LISNASKEA

AN EVALUATION OF THE
RESIDENTIAL FLAT CLUSTER SCHEME
AT LISNASKEA

MARCH 1992 - JULY 1993

Praxis is committed to the evaluation and monitoring of all its services. This report is one of a series of evaluations of various Praxis services.

Praxis currently provides a range of services, including :

(i) Befriending Schemes

(ii) Accommodation and Support Schemes

(iii) Home Response Schemes.

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

This study examines the effectiveness of one of these combination models - A Residential Flat Cluster Scheme.

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1.0 : INTRODUCTION

1.1 : Background.

The Praxis Residential Flat Cluster Scheme at Lisnaskea was developed to provide care and accommodation to a group of individuals experiencing mental ill health. The prospective tenants, who were already living in the community or in hostel accommodation, wished to live in independent accommodation within the community, yet, they also required a high degree of intensive support.

The initial plan was to house 13 people with the proposed model of accommodation being a seven place Residential Care Home and a six place Flat Cluster. Due to the extent of need, and given the time period between planning and the construction of the building which was to house the scheme, it was decided to provide an interim service to a group of prospective tenants. The opportunity to implement this interim scheme arose when Praxis was able to lease a property on a temporary basis.

This privately leased property consisted of a block of flats which were designed for letting as dwellings to the general public and therefore met all such relevant building and safety requirements. The property consisted of five self contained flats which were already furnished by the landlord. Existing furnishings were then supplemented by staff working in the accommodation and support scheme. Laundry facilities were negotiated at a later date, and were sited adjacent to the main building complex.

Working closely in conjunction with the Mental Health Unit of Management of the Western Health and Social Services Board (WHSSB), it was agreed that the level of support required by the tenants was such that staff cover should be provided 24 hours a day. The scheme therefore provided the independence offered by an individual self contained flat with the intensive support provided by a Residential Care Home. This represented a new dimension in service delivery for Praxis, and for Northern Ireland.

Given the prompt identification of the flats, Praxis did not have sufficient time to recruit staff. It was therefore agreed that the scheme would be staffed by WHSSB personnel for the first six months of its operation. The scheme was open for its first intake of tenants in October 1991. During this period, Praxis provided housing management and liaison for the WHSSB staff at the scheme, whilst recruiting its own staff team. In April 1992 WHSSB staff were replaced by Praxis staff.

1.2.1 : Praxis Mental Health Service Principles

The Accommodation & Support Scheme is based on the Praxis service principles outlined below :

Individuals should be afforded opportunities, choices and rights of self determination which accord with those available to other citizens.

Individuals should be given the opportunity to live within local communities and be provided with a standard of housing and local facilities which accord with those available to other members of the community.

The quality of life for individuals should be consistent with what other citizens are entitled to expect in terms of individual choice, standards of privacy and rights to risk taking in daily living.

Individuals should be encouraged to achieve their optimum level of independence through receiving practical help and support in dealing with everyday situations.

1.2.2 : Aims and Objectives of the Accommodation and Support Scheme.

The following aims and objectives are based on the Praxis principle of closely integrating accomodation and care.

The scheme aims to :

(i) establish former psychiatric patients in their own home within the community and,

(ii) reduce the possibility of tenants becoming involved in a "revolving door" pattern of frequent readmissons to hospital.

Objectives:

To enable meeting the above aims, the following objectives were identified:

(i) Offering permanent accommodation of a good standard to people who have suffered from mental ill health. Initially the scheme catered for five people and the accommodation was in the form of a Flat Cluster.

(ii) Ensuring the tenants emotional, social and physical needs are met through individually tailored support packages. Each support package included input from

Praxis staff, Praxis volunteers, and WHSSB staff, with input coordinated and revised by Praxis. Tenants were also included in the decision making process.

(iii) Liaising with statutory/voluntary agencies that can assist with employment/training. The provision of relevant day time occupation outside the environment of the flats was considered to be of great importance. Such occupation should aim to meet the tenants' needs in the area of training for employment.

(iv) Fostering good relationships with the local community through the use of volunteers, liaison with local tenants or residents associations, and communication with immediate neighbours.

1.2.3. The Scheme Model

Having researched the existing literature on supported accommodation schemes, and outlined the aims and objectives of the scheme, the following model was agreed and the corresponding information defined :

Purpose of the Scheme :

It was agreed that the scheme would provide accommodation with 24 hour staff support and care and that it would provide services which meet the needs of socially devalued and vulnerable individuals.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.

Location :

The scheme will eventually provide a seven place Residential Care Home and a six place Flat Cluster Scheme in a permanent purpose-built facility. This was completed in November 1993, but until then, the Scheme operated from rented premises providing accommodation for 4 - 5 persons.

Staffing :

Initially, the scheme was staffed by WHSSB personnel consisting of 3 qualified nurses and 3 nursing assistants, with Praxis staff being appointed in March 1992. The staff team then consisted of Projects Manager, Deputy Projects Manager, Project Workers Grade II (experienced but unqualified). An Assistant Project Officer was later appointed in April 1992, with responsibility for setting up and running a volunteer befriender scheme, as well as undertaking administrative tasks.

Operational Policy :

To provide clear guidance for the management of the scheme, an operational policy was drawn up. The operational policy addressed 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.
(x) Evaluation and monitoring.

Procedures for the selection of tenants, and reviewing of individual support packages (care plans) were formulated and the basic principles were jointly agreed by Praxis and the WHSSB. 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. The Lisnaskea Residential Flat Cluster represents an excellent example of such partnership between voluntary and statutory bodies.

1.3. Individual Support Packages

Praxis operates a system of Individual Support Packages (I.S.P.s) which are implemented to provide individually tailored support and rehabilitation plans according to individual need. I.S.P.s are constructed between the Projects Manager, referral agent and tenant, and cover areas of need, duration of assistance, frequency and specific time of week when such support is required. This information is then translated into a structured rehabilitation programme which outlines how the I.S.P. is implemented. In addition, Praxis operates a system of group activities which form part of the individual's structured rehabilitation programme. The rehabilitation programme is reviewed bimonthly between Praxis staff and the tenant in order to monitor progress, identify strengths and needs, make amendments, and to identify opportunities for change. The I.S. P. is reviewed by a Review Panel approximately every six months. This process also involves the tenant. The policy of ISP's was implemented as part of the Lisnaskea scheme.

1.4 : Evaluation of the Accommodation and Support Scheme.

Praxis welcomes the current emphasis on quality 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". In addition, 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".

This is a time of fundamental change in the provision of health and social care with increasing flexibility in the relationship between the public and private sectors. As part of these changes, voluntary organisations such as Praxis continue to develop and improve community based schemes as an alternative to large institutions. These changes in the type of care available to people who are experiencing mental ill health need to be monitored to ensure that quality is maintained.

The Residential Flat Cluster model is a relatively new concept in supported accommodation, and there was therefore a need to monitor the effectiveness and efficiency of the new service in an empirical manner. This was conducted by the Research Department in Praxis. In addition, 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. The research undertaken therefore has a management function in that it enables Praxis to review its practices regarding the Lisnaskea Scheme and similar schemes.

Monitoring of quality in a scheme of this kind may involve consideration of a number of areas:
(i) Input - i.e. resources, staffing, funding etc.
(ii) Output - i.e. the process of service delivery.
(iii) Outcome - i.e. the outcome of the service delivery for the client.
This evaluation primarily focused on quality issues in terms of the outcome for the clients of the scheme.

2.0 : METHOD

2.1 : Design

The Scheme was evaluated with respect to the outlined framework, using a variety of measures. The measures used included detailed record analyses, standardised questionnaires, structured and semi-structured interviews. The data was compiled from a variety of sources. A large proportion of the data was collected directly from the tenants. Some information was also obtained directly from staff. The remainder of the required information was obtained from tenants' case notes, from management reports, and from other administrative records.

The baseline data for the evaluation was collected 5 months after the scheme had opened and follow up data was collected 17 months later. The service principles of Praxis Mental Health (1.2.1.) provided a framework for this evaluation.

2.2 : Background to the measures implemented.

2.2.1. To use means which are positively valued to enhance the individual's quality of life and facilitate real opportunities for integration within the community.

This aim stresses the importance of integration in improving the quality of life of former psychiatric patients who are living in a community setting. It was decided to assess levels of integration by examining the social networks of the tenants and to use a standardised instrument to measure levels of community integration.

Social networks of the Tenants :

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), and in turn can both influence and reflect a person's integration into the community.

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).

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

Home and Community Integration :

Community integration has been described as one of the main aims of rehabilitation. However, despite numerous articles and books on the topic of community integration, there are few operational definitions of community integration that provide the basis for its assessment.

The most frequently used indicator of community integration is return to competitive employment (Chan et al., 1991; Fryer & Haffey, 1987; Johnston, 1991). For many individuals, however, competitive employment is not feasible. It is therefore not always a sensitive indicator of community integration. As a result, a broader focus on the definition of productive activities which includes vocational activities and unpaid work has been suggested (Gobble et al., 1987).

Independent living or reduced dependency on others in one's residence is also considered an important aspect of community integration (Seaton, 1988). Condeluci (1991), has suggested that interdependence may be more important than independence, especially in the light of the loss of friends and general lonely existence that many individuals with mental ill health appear to endure. A measure of community integration must therefore include the social aspects of integration such as available friends and confidants.

In addition, it is proposed that integration into the home is an important part of community integration which should be defined as active participation of the individual in the management of the home. This includes participation in shopping for groceries, preparation of meals, housework, caring for the children in the home if there are any, and, planning social gatherings in the home (Willer et. al., 1991).

Community integration was assessed in this study using the Community Integration Questionnaire (CIQ), (Willer et. al., 1991). This encompasses integration in three areas :

(i) Integration into the home.
(ii) Social Integration.
(iii) Regular performance of productive activities.

The scale can be either administered directly to the person in question, or can be filled in by a proxy. In this study, tenants' levels of community integration were rated by a member of staff who

knew all tenants particularly well.

2.2.2 The scheme aims to afford 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.

In the evaluation of new community based services for mentally ill people, two main types of information are usually collected. Firstly, descriptions of care settings are made; 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. The Lisnaskea Residential Flat Cluster Scheme aims to facilitate a good quality of life for the tenants, therefore it was important to assess tenants satisfaction with the scheme and to assess their satisfaction with their quality of life in general.

