so they cannot be identified, to ensure anonymity and confidentiality. There will be one list of participant names and their given code number just in case someone decides to withdraw at a later stage. This way their particular interview can be identified

and the information destroyed. This list will be treated as strictly confidential and only the researcher will have access to it.

Part 2

What will happen if I don't want to carry on with the study?
As mentioned in part 1, participation in this study is completely voluntary and you are free to withdraw from the study and stop taking part at any time. If you withdraw during the time of data collection then the information you provided in the study will not be included in the study and will be destroyed. However, after the results are written up and published then it may not be possible to extract your data to destroy it.

What if there's a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions [redacted] complaints procedure advises that you should try to approach the appropriate person first, however if you remain unhappy and wish to complain formally, you can do this. According to [redacted] complaints procedure:

'*If you feel unable to approach the Faculty/School or Service directly involved in your complaint, or you consider that the matter has not been satisfactorily resolved, you should complete a Complaints Form (Form C1) available from the Information Centres, Faculty/School Offices, Service Offices and Libraries'*

Once completed the form should be forwarded to the Dean of Students and Academic Registrar.

Dean of Students and Academic Registrar,
[redacted]

Email: [redacted]
Telephone: [redacted]

What will happen to the results of the research study?
It is envisaged that the results of the study will be published in journal articles to contribute towards knowledge of Supported Housing. It is also hoped that the findings may be used to inform Supported Housing organisations and the Government on best practices and provide evidence of perceptions of the people directly involved in Supported Housing. The researcher will use the results as part of a PhD thesis, and also anticipates that the findings will be disseminated at seminars and/or conferences by way of oral presentations.

Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES Committee [redacted]

Contact details

If you have any further questions please contact the researcher:

Miss Leanne Rimmer

[redacted]

E-mail: [redacted]
Telephone: [redacted]

If you would prefer to contact a member of staff at the University then please contact my Project Supervisor:

Professor [redacted]

[redacted]

E-mail: [redacted]
Telephone: [redacted]

If you would like to talk with somebody independent of the study please contact [redacted] local Patient Advice and Liaison Service (PALS):

E-mail: pals@[redacted]
Telephone: [redacted]

Appendix 4e – Consent form

[redacted]

Title of project:	Stakeholder Perceptions of Success and Goals in Supported Housing: A UK Case Study

Consent Form

1. I confirm that I have read and understood an information sheet dated 01/12/11 (version 4.1) for the above study ☐
2. I confirm that I have had the opportunity to consider the information, ask questions and discuss the study with the researcher; and that all issues and questions have been addressed and answered satisfactorily. ☐
3. I understand that my participation in the study is entirely voluntary and I have the opportunity to withdraw at any time, without giving reason, without my medical or legal rights being affected ☐
4. I give my permission for the researcher to tape-record my interviews and consent to using my information as an anonymous response. I understand that the data will be securely stored at the [redacted] ☐
5. I understand that responses I give may be used as anonymous quotations and give permission for this to happen. ☐
6. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS trust where it is relevant to my taking part in this research. I give my permission for these individuals to have access to my data. ☐
7. I agree to take part in the above study. ☐

Participant name	Date	Participant signature
Leanne Rimmer		
Researcher name	Date	Researcher signature

Researcher Contact details

Miss Leanne Rimmer

[redacted]

Appendix 4f – Interview schedule (phase one)

Warm up questions

1. Clarify what type of Stakeholder – trustee, housing staff, support worker, tenant
2. How long have you worked for/been a tenant at the Organisation's Supported Housing service?
3. Where do you work (staff)/ reside (tenants)

- E.g. Shared house/alone?

Success	
What makes it successful	4. What do you believe makes a successful Supported Housing service? - Completely open, note for further exploration 5. What **qualities** would a really successful Supported Housing service have? *Prompt* - Care about tenants? - Organised? - Well ran
Priorities of what makes success	6. What do you think are the **most important** factors involved? *Prompt* - Making a profit? - Securing money from funders? - Good staff? - The house itself?
Who should decide if the programme Is successful	7. **Who** do you feel should decide whether the Supported Housing service is successful? *Prompt* - Government? - Independent body? - Supported Housing service? - Tenants? - Combination?
Measuring success	8. How is success currently measured? 9. How do you think 'success' should be **measured**? *Prompt* - Quality of life scales - Impact on mental health - Satisfaction of tenants - According to Supporting people/government guidelines 10. Who should decide how to measure it?
Improving success	11. Could anything be done to make the League more successful? 12. Would the tenants/Government have any suggestions to making the Organisation more successful

Perceptions of success	13. Do you think the organisation are successful? 14. What do you think the Government's idea of success is? 15. What do you think about floating support in relation to success? 16. What do you think the tenants/government's views are of the organisation in terms of success?

