‘ANTRIM - ONE YEAR ON’

An Evaluation of the First Year of
Operation of the Flat Cluster Accommodation
and Support Scheme in Antrim

May 1990 - May 1991

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Praxis is committed to the evaluation and monitoring of all its services. This report is the first in a series of empirical studies.

Praxis currently provides a range of services :

(i) Befriending Schemes.
(ii) Accommodation and Support Schemes.
(iii) Anxiety and Agoraphobia Society.

The Accommodation and Support Schemes have been developed from several different accommodation models, including Flat Cluster, Dispersed Intensively Supported Housing (DISH), Hostel, and combinations of these.

This study examines the effectiveness of one of these models, i.e. Flat Cluster.

The contributions from the NH&SSB Personnel are extracted from independent studies carried out by these researchers.

1.0 : INTRODUCTION

1.1 : Background.

This report outlines the findings of the evaluation of the first year of operation of the Praxis Supported Flat Cluster Scheme in Antrim. This scheme was developed to provide care and accommodation to a group of discharged psychiatric patients and vulnerable individuals already living in the community who wished to live in self-contained accommodation, yet who also required a degree of support. The Flat Cluster Scheme provides a level of support which can range from a comprehensive care package to largely independent living with very little formal support.

At the time of the scheme's creation, the range of provision for discharged patients in Northern Ireland who did not live with relatives, was a place in a hostel, group home or Housing Executive accommodation. Hospitals also referred patients to private landladies and old people's homes. In principle, patients were often expected to progress from hostels and half-way houses to more independent living. In practice, residents frequently failed to make this progression. However, many hostels have now set up programmes to enable residents to move on.

In 1986, the Rehabilitation Team at Holywell Hospital identified the need for sheltered accommodation in the community for younger mentally ill patients who did not fit easily into existing residential and housing provision. This group of patients were often 'frequent readmitters' whose placement in existing accommodation had failed, thereby resulting in hospital readmission. These individuals were at risk of becoming new long-stay patients.

The Rehabilitation Team approached Praxis with a request to provide such specialised accommodation. Praxis began researching ideas and formulated several models, one of which was accepted by the Northern Health and Social Services Board and consequently deployed for the Antrim scheme. The model consisted of 2 separate blocks of 1 bedroomed self contained flats with a communal room and shared laundry facilities in each block.

A number of similar schemes operate successfully elsewhere. For example, the Community Psychiatric Research Unit in Hackney, has developed a range of supported accommodation for discharged psychiatric patients, in conjunction with the local Housing Department.

Joint planning of the project commenced with a close and frequent involvement between Praxis and the Rehabilitation Team. Meetings were held regularly to deal with the following issues :

1. Purpose of the Scheme : It was agreed that the scheme should provide individual accommodation with a range of staff support and access to care. The support element of the

scheme would be facilitated by the implementation of individual care plans, which would be drawn up by Praxis in conjunction with statutory services and with the active involvement of the prospective tenants.

2. Location : Representatives from the Northern Ireland Housing Executive, Open Door Housing Association, Praxis, and the Rehabilitation Team met to choose a site on a local housing estate which was equidistant between hospital and the town centre. The Northern Ireland Housing Executive identified blocked up properties which had been empty for some time. Ownership was transferred to the Open Door Housing Association. The Architects met with Praxis and the Rehabilitation Team to draw up an agreed set of plans for the scheme.

3. Staffing : A support package was planned jointly, consisting of Accommodation Officer (now referred to as the Projects Manager) and Community Assistants. The Projects Manager and Secretarial Staff were appointed by Praxis in 1988, and at that stage the recruitment and matching of Praxis befrienders to potential tenants commenced. It was agreed that Community Assistants would be employed when the buildings were ready for occupation.

4. Consultation with the local Community : In 1988, Praxis staff carried out a doorstep consultation exercise with members of the local community about plans for the Sheltered Accommodation and Care Scheme.

5. An Operational Policy including procedures for the selection of Tenants, and reviewing of Care Plans was formulated and the basic principles were jointly agreed in 1989 by Praxis and the NH & SSB.

After four years of joint planning and action, the scheme was open for its first intake of tenants in May 1990.

The Antrim Accommodation and Support Scheme represents an excellent example of partnership between voluntary bodies and statutory authorities. The policy of 'partnership' was first recommended in the Griffiths Report on Community Care (1988) and, subsequently endorsed by the Government Policy Paper 'People First" (1990). The scheme has brought together the Northern Health and Social Services Board, Praxis, Open Door Housing Association, and the Northern Ireland Housing Executive.

1.2.1 : Aims of the Accommodation and Support Scheme.

Having agreed on a suitable model, and given Praxis' commitment to integrating the provision of accommodation and care, it was essential to develop the philosophy of the scheme. Hence, the operation of the scheme was developed according to the following agreed aims:

The Antrim Flat Cluster Scheme:

(i) Is based on the principles of normalisation, uses means which are positively valued to enhance the individual's quality of life and facilitate real opportunities for integration within the community.

(ii) Affords respect to the individual's rights and maximises opportunities for self-determination. Therefore, the quality of the environment should be consistent with what other citizens are entitled to expect with regard to individual choice, standards of privacy and rights to normal amounts of risk taking in daily living.

(iii) Is sensitive to individual needs and encourages each individual to achieve his or her optimal level of independence/dependence. This necessitates the development of appropriate practical and social skills within the context of real situations.

(iv) Prevents tenants becoming involved in a revolving door pattern of frequent readmissions to hospital by monitoring tenants well-being and responding quickly to any change in needs.

In order to translate these principles into a working format, and to provide clear guidance for the management of the scheme, an operational policy was drawn up, which also created a starting point for the evaluation.

1.2.2. : The Operational Policy addresses the following areas:

(i) Aims of the Accommodation and Support Scheme.
(ii) Objectives of the Accommodation and Support Scheme.
(iii) Information relating to the property.
(iv) Tenant selection procedure.
(v) Tenant's rights.
(vi) Tenant's review procedure.
(vii) Termination of Tenancy.

(viii) Staffing and Management.
(ix) Health and safety issues.
(x) Evaluation and monitoring.

1.3. Individual Support Packages

The Flat Cluster Scheme operates a system of Individual Support Packages (I.S.P.s) which are implemented to provide individually tailored support and rehabilitation packages, according to individual need. I.S.P.s are constructed in the following way :

On referral to the scheme the application form identifies:
(i) Areas in which the tenant needs support.
(ii) How these needs can be met.
(iii) Times when staff are required to work on these areas with the tenant.

The Projects Manager, Referral Agent and prospective tenant then meet, prior to selection, in order to draw up a draft service user Individual Support Package (I.S.P). This I.S.P. covers areas of need; who will meet that need; and the duration, frequency, and specific time of week when such support is required. Once the applicant is accepted as a tenant , the Projects Manager, Referral Agent, and Tenant agree on a formal I.S.P.. The Projects Manager translates this into a structured rehabilitation programme, and ensures the Community Assistants implement the programme.

Prior to moving in, the Projects Manager devises the Rehabilitation Programme by :
(i) Referring to the agreed I.S.P.
(ii) Assessing the tenant's attitude, motivation, and mood.
(iii) Assessing the tenant's current strengths.
(iv) Considering existing activities of the tenant and their contacts.

The Programme is then discussed with the tenants, and presented to the Community Assistants. Therefore the Programme outlines how the I.S.P. is implemented.There is a weekly staff meeting and bimonthly review of the Rehabilitation Programme by the Projects Manager and the tenant's keyworker (Community Assistant) for :
(i) Monitoring
(ii) Identifying strengths and needs
(iii) Making amendments
(iv) Identifying opportunities for change

The I.S.P. is reviewed by the Review Panel on a 6 monthly basis, a process involving the tenant who is encouraged to participate at all stages of the I.S.P. process.

From the outset, and throughout the development and operation of the scheme, Praxis has maintained a firm commitment to the evaluation and monitoring of all aspects of the scheme's operation.

1.4 : Evaluation of the Accommodation and Support Scheme.

Staff at Holywell Hospital have always had a good history of following up individual discharged psychiatric patients. This has now become vital in relation to the changes in delivery of service which are currently being planned and implemented. However, in addition, there is also a need to monitor the effectiveness and efficiency of new services in an empirical manner. For example, it is important to know whether a new accommodation scheme is providing a better quality of environment, is seen as more acceptable to residents, is providing adequate support, is reducing hospital readmission, is adding greatly to the burden on community services etc. Clearly, a large number of questions need to be asked from perspectives which range from that of the residents to health services personnel (both hospital and community) and voluntary agencies.

For these reasons it was felt that a study should be planned which would monitor the progress of the Praxis Accommodation and Support Scheme. This would be conducted jointly by the research department in Praxis and members of the NHSSB rehabilitation team. It was proposed that, Praxis would review annually the services provided, in terms of adequacy of staffing, fulfilment of the aims and objectives, the workload, outstanding need, and the quality of the service provided.

There is a widespread acceptance of the need to provide quality in health care provision. The White Paper "Working for Patients" refers to quality in two of its seven key measures, acknowledging the need for quality of service to be both improved and audited. The need for quality assurance has further been emphasised by the NHS Management Executive referring to the need for a "forward-looking and systematic approach to quality of service". Health & Social Services are expected to "include provision to monitor all aspects of the quality of patient care and other services, including the outcome of such services and (to) ensure that quality is the best possible within available resources".

Quality is particularly important at a time of great change in the provision of health and social care. The increased flexibility of the relationship between public and private sector, and voluntary provision and the development of different types of community-based care as replacements for the large institutions are salient issues which have given an increased emphasis on the need to manage quality effectively within mental health and other community care services.

In order to successfully monitor quality, the following aspects have to be considered :

(i) Input - ie. resources, staffing, funding etc

(ii) Output - ie. the process of service delivery.

(iii) Outcome - ie. the results of the delivery of service.

It was in the context of the above that a framework for evaluation was developed. The evaluation of the scheme was carried out one year after opening, and is a comprehensive review of the scheme in all aspects of its first year of operation. The research undertaken will have a management function in that it enables Praxis to review its practices regarding the Antrim Scheme. Recommendations about practices, which have been highlighted by the evaluation, will be reported in the discussion section.

2.0 : METHOD

2.1 : Design

In order to create a structure for the evaluation, the following framework was compiled, outlining the areas included in this study :

1. Occupancy:
   a. Occupancy levels
   b. Absences from Accommodation
   c. Termination of Tenancy
   d. Waiting list

2. Mental Health:
   a. Impact of moving in
   b. Hospitalisation rate
   c. Status vis-a-vis hospital
   d. Medication
   e. Use of on-call system

3. Benefits Issues:
   a. Community Care Grants
   b. Benefits Tenants receive
   c. Problems with benefits

4. Physical Health

5. Physical Aspects of the Accommodation:
   a. Repairs and maintenance
   b. Use of Common facilities
   c. Tenants views re. flats
   d. Staff views

6. Social:
   a. Social activities
   b. Social Networks
   c. Social Support
   d. Relationships within the scheme

7. Support:
   a. Individual Support Packages - Implementation, Monitoring, Review
   b. Contact with Statutory and Voluntary Agencies

8. Community
   a. Responses & attitudes of the local community

2.2 : Background to the measures implemented.

2.2.1 Quality of Life :

In the evaluation of new community based services for mentally ill people, two main types of data are usually collected. Firstly, descriptions of care settings are made. Here, the service is examined to see whether it actually incorporates the environmental characteristics and care practices which are considered desirable. The second type of information can be categorised under the heading of outcome measures, i.e. finding out how the clients have fared under the new service. Often this involves a comparison between groups of hospital and community based patients or the following up of a single group who have moved from the former to latter setting.

One type of outcome measure is that of Quality of Life (Q.O.L.). Concern has been expressed in the literature about this concept or at least attempts to measure it. It has been pointed out that responses to such enquiries may simply reflect factors such as mood, social desirability, enduring temperamental characteristics or mental state. However, work by both Lehman (1982), and Baker & Intagliata (1982), has demonstrated that assessments incorporating both objective and subjective measures can be done reliably. As Lehman's work focuses more on severely disabled individuals living in the community his quality of life interview schedule was chosen for the present study.

2.2.2 : Social Networks :

An individual's social network comprises the network of social relationships in which that person engages. The structure of a social network can influence a person's social behaviour (e.g. Mitchell, 1969). As not all social relationships may be supportive, it is important to understand the structure of each individual's social network as a starting point for the assessment of social support.

The overall network can be divided into a primary and a secondary network. The primary network is considered to fulfil most social support functions and consists mostly of family and friends (Dean and Lin, 1977; Henderson et. al., 1978). The secondary network is made up of more formal and less personal relationships (Bennett and Morris, 1983). Although there is little evidence relating the characteristics of social networks to mental health, network structures have been found to be important in determining satisfaction with social support (Stokes, 1983), and the uptake of professional services (Birkel and Reppucci, 1983).

2.2.3. : Social Support :

Social support has been linked to psychological symptomatology by many studies (e.g. Cohen et. al., 1984; Henderson, 1981; Thoits, 1982). In particular, it was argued that social factors could influence the course and duration of many disorders, and protect the individual from the deleterious

effects of stress (Caplan, 1974; Cassel, 1976; Cobb,1978). This type of research has led to the emergence of social support as a major focus in community psychology. Support may seem a simple and commonly accepted idea, but all too often the complexity of social support has been only recognised implicitly. The new emphasis on social support suggests that embedded in social ties are basic social processes which enhance general adaptation and assure adjustment to particular stressful events.