Quality of life

The Quality of Life Schedule (Q.O.L.), developed by Lehman (1983) was employed in order to assess the extent to which the second principle of the scheme had been met. This questionnaire was specifically developed for use with severely disabled individuals living in the community. As with many of the current methods of measuring quality of life, self reported measures of objective and subjective well-being are used. The schedule covers eight life domains, i.e. living situation, family contacts, social contacts, leisure activities, legal problems and victimisation, physical health, mental health and day activity. It is divided into three sections : overall or global rating of life, objective ratings in the above 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 were regarded as low quality of life; 3, 4, or 5 as intermediate / moderate; and 6 or 7 as high quality of life.

All of the interviews were carried out in the tenants' own flat, and were held in quiet rooms where privacy was assured and interruption avoided. The tenants were assured of confidentiality. The duration of interviews varied between forty-five and seventy minutes, with some tenants requiring a short break.

Staff Views

In addition, staff working in the scheme were asked for their opinions regarding the physical aspects of the accommodation. This enabled the evaluation to assess the environmental characteristics of the scheme from an additional source.

2.2.3. The scheme aims to be sensitive to individual needs and encourages each individual to achieve his or her optimal level of independence. This necessitates the development of appropriate practical and social skills within the context of real situations.

This aim stresses the need for each tenant to reach his/her optimal level of independence, through the development of appropriate practical and social skills and emotional and practical support from others. A two pronged approach was used to evaluate the extent to which this aim was met :

(i) Monitoring the implementation of the tenants' Individual Support Packages.

(ii) Assessing satisfaction with perceived emotional and practical support received .

Individual Support Packages (ISP) :

As outlined previously in Section 1.3, an individually tailored support plan is designed for each tenant within the Residential Flat Cluster. For the purposes of the evaluation, a snapshot of the tenants' ISP's was taken at three intervals: 1) at the beginning of the evaluation, 2) 7 months into the evaluation period and 3) 15 months into the evaluation. At each interval, the number of tenants requiring support in a number of everyday activities was noted.

Emotional and Practical Support :

Social support has been linked to psychological symptomatology by many studies (e.g. Cohen et. al., 1984; Henderson, 1981; Thoits, 1982). There is much evidence that social factors influence the course and duration of many disorders, and protect the individual from the deleterious effects of stress (Caplan, 1974; Cassel, 1976; Cobb, 1978). It is argued that, embedded in social ties are basic social processes which enhance general adaptation and adjustment to particular stressful events.

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

Given the many different methods 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). For the purposes of the evaluation, social support was assessed using a short form of the Significant Others Scale (Power et al., 1988). The scale divides social support into emotional support and practical support.

A subset of significant relationships that an individual engages in, are identified and the level of emotional and practical support the individual perceives he/she obtains from these is assessed (this will be called "actual support"). The ideal level of emotional and practical support the individual would like to receive from each of the relationships is also assessed (this will be called "ideal support"). This enables assessment of the level of discrepancy between perceived level of support received and what the individual would ideally like to have. The scale was used in a structured interview, using each primary relationship generated from the social network assessment.

Emotional Support

To assess the level of emotional support received from each member of the social network, the individual is asked:

(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?

Practical Support

To assess the level of practical support received from each member of the social network, the individual is asked:

(i) Does x give you practical help?

(ii) Can you spend time with x socially?

2.2.4. The scheme aims to prevent 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.

Tenants' admissions into acute psychiatric care were monitored throughout the period covered by this study. As none of the tenants who participated in the study were referred from hospital, data for days spent in acute psychiatric care was not available for the year prior to entry to the Residential Flat Cluster Scheme. However a history of admissions to hospital over a number of years was available.

Permission to carry out the study was granted by the Projects Manager of the Lisnaskea Scheme, and the tenants' consent was sought.

3.0. : FINDINGS OF THE STUDY

3.1. : Respondents

Interviews were carried out with four of the five tenants who had been residing in the Residential Flat Cluster Scheme during the period October 1991 to July 1993. During this twenty one months of operation of the scheme there had been 4 females and one male living in the accommodation scheme. However, one tenant moved out of the scheme in February 1992, due to deterioration of their mental ill health and a need for much more intensive nursing support. This left three females and one male in the age range 47 - 65 years, with an average age of 53 years.

The tenants had a variety of previous living situations. Two were referred from a Health & Social Services Board Hostel; one had been living in independent accommodation within the community; and one was referred from semi-independent accommodation situated in the grounds of the local psychiatric hospital. One of the tenants was widowed, one divorced, and the remaining two were single.

3.2. Social networks of the Tenants :

From the Social Network Interview Schedule (Shepherd, 1985), characteristics of the secondary and primary networks of the tenants were elicited, in terms of the proportion of family members, mental health workers and other individuals.

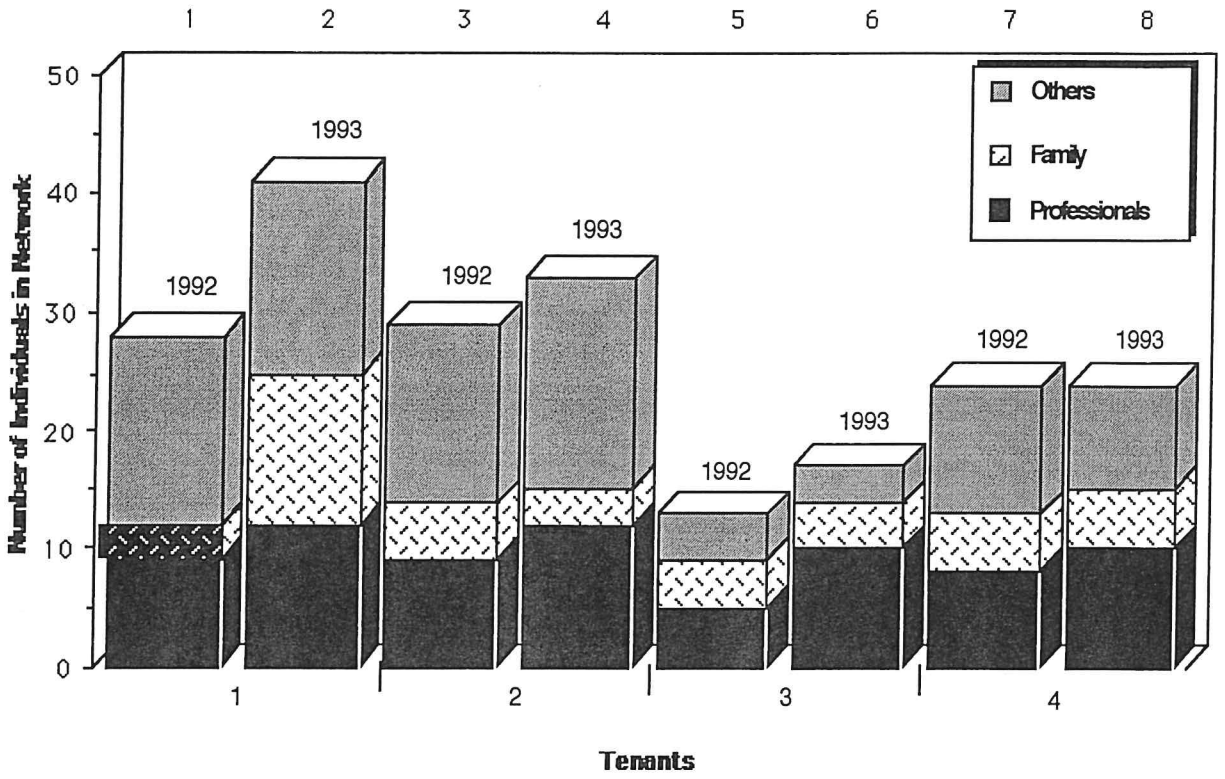
3.2.1. Secondary Social Networks

Figure 1 illustrates the overall changes in the size of the four tenants' secondary networks from 1992 to 1993 and the relative presence of family, mental health workers and others. The total network size for each tenant in 1992 ranged from 13 to 29 individuals, with a mean number of 23. By 1993, there was an overall increase in the size of the tenants' secondary networks. The range of total network size for each Tenant had increased to 17 - 41 individuals with a mean number of 29 individuals.

Mental health workers in the secondary social networks

In 1992, the number of mental health workers (i.e. both Praxis and Statutory Staff) identified within each network ranged from 5 to 9, with a mean number of 8 mental health workers. As a percentage of the total secondary networks, the range for mental health workers was from

Figure 1 : Breakdown of Tenant's Secondary Networks for 1992 and 1993.



31% to 38%. By 1993, the number of mental health workers identified within each network ranged from 10 to 12, with a mean number of 11 mental health workers. As a percentage of the total secondary networks, the range for mental health workers was from 29% to 59%. This indicated an increase in the number of mental health workers at a group level. As illustrated in Figure 1, this increase occurred for all tenants.

Family members in the secondary social networks

In 1992 the number of family members identified in the secondary networks ranged from 3 to 5, with a mean of 4. As a percentage of the total, the numbers of family members ranged from 11% to 31%. In 1993, the number of family members identified in the secondary networks ranged from 3 to 13, with a mean of 6. As a percentage of the total, the numbers of family members mentioned ranges from 9% to 32%. These results indicated that at a group level there was an increase in the number of family members present in the secondary social networks of the group of tenants. However this was not the case for all tenants. One tenant experienced an enormous increase in the number of family members, one experienced a decrease of two family members and for the other two tenants the situation remained the same. The ratio of family members to mental health workers was 1:1.8 in 1992 and 1:1.76 in 1993. Given the very large increase in the number of family members for one tenant, this tenant was excluded from the analysis and the ratio recalculated. The ratio of family to

mental health workers then became 1:1.5 in 1992 to 1:2.6 in 1993, indicating a considerable increase.

Other members of the secondary social networks

The remainder of the secondary network group were classified as "others", with a range of 4 to 16 individuals in 1992, and a mean number of 11. This group constituted the largest proportion of the secondary networks, with a range from 31% to 57% of the total secondary network. In 1993 the number of "others" identified ranged from 3 to 18 individuals, with a mean number of 11. Again, this group constituted the largest proportion of the secondary networks, with a range of 18% to 58% of the total secondary network.

