

Primary Research and Data Collection from Focus Group Interview Survey

A series of focus group interviews were designed developed and implemented with a range of key stakeholders and service providers to capture their experiences and expert opinion of working with service users.

1.0 Consultation Process

The primary aim of the accommodation strategy is the enablement of partnership that draws together services from the Plymouth Primary Care Trust, Local Authority and voluntary and community housing sectors.

To achieve this aim primary and secondary data collection, its analysis and evaluation is used to inform both the direction of the strategy and its implementation.

The process of capturing need data for the purpose of analysis and planning was undertaken in conjunction with a number of partner agencies that has included service user and practitioner participation.

Consultation to determine the most appropriate research methodologies included participation from professionals working within mental health's acute inpatient and rehabilitation services, drug and alcohol services, community psychiatric services, criminal justice system, Adult Social Care, older person's supported housing services, general needs housing, young people and a representative from the University of Plymouth. Service user representation was provided by Plymouth's Service User and Carer's Forum.

The methodologies employed in the collection of primary data have included focus group interviews, attitude questionnaires and single participant interviews, the latter of these can be found in appendices one and three, five and six.

The differing methodologies have all used the rules of inference (heuristic rules) in their construction and implementation. This has been built into the design of the research because service users, practitioners and service managers will have a knowledge and experience of the issues that relate to poor mental health and the process of recovery, see Sanderson (2007) and Chen and Chaiken (1999) and Chaiken et al (1989) for a full discussion on heuristic rules.

2.0 Focus Group Interviews

A standardised focus group interview was implemented with a range of service providers from Plymouth’s teaching Primary Care Trust and voluntary and community sectors.

The primary aim for undertaking these focus group interviews stems from the need to develop an accommodation pathway. An accommodation pathway that is responsive to the needs of the service user and one that promotes move on and independent living is core to the primary aims and objectives of the strategy.

2.1. Target population & Sample

A target population of staff teams and managers were identified and drawn from the City’s inpatient facilities, community psychiatric services and supported housing providers.

The same service providers identified in appendix one were targeted to ensure synergy between the providers of care and support and those who receive care and support (for comparison see the table below and table 1.1 in appendix one).

Table 1.1

1	Assertive Outreach Service & Community Forensic Team	Community Psychiatric services
2	Home Treatment Team	Community Psychiatric services
3	Glenbourne Unit	Inpatient and residential rehabilitation services
4	Lee Mill	Inpatient and residential rehabilitation services
5	Gables	Inpatient and residential rehabilitation services
6	Syrena	Inpatient and residential rehabilitation services
7	Edgcombe	Inpatient and residential rehabilitation services
8	Willows	Inpatient and residential rehabilitation services
9	Inner City PCLT	Community Psychiatric services
10	Ice Break & Insight	Community Psychiatric services
11	Colebrook Housing X3	Community Voluntary Sector
12	Devon & Cornwall Housing Association, Westcounty Housing and Plymouth and District MIND	Community Voluntary sector

Justification for selecting the sample of service providers identified in the table above was based on a short scoping exercise undertaken with key stakeholders and partner agencies from a range of relevant professions. This process

concluded that the list of participating service providers represent the entire service provider population (excluding Outer City Primary Care Liaison Team) relevant to the primary aims of the strategy.

As the chosen methodology for this survey was focus group interviews it was therefore important to ensure it was standardized and the sample of volunteers, or self selected participants were representative of their various skill areas. As such each service provider was asked in advance of each focus group to provide a quota sample of between 6 and 8 volunteers to participate in each of the 14 focus group interviews (see Silverman, 1997 & Berg, 1998 & Robson, 1993 for a wider discussion). In practice the number of participating volunteers varied between focus groups.

2.2. Design

To achieve the primary and secondary aims of the research and ensure synergy between the research outcomes and those identified from the service user questionnaires and single participant interviews the same four theme areas were applied.