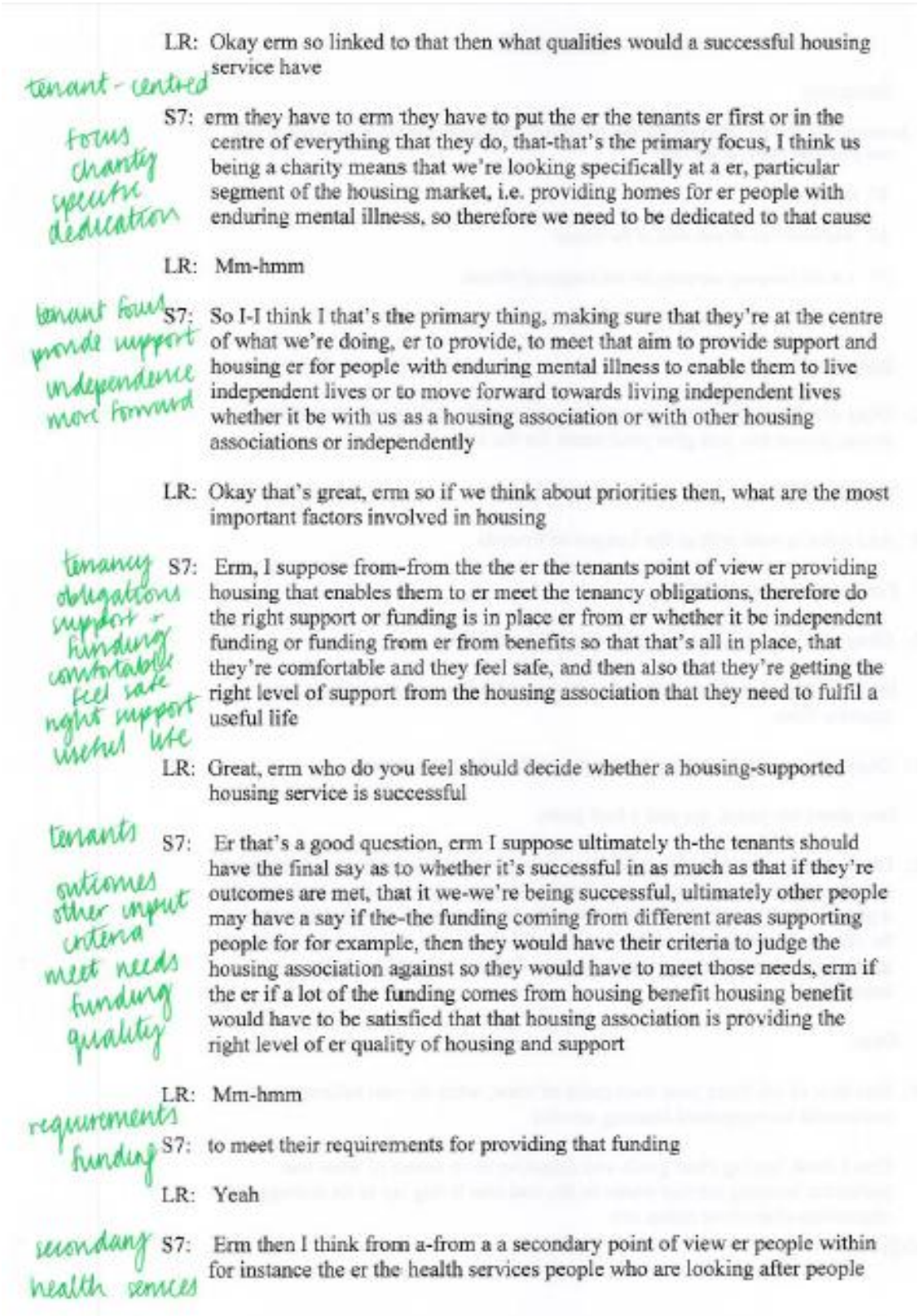
Goals	
Determining goals	17. a. What goals do you have for yourself? b. What goals do you have for staff/tenants? 18. a. What would you like to achieve from the Supported Housing? b. What would you like the staff/tenants to achieve from the Supported Housing?
Priority of goals	19. What is your number one, **most important** goal?
Setting goals	20. Who **currently sets goals** for you/tenants in Supported Housing? *Prompt* - Don't have any - Tenant personal goals - Staff at the organisation - Government 21. Who do you believe **should set goals** for tenants in Supported Housing? *Prompt* - Tenants - Staff – specifically any groups (e.g. key worker) - Government
Support plans	22. Tell me about the support plans 23. Are you aware of what goals are in the support plans 24. Are staff/tenants aware of what goals are in the support plan?
QAF	25. Are you aware what the QAF core objectives are? 26. If known, do you agree with these priorities? 27. Does everybody at the organisation know what the QAF is? 28. What are your thoughts on the QAF and its priorities?
Future/ working towards	29. What are you working towards? *Prompt* - Moving on from the organisation to living independently - Avoiding re-admission to psychiatric services - Being stable in the organisation's Supported Housing 30. If moving on to live independently is a goal do you have a time frame for this? *Prompt* - No, take each day as it comes - Within 1 year - Within 2 years - Within 5 years?

	31. If being stable in the organisation's Supported Housing is a goal how long would you like to stay there for? *Prompt* - Unsure - Another year - 2 years - Indefinitely/forever
Trends	32. Do the tenants have the same goals? 33. What do the tenant goals tend to revolve around? *Prompt* - Themes - Finance, paperwork etc
Motivation	34. What is the tenants attitude/response to goals 35. What is the tenant's response to motivation when you set them goals 36. What do you do for motivation with goals?
Government and goals	37. What is the tenant's response/reaction to goals set by the Government? 38. What are your feelings about the government setting goals 39. How do you feel the government are doing setting goals in terms of accuracy?

Move on
40. What are your thoughts on the 2 year time frame? 41. What are the chances of someone being able to move on Prompt - Is everyone capable? - Has this changed at all - Will some people never be able? 42. Tell me what you think about the government and move on 43. When are the tenants informed they have a 2 year time frame 44. How often do people moved on come back?

Conclusion
45. Do you have any questions?
46. Is there anything else you would like to discuss?

Appendix 4g – Line-by-line coding example (screen shot of interview)



LR: Okay erm so linked to that then what qualities would a successful housing service have

tenant-centred

S7: erm they have to erm they have to put the er the tenants er first or in the centre of everything that they do, that-that's the primary focus, I think us being a charity means that we're looking specifically at a er, particular segment of the housing market, i.e. providing homes for er people with enduring mental illness, so therefore we need to be dedicated to that cause

focus
charity
specific
dedication

LR: Mm-hmm

tenant focus
provide support
independence
move forward

S7: So I-I think I that's the primary thing, making sure that they're at the centre of what we're doing, er to provide, to meet that aim to provide support and housing er for people with enduring mental illness to enable them to live independent lives or to move forward towards living independent lives whether it be with us as a housing association or with other housing associations or independently

LR: Okay that's great, erm so if we think about priorities then, what are the most important factors involved in housing

tenancy obligations
support + funding
comfortable
feel safe
right support
useful life

S7: Erm, I suppose from-from the the er the tenants point of view er providing housing that enables them to er meet the tenancy obligations, therefore do the right support or funding is in place er from er whether it be independent funding or funding from er from benefits so that that's all in place, that they're comfortable and they feel safe, and then also that they're getting the right level of support from the housing association that they need to fulfil a useful life

LR: Great, erm who do you feel should decide whether a housing-supported housing service is successful

tenants
outcomes
other input
criteria
meet needs
funding
quality

S7: Er that's a good question, erm I suppose ultimately th-the tenants should have the final say as to whether it's successful in as much as that if they're outcomes are met, that it we-we're being successful, ultimately other people may have a say if the-the funding coming from different areas supporting people for for example, then they would have their criteria to judge the housing association against so they would have to meet those needs, erm if the er if a lot of the funding comes from housing benefit housing benefit would have to be satisfied that that housing association is providing the right level of er quality of housing and support

LR: Mm-hmm

requirements
funding

S7: to meet their requirements for providing that funding

LR: Yeah

secondary
health services

S7: Erm then I think from a-from a a secondary point of view er people within for instance the er the health services people who are looking after people

Appendix 4h – Summary of key issues given to participants prior to phase two

Focus groups

From the interviews 10 themes emerged. These can be found in the table below. These themes will be further explored in the focus groups. Questions which relate to each of the themes will be asked.