Figure 2 shows the numbers of individuals seen weekly by each of the tenants in 1992, broken down into family members and mental health workers. The number of mental health workers seen weekly ranged from 5 to 7, with a mean number of 6. The number of family members seen weekly ranged from 0 to 4, with three of the tenants not seeing family members on a weekly basis. Tenants had more frequent contact with mental health workers than with members of their families.

Figure 2 : Numbers of Family and Mental Health Workers seen Weekly by each Tenant in 1992.

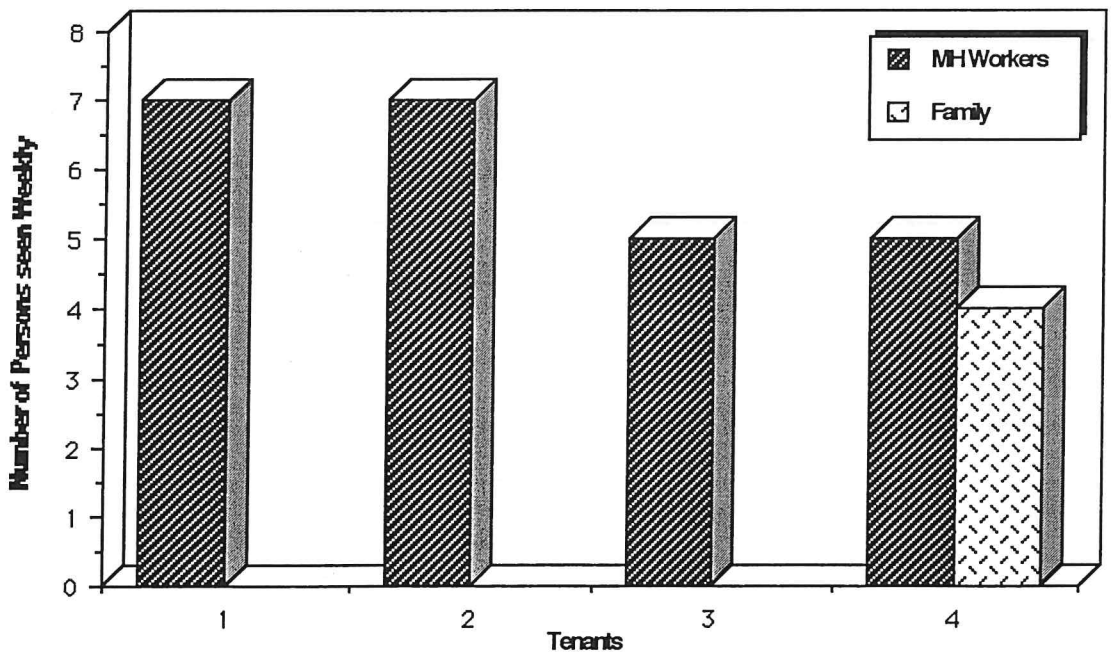
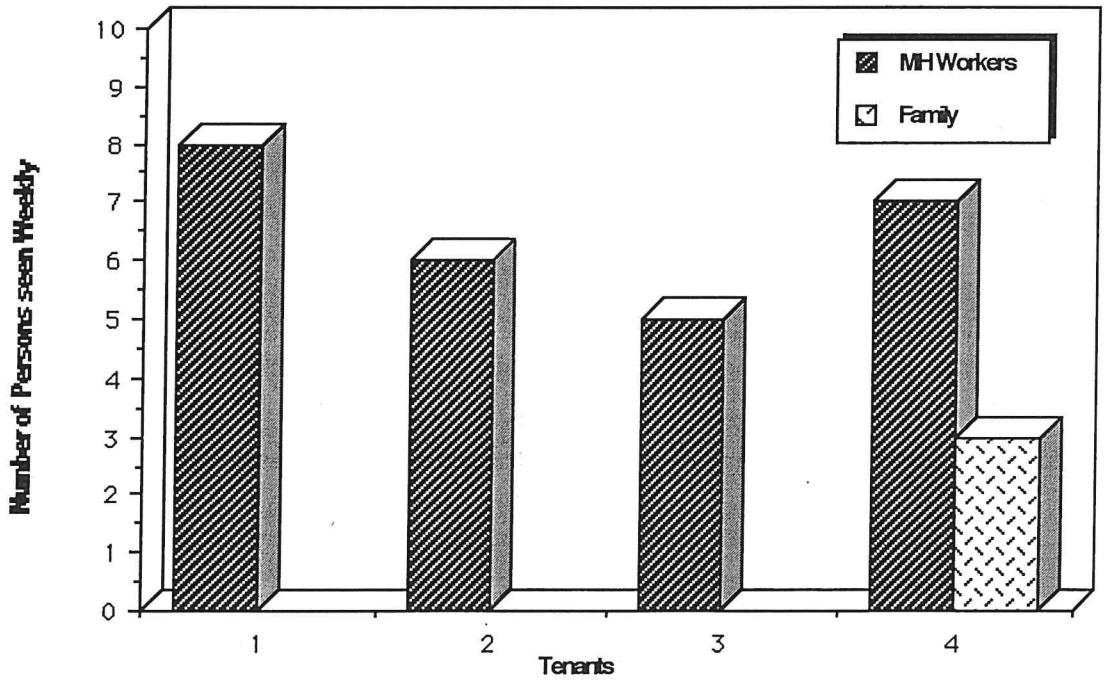


Figure 3 shows the numbers of individuals seen weekly by each of the tenants in 1993, broken down into family members and mental health workers. By 1993, the number of mental health workers seen weekly ranged from 5 to 8, with a mean number of 6. The number of family members seen weekly ranged from 0 to 3, showing that after a year in the scheme, tenants still had more frequent contact with mental health workers than with members of their family.

Figure 3 : Numbers of Family and Mental Health Workers seen Weekly by each Tenant in 1993.

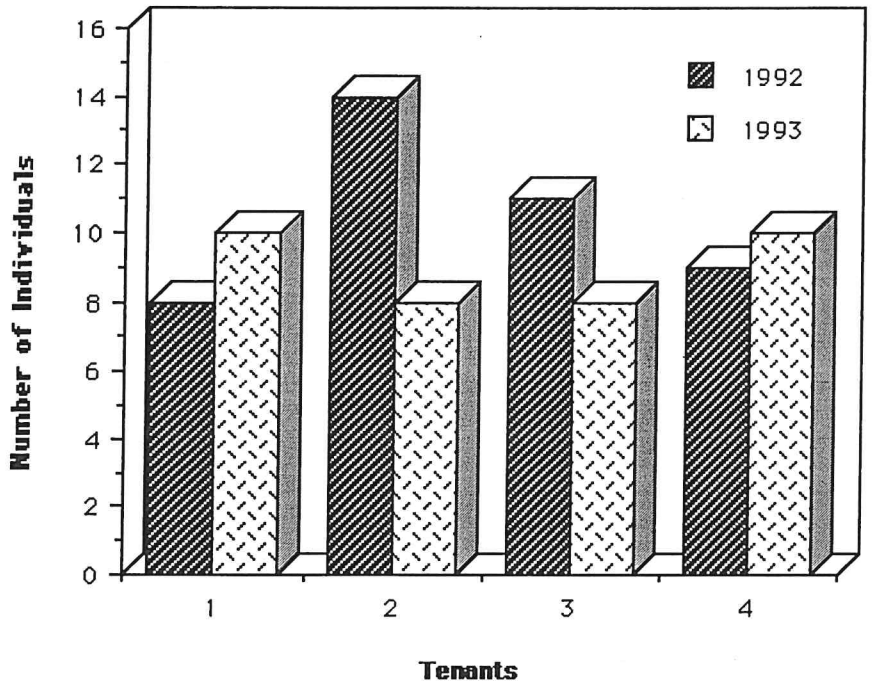


This is a very common pattern of social contacts in individuals who have had chronic mental ill-health. Thompson (1989) found that chronic psychiatric patients have a large proportion of professional contacts listed in their social networks.

3.2.2. Primary Social Networks

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. Figure 4 illustrates the size of each individuals primary social networks in 1992 and 1993. In 1992, the size of the primary networks ranged from 8 to 14 individuals, with a mean number of 10 individuals. In 1993 the mean size of the primary social networks had decreased slightly to 9 and the range was from 8-10.

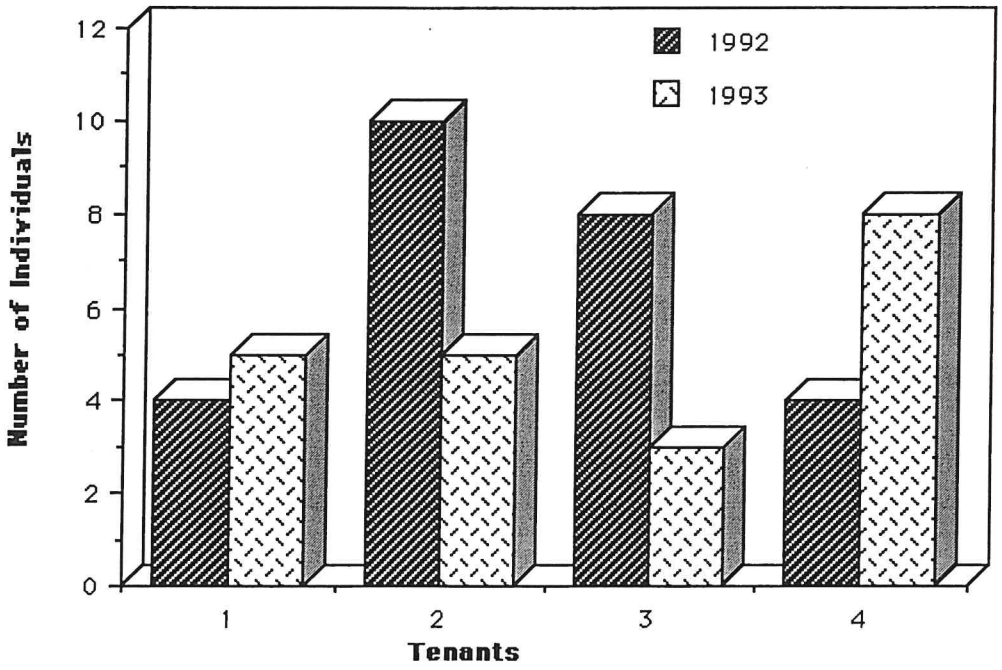
Figure 4 : Primary Social Networks in 1992 and 1993



Weekly contact with members of the primary network is illustrated in Figure 5. In 1992, this ranged from weekly contact with 4 to 10 individuals, with a mean number of 6. By 1993 this had decreased slightly to a mean of 5 and a range of 3-8.