According to a number of reviews (e.g. Kessler & McLeod, 1985; Wortman & Conway, 1985) substantial evidence exists to indicate that social support buffers the potentially harmful effects of stress. Several theorists have argued that supportive actions can be divided into different types of assistance or resources, thus implying that the different types may play different roles in dealing with challenging events.

As there are many different ways of measuring social support, it is essential to select a measure which is based on a clear conceptual framework, and which distinguishes between different functions of support (Cohen and Willis, 1985). In this particular study two of the types of support have been examined i.e.:

(i) Emotional support - the expression of feelings that a person is well regarded and valued.
(ii) Practical support - the provision of financial and material resources, as well as actual assistance toward completing a task.

The Significant Others Scale (S.O.S.) used in this study (Power et. al., 1988), measures the perceived adequacy of both emotional and practical support.

2.2.4. : Community Attitudes to Mental Illness :

There is a considerable body of literature (Goffman, 1961), which holds that institutional care has involved the removal, isolation and stigmatisation of the mentally ill. Furthermore, it has been argued that this process has encouraged a public reaction of ignorance, prejudice and rejection (Busfield, 1986). If such stigmatised individuals are to live outside hospitals, then public attitudes towards the care and treatment of people with mental illness become crucially important. These attitudes will influence how the community responds to the resettlement of patients outside hospital.

The community response to people with mental illness may be viewed from a number of perspectives : sociological, psychological and geographical. The sociological perspective (Becker, 1967) emphasises the labelling of mental illness by others as the crucial event in becoming mentally ill. Being mentally ill becomes a 'master status'(Scheff, 1966) by which the individual is defined by others. Labelling theory (Lemert, 1972) suggests that outside of hospital, the individual will still be perceived in terms of his former role as psychiatric patient. As the patient role is a stigmatised

status, the potential for reintegration may be severely limited. People may continue to interpret the patient's actions according to previous status of the patient.

The social-psychological perspective (Rabkin, 1974) places emphasis on the importance of public attitudes in influencing the community response towards people with mental illness. Attitudes are related to social behaviour although the precise nature of this association is unclear. For instance, a person may hold very definite attitudes but may not act upon them. Alternatively, real attitudes may be hidden in order to portray what is perceived to be a socially acceptable response. Bearing these caveats in mind, the measurement of attitudes may be an important indicator of the community response to the resettlement of ex-patients.

The third perspective is that of social geographer (Taylor and Dear, 1981). Such a perspective links tangible factors like proximity, location and neighbourhood to the more intangible factors already mentioned, such as societal reaction and public attitudes (Smith and Giggs, 1988). Public facility location theory (Taylor and Dear, 1981) deals with the spillover effects of public facilities on the surrounding communities. These external variables may be perceived as negative or positive and are an important factor in shaping local attitudes. Facility characteristics like size, design, visibility, and level of supervision are one set of external variables. Neighbourhood characteristics like household composition, house ownership and beliefs about property prices are another.

The Community Attitudes to Mental Illness (CAMI) Scale, used in this study, combines the Opinions about Mental Illness Scale, originally used to measure staff attitudes (Cohen & Struening, 1962), and the Community Mental Health Ideology Scale (Baker & Schulberg, 1967). The CAMI Scale was developed to measure community attitudes to discharged psychiatric patients in Toronto, Canada (Dear & Taylor, 1982).

2.3 : Subjects

This study included interviews with eleven of the twelve tenants who have taken up residency in the Flat Cluster Scheme since May 1990. Of the twelve, eight are females and four males, in the age range 27-60 years, with an average age of 38.6 years.

The tenants had a range of previous living situations, including independent accommodation, hostels, and direct referrals from hospital. One tenant was married, one divorced, two were legally separated, and the remaining eight were single. In addition, staff at the Accommodation Scheme were also asked for their comments regarding the physical characteristics of the Scheme. Permission to carry out the study was granted from the Projects Manager of the Antrim Scheme.

Surveys were also carried out on sixteen households in the neighbourhood of the Flat Cluster Scheme. This sample was predominantly young, female, married with children in public housing and from Social Class III.

2.3 : Material

Several standard questionnaires were used to address the different sections on the evaluation framework, as well as the detailed analysis of records kept on various aspects of the scheme throughout the year.

2.3.1. Quality of Life (Q.O.L.)

The first questionnaire to be administered was the Q.O.L. structured interview schedule (Lehman, 1983). This interview inquired about tenant's quality of life in eight life domains: living situation, family contacts, social contacts, leisure activities, legal problems and victimisation, physical health, mental health and day activity.

The schedule is divided into three sections - overall rating of life, objective ratings in the above life domains, and subjective ratings in those same categories. The global ratings and subjective ratings were all made on a seven point scale and, throughout the results section, scores of 1 and 2 will be regarded as 'low'; 3, 4, or 5 will be 'intermediate/moderate'; and 6 or 7 will be rated as 'high'. Greater variation occurs in the obtainable scores on the objective ratings. However, in the results section, these scores are again broken down into low, intermediate/moderate and high grades.

2.3.2. Social Network

Social networks of the tenants were assessed by using a modified version of the Social Network Interview Schedule developed by Shepherd (1985). This semi-structured interview assesses the primary and secondary networks by exploring various domains of life, such as home, work, family, etc.

2.3.3. Social Support

Social support was assessed using a short form of the Significant Others Scale (Power et. al., 1988). The scale samples a subset of significant relationships that an individual engages in, taking account of perceived type of support (emotional and practical) and quality of support in different relationships. The short form of the scale contains the following 4 questions from the original 10, which had 5 items for emotional support and 5 items for practical support.

(i) Can you trust, talk to frankly and share feelings with x?
(ii) Can you lean on and turn to x in times of difficulty?
(iii) Does x give you practical help?
(iv) Can you spend time with x socially?

The scale was used in a structured interview, using each primary relationship generated from the social network assessment.

2.3.4. Community Attitudes to Mental Illness

The CAMI Scale (Dear & Taylor, 1982) contains the following four dimensions :

a. Authoritarianism - e.g. the need for early hospitalisation.
b. Benevolence - e.g. willingness to become personally involved.
c. Social restrictiveness - e.g. the dangerousness of the mentally ill.
d. Community mental health ideology - e.g. the impact of mental health facilities on local neighbourhoods.

2.3.5. The Neighbourhood Impact of the Local Facility

This was gauged using a four item, five point rating scale, where the subjects were asked to rate their views of the Scheme. Subjects were also asked to explain their views.

2.3.6. Interaction with Tenants.

This was measured using a semi-structured interview with the members of the local community who had contact with the tenants from the Scheme. Questions were designed to assess the problems and difficulties which occurred when former patients and members of the community interacted.

2.4. Procedure

In accordance with the evaluation framework detailed in section 2.1., the data was compiled from a variety of sources. A large proportion of the required information was obtained from tenants' case notes, from management reports, and from other administrative records. As outlined previously, the remainder of the data was collected using structured and semi-structured interview schedules and questionnaires.

2.4.1. Quality of Life (Q.O.L.)

Prior to moving into the Flat Cluster Scheme and whilst resident in psychiatric hospital, seven of the prospective tenants had been interviewed using the Lehman QOL interview schedule. The same interviews were then repeated for the same group of tenants, when they had been resident in the Scheme for approximately one year. Findings from both sets of interviews will be described and discussed in following sections of this report, and comparisons between the group of people who had been interviewed twice will be noted.

Interviews took place in one of two locations - the tenant's own flat or at a sheltered workshop which some of them attended. In both settings, the meetings were held in quiet rooms where privacy was assured and interruption avoided. Interviewees were assured that the format of feedback to Praxis would retain confidentiality. There was some variation in the duration of interviews, but most took between forty-five and sixty minutes.

2.4.2. Social Network

Using a modified version of the Social Network Interview Schedule (Shepherd,1985), both secondary and primary networks were identified. The secondary network was made up of everyone whom tenants identified as people that they would know to talk to. The secondary network was then further broken down into mental health workers, family members, and others. Tenants were also asked how often they would have contact with the individuals whom they had identified.

Within this secondary network, certain individuals can be identified as constituting members of an individual's primary network, i.e. people whom the tenants feel that they depend on to fulfil most of their support functions. Tenants were also asked to list the numbers of these individuals with whom they would have weekly contact.

2.4.3. Social Support

Using a short form of the Significant Others Scale as outlined in section 2.3.3 (Power et al.,1988), tenants were asked to think about individuals with whom they had a significant relationship. For each of these people, tenants were then asked to rate on a 5 point scale the amount of actual practical and emotional support which they felt that they received. Tenants were then asked to think about the amount of practical and emotional support which they would ideally like to receive, and again rate it on the same 5 point scale. For the purposes of this study, scores of <2.5 = low; 2.6 - 3.5 = moderate; and >3.6 = high. Discrepancy scores were then calculated for both practical and emotional support, by subtracting actual support from ideal support, thereby giving an indication as to the adequacy of the social support.

2.4.4. Community Attitudes to Mental Illness (CAMI)

The overall sample (n=114) consisted of the following :

a. Households from three neighbourhoods containing sheltered accommodation for individuals with mental ill health.
b. Relatives of ex-patients who had been resettled through the rehabilitation process.
c. Volunteers, primarily Praxis Befrienders, who were part of the social network of ex-patients.
d. A sample of third and fourth form pupils from a local secondary school.

Sixteen houses in the neighbourhood of the Praxis Accommodation Scheme were surveyed, between January and March 1991, with regard to attitudes towards mental illness in general, and also attitudes towards the community care policy. Households were randomly selected from the streets adjacent to the Scheme. The Respondent was an adult member of the household who was willing to be interviewed. The sub-sample were predominantly female, married with children, between 21 and 40 years of age, either housewives or in employment, and belonging to Social Class III. These characteristics were broadly similar to the main sample.

Attitudes towards community care policies were gauged using a 4 item questionnaire containing 3 forced choice type questions. The fourth question asked whether residents in the local neighbourhood were aware of mental health accommodation in their area. Respondents were then asked to complete the (CAMI) scale.

The CAMI scale contains 40 general statements about mental illness. Respondents were asked to rate how they felt about the statements on a 5 point scale ranging from "Strongly Agree" through to "Strongly Disagree". Their responses elicited their attitudes to mental illness along the four dimensions of authoritarianism, benevolence, social restrictiveness, and community mental health ideology.

In scoring the positively stated Likert items, 'strongly agree' = 1; 'agree' = 2 etc. The scoring is reversed for negatively worded items. Thus, responses indicating a positive attitude towards people with a mental illness result in low scores.

2.4.5. The Neighbourhood Impact of the Local Facility.

Respondents were also asked to rate on a 5 point scale how acceptable they would find an accommodation scheme in their area, ranging from "Extremely Desirable" to "Extremely Undesirable", if they were unaware of an accommodation scheme in their area.

If respondents were aware of the local scheme, they were asked to rate their views of the local facility, again on a 5 point scale, ranging from "Strongly in favour" to "Strongly against".

Respondents were then asked whether they had any contact with the residents, and, if they had, they were then asked several questions about the nature of the interaction.

2.4.6. Interaction with Tenants

The interviewer identified "typical" situations of concrete interaction between tenants and respondents using guidelines identified in the Interaction Schedule. These guidelines covered areas such as comprehension, appearance, perception, unpredictability, inactivity, relationships, fear,

reality orientation, manner, and mood. From this, the interviewer attempted to elicit any difficulties and types of responses made, during interactions of members of the local community with the tenants of the Flat Cluster Scheme.

3.0. : FINDINGS OF THE STUDY

The findings will be presented, and discussed, in the same order as in the evaluation framework outlined previously in the method section.

3.1. Occupancy

3.1.1. Occupancy Levels

The period covered by this study extends from May 1990 through to May 1991. The full level of occupancy is 12 tenants, and this was reached for three months. The drop to 11 tenants occurred as a result of one tenant moving out of the scheme in March 1991.

Although tenants who are selected for the scheme may remain in the scheme for as long as they wish, it emerged during the Lehman interviews, that more than 50% of the tenants did not regard their present location as permanent. They felt that it represented a stepping stone to having a place of their own, and achieving greater independence. It was encouraging to note that the Tenants regarded the Accommodation Scheme and Support system as a means of helping them achieve greater levels of independence, as one of the aims of the Flat Cluster Scheme is, to encourage and facilitate, with appropriate support, optimum levels of independence.