No.	***Theme***	***No.***	***Theme***
1	Goals	6	Support
2	Service Provision	7	Organisation
3	Move on	8	Self-efficacy*[49]
4	Environment	9	Experience
5	Change	10	Recovery

Theme 1 – Goals

In the interviews staff and tenants identified goals that the tenants are working towards. The answers have been categorised and can be found in the table below. However, some tenants said they didn't have any goals so this is something to discuss.

Finances	*Day to day activities*	*Health*	*Living*	*Social world*	*Outcomes*
Budgeting, Benefits	Shopping, Catch a bus, Attend appointments, Attend day centre	Drug free, Not drinking, Eat healthy, Maintain mental health	Independent living, Move on, Community living, Keep in community	Social networks, Family links, Get a job, Voluntary work	Normal/ better life, Independ-ence, Happiness

Theme 2 – Service Provision

During the interviews staff were asked about the future of the organisation. This provided a range of answers which can be found in the table below.

[49] *Self efficacy refers to one's perceived competence to reach a goal. For example, it could be the tenants' belief that they will move on to independent living.

Ideas for interventions	Needs for interventions	How to implement plans
• Intensive housing management • Step down projects • Social evenings • Drop-in centres • Supported housing in local area	• More properties • More funding • Expand company	• Keep Supporting People processes • Regular reviews of tenants

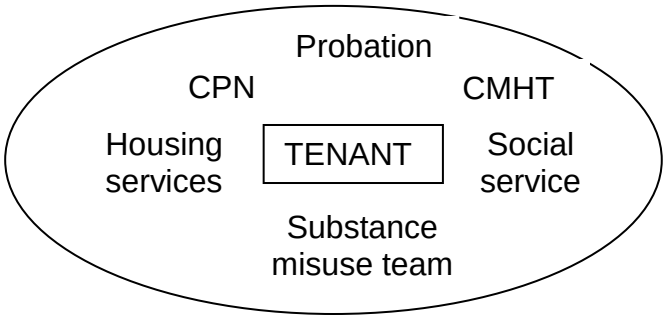
Theme 3 – Move on

In the interviews both staff and tenants talked about 'moving on'. Amongst staff and tenants there was mixed ideas about how they felt about the idea of having to move on. The arguments for and against this can be found in the Table below. Because there were different opinions I would like to explore the purpose and potential impact of moving people on from the service.

Staff		Tenants	
For	Against	For	Against
• Move on is ideal • Keeping them is not the right way to do things • You can't leave people to stagnate • Shouldn't stay in housing for years	• We want them to stay it's appropriate with them • Prefer to keep them • Adding to their instability • Prevented hospital so positive outcome • Don't want to desert them	• Don't want to be sharing for the rest of my life • Want my own place • I want to start my life on my own • Happy to move on	• Happy to stay, feel safe • Liked it where I was • Upset me • 'keep moving' – disruptive • Stressful and confusing • Put me in hospital

Theme 4 – Environment

We are aware that the organisation is not the only service/network that the tenant is involved with. Their environment is filled with many other services and people, some of which have been identified in the diagram below. What is of interest now is how the service fits in with both the tenant and the other services.



Theme 5 – Change

Since the start of the PhD the organisation has encountered some changes which were highlighted from the interviews. On a funding/policy level the organisation are no longer working under the Supporting People contract. In terms of service provision the organisation is now implementing Intensive Housing Management (whereas previously it was supported housing) and with staff and tenant turnover the people within the organisation have changed. I am interested to learn the possible impact/implications of these changes.

Theme 6 – Support

The organisation provides housing-related support and from the interviews it was possible to categorise what was identified by the staff and tenants. This can be found in the table below. In terms of support I am interested in which of these (and/or additional areas) are the responsibility of the organisation and which are not.

Money/finance	Appointments/other services	Health
Medication	Paperwork	Social network
Guidance/signposting	Care/practical issues	General

Theme 7 – Organisation

In the interviews the staff and tenants talked about the organisation itself. I am interested in exploring what the role of the organisation is. Some ideas which emerged from the interviews can be found in the table below. As well as understanding how the organisation fits with the tenant and other services I am interested in how the organisation fits with concepts such as deinstitutionalisation.

The role of the organisation
• A nurturing environment • Provides support • A business • A mediator/middle man between Government and service users

Theme 8 – Self Efficacy

As explained in the footnote on page one, self efficacy concerns a person's believed ability to reach a goal. Issues relating to this concept were found in the staff and tenant interviews, and can be found in the table below. I am interested in exploring these issues further.

Self Efficacy	
Readiness to move on	Ability/capability to move on
Decision making	Staff and tenant relationship
Time perspective (future plans)	Perceived competency

Theme 9 – Experience

The interviews explored the experience of both delivering and receiving housing related support. Whilst looking at the 'role' addresses a person's understanding of the organisation, this doesn't capture the person's understanding of the properties themselves. In the tenant interviews some spoke of the properties as their 'home' whilst others spoke of them as 'stop-gaps' or temporary arrangements. How the staff view the properties and their opinion on this topic are of interest.

Theme 10 – Recovery

During the interviews staff and tenants identified factors which can be related to recovery. These can be found in the table below. The involvement/role the organisation in a person's recovery will be explored further.

RECOVERY			
Barriers	*Mediators*	*Impact*	*Outcomes*
• Trust • Over-reliance • Insitution-alised • Revolving door • Regression • Safety net	• Stability • Medication • Safety • Management • Coping	• Mental health • Substance use • Quality of life	• Independence • Confidence • Sense of purpose • Community living • Happiness • Empowerment • Life skills • Normal life

Please note that this is not a strict schedule. Feel free to add anything to the discussion that has not been identified here. There are no right or wrong answers and you do not need to answer or contribute to any discussions if you do not want to. Participation is entirely voluntary and you are free to withdraw at any time.