Primary network size in individuals who have not experienced mental ill health 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 people diagnosed as suffering from neurosis 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 size of the primary social networks of the tenants of the residential cluster scheme are similar to previous findings for individuals suffering from mental ill-health.

Figure 5 : Weekly Contact with Network Members in 1992 & 1993



Members of the primary social networks

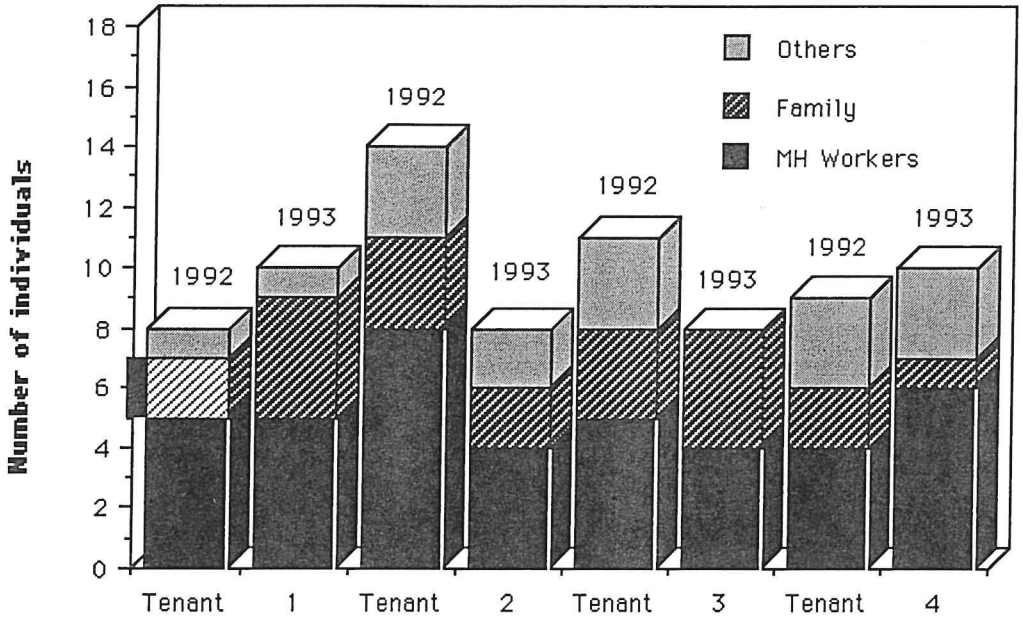
Breaking down the primary networks into family, mental health workers, and others (Figure 6) shows a similar imbalance in the proportion of mental health professionals to family members as that found in the tenants secondary social networks. In the group as a whole the proportion of mental health professionals to family in the primary social network dropped slightly from 2.2:1 in 1992 to 1.7:1 in 1993.

Individual differences

Although at a group level, the changes were not very meaningful, at an individual level there were some notable changes. For tenants 1 and 4, from 1992 to 1993, there were increases in the size of their primary social networks. For tenant 1 there were 2 extra family members making up the primary network. For this tenant there was also a considerable increase in the number of family members making up the secondary network. For tenant 4 there was one extra person in the primary network. There was also a redistribution of who made up the network. There was one less family member and 2 more health professionals. There were also two extra health professionals in the secondary social network of this tenant in 1993 compared to 1992. Also, five of the health professionals in the primary network were seen on a weekly basis in 1993 compared to two in 1992. For tenants 2 and 3, there was a

decrease in the size of their primary social networks and in the number of network members

Figure 6 : Breakdown of Tenants Primary Networks for 1992 and 1993



with whom there was weekly contact. For tenant 2 the decrease was primarily due to the number of mental health workers in the network being halved. For tenant 3 the decrease was due to the total shrinkage of the "other" category. For both these tenants there was a corresponding increase in the size of their secondary social networks across the 17 months of evaluation. Given the intensive support levels of the scheme it is not surprising that tenants have involvement with a large proportion of mental health workers - e.g. there are 5 Praxis staff working at the scheme.

Primary and Secondary Networks

As would be expected with individuals with mental health problems, there were a large number of mental health workers in their secondary social networks. It is positive however that there was a smaller proportion of mental health workers in the primary networks compared to the secondary networks (1:1.4 in 1992 and 1:2.3 in 1993). That mental health workers mainly fulfill roles in the secondary network reduces the possibilty of emotional dependencies.

3.3. Community Integration

This was assessed using the Community Integration Questionnaire (Willer et al., 1991). According to the authors the CIQ is a useful measure for evaluation of the impact of rehabilitation. However, it should be noted that the CIQ does not assess integration skills or deficit skills. Rather, it assesses integration outcomes. In the light of this, tenants were assessed only in 1993, after twenty one months of living in the Accommodation and Support Scheme.

The questionnaire generates an overall CIQ total score, in addition to the following three subscales:

(i) Home Integration
(ii) Social Integration
(iii) Productive Activity

Tenants ratings on the CIQ are detailed in Table 1. All of the tenants were less integrated on both the Social Integration and the Productive Activity subscales than a sample who did not have mental ill health. In addition, all but one of the tenants had lower total CIQ scores than the non mental illness sample. All tenants, however scored higher on the Home Integration subscale than a group of people not suffering from mental ill-health.

Table 1 : Scores for each Tenant on the CIQ compared to a non mental illness sample

	Tenants 1	2	3	4	NonMental Illness Sample
Home Integration	10.0	7.5	7.5	7.5	5.15
Social Integration	6.0	4.0	6.0	8.0	9.18
Productive Activity	6.0	2.0	2.0	2.0	6.06
CIQ Total	22.0	13.5	15.5	17.5	20.39

* Source : Willer et. al. (1991)

Home integration

Integration into the home is defined as active participation of the individual in the operation of the home. This includes participation in shopping for groceries, preparation of meals, housework, caring for children in the home (if there are any) and planning social gatherings in the home. One of the aims of the scheme is to promote independent living and the development of appropriate daily living skills. To achieve this aim, staff work closely to enable tenants to do things for themselves. The high level of home integration is therefore very encouraging.

Social integration

Scores on the social integration subscale are lower than the norms. Social integration refers to participation in a variety of activities outside the home including shopping, leisure activities and visiting friends. Other aspects of social integration reflect aspects of interpersonal relationships such as having a best friend and participating in social activities with friends who are not users of mental health services. An individual who is restricted or who choses not to participate in social events outside the home will be considered poorly integrated into a social network.

Productive activity

Tenants scored lowest on the productive activity subscale, ie. the extent to which a person gets out of the house during the day and includes employment and educational activities. This is not a surprising finding given the age and physical health of some of the tenants, and the fact that only one person was on a training programme, the remaining tenants attending day centres. However lack of productive or meaningful employment is also very common in individuals who have suffered from chronic mental ill-health.

Overall community integration

Willer et al (1991) noted that individuals with or without disabilities may elect to balance their lives in a manner that may produce greater integration into one area over another, e.g. a housewife may elect to be integrated to a maximum in the home but less so with outside productive activities. It is also perhaps inappropriate to compare this group of tenants to norms from a non-mentally ill sample. Comparison with those suffering from mental ill health at different stages of rehabilitation and integration may provide more meaningful information. Looking, therefore, at the overall picture, whilst general integration into the community and productive activities is somewhat poor, the tenants are extremely well integrated into their homes.

3.4. Quality of Life

This was assessed using the Q.O.L. structured interview schedule (Lehman, 1983). This interview inquired about tenants' 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. Scores were obtained for three main aspects; global well being, objective ratings in the above life domains, and subjective ratings in those same categories.

3.4.1. Global Well Being

There was variability amongst the tenants in how they rated their overall quality of life and in how this changed from 1992 to 1993. One tenant rated overall quality of life as being high in both 1992 and 1993. Another tenant rated overall quality of life as being moderate in both 1992 and 1993. The other two tenants reported a change in their quality of life across the evaluation period. For one tenant overall quality of life dropped from moderate to low, for the other tenant it increased from low to moderate. These self-reports would indicate that apart from one, the tenants felt positve about their life as a whole in 1993.

When asked about their feelings regarding the future, in 1992 two tenants were in the highly positive category, one tenant in the moderate category, and one in the low category. In 1993, three of the tenants reported themselves as being in the high category, and the remaining tenant had decreased their rating from the moderate to the low category. It would appear, therefore, that even 5 months into the scheme in 1992, tenants were feeling positive about the future.

3.4.2. Objective Ratings in Life Domains

The objective life domain of "living" situation was further divided into the areas of comfort, independence, cohesion, and influence. This domain was of particular interest in the evaluation as it provided an opportunity to look at how specific aspects of the scheme impacted on tenants quality of life.

Comfort

It was clear that everyone thought the flats were comfortable and of a very high standard. Although the ratings for comfort were still high in 1993, on examining the individual ratings, three of the tenants had given the scheme slightly lower ratings than they had in the previous year. This may be due to a change in the expectations of the tenants rather than a change in

the comfort of the accommodation.

Independence

The scheme also ranked very highly in terms of independence. A comparison of individual ratings made for the two years shows that, in 1993, all tenants rated their levels of independence as being higher than in the previous year. This would be in keeping with the aim of enabling tenants to have as much independence as possible through developing and improving the necessary skills.

Cohesion

Cohesion examines the degree of cooperative work and sense of community within the scheme amongst tenants and between staff and tenants. In 1992, two tenants rated levels of cohesion in the scheme as being high, one tenant rated cohesion as being moderate, and the remaining tenant felt that there was a low level of cohesion within the scheme. However, by 1993, three of the tenants now felt that there was a high level of cohesion within the scheme. The tenant who rated cohesion as being moderate in 1992, gave it a similar rating in 1993. Regarding the level of social contact within the scheme, all tenants reported high levels. This remained constant for both 1992 and 1993. It is possible that this high level of cohesion and social contact can be attributed to the fact that the scheme is a residential flat cluster scheme and consequently there is very high staff/tenant and tenant/tenant contact.