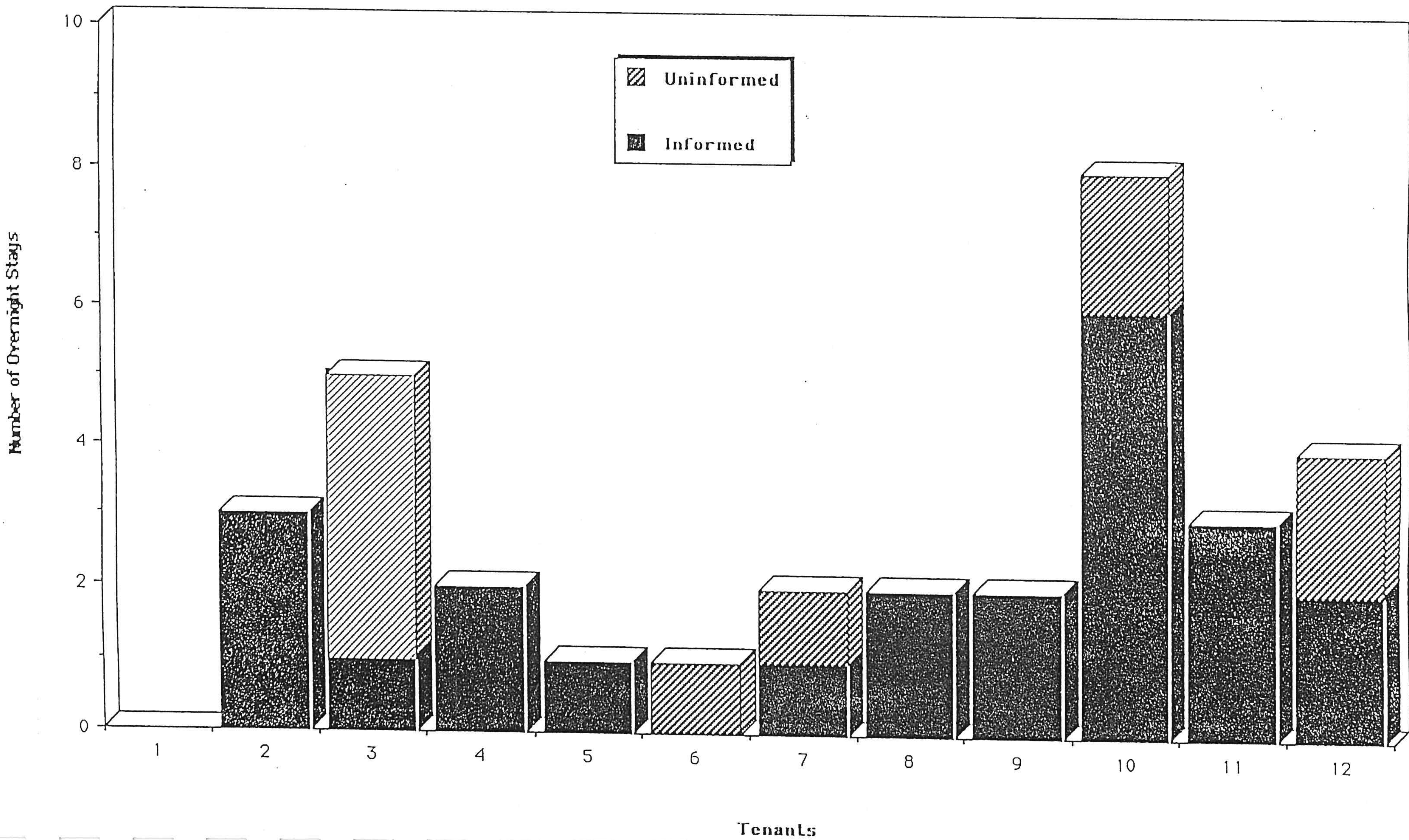
3.1.2. Overnight Stays away from the Accommodation

For the majority of the tenants, living in the Flat Cluster Scheme has been a totally unfamiliar living situation. As the tenants are a particularly vulnerable group of people, it was decided to monitor the number of overnight stays away from the accommodation, for each of the 12 tenants. This would include occasions when staff at the scheme had been informed about the tenants intentions to stay away overnight, and also times when tenants had not informed staff that they would not be returning to the scheme in the evening. However, care needs to be taken in order to balance independence with risk. Figure 1 shows the distribution of these overnight stays for each of the tenants. Only one of the tenants has not spent any nights away from the accommodation. In total, there were 33 overnight stays away from the accommodation. On 10 of these occasions, tenants had not informed staff of their intentions to stay away overnight, but on the remaining 23 occasions, tenants had mentioned to staff in advance that they would not be returning to their flats in the evening.

3.1.3. Termination of Tenancy

Between May 1990 and May 1991, only one of the tenants decided to terminate their tenancy, in order to get married. However, 2 tenants have expressed a desire to leave the Praxis Scheme, one

Figure 1 : Number of Overnight Stays away from the Accommodation Scheme.



to return to her husband, and the other intending to lead a completely independent life. To date, these requests have not been taken any further by the tenants in question.

3.1.4. Waiting List

At the time of writing, one application is being discussed.

3.2. Mental Health

3.2.1. Impact of Moving in.

Much of the information obtained in this area was derived from the Quality of Life Interviews using the Lehman interview schedule, as described in the Method section.
The results will be presented in two sections :

(i) Tenants perceptions of life now.
(ii) A comparison between perception of life now and life in hospital.

(i) Life now.

(a) Global Well Being Scales

On all of the global well being measures the majority of tenants rated themselves in the high or intermediate category (only one was in the low range). Likewise, when asked their feelings about the future, all except one were in the same two categories.

(b) Objective Ratings in Life Domains

The objective life domain of "living situation" was further divided into the areas of comfort, independence, cohesion, and influence. Some interesting differences emerged between these. It was clear that everyone thought the flats were comfortable and of a very high standard. The scheme also ranked highly in terms of independence, and tenants generally felt that they could have as much, or as little of this as they needed. The picture emerging from the questions about cohesion is not quite so simple. This concept examines the degree of cooperative work and sense of community between staff and tenants and between tenants themselves. If one separates these two elements then a high degree of staff-client cohesion is found, but that between tenants is low. Despite the lack of tenant-tenant cohesion noted, on the whole, respondents had either high or moderate frequency of contact with fellow tenants. There were fewer contacts with people outside the scheme, but the majority of people fell into the moderate category. The findings with regard to influence are the most varied with almost equal number of tenants reporting high, moderate or low degrees of this concept.

It emerged that nobody had been a victim of a crime or had got into difficulties with the authorities. This may not seem surprising, but it is in marked contrast to the experiences of discharged psychiatric patients in other parts of the world(e.g. Lehman, 1982). However, tenants had expressed some concern regarding their safety, so perhaps some means of addressing such fears should be considered. The majority of people had detailed knowledge of how to get legal help if required.

However, two incidents of vandalism to the flats had occurred, and had been distressing for tenants. It was reassuring to note that the flats were not the sole target of the vandalism, but that other properties in the vicinity had also received some damage. Therefore, it can be concluded that the vandalism was simply random, and not as intended victimisation for the tenants.

(c) Subjective Ratings in Life Domains.

Over most life domains the majority of tenants expressed high or moderate levels of satisfaction. Therefore it is probably the exceptions to this rule which are of most interest. Most dissatisfaction is expressed about unemployment - no one rated themselves as highly satisfied with this situation. Although this finding is not surprising, an explanation of it must take into account that these same individuals were on the whole satisfied with their financial position and their attendance at sheltered work.

The two other areas in which a greater degree of dissatisfaction was expressed were leisure activities and safety. Specifically, tenants would have welcomed more opportunities for leisure activities and some had quite strong fears about their safety e.g. in relation to the vandalism mentioned above or concerns about sectarian violence that might be directed towards them.

<u>(ii) A Comparison Between Life Now and Life in the Hospital.</u>

Seven tenants in the scheme had been interviewed using the same instrument when they were still in a psychiatric hospital. Therefore, it was possible to make a direct comparison between their perceptions of both places and times. Statistical comparisons were carried out using the Wilcoxon Signed Ranks Test.

One comparison which reached statistical significance showed that tenants in the accommodation scheme were more aware of how to access legal help if required than they had been whilst in hospital ($p<0.05$). All other comparisons, whether global, objective or subjective ratings were considered, failed to yield significant results.

Another factor which showed a trend i.e. ($p<0.1$) was the number of leisure activities. Respondents had more leisure pursuits in hospital than in the community setting, although satisfaction with leisure activities did not differentiate between the group.

From the series of interviews, and scoring of the questionnaires, it was seen that tenants expressed high levels of satisfaction with their living arrangements and generally viewed their quality of life as good.

Only one tenant expressed a wish to return to hospital or move into a hostel. The remainder of the tenants wished to remain in the scheme, mainly due to there being a greater sense of freedom in the Flat Cluster Scheme, when compared to the hospital. Although this feeling of independence was regarded as one of the scheme's great attractions, at the same time, several tenants did feel that there were too many people, both from Praxis and Statutory Services, organising their lives. Some went as far as saying that it was little different from hospital in this regard.

As mentioned previously, the majority of tenants had expressed dissatisfaction with being unemployed. This complaint was noted both in a hospital setting and when individuals are in the community. In reality, however, the possibility of significant numbers of ex-psychiatric patients achieving full employment in the economic realities of Northern Ireland is unlikely, but as such an issue is of great importance, it would be desirable that active responses such as liaison with the job placement officer of I.T.O. are seen to be made.

The overall levels of satisfaction and dissatisfaction remained remarkably similar over time and different living situations. Obviously the small numbers of subjects mitigates against uncovering significant differences although an alternative hypothesis may be that the responses reflect the fairly stable temperamental characteristics of those questioned. However, an examination of individual raw data and responses to the question "Where would you rather be ?" revealed that tenants do distinguish between the hospital and community settings. Generally, both were seen positively, but a preference was expressed for living within the Praxis Scheme.

3.2.2. Hospitalisation Rate

Another of the original aims of the Flat Cluster Scheme is :
"To prevent Tenants from becoming involved in a revolving door pattern of frequent readmissions to hospital by monitoring tenants well-being, and responding quickly to any change in needs".

Throughout the first year of operation of the scheme, the total number of days spent in acute hospital care by the tenants was 69. In the year prior to entry to the scheme, the total number of days in hospital was 136. This shows that the figure has been almost halved. While this reduction may not be due solely to the scheme, it is likely that the comprehensive support and monitoring provided by

both Praxis staff and Statutory services has played a major contributing role in the reduction of number of days spent in hospital.

3.2.3. Status vis-a-vis hospital

Initially, the majority of tenants were officially classed as being either 'discharged' or 'on-leave' from the hospital. One tenant was classed as being 'detained'. All tenants are now officially regarded as 'discharged'.

3.2.4. Medication

Throughout the period of this evaluation, apart from minor adjustments, there were no significant changes in medication regimes for tenants.

3.2.5. Use of On-Call System

Praxis provides 24 hours-a-day support by means of an on-call system, whereby a member of staff can be contacted outside of hours, if needed. For the period May 1990 - May 1991, the on-call system was used a total of 15 times. Figure 2 shows the use of the on-call system compared to the occupancy level for the first year of operation of the scheme. Figure 3 shows the actual breakdown of number of calls made by each of the tenants. Only 5 of the tenants have made use of the system, with one particular tenant being responsible for 7 uses of the on-call system. The majority of calls were made if tenants were anxious, experiencing panic attacks, feeling unwell, or if they were concerned about the possibility of vandalism occurring.

Initial contact with the tenant is made by telephone, but if needed, a staff member will visit the tenant in question. Usually, reassurance from Praxis staff is adequate, but on certain occasions, statutory services have had to be contacted. This prompt action and close monitoring could be regarded as a contributing factor to the decrease in hospitalisation rates.

3.3 Benefits Issues

3.3.1. Community Care Grants

Eight of the twelve tenants were in receipt of community care grants ranging from £330 to £915. The remaining four tenants who did not receive grants were deemed not to be entitled to receipt of such awards, because they were not in receipt of Income Support. However, two of the tenants who had been in receipt of a community care grant in the past, were allocated a smaller sum due to their individual circumstances.