Appendix 6a – Detailed database search

Round 1 - Search

CINAHL

Search ID#	Search Terms	Search Options	Actions
S9	S7 AND S8	**Search modes** - Boolean/Phrase	View Results (21)
S8	S3 OR S4 OR S5 OR S6	**Search modes** - Boolean/Phrase	View Results (94,492)
S7	S1 AND S2	**Search modes** - Boolean/Phrase	View Results (359)
S6	mental health services	**Search modes** - Boolean/Phrase	View Results (28,960)
S5	mental health	**Search modes** - Boolean/Phrase	View Results (69,017)
S4	mental disorders	**Search modes** - Boolean/Phrase	View Results (37,920)
S3	homeless persons	**Search modes** - Boolean/Phrase	View Results (3,152)
S2	assisted living	**Search modes** - Boolean/Phrase	View Results (2,535)
S1	housing	**Search modes** - Boolean/Phrase	View Results (10,687)

Medline

elect / deselect all | **Search with AND** | **Search with OR** | **Delete Searches**

Search ID#	Search Terms	Search Options	Actions
S8	S6 AND S7	**Search modes** - Boolean/Phrase	View Results (57)
S7	S3 OR S4 OR S5	**Search modes** - Boolean/Phrase	View Results (144,576)
S6	S1 AND S2	**Search modes** - Boolean/Phrase	View Results (245)
S5	mental health services	**Search modes** - Boolean/Phrase	View Results (46,446)
S4	mental health	**Search modes** - Boolean/Phrase	View Results (140,478)
S3	homeless persons	**Search modes** - Boolean/Phrase	View Results (5,270)
S2	residential facilities	**Search modes** - Boolean/Phrase	View Results (5,323)
S1	housing	**Search modes** - Boolean/Phrase	View Results (35,422)

PsycINFO

Search ID#	Search Terms	Search Options	Actions
S12	S10 AND S11	**Search modes** - Boolean/Phrase	View Results (32)
S11	S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9	**Search modes** - Boolean/Phrase	View Results (467,832)
S10	S1 AND S2	**Search modes** - Boolean/Phrase	View Results (82)
S9	psychiatric patients	**Search modes** - Boolean/Phrase	View Results (47,223)
S8	mental health services	**Search modes** - Boolean/Phrase	View Results (94,772)
S7	mental health program evaluation	**Search modes** - Boolean/Phrase	View Results (2,099)
S6	mental health programs	**Search modes** - Boolean/Phrase	View Results (13,898)
S5	mental health	**Search modes** - Boolean/Phrase	View Results (378,623)
S4	mental disorders	**Search modes** - Boolean/Phrase	View Results (100,715)
S3	homeless mentally ill	**Search modes** - Boolean/Phrase	View Results (885)
S2	assisted living	**Search modes** - Boolean/Phrase	View Results (859)
S1	housing	**Search modes** - Boolean/Phrase	View Results (12,231)

Social Care Online

Search	Results
“Housing” + “Supported Housing” + “mental health”	1
“Housing” + “Supported Housing” +”mental health care”	0
“Housing” + “Supported Housing” + “mental health problems”	26
“Housing” + “Supported Housing” + “Mental health services	8
RESULTS AFTER ERASING DUPLICATES	**31**

First round of searching:

Database	Results:
CINAHL	21
Medline	57
PsycINFO	32
Social Care Online	31
TOTAL	**141**

Round 2 – remove duplicates

CINAHL

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Medline

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Drake (1998)	Miller, Murphy and Brady (2007)
Duncan (1990)	Molyneux (2011)
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Garwood (2007)	Molyneux and Van Doorn (2011)
Goldie (2004)	National Mental Health Development Unit

Griffiths (1997) Hogan and Carling (1992) Inman (2003) Jackson (2005) Johnson (2006) Johnson (2008) Joy (1994) Kralik, Koch and Ashton (2004)	(2011) Prance (1996) Shipley (2008) Sohng (1996) Umb-Carlsson and Jansson (2009) Yanos, Barrow and Tsemberis (2004) Warner et al (1997) Welch and Fernandes (2010)

After removing duplicate studies: **138**

Round 3 – screen abstracts

	Included article
1	Carling, P (1993). Housing and Supports for persons with mental illness: emerging approaches to practice. *Hospital and Community Psychiatry, 44,* (5), 439-449.
2	Hogan, M., and Carling, P (1992). Normal Housing: A Key Element of a Supported Housing Approach for People with Psychiatric Disabilities. *Community Mental Health Journal, 28,* (3), 215-226.
3	Johnson, R (2004). Mental Health, Social Inclusion and Housing: Mapping the issues for Service Providers. *Housing, Care and Support, 7,* (2), 10-16.
4	Johnson, R (2008). Bringing it all back Home. *A Life in the Day, 12*, (2), 9-13.
5	Kenny, D., Calsyn, R., Morse, G., Klinkenberg, W., Winter, J., and Trusty, M (2004). Evaluation of Treatment Programs for Persons with Severe Mental Illness: Moderator and Mediator Effects. *Evaluation Review, 28,* (4), 294-324.
6	Lamb, H., and Talbott, J (1986). The Homeless Mentally Ill. The perspective of the American Psychiatric Association. *JAMA: The Journal of the American Medical Association, 256,* (4), 498-501
7	Lipton, F., Siegel, C., Hannigan, A., Samuels, J., and Baker, S (2000). Tenure in Supportive Housing for Homeless Persons with Severe Mental Illness. *Psychiatric Services (Washington D.C.), 51,* (4), 479-486
8	Melcher, B., and Watson, H (2012). Meeting the Challenges of Community-Based Care. *North Carolina Medical Journal, 73,* (3), 222-226.
9	Molyneux, P (2011). *Mental Health and Housing: Resources for Commissioners and Providers: Mental Health and Housing Improving Outcomes, integrating lives.* London, National Mental Health Development Unit
10	Randolph, F., Lindenberg, R., and Menn, A (1986). Residential Facilities for the Mentally Ill: Needs Assessment and Community Planning. *Community Mental Health Journal, 22* (2), 77-93.
11	Rog, D (2004). The Evidence on Supported Housing. *Psychiatric Rehabilitation Journal, 27,* (4), 334-344.

Round 4 – Access full article

Articles unable to access
Randolph, F., Lindenberg, R., and Menn, A (1986). Residential Facilities for the Mentally Ill: Needs Assessment and Community Planning. *Community Mental Health Journal, 22* (2), 77-93.

Round 5 – Screen introduction

Articles removed after screening introduction
Lipton, F., Siegel, C., Hannigan, A., Samuels, J., and Baker, S (2000). Tenure in Supportive Housing for Homeless Persons with Severe Mental Illness. *Psychiatric Services (Washington D.C.), 51,* (4), 479-486
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Molyneux, P (2011). *Mental Health and Housing: Resources for Commissioners and Providers: Mental Health and Housing Improving Outcomes, integrating lives.* London, National Mental Health Development Unit