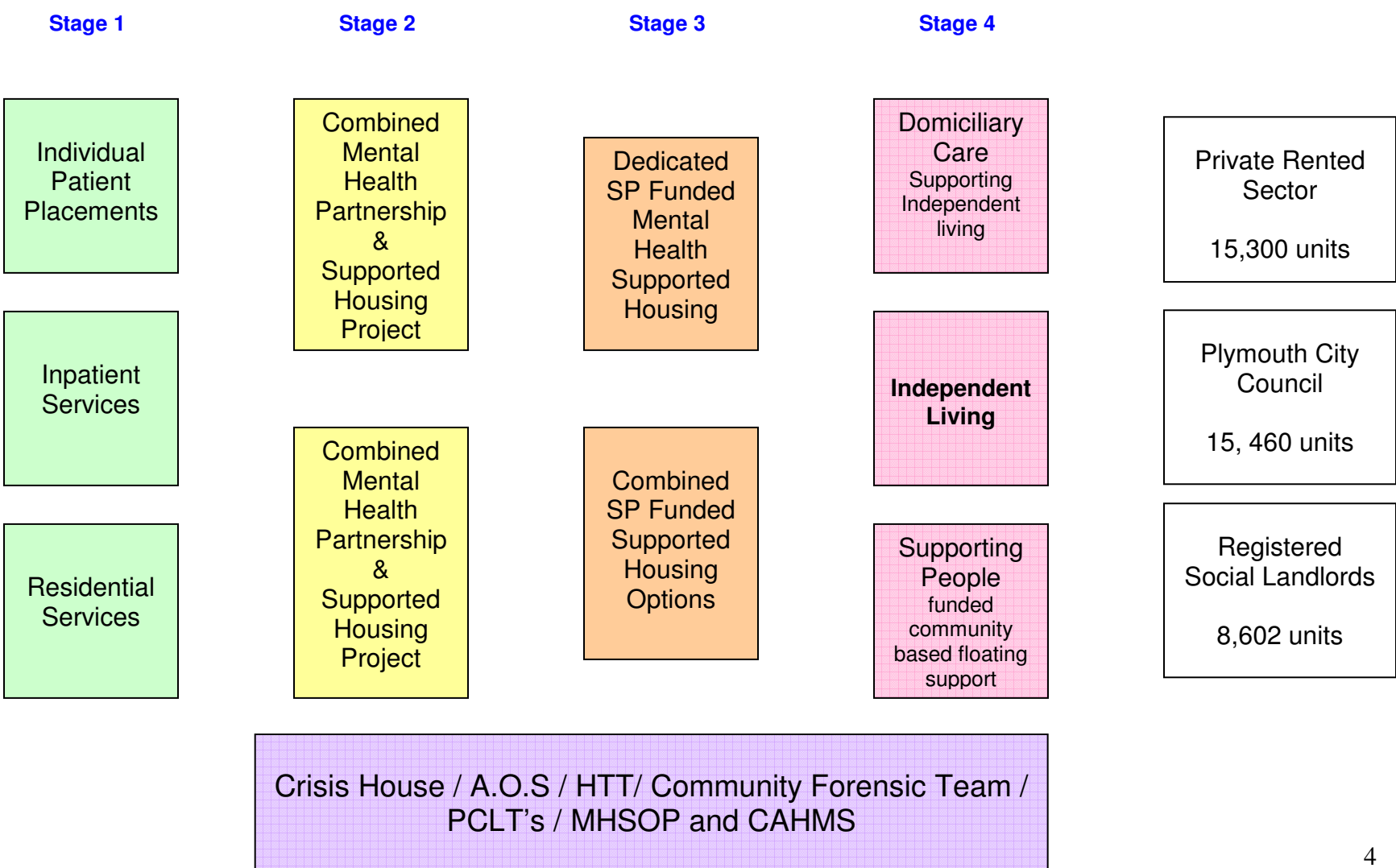
These were agreed with members of a project board, who themselves represent a number of related and relevant disciplines that included service user representation.

The themes agreed were training, the development of a mental health crisis house, support, barriers and training. Each theme was summarised in the form of a statement or question and read out to participants during the interview.

Each theme was then broken down into 5 subsections that linguistically relate to each of the questions posed in the service user questionnaire and single participant interviews. These were designed to be individually incorporated into the interview and used as cues in the development of the interview process.

A flow chart labelled 'Accommodation Pathway' was provided to each of the focus groups so the questions and prompts used by facilitators could be related to the aim of the strategy and way in which service provision might be remodelled to achieve the strategies objectives. Please see pages 4 and 5 for examples.

Accommodation Pathway



ACCOMMODATION PATHWAY

Mental Health Partnership & Supporting People Funded Services

This document should be read in conjunction with the accompanying flow chart, Accommodation Pathway. The purpose of the flow chart is to map and model existing provision. The aim of the flow chart is to demonstrate how service provision can be re-modelled to enable service users to move between stages in a planned way. The pathway represents a process that will enable a service user to move between services based on their changing need.

The first green box in stage 1 represents all the individual patient placements located outside Plymouth. The second box represents the inpatient services and the third box longer term residential care. These have been identified as stage one services as they represent the highest level of care and support. The focus for move on at this stage is preparation for the next stage and independent living. Stage one, like stages two, three and four can refer and receive referrals from other stages based on a service users need.

The yellow boxes in stage 2 represent a step down from stage one and a step up from stage 3 in terms of levels of support. Stage two services will provide psychiatric care and housing related support delivered by both Supporting People funded services and the Mental Health Partnership. The aim of this stage is the continuation of service user progression toward independent living. Stage two services will receive referrals from the community and other supported housing providers.

The orange boxes in stage 3 signify the next stage in a service user's progression toward independent living. This stage represents two distinct pathways which can be accessible from any stage. The box described as 'dedicated mental health supported housing' represents all the Supporting People funded residential units whose primary client group is mental health. The box described as 'combined supported housing options' represents the large number of residential housing related support units in the single homeless, ex-offender, young people, older people and substance misuse sectors. While these sectors provide support to a number of differing primary client groups, recognition exists that they also work with a significant proportion of people who have a number of vulnerabilities that includes mental health problems. For this reason services within these sectors will for some service users provide the most appropriate option for move on and support.