Figure 2 : Use of On-Call System compared to Occupancy Level

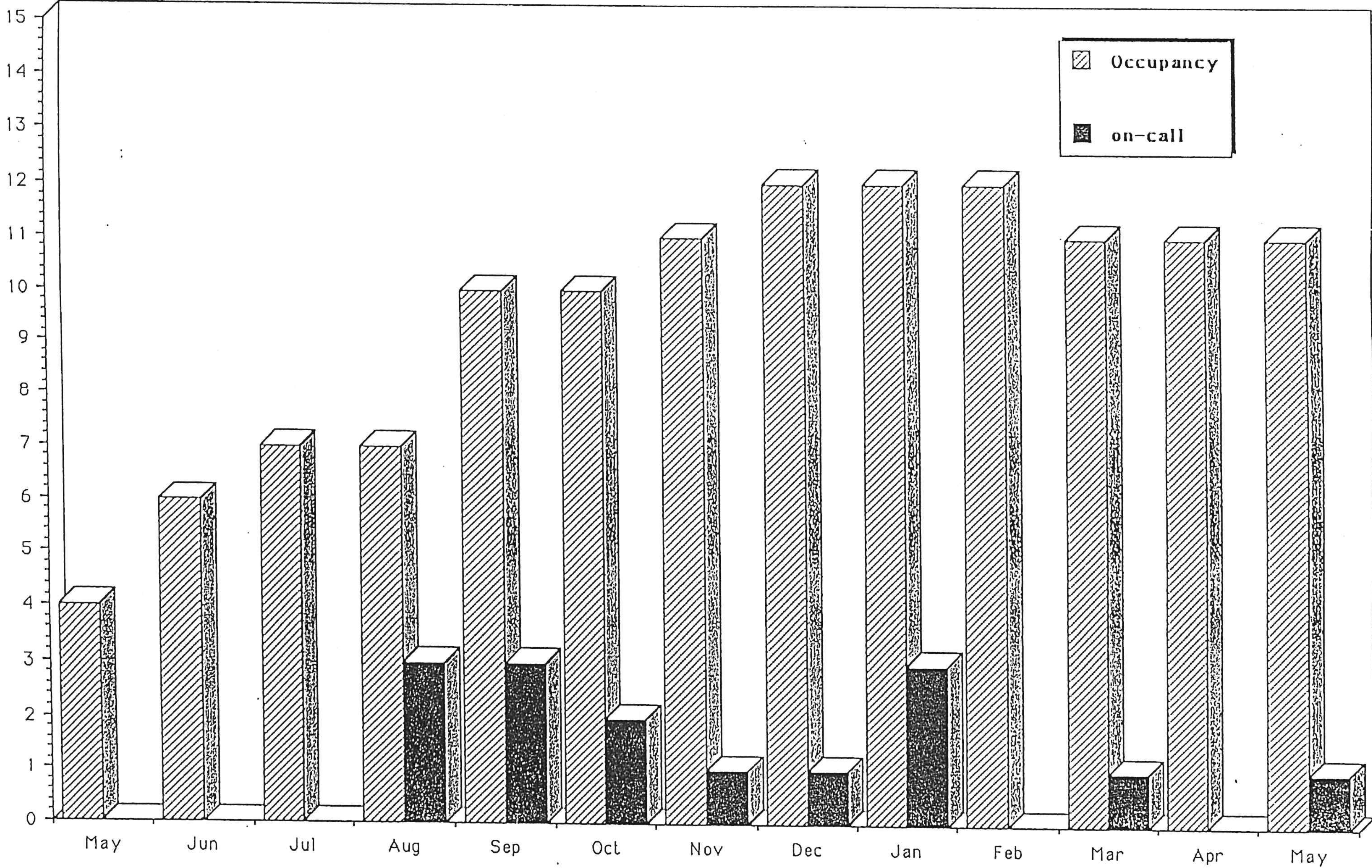
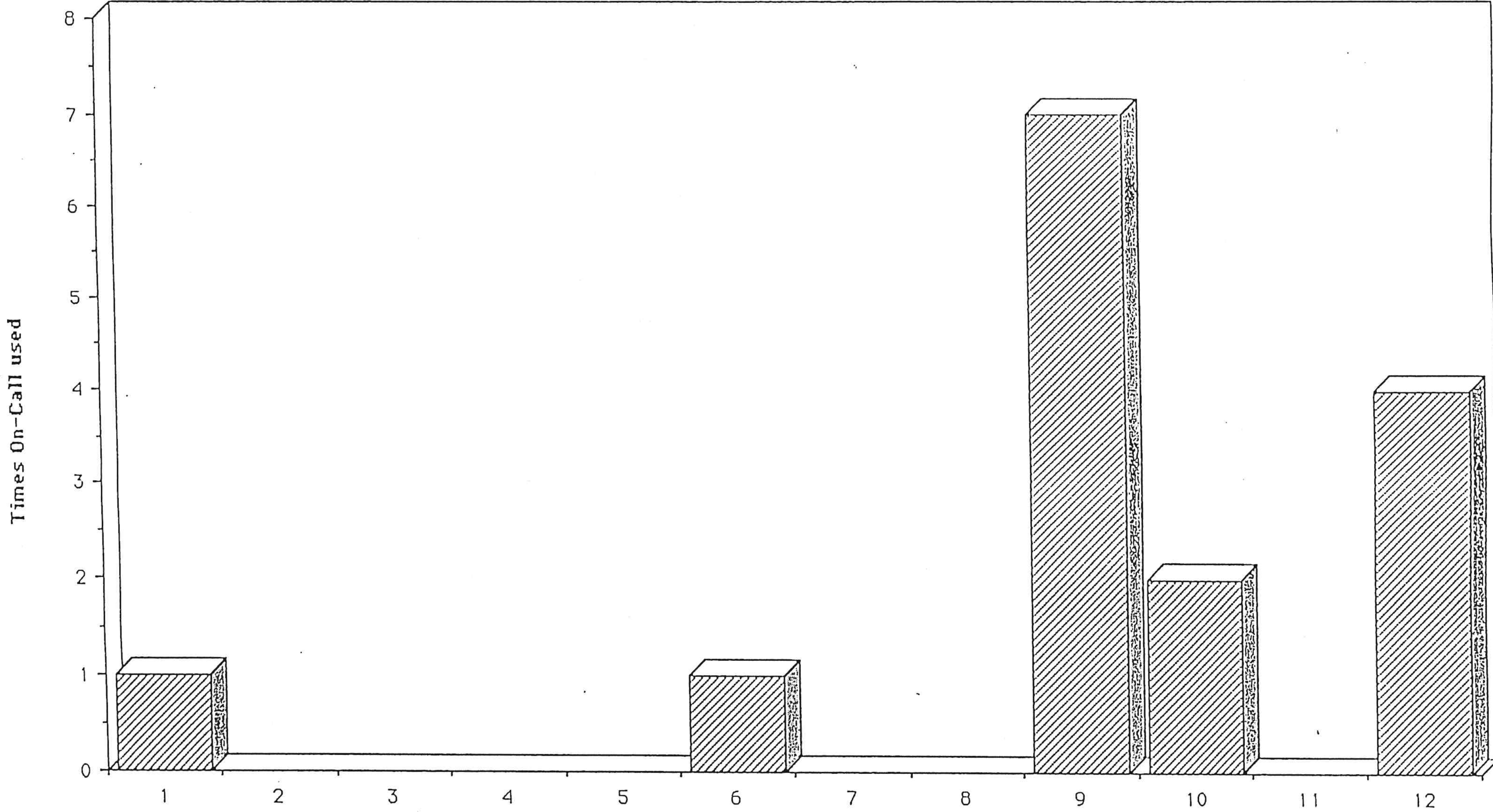


Figure 3 : Number of Times Individual Tenants Have Used On-Call System.



Although not all tenants received community care grants, each tenant's flat was furnished to the same standard. The procedure for obtaining these grants meant that the money came to Praxis, who then purchased articles of furniture for that particular tenant.

If a tenant chooses to leave the scheme, they either have the choice of taking the furniture which was purchased with the community care grant, or they can sell the furniture to Praxis. This system ensures that the tenants do not lose any property, and applies to everything on the itemised list which is credited against the grant.

On entry to the scheme, tenants were also given £100 with which they could purchase personal items for their flat. Again, on leaving the scheme, these items would be taken by the tenant who had purchased them.

3.3.2. Benefits Tenants Receive

Some of the tenants are in receipt of Income Support, some Severe Disablement Allowance, and others Invalidity Benefit. In addition, all twelve tenants receive housing benefit.

3.3.3. Problems with Benefits

It was reassuring to note that tenants did not endure any serious problems re. payment of benefits. Any minor delays in payment, were promptly sorted out by Praxis staff. This area is an important issue, as delays in payment of benefits can have serious implications for individuals who are attempting to settle into the community, and take responsibility for their financial affairs.

3.4. Physical Health

Overall, there were no major problems regarding the physical health of the tenants. However, there have been several occasions where tenants could have been at risk from self-injury, but due to the nature of support and monitoring provided by Praxis and Statutory Services, action was promptly taken to ensure that the tenants in question did not come to any harm.

Minor problems are usually dealt with by contacting a member of staff who would then visit the tenant prior to contacting the G.P.

One tenant was required to attend an outpatients clinic at a Belfast Hospital on several occasions. Here, the tenant was accompanied by one of the Community Assistants, on each visit.

From the Lehman interview, no one noted their overall health condition to be poor - everyone fell into the fair, good or excellent categories. All tenants were receiving ongoing mental health care and knew how to access this if required in an emergency.

It has emerged that alcohol misuse is a pertinent issue for two of the tenants. Praxis staff are instructed to monitor this aspect very closely, and to discourage the tenants in question from engaging in alcohol abuse.

3.5. Physical Aspects of the Accommodation.

3.5.1. Repairs and Maintenance

There have been several problems with some of the structural aspects of the flats, mainly due to it being a newly renovated building, and hence building defects are to be expected. These defects were reported to Open Door Housing Association and the firm of contractors. Throughout the first year of operation of the Scheme, these defects have been dealt with, and maintenance work has been undertaken. However, steps have been taken to ensure that repairs are carried out as soon as possible after they come to light. A schedule of repairs has been implemented, and is reviewed on a regular basis, leading to an effective system of repairs being in operation.

Other faults regarding interior furnishings and electrical appliances have been dealt with as quickly as possible. A Praxis Handyperson is employed for everyday repairs. However, there has been an on-going fault with some of the laundry equipment, which has been reported to, and dealt with, by the appropriate persons. Unfortunately, one of the Tumble Driers still presents a problem, but action has been taken to ensure that the appropriate venting is installed.This has had implications for the tenants, who have been unable to use the equipment in their block of flats, and who have had to use the equipment in the other block of flats.

3.5.2. Use of Common Facilities

As mentioned in the introduction, both blocks of flats have shared laundry facilities and a communal room. Laundry facilities are used by all the tenants, initially with supervision by the Community Assistants who work to provide support for the tenants. The majority of tenants can now use the laundry facilities totally independently.

The communal room in each block provides a place where tenants have the opportunity to meet and socialise together, and for informal interaction with the Community Assistants. Each room contains a Television, tea and coffee making facilities, and several recreational activities such as board games, which were requested by the tenants.

It is pleasing to note that the majority of tenants use this facility. Indeed, one tenant was reported to use this facility even more than their own flat. This, in itself, is a cause for concern in that it may suggest that, for that individual, feelings of loneliness would be a pertinent issue. On the opposite end of the spectrum, one tenant is very reluctant to go into the communal room, preferring to remain alone in their flat. This particular tenant is actively encouraged to use the common room and to interact more frequently with the other tenants. Although the facility is utilised, there have been criticisms of the communal room which will be noted in the recommendations section.

3.5.3. Tenants views re. Flats.

Much of the opinions emerged during the Lehman's Quality of Life Interviews, and also from the weekly tenants meetings. It was clear that all of the tenants thought that the flats were comfortable and of a very high standard. After scoring the questionnaires, it was obvious that the tenants expressed high levels of satisfaction with their living arrangements and generally viewed their quality of life as good.

When asked whether they preferred living in the scheme or in their previous accommodation (for most people this meant hospital), ten chose the Flat Cluster Scheme and only one wanted to return to either a hostel or hospital.

Also emerging from the Lehman interviews were several areas of dissatisfaction. One complaint which was widely expressed, was about sound insulation between flats. Noise seemed to carry very easily between them e.g. conversations or the noise of the water/plumbing system. There also seemed to be dissatisfaction about rules governing the communal areas where there appeared to be some conflict between individual and collective responsibilities.

In addition, tenants had a choice in selecting their furnishings, yet it was noted that this choice was not wide enough, as many tenants ended up with the same curtains, fabrics and colour schemes. This is an important issue for Praxis as one of the scheme's aims is to "provide a quality environment consistent with what other citizens are entitled to expect with regard to individual choice". However, the practicalities of allowing total freedom of choice with furnishings may have severe financial implications. This is an issue which could be taken into consideration when planning future schemes. This restricted choice was also highlighted and echoed by staff members, who felt that a greater variety in interior decorations and furnishings would provide a more personal, lived-in atmosphere.

3.5.4. Staff Views re. Flats.

All members of the accommodation scheme staff were asked for their opinion regarding the physical aspects of the flats. Again , all staff agreed that the standard of the flats was excellent, and that they

were, indeed very comfortable. However, the staff did make a few suggestions as to what they would consider as improvements :

(i) A bigger communal room, ideally with a Cafeteria Bar.
(ii) Some coloured paint on the walls giving the Flats and Communal Rooms a more personal, lived- in atmosphere.
(iii) Screens should be placed on switch panels at 44 and 165 Rathkyle to give more space in Communal areas.
(iv) Gaps should be left in the fences between gardens for easier access if tenants need to use the bleep system in the Communal Room, especially late at night.
(v) If the flats had one main entrance to each block with flats leading off, this would mean that tenants wishing to use the telephone etc. would not have to come outside the building.
(vi) Telephones in each flat, with the tenants responsible for payment of rental and bills etc.

Any potential problems which the current layout may present, have not been an issue so far. However, it may be suggested that difficulties may arise if tenants need to access the on-call system in times of difficulty. Telephone facilities are provided in the communal rooms. Therefore, if a tenant is feeling anxious, unwell, threatened etc., they have to leave the security of their own flat, in order to contact the staff-member on call. An alternative solution would be to install telephones in each flat, with tenants being responsible for the rental and payment of bills. This would involve further assistance with budgeting for several of the tenants.

3.6. Social aspects.

3.6.1. Social Activities

Of the sixteen leisure activities listed within the Lehman Interview for objective ratings, tenants had engaged in an average of nine during the week preceding interview. All respondents fell into the intermediate category in relation to leisure pursuits. In addition, tenants expressed a degree of dissatisfaction regarding their leisure activities, and would have welcomed more opportunities for leisure activities.

When leisure activities were compared between life in the Flats and life in the Hospital, using the Wilcoxon Signed Ranks Test, there was a slight trend (i.e. $p<0.1$). Respondents had more leisure pursuits in hospital than in the community setting, although satisfaction with leisure activities did not differentiate between the group. This study highlighted the general dissatisfaction with leisure activities. For all tenants, the opportunities for leisure activities were reduced, in comparison to life in hospital. This finding closely parallels the work of Prior (1991) who echoed in his study of discharged patients that ex-patients were no more involved in activities than in-patients, and that

people discharged 'home' were relatively inactive. Dr Prior also quotes that this can lead to further isolation and feelings of dissatisfaction with life, ultimately resulting in a return to hospital.

All respondents were also asked a question about good or bad experiences during the week prior to their interview. A noticeable number of tenants cited as an enjoyable activity either a visit to the Rehability Resource centre or participating in one of the outings organised by this group. Rehability is a voluntary group which organises and facilitates leisure, recreational and holiday activities for people with a chronic mental illness living in the community. As many tenants mentioned Rehability, it would appear to confirm the need for maintaining, if not increasing, opportunities for social activities sensitive to the needs of individuals with chronic mental illness.