Appendix 6b – Process of snowballing

Stage	Study	Snowballing			
		1		2	3
1. Electronic Database search					
	Carling (1993)	-		-	-
	Kenny et al (2004)	-		-	-
	Rog (2004)	Rog et al (1996)		-	-
2. Grey Literature	WHO (1993)	-		-	-
	Brunette et al (2004)	-		-	-
	NICE (2005)	-		-	-
	Chilvers et al (2006)	-		-	-
	Kane et al (2007)	-		-	-
	Kyle and Dunn (2008)	-		-	-
	Pleace and Wallace (2011)	O'Campo et al (2009)		-	-
		O'Malley and Croucher (2005)		-	-
	Johnson (2013)	Page (2002)		-	-
3. Informal Scoping	Brown (2004)	-		-	-
	Kirsch et al (2009)	Parkinson et al (1999)		-	-
	Leff et al (2009)	Barrow and Zimmer (1999)		-	-
	Rogers et al (2009)	Newman (2001a)			
		Newman (2001b)			
	Nelson (2010)	Carpenter (1978) Colton (1978) Cometa et al (1979) Frankish et al (2005) Hall et al (1987) Hwang et al (2005)	Macpherson et al (2004) Nelson et al (2007) Nelson et al (1987) Parkinson et al (1999) Rog and Rausch (1975) Rosenheck (2000)		
	Tabol et al (2010)	Fakhoury et al (2002)		-	-
		Ogilvie (1997)		-	-
	Foster et al (2011)	Evans et al (2003)			

Appendix 6c – data extraction summary table

Summary of articles included in CIS.							
Author(s) and location		**Area of review**	**Population**	**Years**	**Types of articles**	**Methodology**	**Methods**
Rog and Raush (1975)	US	Psychiatric halfway house	Half-way house residents	-	Statistical reports	- Not specified 'survey of the literature'	- Not specified
Carpenter (1978)	US	Residential placement	Chronic psychiatric patient	-	-	- Not specified 'review – evaluative approach'	- Not specified
Colton (1978)	US	Community residential treatment	Handi-capped individuals	-	-	- Not specified	- Not specified
Cometa (1979)	US	Psychiatric halfway houses	Psychiatric clients	-	-	'Critical review'	- Not specified
Nelson and Smith-Fowler (1987)	CAN	Community housing programmes	Chronically mentally disabled	-	Experi-mental and observation-al studies	- Not specified 'review'	- Not specified
Carling (1993)	US	Housing and Supports	Persons with mental illness	'past 15 years': 1978 - 1993	Research studies and policy analyses	- Not specified 'review'	Reviews studies of the effectiveness of traditional housing programmes and programmes - Database >4000 studies

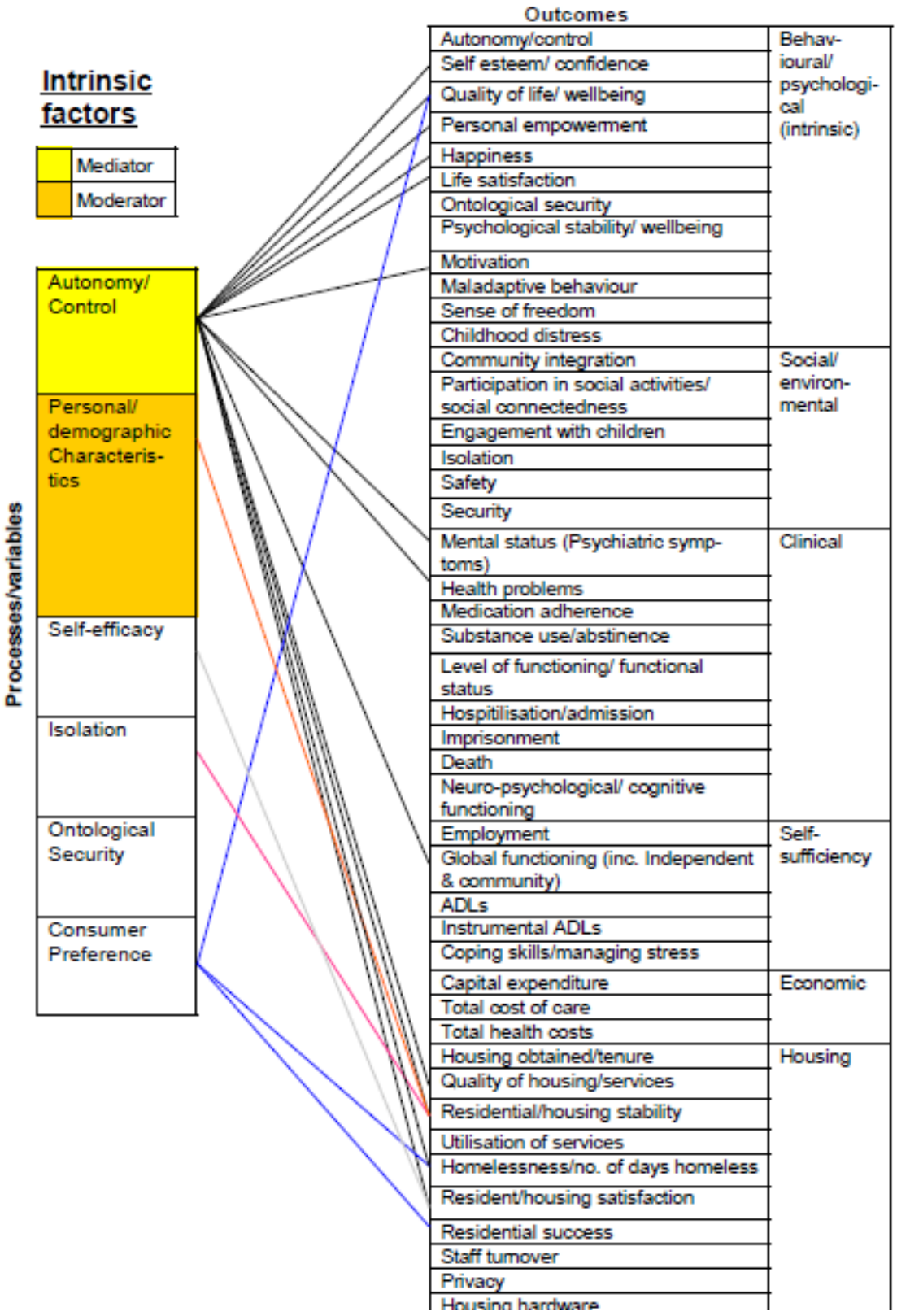
Rog et al (1996)	US	Supportive housing	Individuals with mental illness	-	-	- Not specified 'review'	- Not specified
Ogilvie (1997)	CAN	Supported Housing	Mental health consumers	-	-	Systematic review	- Not specified
Barrow and Zimmer (1999)	US	Transitional housing and services	Mentally ill individuals	-	-	- Not specified – 'synthesis'	- Not specified
Parkinson et al (1999)	CAN	Housing approaches	Psychiatric consumers/ survivors	-	-	- Not specified	- Not specified
Rosenheck (2000)	US	Services	Mentally ill homeless people	-	-	- Not specified 'review'	- Not specified
Newman (2001b)	US	Housing attributes	Serious Mental illness	1975 - 2000	Quantitative studies only	Critical review	Database searches, consultations with housing researchers
Fakhoury et al (2002)	UK	Supported housing	People with mental illness	No limit	Published literature	Not specified – 'review'	Database search, hand search and contacting experts
Page (2002)	UK	Housing	Mental ill health	-	-	- Not specified – 'review'	- Not specified
Evans et al (2003)	US	Housing	Mental health	-	-	- Not specified – 'review'	- Not specified
Brown (2004)	US	Supportive housing programmes	Homeless mentally ill	-	-	- Not specified	- Not specified