In addition, the staff facilitate organised group activities for the tenants. For example on Mondays whilst the male tenant is at work, there is a ladies group which aims to bring the three female tenants together on a social basis whilst teaching domestic skills. The group also aims to develop the tenants social skills in external situations. On Fridays, tenants take turns to host their own social events in each others flats. Staff are invited as guests. This was initially a staff organised activity. Tenants take great pleasure in hosting the event, and work hard in getting the flat ready for visitors. Tenants also have a meeting every Sunday in the form of an open forum. Therefore, there is quite a busy social life within the scheme for each tenant to participate in.

In comparison to social contacts within the scheme, only one tenant reported moderate levels of contact with people outside the scheme, the remainder reporting low frequency of contacts outside the accommodation scheme. In 1993, all tenants rated themselves as having low frequency of social contacts outside scheme. This is also reflected in the social networks of tenants which have previously been discussed.

Influence

Influence refers to the amount of say which the tenants feel that they have within the scheme. In 1992, three tenants reported moderate degrees of influence, with the remaining tenant reporting low levels of influence. However, in 1993, three of the tenants reported high levels of influence, with the remaining tenant reporting moderate levels of influence.

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).

3.4.3. Subjective Ratings in Life Domains

Over most life domains the majority of tenants expressed high or moderate levels of satisfaction. No one area stood out as being an area with which there was a high degree of dissatisfaction. Table 2 shows the tenants' subjective ratings for some of the life domains in the QOL scale.

Table 2 : Subjective quality of life for tenants in 1992 and 1993

	Tenant	1992	1993
Living situation	1	H	H
	2	M	M
	3	M	H
	4	H	M
Family	1	H	H
	2	M	M
	3	L	H
	4	M	H
Social Relations	1	H	H
	2	M	H
	3	M	M
	4	-	H
Leisure	1	H	H
	2	M	H
	3	M	M
	4	M	H
Finances	1	L	M
	2	L	M
	3	L	M
	4	L	L
Safety	1	H	M
	2	M	H
	3	M	H
	4	L	H

Regarding satisfaction with living arrangements, tenants were evenly divided between moderate and high levels of satisfaction at both assessment times. For one tenant, levels of satisfaction increased and for another tenant they decreased. Satisfaction with leisure activities and particularly their financial situation increased for some of the tenants across the 17 months. In 1992 one tenant expressed high satisfaction with leisure time and the other three tenants expressed moderate satisfaction. In 1993, three tenants reported high satisfaction and one remained at moderate. On the objective quality of life scale for leisure, which measured the number of leisure activities clients had participated in the week prior to the interview, only one tenant reported a change in the level of activity from 1992 to 1993. Therefore the increase in satisfaction may be a reflection of the tenants "getting more out of" their leisure activities. For the tenant who did report a change, the frequency of leisure activities doubled and there was an improvement from moderate to high satisfaction.

Tenants increase in satisfaction with their financial situation is quite striking. This may be due to two factors. Firstly, help from staff with sorting out problems with benefits may have led to more stability in their financial situation. Secondly, tenant satisfaction may have been increased by enabling tenants to budget more appropriately through teaching of the relevant skills.

When asked how they would feel about the prospect of staying on in the scheme for a long period of time, initially 2 tenants agreed that they would like to stay on. One tenant had mixed feelings and one tenant stated that they would be unhappy at the prospect of staying in the scheme. Seventeen months later that particular tenant expressed being happy to stay on. Two others also expressed a wish to stay on. Only one tenant mentioned that they would no longer be happy to stay in the scheme, and expressed a wish to move to a more independent type of accommodation. This tenant is presently on the waiting list for Housing Executive accommodation.

In 1992, all the tenants except one felt at least moderately happy about their safety within the property. In 1993, however, three tenants reported high satisfaction and the other tenant low levels of satisfaction All respondents were also asked a question about good or bad experiences during the week prior to their interview. The responses can be seen in Table 3.

Table 3 : Good and bad experiences for tenants

	1992	1993
Good Experiences	"Going to the Beacon House"	"A day trip to Portrush"
	"Drawing benefit money in the Post Office"	"Seeing my Friend"
	"I got a letter and a phone call from my son"	"A day trip to Donegal"
	"Seeing a job done right, knowing I had a hand in doing it"	"Bingo at Beacon House, Enniskillen, Lisnaskea, and Praxis Tenants' Social"
		"Trip to Donegal on Tuesday"
		"New training programme to join ITO , when present one at Enterprise Ulster ends"
		"Receiving priority status in Housing Executive waiting list"
Bad Experiences		"Poor health"
		"Not getting Disability Living Allowance, after I was told I was getting it"
		"The weather"
		"Not enough people to talk to "
		"The weather"
		"Pain in hinch"
		"Bad Weather"
		"Getting the finishing date for Enterprise Ulster and having to leave the friends made there"

Tenants were less inclined to offer information regarding their subjective experiences in 1992. In 1993, all tenants offered a variety of good and bad experiences. This change in willingness to respond and volunteer information could also be seen for other parts of the evaluation and must be viewed in a positive light.

Tenants were also asked if they could change one thing in their life to make it better what would it be. There were a variety of responses which included the following :

"My whole self - if I felt 'weller' I'd be happy"
"Getting rid of these voices"
"I'd like to change so that everything was going right for me"
"More Money"
"Giving up smoking"
"I'd like to have more money and be able to live completely independently"
"Getting a home of my own and settling into it"

These responses vary from wanting to change aspects of their illness through to an expression of a desire to live more independently.

3.5 Staff views about the accommodation

All members of the accommodation scheme staff were asked for their opinion regarding the physical aspects of the properties.

Situation

There was general agreement that because the scheme was situated on the main road through the Town, there was quite a lot of noise from the traffic and people in the street. However, it was highlighted that none of the tenants slept at the front of the house, and that they enjoyed the activity in the street. All staff agreed that one of the main positive features of the scheme's location was its accessibility to important local facilities such as shops, the library, the health centre, Beacon House Centre and local public transport. All amenities were within a short walking distance. It was pointed out by some staff that the local church attended by the tenants was situated at a steep bray, making it difficult for some tenants to walk to church.

The flats

All staff agreed that the flats were generally in very good condition, and were very comfortable. However, some staff mentioned that two of the flats had large living rooms which could be hard to heat in winter. Staff also felt that the interior decor was satisfactory, but a unanimous criticism was voiced regarding the fact that throughout the properties there was the same colour scheme. Furniture was regarded by some staff as being unattractive and somewhat drab, although comfortable.

Health and safety

The safety and security of the properties was rated as generally very good, although one major criticism which was highlighted by several staff was the lack of a fire escape from the bedrooms - tenants had to reach the ground floor in order to escape. Another criticism was that the bedrooms were not connected to the main fire detection system. Several staff also mentioned that the final flight of stairs up to the top flat were very steep and narrow. None of these however were health and safety requirements for the building

All staff were in agreement regarding the adequacy of the heating. They felt that the heating was adequate but that the two flats with the larger living rooms were perhaps not as warm as they could be. In particular, there was criticism that the top flat was too large for one person. This had originally been a two person flat but at the time of gathering staff views one of the occupants had been in hospital for some time. In addition, this particular flat had skylights which meant that the tenant in question did not have any view of outside. It was felt by the staff that windows in the flats were quite difficult for some of the tenants to open and close

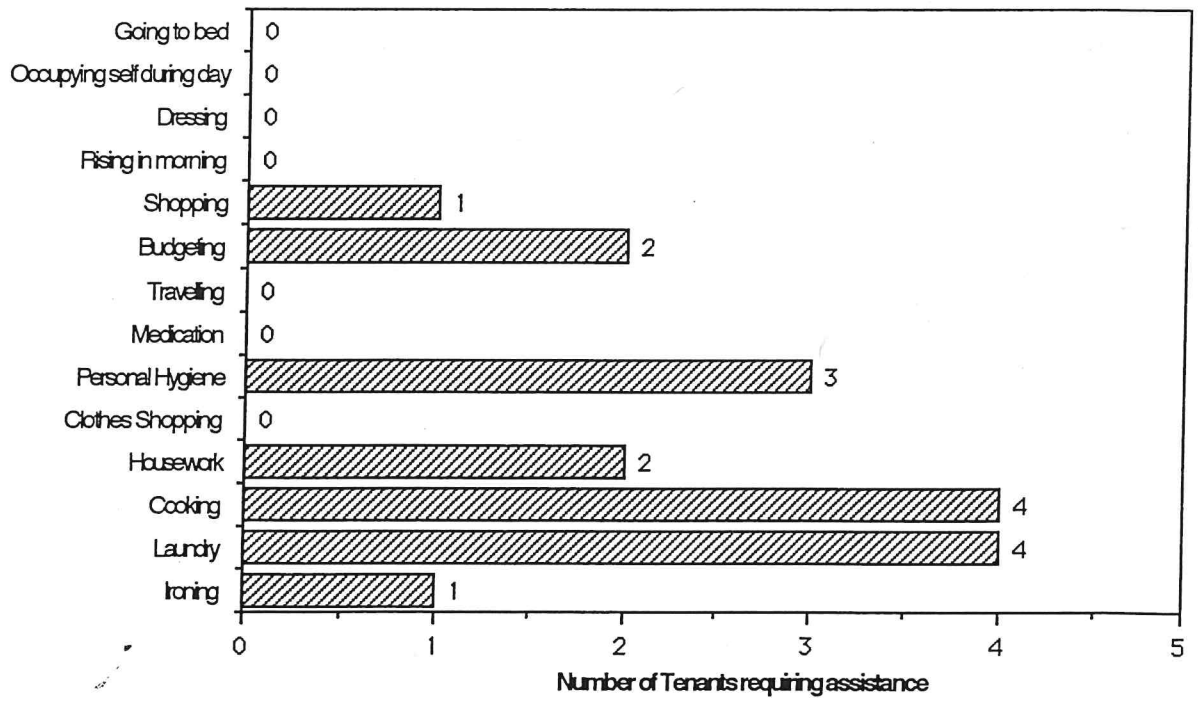
without assistance. As a makeshift arrangement, the laundry facilities were situated across a yard and up a set of steps. This was also criticised, with a preference for the facilities to be incorporated within the main building.

The most positive aspect of the scheme was highlighted as being its accessibility to local amenities, the comfortable and easy to maintain nature of the flats and the fact that the tenants themselves were happy with the accommodation. It should be noted that the current premises, which were not especially designed, were leased on a temporary basis, and the scheme was moved to its purpose built permanent location in ~~November~~ December 1993.