3.6.2. Social Networks

From the Social Network Interview Schedule (Shepherd, 1985), characteristics of the secondary and primary networks of the tenants were highlighted. Table 1 shows the summary data for the secondary networks. The total network size for each tenant ranges from 10 to 60 individuals, with a mean number of 31. The number of mental health workers (i.e. both Praxis and Statutory staff) identified within each network ranges from 5 to 19, with a mean number of 7.5. As a percentage of the total networks, the range for mental health workers is from 15% to 50%, with a mean of 26%.

The number of family members identified in the secondary networks ranges from 2 to 13, with a mean of 6. As a percentage of the total, the numbers of family members mentioned ranges from 7% to 41%, with a mean of 22%.

The remainder of the secondary network group were classified as "others", with a range of 2 to 36 individuals being identified, and a mean number of 17. This group constitutes the largest proportion of the secondary networks, with a range of 20% to 72%, and a mean of 53% of the total.

The proportion of family members, mental health workers, and other individuals included in the secondary networks can be viewed in Figure 4, which shows the breakdown for each individual tenant.

Figure 5 shows the numbers of mental health workers and family members seen weekly by each of the tenants. The number of mental health workers seen weekly ranges from 1 to 11, with a mean number of 5. The number of family members seen weekly ranges from 0 to 4, with a mean number of 1, showing that the tenants would have more frequent contact with mental health workers than with members of their families.

From the secondary networks identified, tenants then named those individuals they felt were most important to them and with whom they would not wish to be without; this group constituted the primary network.

TABLE 1 : CHARACTERISTICS OF TENANTS' SECONDARY NETWORKS

TENANTS	TOTAL IN NETWORK	OTHERS	% OF TOTAL	MEN. HEALTH WORKERS	% OF TOTAL	FAMILY	% OF TOTAL
1	28	20	72	6	21	2	7
2	39	20	52	6	15	13	33
3	38	22	58	8	21	8	21
4	60	36	60	19	32	5	8
5	29	18	61	7	24	4	15
6	34	21	62	9	26	4	12
7	26	12	46	5	19	9	35
8*	--	--	--	--	--	--	--
9	22	7	32	6	27	9	41
10	10	2	20	5	50	3	30
11	23	11	48	6	26	6	26
12	30	21	70		20	3	10
MEAN	31	17	53			6	22
S.D.							
RANGE	10 - 60	2 - 36	20 - 72	5 - 19	15 - 50	2 - 13	7 - 41

* Data unavailable for Tenant

Figure 4 : Breakdown of Tenant's Secondary Networks into Numbers of Family, Mental Health Workers and Others

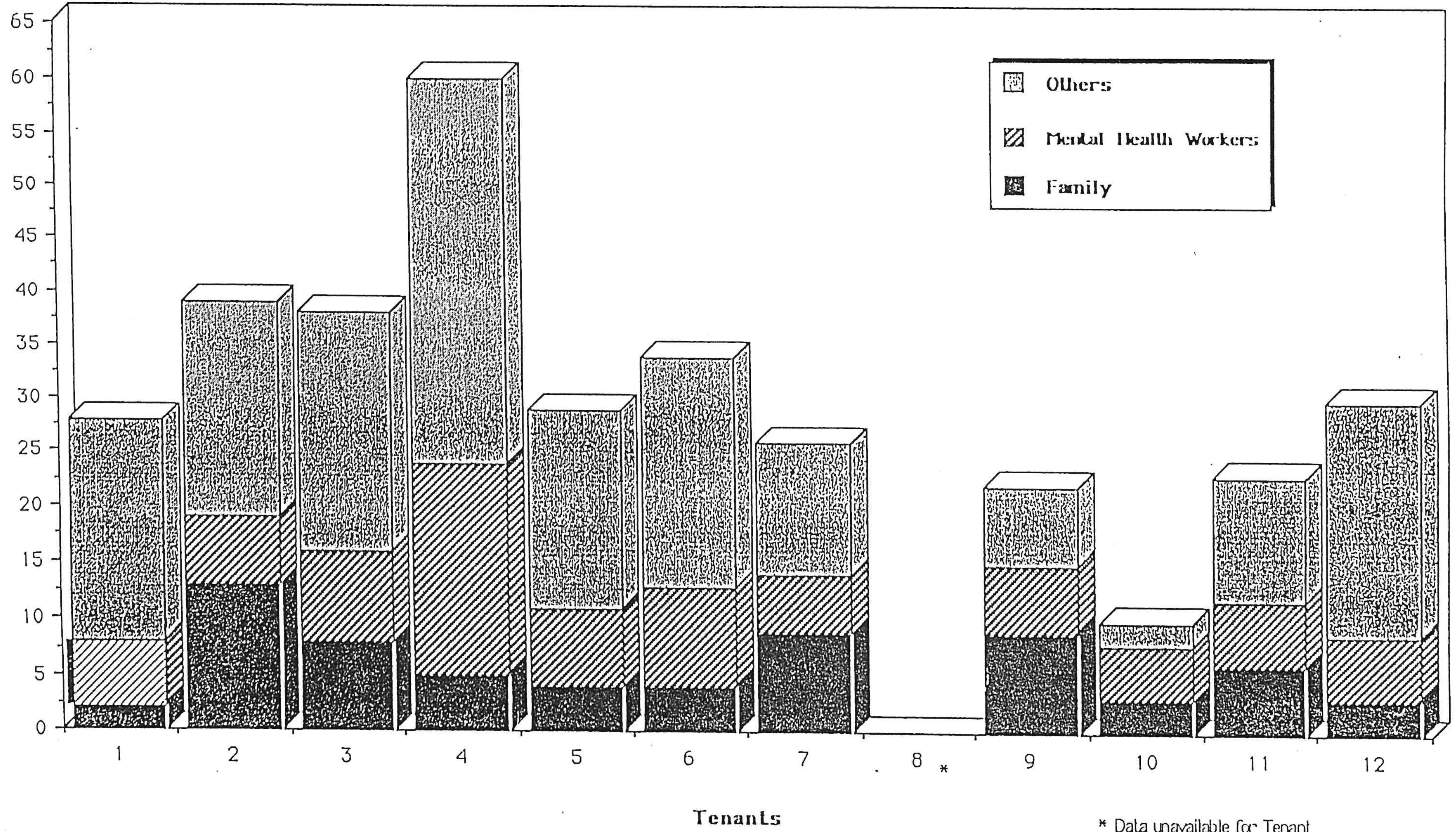
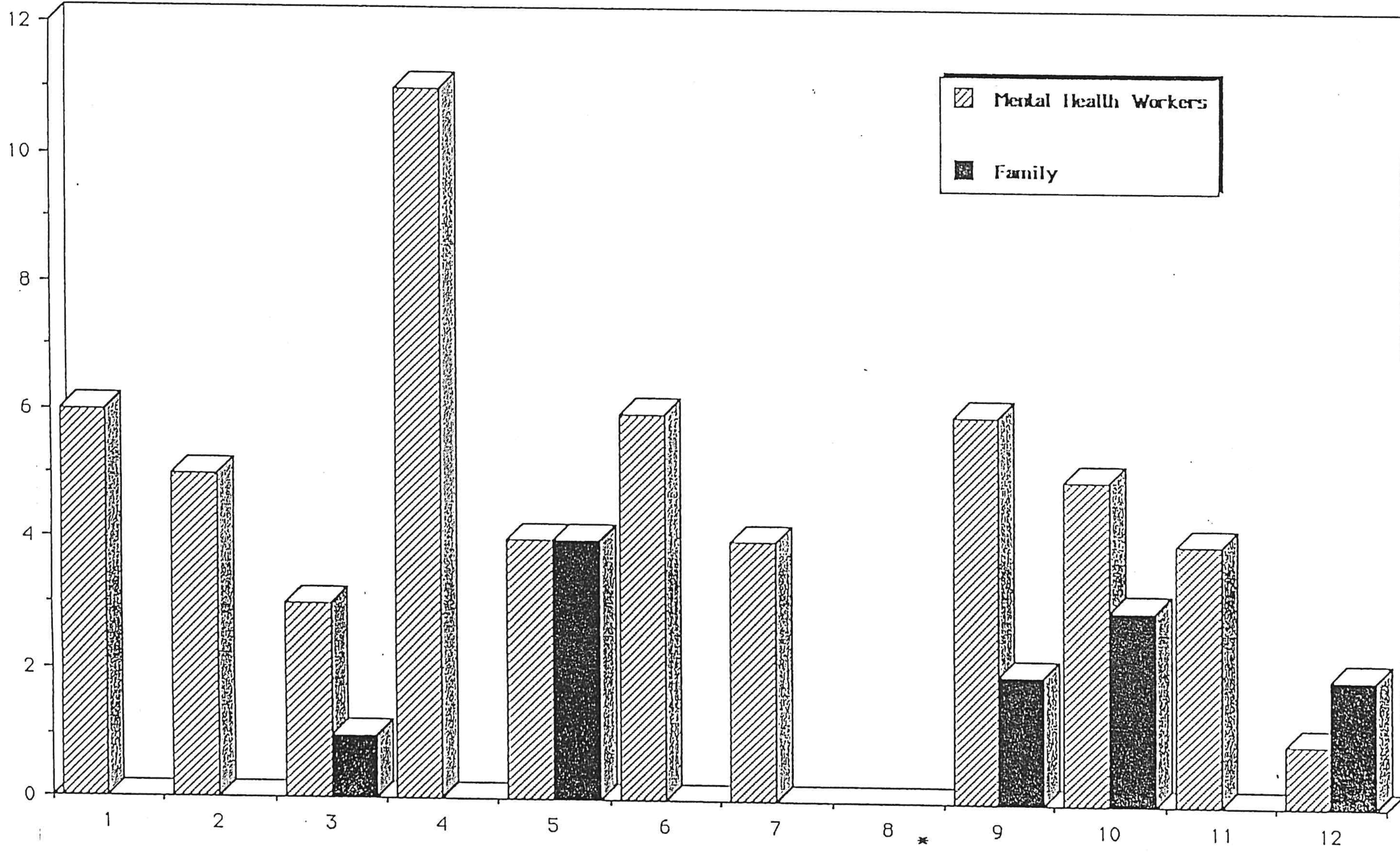


Figure 5 : Number of Mental Health Workers and Family Members seen weekly by each of the Tenants.



The size of the tenants' Primary Networks ranged from 4 to 10 individuals, with a mean of 7. Weekly contact with members of the Primary Network ranges from 3 to 6 individuals, having a mean number of 4. The numbers of individuals within the Primary Network with whom there is weekly contact can also be seen in Figure 6.

The tenants reported a wide range of secondary network sizes (10 - 60 individuals, with a mean of 31). In comparison to a "normal" sample, these figures are very low, with a large percentage being mental health workers (including Praxis staff and Statutory Services personnel). This corresponds to previous findings, e.g. Thompson (1989) : that chronic psychiatric patients have a large proportion of professional contacts listed in their social networks.

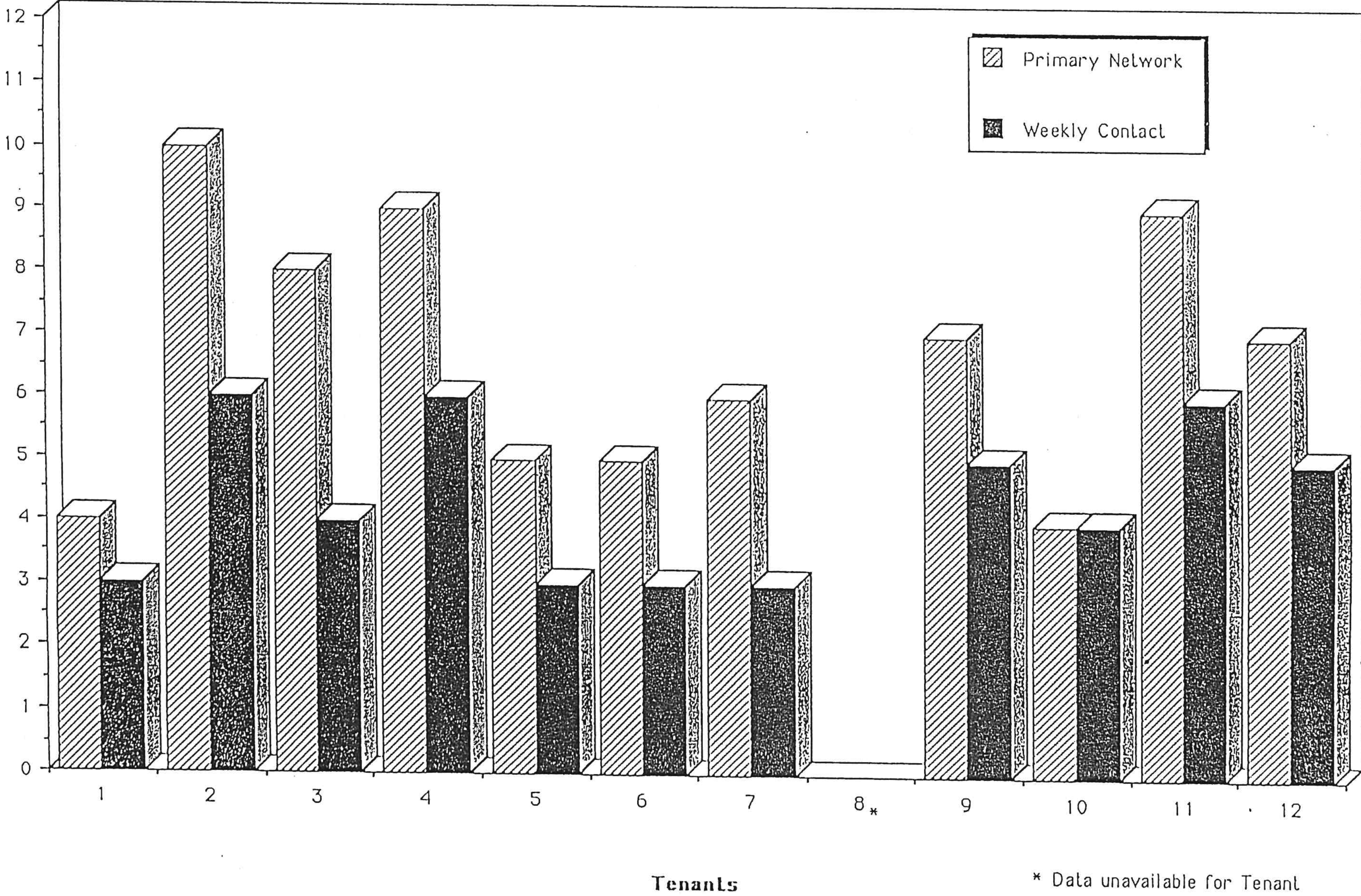
For Praxis tenants, the large number of mental health workers reported as being seen weekly (mean = 5), may be due to the nature of the support given by the Flat Cluster Scheme, and the undertaking of Statutory Professionals from the NH&SSB of a commitment to provide a high level of support. A reduction in the level of professional contact may be possible in the Praxis Accommodation Scheme, however, more 'natural' helping networks would probably need to be established prior to any change of this kind.