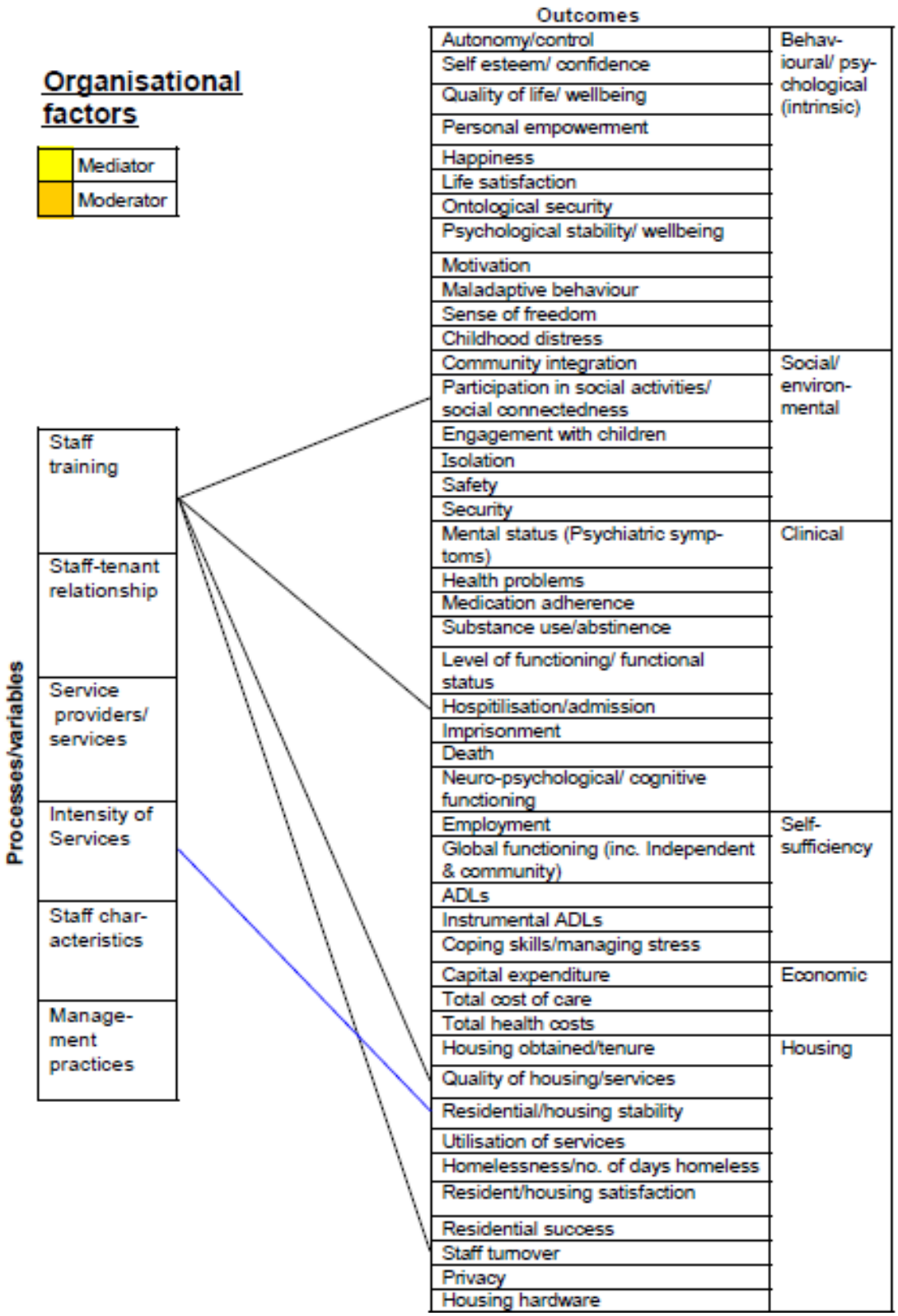
Brunette et al (2004)	US	Residential programmes	People with severe mental illness and co-occuring substance use disorders	-	controlled studies' – Experi-mental and quasi-experi-mental	- Not specified 'Review'	Database searches
Rog (2004)	US	Supported Housing	Serious mental illness	1988-2001	-	-	Ranked the evidence on levels based on rigour, design and outcomes
Frankish et al (2005)	CAN	Homeless-ness	health	1990 - 2005	General reports excluded	- Not specified – 'review'	Database search, website search
Hwang et al (2005)	CAN	Interventions for homeless people	Homeless people with mental illness	1988 - 2004	Must have comparison group	Systematic review	Database search
NICE (2005)	UK	Housing interventions	Public health	1996-2004	Systematic reviews, syntheses, meta-analyses, review level papers	Narrative synthesis review of reviews	Systematic searching of literature, Database searches
O'Malley and Croucher (2005)	UK	Supported Housing Services	People with mental health problems	-	-	Scoping study technique	Scoping study method Database search