3.6. Individual Support Packages

Individual Support Packages (I.S.P.s), as outlined in the introduction, are put in place for all of the tenants when they are selected for the scheme. This is based on information from the tenant and perhaps the referral agent. Where there is no information available for particular areas of functioning, tenants may be assessed over their first few weeks in the scheme. A support package is implemented only with the agreement of the tenant. Figure 7 outlines a breakdown of the types of assistance formally identified in the initial I.S.P.s in April 1992.

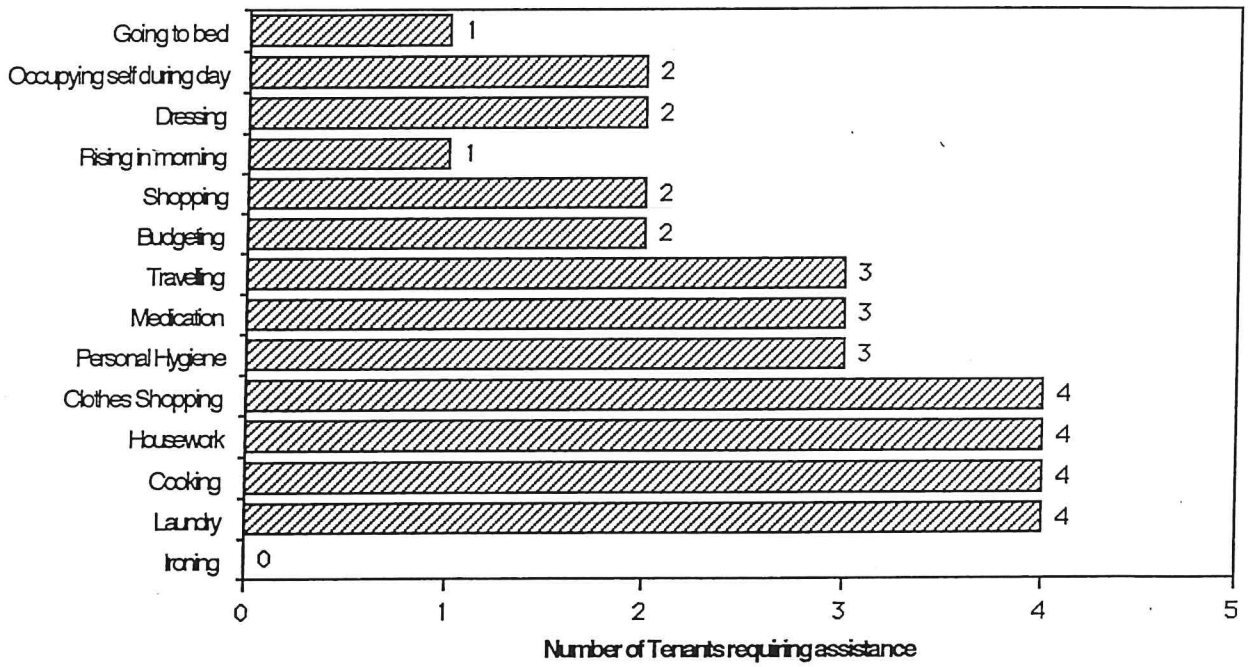
Figure 7 : Types of assistance required from Accommodation Staff in April 1992.



For the 4 tenants, a total of 7 different types of assistance were formally identified as areas with which the Project Workers were expected to provide support. All tenants are formally identified as requiring assistance with cooking and laundry, 3 with personal hygiene, and 2 with budgeting and housework. The least requested types of assistance included shopping and ironing and basic activities such as going to bed and rising in the morning.

Figure 8 shows the areas of assistance and support, identified from the tenants' I.S.P's in November 1992. Some major differences are apparent across the seven months from April to November. A total of 13 types of assistance were identified as being areas with which the tenants required help. All tenants required assistance with cooking, laundry, housework and clothes shopping whereas, in November, all four tenants required assistance only in the areas of cooking and laundry. In four areas the same number of clients required assistance and in nine areas an increasing number required support. A number of new areas of support were formally identified. Amongst these was going to bed at night and getting up in the morning.

Figure 8 : Types of assistance required from Accommodation Staff in November 1992.

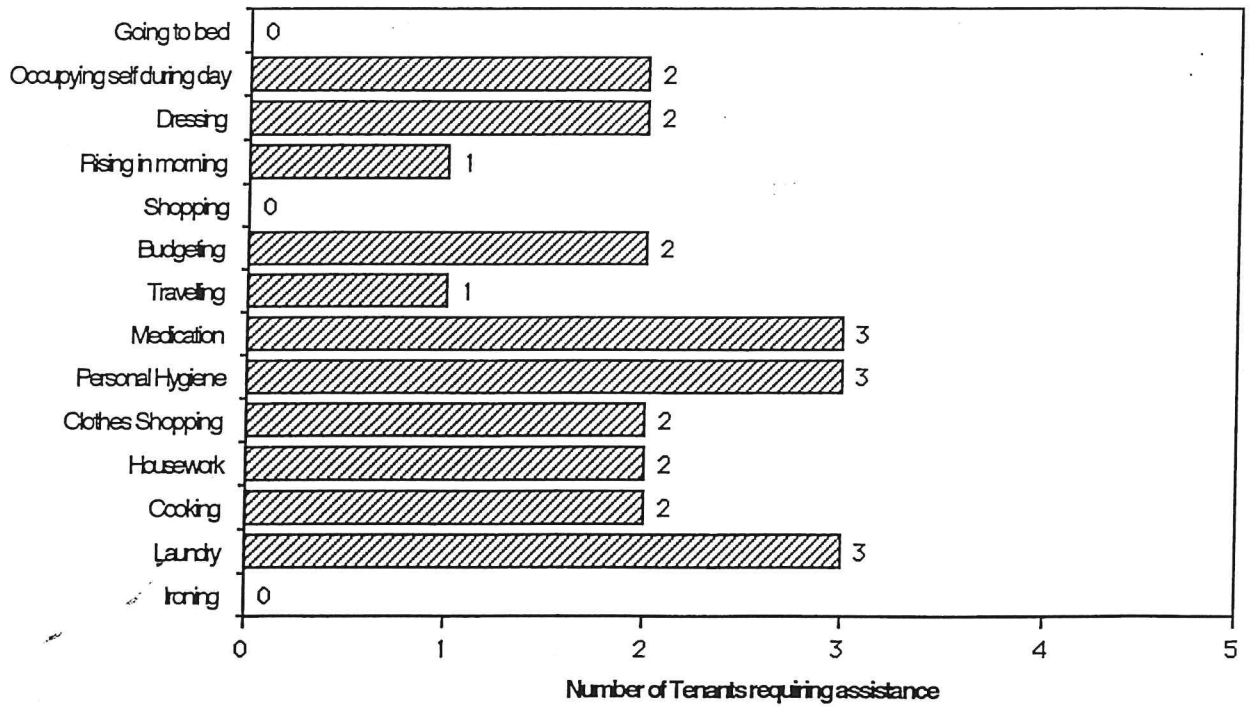


The ISP's were reviewed again in July 1993 (Figure 9). Over the eight months from November to July there were further changes in the number of tenants requiring support and assistance in the various areas of functioning. There was a decrease in the number of tenants requiring support for going to bed, shopping, travelling, clothes shopping, housework, cooking and doing the laundry. For some areas of functioning, the number of tenants requiring support remained the same across the eight months. These areas of functioning were occupying self, dressing, rising in the morning, budgeting, taking

medication and personal hygiene. By the final evaluation period, support was still required in a number of areas.

However, staff on the scheme reported that at that point in time the support provided was purely in a monitoring role, for most tenants in most areas of functioning. For example, although three tenants were reported as requiring assistance with medication, this was in a supervisory capacity as all patients were self-medicating by the end of the seventeen months. It has also been pointed out by staff, that, if a new tenant does not voice a need, it may be difficult to assess that tenant's need if they have not yet performed a particular task. Brewin et al (1987) have emphasized the distinction between lack of competence and lack of performance. They define lack of competence as "a skill (that) has never been acquired or lost" whereas lack of performance is 'in spite of knowing what to do, a person nevertheless fails to demonstrate skilled performance whether through anxiety, lack of interest (or) lack of opportunity". Therefore, if for example, an individual moves into a residential flat cluster and eats out all the time, it becomes very difficult to assess cooking skills unless specific information can be provided by the referring agent. As the individual begins to do more of his/her cooking at home, help with cooking may be identified, through the tenant and member of staff, as an area where assistance may be valuable in the development of skills. Unfortunately this distinction between lack of competence and lack of performance cannot be made from the baseline evaluation as the focus was on how many individuals were requiring assistance in each area of functioning.

Figure 9 : Types of assistance required from Accommodation Staff in July 1993



3.7. Emotional and Practical Support :

The Significant Others Scale (SOS) measures both emotional and practical support. The scale also enabled measurement of (1) tenants' perception of the levels of support they actually received from members of their primary network and (2) the levels of support which tenants felt, ideally, they would like to receive.

Emotional Support

Only one tenant indicated a decrease in the level of emotional support perceived to be available from 1992 to 1993 (Figure 10). One tenant indicated a very small increase in emotional support over the time period and the other two tenants indicated a larger increase. There was also variability in what tenants felt would be the ideal level of emotional support. For one tenant there was a decrease in expectations regarding the ideal level of emotional support he/she wished was available. This was the same tenant for whom there was a drop in perceived emotional support. For the other tenants there was an increase in expectations (Figure 11).