Primary network size in a 'normal' sample is considered to be approximately 40 in number, of which between 6 and 10 are known intimately (Hammer et. al., 1978; Henderson et. al., 1981). In contrast, the primary networks of neurotic patients range from 10 to 12 people, whilst those of people suffering from schizophrenia are only 4 to 5 people, and usually comprise family members (Henderson, 1980: McFarlane et.al., 1981: Tolsdorf, 1976).

The findings from the tenant group closely resemble those of previous work in this area. Tenants' primary network size ranged from 4 to 10, with a mean number of 7. Research into the importance of social networks has begun to provide indications as to how chronic psychiatric patients can be successfully supported in the community. If social networks provide a framework for social support, then it could be proposed that, modification of social networks may improve levels of social support.

The Lehman Interview highlighted that all of the tenants had some contact with their families, and only two of the eleven had low frequency contact. With regard to other social contacts only one person had a low number of social contacts, but interestingly, this same individual expressed themselves as very satisfied with the amount of social contact they had. The two people who fell into the high category on this dimension were the only ones who had an ongoing relationship with someone of the opposite gender.

Figure 6 : Size of Primary Network and Weekly Contact with Network Members



* Data unavailable for Tenant

Figure 7 shows the findings from the interviews using the Significant Others Scale (SOS). This measures social support received by the tenants from members of their primary network. The two graphs show a comparison between perceived levels of actual and perceived levels of ideal support for the tenants as a group. Results were divided into either high, moderate or low levels of perceived support, for both emotional and practical support, and frequency of occurrences in each category were noted. The actual ratings for each tenant can be seen in Appendix 1.

With regard to perceived levels of actual support, it can be seen that all tenants rated their emotional support level as being moderate or high, with tenants being almost evenly divided between the two categories. The majority of tenants also rated their levels of practical support as being moderate, only one tenant reported a low level of practical support, and no one rated themselves as being in receipt of high levels of practical support.

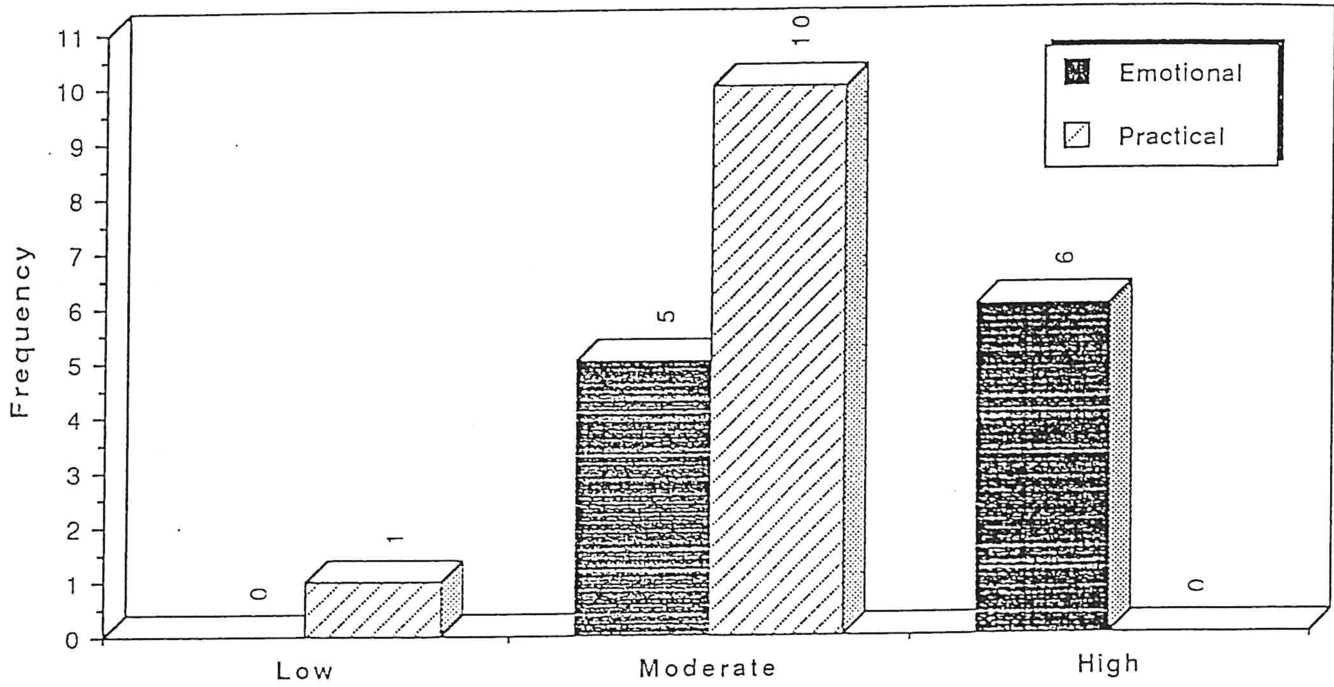
The second graph displays how the tenants rated their ideal levels of support, again, for both emotional and practical support. In this case, again, no-one rated their ideal level of emotional support as being low, all the tenants rated their ideal levels as being either in the moderate or high category. In this instance, the majority of tenants stated that their ideal levels of emotional support would fall into the high category.

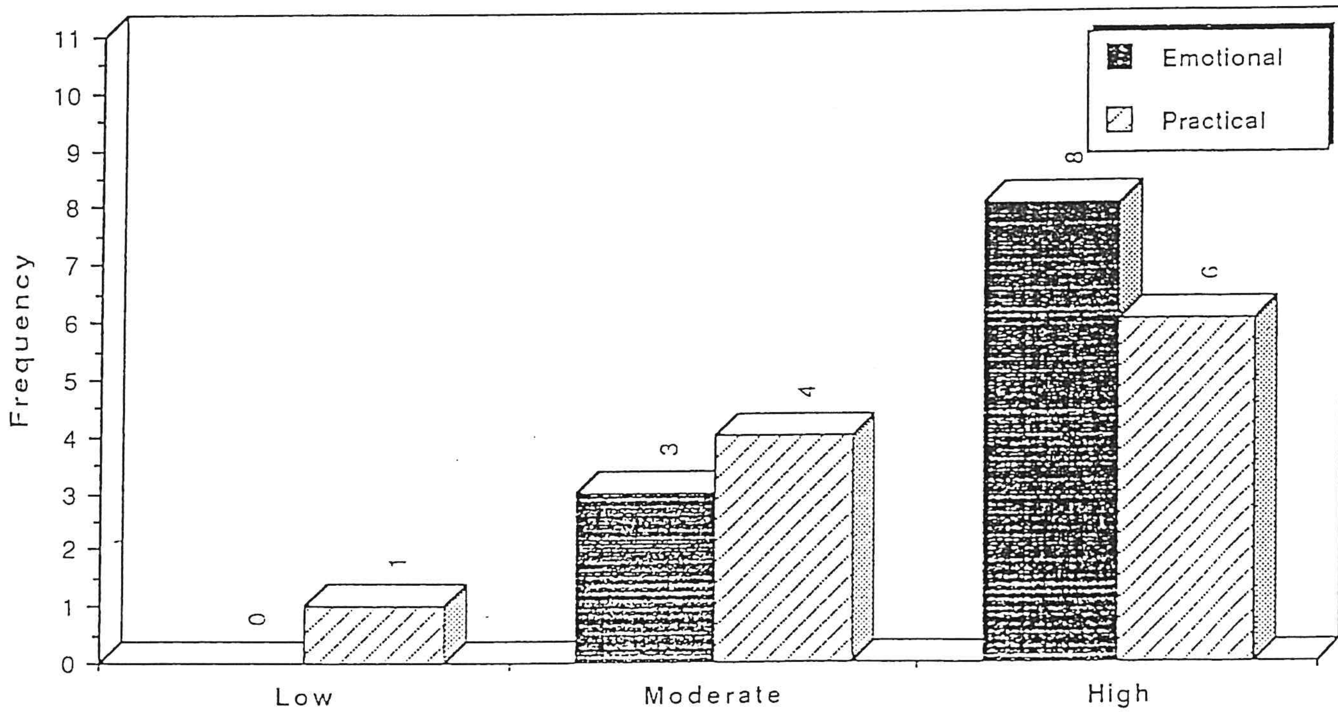
Although the majority of tenants rated their ideal level of practical support as being in the moderate or high category, again one tenant rated ideal practical support as being low. Interestingly, on examination of individual tenant responses, it was the same tenant who rated their actual level and ideal level of practical support as low.

Tenants consider that they are receiving more emotional than practical support. Comparing actual levels with ideal levels of support suggests that tenants would ideally like more of both emotional and practical support. However, it is worth noting that there is a greater discrepancy between actual and ideal levels of support for practical compared to emotional support (see Appendix 1). This suggests that there is an overall greater level of dissatisfaction with practical support.

All tenants were also offered the choice of having a volunteer befriender. However, currently, only two of the tenants are involved in one-to-one befriending relationships, one of which has been ongoing for over 1 year, the other has only been going for 1 month. Both of these relationships are going well and volunteer and tenant both feel that they are getting on well with each other.

In addition, a Praxis volunteer is in a group placement with the Accommodation Scheme and visits regularly. This volunteer has struck up a particular friendship with one of the tenants, and the two go out to play snooker on a fairly frequent basis.


Perceived levels of actual support
Frequency
11
10
9
8
7
6
5
4
3
2
1
0
Emotional
Practical
0
1
5
10
6
0
Low
Moderate
High


Perceived levels of ideal support
Frequency
11
10
9
8
7
6
5
4
3
2
1
0
Emotional
Practical
0
1
3
4
8
6
Low
Moderate
High

Results from that section of the Q.O.L. interview measuring cohesion, i.e. the degree of cooperation between staff and tenants, and sense of community between tenants themselves, showed that although there was a high degree of staff-tenant cohesion, there was a low degree of tenant-tenant cohesion. Despite this lack of tenant-tenant cohesion, there was either high or moderate contact between tenants.

From the monthly management reports, tenants do, on the whole, interact with each other well, with no obvious friction between any of the tenants. Several of the tenants have quite close relationships with each other. However, in the past, slight friction between several of the tenants had been noticed, but this appears to have been resolved, as no complaints have come to light recently.

3.7. Support.

3.7.1. Individual Support Packages. (I.S.P.)

3.7.1.(a) : Implementation of I.S.P.s.

Draft I.S.P.s are drawn up during a meeting of Projects Manager, Referral Agent and Prospective Tenant. Once the applicant has been accepted as a tenant, the formal I.S.P. is agreed. The Projects Manager then translates this into a structured rehabilitation programme, and ensures that the Community Assistants implement the programme.

The above process as outlined in the introduction section, is put in place for all of the tenants from the moment they are selected for the scheme. Figure 8 outlines a breakdown of the types of assistance formally requested in the initial I.S.P.s, and the frequency of requests in each area. From the graph, it can be seen that, for the 12 tenants, a total of 16 different types of assistance were formally identified as areas with which the Community Assistants were expected to provide support. The most requested activities are those of general daily living skills. For example, 9 of the 12 tenants are formally identified as requiring assistance with budgeting, 8 with laundry and 7 with general housework and assistance in attending day activity. The least requested types of assistance include communication skills, reassurance, help in attending appointments and obtaining prescriptions, shopping and encouragement to participate in relaxation techniques.

Figure 9 shows a breakdown of formal requests for assistance and support, taken from the tenants' most recent action plans. In comparison to Figure 8, some major differences are apparent. For example, only 3 of the tenants are formally identified as requiring assistance with budgeting, in comparison to 9 tenants outlined in the original I.S.P.s, which were compiled on initial admittance to the scheme. Similarly, only 1 tenant is still identified as requiring support with laundry, 6 with

Figure 8 : Types of Assistance Requested from the Community Assistants as in the Original I.S.P.s.