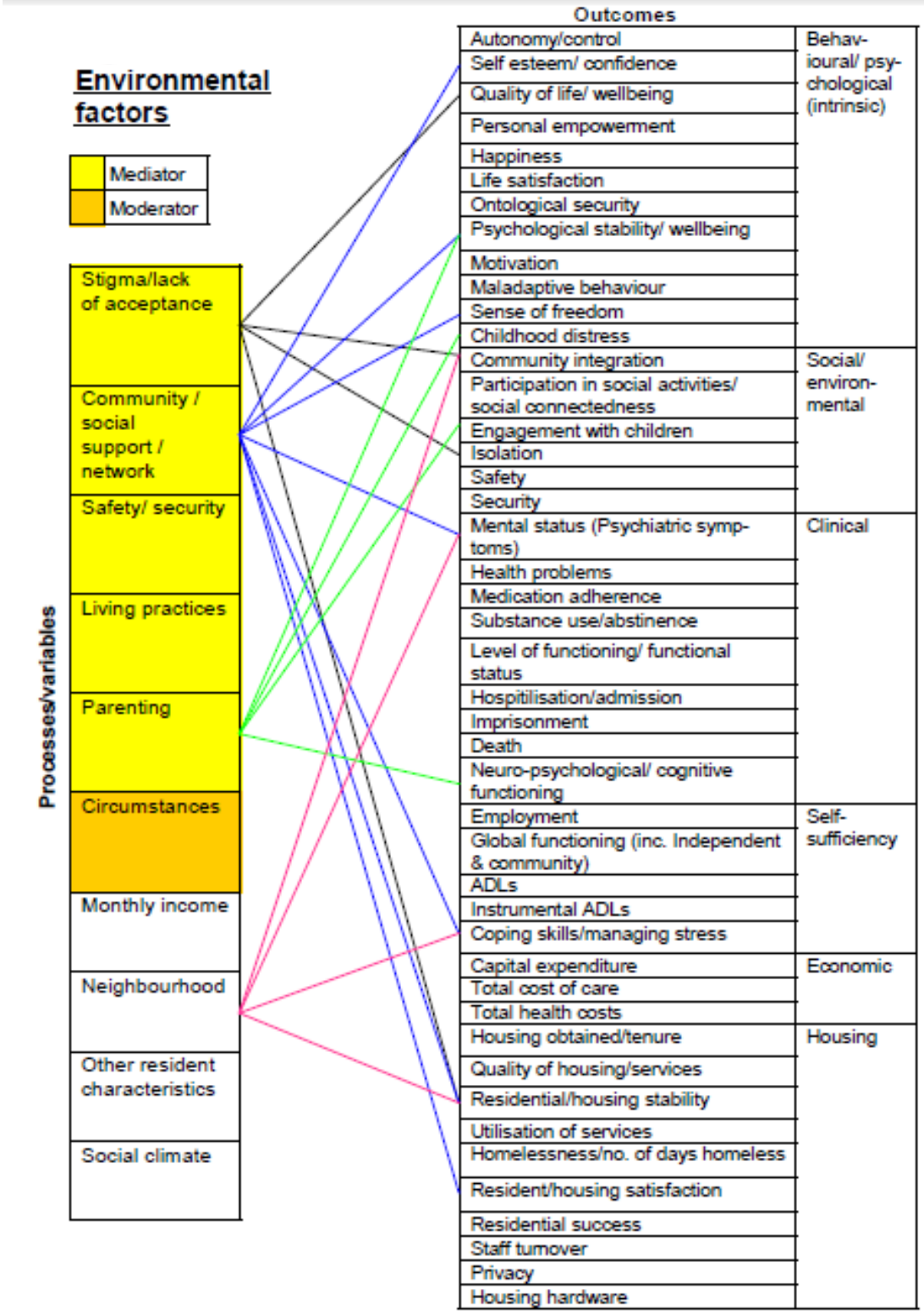
Chilvers et al (2006)	UK	Supported Housing	Severe Mental Disorders	-	Random-ised or quasi-randomised trials	Systematic review	Searched Cochrane Schizophrenia Group Trials Register and CENTRAL for RCTs or quasi-RCT
Kane et al (2007)	US	Assisted Living	Older people	1989 - 2004	All	- Not specified	Database searches, 'coding'
Nelson et al (2007)	CAN	Housing and support interventions	Persons with mental illness	Up to Dec 2004	Controlled outcome evaluations	Not specified – 'review'	Effect sizes Database search
Kyle and Dunn (2008)	CAN	Housing circumstance	People with severe mental illness – aged 18-64	1980 - 2008	-	Systematic Review	Online database searches Excluded solely qualitative studies Assessed strength of evidence
Kirsh et al (2009)	CAN	Supported Housing	Severe Mental Illness	1990 - 2006	Academic literature, grey literature,	'Systematic approach'	Database searches
Leff et al (2009)	US	Housing models	Persons with mental illness	1983 - 2006	US lit, eliminated qualitative reviews	Meta-analysis	Outcome scores converted to effect size measures
O'Campo et al (2009)	CAN	Community based services	Homeless adults – mental health disorders	1980 - 2009	Peer-reviewed lit, grey lit,	'Systematic evidence synthesis' drawing from Realist review methodology	Realist review/ synthesis
Rogers et al (2009)	US	Supported Housing	Severe mental illness	1993 - 2008	All literature	Systematic review – narrative synthesis	Systematic search Database searches