Figure 10 : Perception of level of emotional support in 1992 and 1993

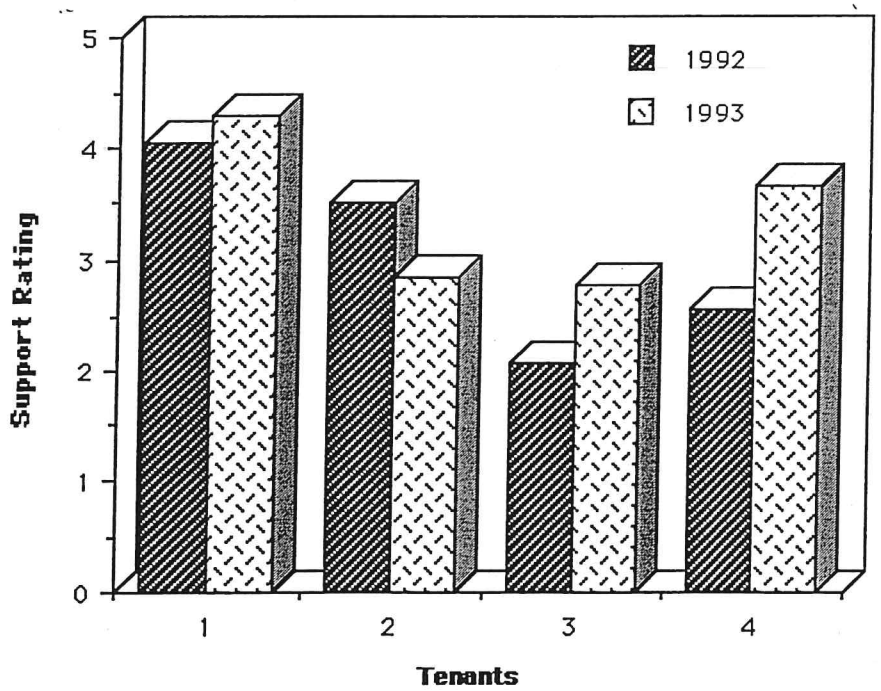
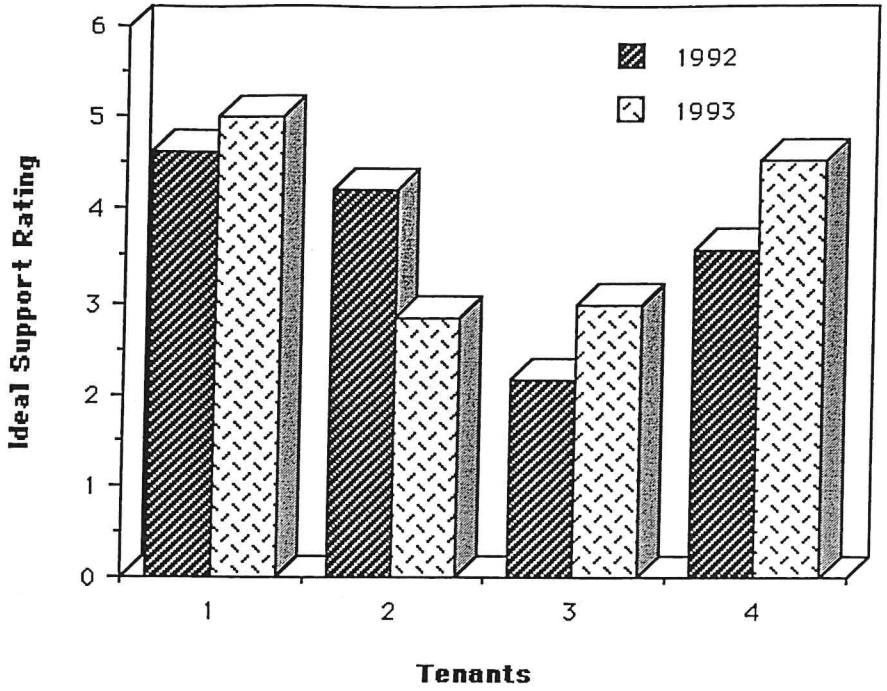
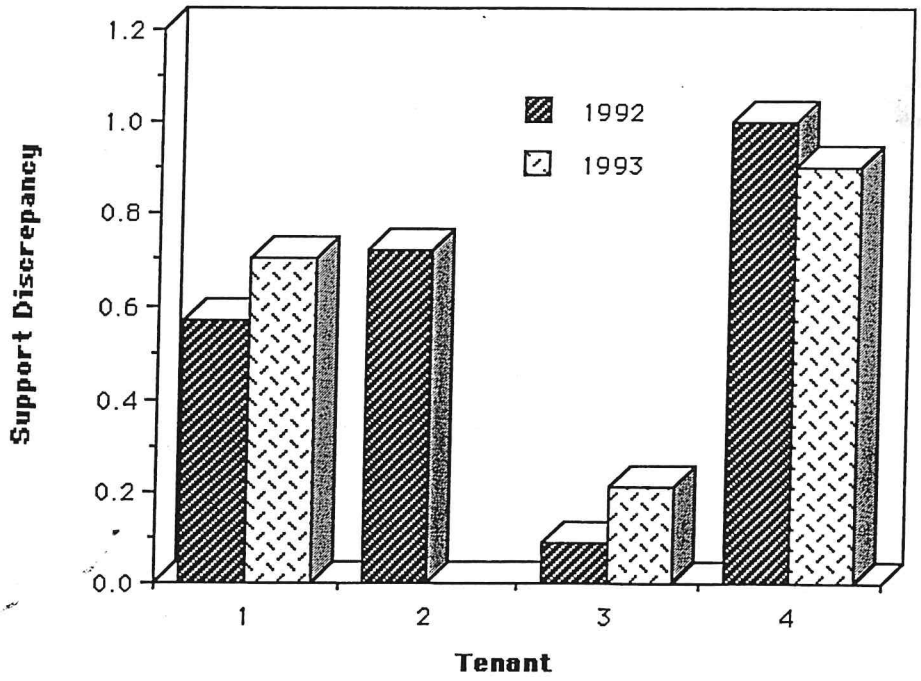


Figure 11 : Ideal level of emotional support in 1992 and 1993



In 1992, all tenants experienced a discrepancy between the level of emotional support they would ideally like to receive and the level of emotional support they felt they were already receiving (Figure 12). They all felt that they were not receiving as much emotional support as they would like to, though, for one tenant the discrepancy was quite small. For this tenant

Figure 12 : Discrepancy between ideal level of emotional support and support received



the discrepancy had increased slightly by 1993. One other tenant showed an increased discrepancy between perceived support received and ideal levels of support by 1993. For one tenant there was a very small decrease in the discrepancy and for the final tenant the decrease was such that there was no longer a mismatch between ideal and actual support received.

Practical Support

As illustrated in Figure 13, for three of the tenants, there were only very small changes from 1992 to 1993 in the perception of levels of practical support received. The other tenant showed a more noticeable decrease in perceived level of practical support received. Overall, there were only small changes in what tenants thought were ideal levels of practical support (Figure 14), For two tenants there were slight increases, for one tenant there was a decrease and for the other tenant there was negligable change.

Figure 13 :
Perception of level of practical support in 1992 and 1993

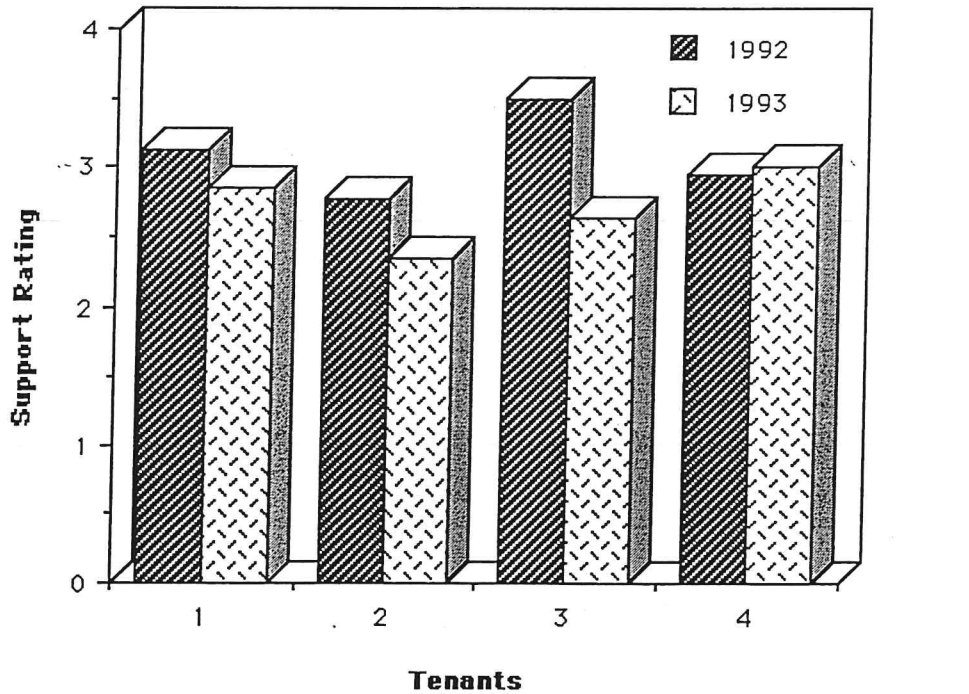
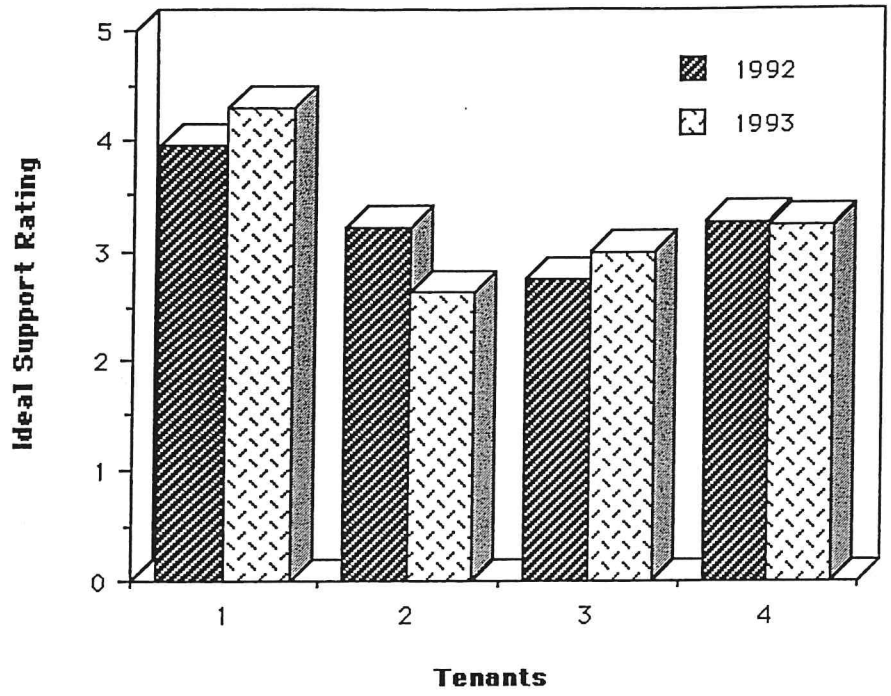
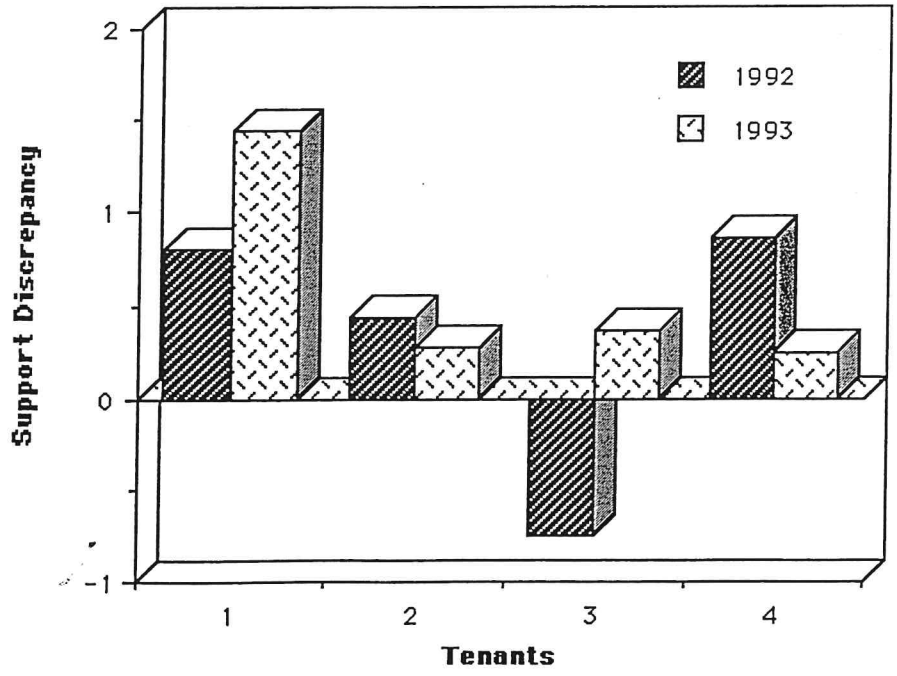