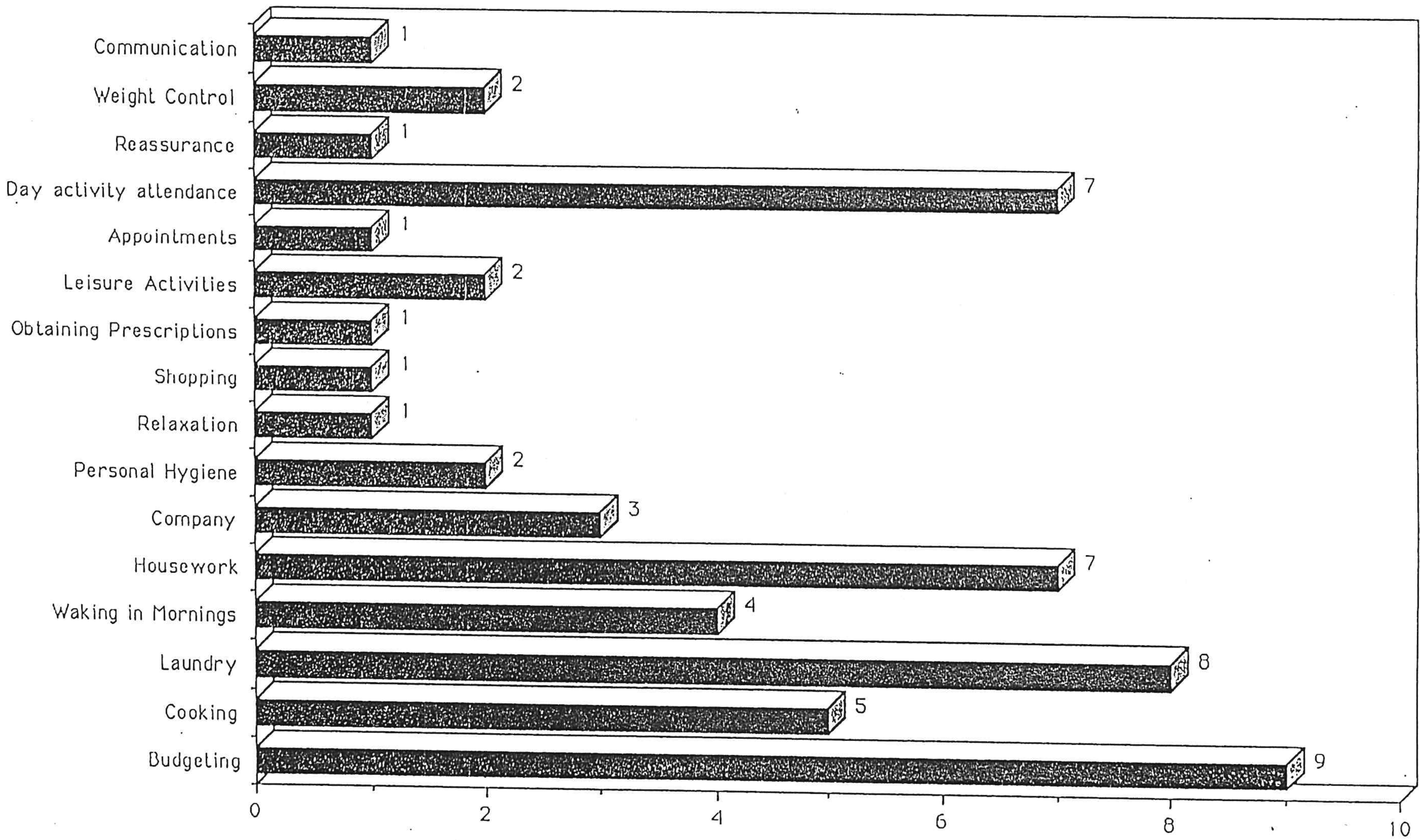
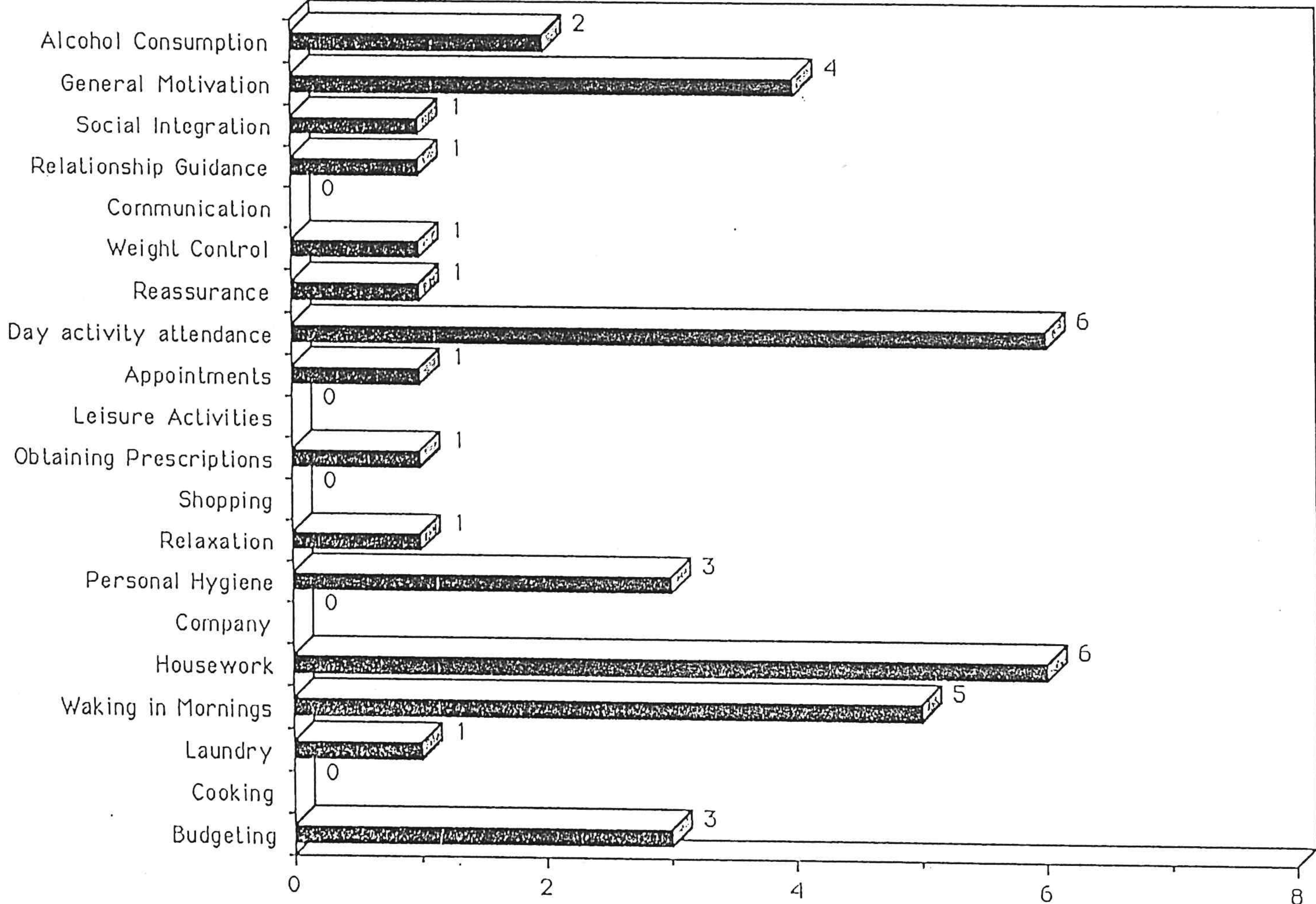


Figure 9 : Types of Assistance Requested from the Community Assistants in most Recent Action Plans.



housework and attendance at daily activity. In addition several new types of assistance have been formally identified as areas with which several tenants require support. These include : relationship guidance and counselling, encouragement of social integration with the rest of the tenants, general motivation, and guidance and monitoring of alcohol consumption.

In addition to providing support in areas formally highlighted in tenants' action plans, the Community Assistants are responsible for providing tenants with informal emotional support. This may not have been included in the I.S.P.s, simply due to tenants having difficulty in articulating their emotional needs, and also due to the sensitive nature of emotional needs.

The review of this area has shown that such ISP's are in place, and are formally and closely monitored, with a view to assessing progress and implementing change. This shows that another of the aims of the scheme has been successfully met in that "Tenants are encouraged to develop appropriate practical and social skills within the context of real situations".

In particular, it was interesting to note how the types of assistance initially requested had changed one year later. This shows that, for many of the tenants, such daily living skills as budgeting, laundry and housework are no longer considered as areas where the tenants need formal support. However, from the tenants daily and weekly notes, it can be seen that areas which are no longer formally identified as support needs, are still being monitored and informal support and guidance offered when necessary. In addition, excessive alcohol consumption has emerged as being an issue for two of the tenants, although it was not formally identified in the initial I.S.P.

3.7.2. Contact with Statutory and Voluntary Agencies.

Everybody living in the Flats was in regular contact with Statutory Mental Health Services, and knew how to obtain mental health support in an emergency. This was not a surprise as the scheme was jointly planned, and a commitment was made at an early stage by the Northern Health and Social Services Board to provide appropriate statutory support.

However, several tenants did complain that there was too much statutory activity, and felt that although the scheme is supposed to promote independence, there were too many mental health workers, both from Praxis and Statutory Services trying to organise their lives. This is an important issue, as clearly, there needs to be a balance between the provision of adequate support, and the promotion of independence, freedom of action and self-efficacy.

The majority of the tenants are also involved with the Industrial Therapy Organisation, which provides sheltered employment opportunities. Other voluntary agencies, with which the tenants had contact, included Rehability, which has been mentioned previously.

3.8. Community Response.

3.8.1. Community Attitudes towards Mental Illness.

The distribution of responses on the CAMI scale can be seen in Appendix 2. The scale contains five positive and five negative statements for each of the 4 dimensions outlined previously. In comparison to the other 3 dimensions, a wider spread of response can be seen for the authoritarianism dimension. There is evidence of some uncertainty about the causes and treatment of mental illness with a number of respondents having a moral explanation and approach to mental illness. General support for the notion of community care, as opposed to hospital care, is apparent, and a majority of respondents hold a medical model of mental illness.

For the benevolence dimension, a more homogeneous picture emerges, with overwhelming support for statements containing liberal and sympathetic attitudes. Further evidence of the negative view of hospital care was shown by the fact that 75% of the sub-sample agreed with the statement : "Our mental hospitals seem more like prison than like places where the mentally ill can be cared for."

The social restrictiveness dimension revealed that there was generally a high level of acceptance of former patients in a number of roles. However, there were exceptions the most important being a marked reluctance to consider former patients as suitable babysitters. This indicates a particular area of concern voiced by neighbours about the integration of former psychiatric patients.

The responses on the Community Mental Health Ideology dimension were uniformly positive with unanimous support for three of the ten statements. In comparison to the rest of the households who took part in the study, the sixteen respondents who lived in the Stiles Estate (where the Scheme is sited), were most positive about community mental health developments, most benevolent towards the mentally ill, but somewhat more cautious about social openness and more authoritarian towards the mentally ill.

Table 2, overleaf, shows the variation of responses for all of the different groups who participated in the study.

Table 2 : Community Attitudes towards Mental Illness.

Subsample	Attitude Scores Strongly Agree 40 - 60 %	Agree 61 - 80 %	Neutral 81 - 100 %	Disagree 101 - 120 %	Total %
Rathenraw	6.3	18.8	75.0	-	100
Greystones	5.3	42.1	52.6	-	100
Stiles	12.5	37.5	50.0	-	100
Volunteers	10.0	60.0	30.0	-	100
Family	12.5	18.8	62.5	6.3	100
School	7.4	37.0	48.1	7.4	100
Total Sample	8.8% (10)	36.8% (42)	51.8% (59)	2.6% (3)	100% (114)

The above table shows that members of the 3 local communities who took part in this study have positive attitudes towards the mentally ill. All community respondents scored in the 'neutral' to 'strongly agree' range ; some 45.6% of the sample 'agree' to 'strongly agree' ; over half (51.8%) of respondents gave neutral scores ; and only 3 (2.6%) scored in the 'disagree' category.

Overall, the majority of respondents scored highly on positive responses. When the responses from each sub-sample were compared, it was found that the Stiles group had the highest level of positive responses of the three neighbourhoods.

3.8.2. The Neighbourhood Impact of the Local Facility.

Neighbours were asked to rate on a 5 point scale their view of the sheltered flats. Over half reported they were strongly in favour, with the remainder of respondents in favour. The Stiles Estate showed the strongest level of acceptability for its local facility amongst the three neighbourhoods. This is an extremely encouraging response, particularly as the scheme has only been recently established. There clearly exists a reservoir of goodwill and a commitment towards the principles of community care amongst the local population, which was endorsed by the fact that the Stiles Estate had the highest positive score on the CAMI Scale.

When asked to explain their views, respondents most frequently emphasised the value of community living, in terms of normalisation. Respondents praised the residents who were described as "better than ordinary neighbours!". The quality of the accommodation and the level of staff support were also positive factors in community acceptance.

3.8.3. Interaction with Tenants

In the Flat Cluster Scheme, tenants shop, cook and budget for themselves. Whilst following these activities, tenants are in frequent contact with neighbours at the post office, the local shop, the bus stop etc. These instances all provide opportunities for normal, everyday interaction, not as former patients to community member, but as neighbour to neighbour.