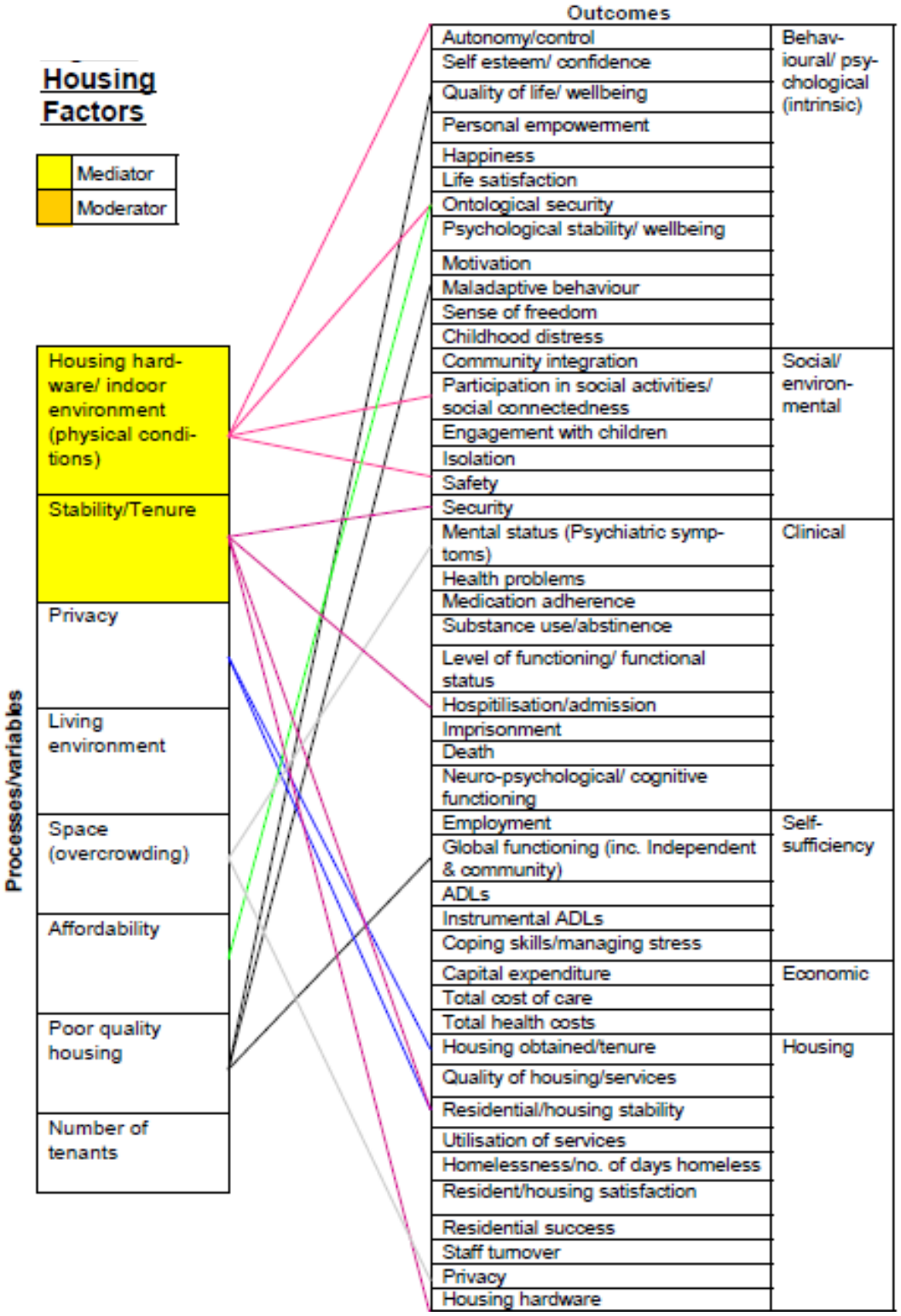
Johnsen and Teixeira (2010)	UK	Housing models	Homeless people with 'complex support needs', adults aged 25+	-	-	- 'Review of international literature'	-
Nelson (2010)	CAN	Housing	Serious mental illness	-	-	- Not specified	- Not specified
Schiff et al (2010)	CAN	Housing	Disabled mentally ill	1995 - 2010	Peer reviewed jounals and grey lit	- Not specified	Database searches
Tabol et al (2010)	US	Supported and supportive housing	Psychiatric disabilities	1987 - 2008	Published articles	- Not specified – 'comprehensive review'	Database searches
Foster et al (2011)	AUS	Precarious housing	Health (not specific to MH)	-	Empirical research	Research synthesis (based on realist synthesis)	Realist Synthesis
Pleace and Wallace (2011)	UK	Housing Support Services	People with mental health problems	1990-2010	Empirical studies	Rapid Evidence Assessment	Critical assessment of methodologies which have been used in the effectiveness of HRS Database searches
Johnson (2013)	UK	Housing interventions	Adult mental health	-	-	Purposive review	- Not specified

Appendix 6d – Mapping variables




Organisational factors
Mediator
Moderator
Processes/variables
Staff training
Staff-tenant relationship
Service providers/ services
Intensity of Services
Staff char-acteristics
Manage-ment practices
Outcomes
Autonomy/control
Self esteem/ confidence
Quality of life/ wellbeing
Personal empowerment
Happiness
Life satisfaction
Ontological security
Psychological stability/ wellbeing
Motivation
Maladaptive behaviour
Sense of freedom
Childhood distress
Behav-ioural/ psy-chological (intrinsic)
Community integration
Participation in social activities/ social connectedness
Engagement with children
Isolation
Safety
Security
Social/ environ-mental
Mental status (Psychiatric symp-toms)
Health problems
Medication adherence
Substance use/abstinence
Level of functioning/ functional status
Hospitilisation/admission
Imprisonment
Death
Neuro-psychological/ cognitive functioning
Clinical
Employment
Global functioning (inc. Independent & community)
ADLs
Instrumental ADLs
Coping skills/managing stress
Self-sufficiency
Capital expenditure
Total cost of care
Total health costs
Economic
Housing obtained/tenure
Quality of housing/services
Residential/housing stability
Utilisation of services
Homelessness/no. of days homeless
Resident/housing satisfaction
Residential success
Staff turnover
Privacy
Housing hardware
Housing


Environmental factors
Mediator
Moderator
Processes/variables
Stigma/lack of acceptance
Community / social support / network
Safety/ security
Living practices
Parenting
Circumstances
Monthly income
Neighbourhood
Other resident characteristics
Social climate
Outcomes
Autonomy/control
Self esteem/ confidence
Quality of life/ wellbeing
Personal empowerment
Happiness
Life satisfaction
Ontological security
Psychological stability/ wellbeing
Motivation
Maladaptive behaviour
Sense of freedom
Childhood distress
Behav-ioural/ psy-chological (intrinsic)
Community integration
Participation in social activities/ social connectedness
Engagement with children
Isolation
Safety
Security
Social/ environ-mental
Mental status (Psychiatric symp-toms)
Health problems
Medication adherence
Substance use/abstinence
Level of functioning/ functional status
Hospitilisation/admission
Imprisonment
Death
Neuro-psychological/ cognitive functioning
Clinical
Employment
Global functioning (inc. Independent & community)
ADLs
Instrumental ADLs
Coping skills/managing stress
Self-sufficiency
Capital expenditure
Total cost of care
Total health costs
Economic
Housing obtained/tenure
Quality of housing/services
Residential/housing stability
Utilisation of services
Homelessness/no. of days homeless
Resident/housing satisfaction
Residential success
Staff turnover
Privacy
Housing hardware
Housing


Housing Factors
Mediator
Moderator
Processes/variables
Housing hard-ware/ indoor environment (physical condi-tions)
Stability/Tenure
Privacy
Living environment
Space (overcrowding)
Affordability
Poor quality housing
Number of tenants
Outcomes
Autonomy/control
Self esteem/ confidence
Quality of life/ wellbeing
Personal empowerment
Happiness
Life satisfaction
Ontological security
Psychological stability/ wellbeing
Motivation
Maladaptive behaviour
Sense of freedom
Childhood distress
Behav-ioural/ psy-chological (intrinsic)
Community integration
Participation in social activities/ social connectedness
Engagement with children
Isolation
Safety
Security
Social/ environ-mental
Mental status (Psychiatric symp-toms)
Health problems
Medication adherence
Substance use/abstinence
Level of functioning/ functional status
Hospitilisation/admission
Imprisonment
Death
Neuro-psychological/ cognitive functioning
Clinical
Employment
Global functioning (inc. Independent & community)
ADLs
Instrumental ADLs
Coping skills/managing stress
Self-sufficiency
Capital expenditure
Total cost of care
Total health costs
Economic
Housing obtained/tenure
Quality of housing/services
Residential/housing stability
Utilisation of services
Homelessness/no. of days homeless
Resident/housing satisfaction
Residential success
Staff turnover
Privacy
Housing hardware
Housing

Appendix 6e – HRS mapped onto RAA