Figure 14 : Ideal level of practical support in 1992 and 1993



There was a discrepancy between perceived levels of practical support received and ideal levels of practical support, for all tenants, in both 1992 and 1993 (Figure 15). The extent of the discrepancy changed for all tenants across the 17 months. At the first evaluation, one

Figure 15 : Discrepancy between ideal level of practical support and support received



tenant felt that the level of practical support received was greater than he/she would ideally like to have. By 1993 the situation was reversed for this tenant. All the other tenants felt that they were not getting the level of practical support they would ideally like to be getting. For one tenant this discrepancy increased from 1992 to 1993. For the other two tenants there was a decrease in the discrepancy.

Regarding the relative levels of perceived emotional and practical support, two tenants felt they were getting more emotional than practical support in both 1992 and 1993. In 1992 the other two tenants felt they were receiving more practical than emotional support. However by 1993 they reported slightly more emotional than practical support.

Readmission

Going back a number of years, all tenants had a history of several admissions to hospital. Two tenants were former long stay patients until moving to a health board hostel in 1990. These tenants have had no admissions since then. One tenant had had several admissions whilst living in semi-independent accommodation. This tenant was last admitted for a short period in 1991 before returning to semi- independent accommodation, and prior to moving to Praxis accommodation. The remaining tenant had been living with family in the community until the family member died. After that, the tenant had several admissions in early 1991 before becoming a tenant in the Praxis scheme. Since becoming tenants in the scheme, there have been no readmissions to hospital.

4.0. CONCLUSIONS

This was an evaluation across approximately one and a half years of operation of a Residential Flat Cluster Model of accommodation. The evaluation focused on quality issues primarily in terms of outcome for the four tenants. As would be expected, there was considerable individual variability amongst the tenants on some of the baseline measures and this was also the case 17 months into the scheme. This makes it difficult to make broad generalisations or conclusions about the scheme. However there were some aspects of tenants lives across the evaluation period which were particularly noteworthy. This initial evaluation of the scheme showed the aims and objectives of the scheme starting to be fulfilled, within the context of the four Praxis principles. Through the evaluation, some areas were identified as needing further attention.

For all tenants, there was a high level of integration into their home surroundings and home life. One tenant also showed a reasonable level of integration into productive activities. Another showed quite a high level of social integration in addition to home integration. The other two tenants however showed integration into only one out of the three areas of community integration. This highlights the difficulties faced by a supported housing scheme in enabling integration in areas of life outside the scheme.

In terms of quality of life, the evaluation particularly focused on how aspects of the scheme impacted on the tenants. In keeping with the high level of home integration, objective ratings for comfort, independence, cohesion and influence were moderate or high in 1992 and 1993. Also in keeping with the high level of home integration was the high level of social contact within the scheme. Given the low levels of social integration it is not surpising that the levels of social contact outside the home are low. Despite this, the subjective ratings of social relationships were medium or high for all the tenants in 1992 and 1993. However, subjective quality of life may be partly determined by expectations and the quality of life measure used does not take into account the level of expectations individuals have regarding various aspects of their lives. It is possible that tenants may have low expectations about what they should receive from their social relationships. Therefore, these individuals may be satisfied with quite low levels of social contact due to their low expectations.

Unfortunately it was not possible to compare rates of readmission during the period of evaluation to those before commencement of the scheme. It is however notable that none of the tenants were readmitted to hospital during the evaluation period despite previous periods of hospitalisation. As a global indicator of satisfaction with the scheme, tenants were asked how they would feel about the prospect of staying on in their accomodation for a long period of time. Seventeen months into the scheme, 3 tenants reported being happy about this prospect and one tenant reported preferring to

move to a more independent type of accommodation. In general it would seem fair to conclude that tenants were pleased with the quality of their accomodation and that they felt positive about various aspects of their lives.

5.0. RECOMMENDATIONS

This evaluation raised a number of issues. Some of the aspects of the scheme highlighted in the evaluation were very positive, others were less positive. The recommendations will include all of these as it is as important to look at the strong aspects of a scheme and build on those as it is to correct weaker aspects.

5.1. The overall increase in the tenants' secondary social networks is a very positive outcome. It is difficult to assess whether this was due to the nature of this particular scheme model, as evaluations of previous schemes have taken a snapshot of service users social networks rather than look at progression over time. Future evaluations should replicate the methodology of the Lisnaskea evaluation and look at changes in social networks over time, therefore, enabling comparison between scheme models. (Para. 3.2.1.)

5.2.1. For one tenant there was a large increase in the number of family members in the social networks and it is probable that staff may be aware of this. It would be valuable for staff to consider whether there have been any particular aspects of the scheme that have enabled this to happen. (Para. 3.2.1.)

5.2.2. For the tenant who experienced a considerable increase in secondary network size and a small increase in primary network size, there was corresponding increase in the emotional support they felt they were receiving but a decrease in the practical support they were receiving. Therefore while an increase in network size is likely to be a positive development, it cannot be automatically presumed that the individual feels the benefit in terms of increased emotional and practical support. Emphasis should therefore continue to be placed on the evaluation of the adequacy of attachments as well as the availability and number of attachments. (Para. 3.7.)

5.3. The overall increase in the proportion of mental health workers in the secondary social networks will require continued monitoring. (Para. 3.2.1.)

5.4. The presence of a large number of mental health workers in an individual's primary social network raises the possibility of increasing dependency. The overall small decrease in the proportion of mental health workers to family members (only one individual showed an increase) that tenants defined as part of their primary networks is therefore positive. So too is the greater likelihood of finding mental health workers in the secondary rather than the primary networks. (Para. 3.3.2.)

5.5. The high levels of independence and influence reported by tenants is very positive and encouraging especially given the high staff to tenant ratio and the fact that staff were working with a very small group of individuals. This was also reflected in the increased likelihood of tenants to speak out about their accommodation and recent negative experiences in their lives. The work which has created this climate should continue and Praxis should endeavour to have a further understanding of this. (Para. 3.4.2. and 3.4.3.)

5.6. Because the Lisnaskea scheme was a new type of model, the fact that satisfaction with the Residential Flat Cluster Scheme was medium or high for all tenants, even early on in the scheme, indicates that it is an acceptable model of accommodation and support for service users. (Para. 3.4.2.)

5.7. The increase in the types of assistance given to tenants, through the ISP's, across the first 7 months, may be interpreted as an increased sense of comfort and confidence on the part of tenants to request assistance. There was subsequently a tailing off of support requested as individuals became more skiiled in various activities. It is important that future evaluations of ISP's take this early reticence to request support into account. (Para. 3.6.)

5.8. The level of social integration is quite low. There is a need to identify ways of improving the balance between activities at home and facilitating social contact outside home and outside special needs environments. (Para. 3.3.)

5.9. Although the provision of relevant day time occupation outside the environment of the flats was identified as an objective of the scheme, only one tenant showed regular performance of productive activities. However, given the age and health of some of the tenants, this may not be a realistic aim for these individuals. However it further stresses the importance of enabling individuals to develop meaningful social contacts outside the environment of the accommodation scheme. (Para. 3.3.)

5.10. Calman (1984) has proposed that the differences between a persons expectations and their present experience is reflected in their quality of life. The way in which quality of life is currently measured by Praxis, does not take into account the level of expectations individuals have regarding their lives. The Research Department should investigate ways of taking into account individual differences in expectations and changes in expectations over time. (Para. 2.2.2. and 3.4.)

5.11. In a recent review article O'Boyle (1984) commented that "because each person is an individual with their own unique set of circumstances, perceptions, fears and aspirations it has been argued that assessment of quality of life must incorporate the unique perspective of the individual".

Some of the quality of life measurement instruments presently used by
value system on tenants by making assumptions about what issues are impo
Research Department should explore the feasibility of taking a more individual pe
measuring quality of life. (Para. 2.2.2. and 3.4.) Research.

5.12. The problems of using privately rented accommodation were highlighted in the evaluation. This could particularly be seen in staff comments about the furniture and heating and the lack of control there was over these. If privately rented accommodation is to be used in the future Praxis should explore the feasibility of upgrading the furnishings for that accomodation. (Para. 3.5.)

Upgrading.

6.0. REFERENCES

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