There was a good level of interaction between tenants and their neighbours. Such everyday interaction included bringing bones over for the dog, exchanging Christmas cards and talking to the children. Examples of closer contact in the nature of friendship included going to bingo together, attending each other's parties and babysitting.

These instances of interaction are vital in ensuring successful reintegration into the community for ex-psychiatric patients. In his study on the social worlds of ex-psychiatric patients, Prior (1991), showed that the stigma of mental illness can lead to isolation and subsequently a desire to return to hospital. The interactions described above have shown a good level of trust and acceptance for the tenants within the local community.

However, a cautionary note was sounded by one respondent who expressed concern about the safety of her children because of the scheme. The safety of children is a preoccupation for parents on these estates, as child abuse has occurred locally in the past. Hence, these are genuine concerns for parents. As a result it may well be that the community will be cautious and wary in their response to young single adults, who have been in psychiatric hospital.

4.0. CONCLUSIONS.

To conclude, this first evaluation of the first year of operation of the Flat Cluster Scheme has raised many points. In returning to issues raised in the introduction, the purpose of this evaluation was :

1. To monitor effectiveness and efficiency of new services i.e.
   (i) Does the scheme provide a better quality of environment /
   (ii) Is it acceptable to residents ?
   (iii) Is adequate support provided ?
   (iv) Are hospital readmission rates reduced ?

2. To review the services provided in terms of :
   (i) Adequacy of staffing.
   (ii) Fulfilment of Aims and Objectives
   (iii) Workload
   (iv) Outstanding need
   (v) Quality of Service provided

On reflection, the above issues have all been addressed, directly or indirectly, during the course of this study. Tenants are pleased with the quality of their accommodation and the overwhelming majority wish to remain in their present accommodation as opposed to returning to hospital/a hostel. However, several tenants do not see the scheme as permanent, but see it as a stepping stone to greater independent living, which is, in itself, what the scheme ultimately aims to promote.

In addition, total days spent in hospital were halved, during the first year of operation of the scheme, thus showing that the work of the scheme has begun to tackle the issue of "the revolving door syndrome" which is all too common in people who are experiencing chronic mental ill health. It is extremely encouraging to note that this idea, which was specifically highlighted as being one of the aims of the scheme, is being fulfilled.

With regard to the issue of adequate support, tenants have access to as much or as little support, as they feel they require. Many tenants with the support provided by the scheme, have shown proficiency in several areas of daily living skills at the time of this evaluation, whereas, prior to entry to the scheme, tenants were formally identified as requiring support and assistance with various tasks. However, as such skills become proficient, tenants appear to require the same level of support, but directed towards other issues. By reviewing the ISP's, it can be noted that there is a slight trend for practical support to be replaced/supplemented with increased emotional support, and, in particular, general motivation appears to be an issue for many of the tenants. This is a common characteristic for many people with a chronic mental illness.

The scheme was very favourably received by members of the local community. This is important, as all too often, stigma and rejection by a 'normal' population, can lead to the rehospitalisation, and further institutionalisation of the long-term mentally ill.

Staffing levels at the scheme have proved adequate. As a change to the original staffing structure, Praxis now has a resident Community Assistant who lives close to, but not in the Accommodation Scheme. This assures tenants of extra support, should they require it.

If quality of life is a reflection of quality of service, then, from this study, whereby tenants rated their overall quality of life and satisfaction with life as being of high or moderate levels. Although this was not significantly different from hospital rating, it should be noted that tenants have expressed no desire to return to hospital. Hence, it could be concluded that the Flat Cluster Scheme has provided a high quality service, in that, from this initial evaluation, the aims and objectives are being seen to be met.

Ultimately, it will take the scheme to be in operation for several years, before totally conclusive results can be seen, but the first year of operation has raised many salient issues, as well as making an initial fulfilment of the Aims and Objectives of the Scheme. The scheme will be reassessed and some aspects of its functioning will be re-examined, and improvements made. The impact of these, and other developments will be continued to be monitored on an annual basis.

5.0. RECOMMENDATIONS

5.1.1. Given that Praxis offers accommodation on a permanent basis, and as more than 50% of the tenants did not regard their present location as permanent, consideration should be given as to how the scheme should be explained to future tenants. (Ref. Para. 3.1.1.)

5.1.2. Praxis, in conjunction with the Selection Panel, may need to give consideration to identifying potential future tenants, as many of the present tenants regard the accommodation as being a stepping stone to more independent living. (Para. 3.1.4.)

5.2. There is a need to give consideration to the practice of tenants informing staff of intended overnight stays away from the accommodation. For example, this could be integrated into the Individual Support Packages and be specific for those tenants who require this form of monitoring. (Para. 3.1.2.)

5.3. With respect to the use of tenants' community care grants, Praxis should consider a system which allows new tenants more control over spending of their grants. This would require coordination and cooperation with the DHSS, Referral Agent and Praxis Projects Manager. (Para. 3.3.1., 3.5.3.)

5.4. Praxis should endeavour to facilitate greater choice regarding the number of furnishing suppliers with whom they deal. An internal decoration programme allowing greater choice should be developed and implemented. (Para. 3.5.3., 3.5.4.)

5.5. Whilst a high level of sound insulation is in place, consideration should be given to how this may be improved if it became problematic for individual tenants. In addition, consideration should be given to sound insulation in future Praxis developments. (Para. 3.5.1., 3.5.3.)

5.6. The physical design of the flats is one which promotes independent living whilst providing opportunities for social interaction between tenants. One comment made was that the limited space within the communal lounge restricted the opportunities for home based leisure activities. Consideration should be given to ways of creating more space within these areas and in future schemes. (Para 3.5.2.)

5.7. Whilst respecting the rights of the individual, Praxis should continue to educate tenants with respect to the dangers involved in mixing alcohol with medication. (Para. 3.4.)

5.8. As several tenants felt that there were too many people, both from Praxis and Statutory Services, organising their lives, it is essential to review :

(i) the number of mental health workers involved.

(ii) the frequency of contacts.

(iii) reason for the contacts.

It is recommended that Praxis works towards streamlining the number of mental health workers (i.e. both Praxis and Statutory staff) with whom tenants have contact. This would be a highly sensitive, and therefore slow, process which should be primarily determined by the tenants' mental health needs. (Para. 3.2.1.(ii)., 3.7.2.)

5.9. As many of the tenants expressed dissatisfaction with being unemployed, Praxis should explore realistic ways of enabling tenants to enter the labour market. (Para. 3.2.1.(c).)

5.10. Praxis should undertake to explore tenants' fears about safety, and to implement means by which these fears can be alleviated. (Para. 3.2.1.(i)(b).)

5.11. There should be a widening of opportunities for leisure activities, via organised activities within the accommodation scheme. Links should be made and maintained with facilities / groups in the Antrim area. Staff, in conjunction with volunteers, should seek appropriate ways to facilitate this activity, which should also include increasing the number of lay people with whom tenants have contact. (Para. 3.2.1.(i)(c), 3.6.1., 3.6.2.)

5.12. Consideration should be given to reviewing the system of assessing the emotional support needs of the tenants. Praxis, in conjunction with the tenants, should establish meaningful ways to meet these needs. (Para. 3.6.3.)

5.13. There is a need to review the current system by which tenants' practical support needs are assessed. A realistic programme which is consistent with the principle of independent living should be implemented to meet these needs . (Para. 3.6.3.)

5.14. This evaluation has reported incidents where tenants' understanding of certain aspects of the scheme are contradictory to the stated aims and objectives of the scheme, for example : several tenants are under the impression that they have to vacate their flats during the day, and some confusion also results over rules pertaining to communal areas. Scheme Managers should acknowledge these contradictions, and should endeavour to clarify these situations with the tenants. (Para. 3.5.2., 3.5.3.).

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APPENDIX 1: PERCEIVED ACTUAL AND IDEAL RATINGS OF SUPPORT.

TENANTS	ACT. EMOT.	IDEAL EMOT.	EMOT. DISCREP.	ACT. PRACT.	IDEAL PRACT.	PRACT. DISCREP.
1	3.38	3.88	0.50	2.63	3.88	1.25
2	3.45	3.45	0.00	2.95	3.35	0.40
3	2.75	3.38	0.63	1.94	2.25	0.31
4	3.00	3.28	0.28	2.84	3.05	0.21
5	3.40	4.60	1.20	3.70	3.90	0.20
6	4.60	4.90	0.30	3.00	4.10	1.10
7	4.34	4.34	0.00	2.92	3.09	0.17
8*	--	--	--	--	--	--
9	4.50	4.71	0.21	3.21	3.79	0.58
10	4.00	4.38	0.38	3.38	3.88	0.50
11	4.11	4.50	0.39	5.00	5.34	0.34
12	4.43	4.22	-0.21	3.29	3.43	0.14
MEAN	3.81	4.15	0.35	3.17	3.64	0.47
S.D.	0.64	0.57	0.35	0.76	0.78	0.37

*Data unavailable for Tenant

Appendix 2 : Percentage of Respondents endorsing the responses to each item of the 4 sub-scales

1. Authoritarianism

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
One of the main causes of mental illness is a lack of self-discipline & willpower (N)*	-	12.5(2)	12.5(2)	44(7)	31(5)
The best way to handle the mentally ill is to keep them behind locked doors(N)	-	-	-	25(4)	75(12)
There is something about the mentally ill that makes it easy to tell them from other people(N)	-	12.5(2)	12.5(2)	56(4)	12.5(2)
As soon as a person shows signs of mental disturbance he should be hospitalised(N)	6(1)	12.5(2)	25(4)	50(8)	6(1)
Mental patients need the same kind of control and discipline as a young child (N)	-	50(8)	25(4)	19(3)	6(1)
Mental illness is an illness like any other.	6(1)	62.5(10)	6(1)	19(3)	6(1)
The mentally should not be treated like the outcasts of society.	69(11)	25(4)	-	6(1)	-
Less emphasis should be placed on protecting the public from the mentally ill.	6(1)	62.5(10)	12.5(2)	19(3)	-
Mental hospitals are an outdated means of treating the mentally ill.	12.5(2)	31(5)	37.5(6)	19(3)	-
Virtually anyone can become mentally ill.	12.5(2)	87.5(14)	-	-	-

*(N) = Negatively worded items

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The mentally ill have, for too long, been the subject of ridicule.	37.5(6)	62.5(10)	-	-	-
More tax money should be spent on the care and treatment of the mentally ill.	12.5(2)	87.5(14)	-	-	-
We need to adopt a far more tolerant attitude toward the mentally ill in our society.	37.5(6)	62.5(10)	-	-	-
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.	19(3)	56(9)	6(1)	12.5(2)	6(1)
We have a responsibility to provide the best possible care for the mentally ill.	37.5(6)	62.5(10)	-	-	-
The mentally ill don't deserve our sympathy(N)*	-	-	6(1)	56(9)	37.5(6)
The mentally ill are a burden on society(N).	-	-	-	56(9)	44(7)
Increased spending on mental health services is a waste of taxes (N).	-	-	-	62.5(10)	37.5(6)
There are sufficient existing services for the mentally ill (N)	-	-	19(3)	56(9)	25(4)
It is best to avoid anyone who has mental health problems (N).	-	-	6(1)	50(8)	44(7)

*(N)= Negatively worded items

3. Social Restrictiveness.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The mentally ill should not be given any responsibility(N)*	-	-	6(1)	81(13)	12.5(2)
The mentally ill should be isolated from the rest of the community(N).	-	-	6(1)	50(44)	44(7)
A woman would be foolish to marry a man who suffered from mental illness, even though he seems fully recovered(N).	-	-	19(3)	81(11)	-
I would not want to live next door to someone who had been mentally ill(N).	-	-	6(1)	50(8)	44(7)
Anyone with a history of mental problems should be excluded from positions of authority(N).	-	-	25(4)	75(12)	-
The mentally ill should not be denied their individual rights.	19(3)	75(12)	-	6(1)	-
Mental patients should be encouraged to assume the responsibilities of normal life.	31(5)	69(11)	-	-	-
No-one has the right to exclude the mentally ill from their neighbourhood.	25(4)	69(11)	-	6(1)	-
The mentally ill are far less a danger than people suppose.	12.5(2)	75(12)	6(1)	6(1)	-
Most women who were once patients in a mental hospital can be trusted as babysitters.	6(1)	25(4)	62.5(10)	6(1)	-

*(N)= Negatively worded items

4. Community Mental Health Ideology.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Residents should accept the location of residential facilities for the mentally ill in their neighbourhood to serve the needs of the local community.	12.5(2)	87.5(14)	-	-	-
The best therapy for many mental patients is to be part of a normal community.	31(5)	62.5(10)	6(1)	-	-
As far as possible, mental health services should be provided through community based facilities.	12.5(2)	75(12)	6(1)	-	-
Locating mental health services in residential neighbourhoods does not endanger local residents.	19(3)	62.5(10)	19(3)	-	-
Residents have nothing to fear from people coming into their neighbourhoods to live after discharge from mental hospital.	19(3)	75(12)	6(1)	-	-
Mental health facilities should be kept out of residential neighbourhoods(N)*.	-	-	-	75(12)	25(4)
Local residents have good reason to resist residential schemes for ex-patients in their neighbourhood(N) [one case missing]	-	-	7(1)	80(12)	13(2)
Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great(N).	-	-	-	81(13)	19(3)
It is frightening to think of people with mental problems living in residential neighbourhoods(N).	-	6(1)	6(1)	62.5(10)	25(4)
Locating mental health facilities in a residential area downgrades the neighbourhood(N).	-	-	6(1)	75(12)	19(3)

*(N)=Negatively worded items.