The pink boxes arranged under stage 4 represent independent living with support. The box described as 'domiciliary care supporting independent living' represents the type of support available to those who qualify in the usual way. Access to this type of support is considered relevant to some service users who need domiciliary care to maintain their independence. The box marked 'Supporting People funded community floating support' represents all the floating support services based in the community that support service users in their homes, wherever they are in the Plymouth area. The box marked 'independent living' represents the white boxes indicating the number of available units and types of tenure available to enable move on.

The purple box that sits below the staged move on boxes, 2, 3 and 4 represent existing specialist services that operate to maintain and enable service users to continue to live independently. The crisis house identified in this box is a new service that will only be accessible from stages 2, 3 and 4. The crisis house is a joint funded service managed by a provider of supported housing in the voluntary sector. Crisis accommodation refers to a house or number of residential units that people living anywhere in the community can access when they experience personal or social difficulties that do not require hospital, or inpatient care.

The white boxes at the end of the 4 stages have been inserted to illustrate the types of tenure and number of available units within the private rented and social housing sectors. It is also intended to demonstrate the options service users have when moving on from supported or residential care and into independent living. The number of units within each box has been provided by Plymouth City Council's Housing department. For information; the number of units recorded in the residential social landlord box contains a small percentage of sheltered and supported housing as these could not be separated from the figures submitted and entered into the overall calculation.

Each participant was provided with a copy of the flow chart before the start of each focus group interview and at the conclusion of each interview individuals were provided with the supporting document, an example of which has been provided on page 5. This document was provided after the interview to ensure the focus remained on the flow chart and the questions posed during the interview.

A time period of 30 minutes was allowed for each focus group interview to ensure standardization. A script for facilitators was drafted and read to each of the focus groups prior to implementation.

A copy of the script template used during the focus group interviews is provided below:

Focus Group Interview format

Distribute handout (Accommodation Pathway Map)

- Thank you for providing us with the opportunity to undertake this focus group interview. Before I explain its purpose can I first of all explain what a focus group is and what it seeks to achieve.
- A focus group interview is simply a means of collecting people's attitudes and opinions to a specific topic or set of topics through an informal group discussion.
- To help us record your comments and opinions we will be using a tape recorder and making notes. All the information we record or document during this focus group interview will be done so anonymously. We will treat all your individual comments and opinions as confidential to the group discussion.
- The purpose of this focus group interview is to provide you and some of your colleagues with the opportunity to participate and contribute to the development of an accommodation strategy.
- As you may or may not be aware the Mental Health Partnership (Teaching Primary Care Trust & Adult Social Care) in partnership with Supporting People are developing a joint accommodation strategy that we hope will enable an accommodation pathway to be developed between the Mental Health Partnership and providers of supported housing in the voluntary sector.
- We need your views and opinions on how this might be achieved. To focus this discussion we will introduce 4 subject areas during this discussion. They will be training, crisis accommodation, barriers and support.
- To help you focus on the main topic area we have provided you with a map titled 'Accommodation Pathway'. I will briefly explain the map to you before we formally begin.
- For reasons of standardisation we have allowed 30 minutes for the focus group discussion.
- We are required to advise you that you can withdraw at any point during this process. Are there any questions before we start?

2.3 Survey Questions

A standardised set of 4 questions were used in the implementation of each of the focus group interviews. A series of prompts called cues, were likewise used by facilitators. The questions and the cues were designed to correspond precisely with the questions posed in the service user questionnaire and single participant interviews. This enables a full and complete comparative evaluation to be undertaken, which can be found in chapters 2 and 7 in the mental health accommodation strategy.

Table 1.2 provides an illustration of the themes, questions and cues used in each of the focus groups interviews. The order in which each question was posed differed from focus group interview to interview. Facilitators were likewise rotated. This was incorporated into the methodology to avoid researcher bias (see Robson, 1993).

Table 1.2

	Themes	Questions	Cues
1	Training	What additional training will be needed and where should it be targeted to increase service user move on, or enable service users to sustain their independence in the community.	A Staff have the skills and the knowledge
			B Psychological Therapies
			C Service users have the skills
			D Support Plans
			E Service user access to training
2	Crisis House	How important do you think crisis accommodation might be in helping service users move on or sustain their independence in the community?	A Extra help
			B Crisis house access
			C 5 day stay
			D Practical support
			E Supported housing providers have access
3	Barriers	What barrier might prevent service users from moving on?	A Accommodation options
			B Wish to live independently
			C Confidence to reduce support
			D Knowing what is out there
			E Time
4	Support	What type and level of support do you think service users will need to help them move on?	A Medication
			B Access to drug or alcohol treatment
			C Ex-offenders
			D Co-located housing advice resource
			E Access to all types of supported housing

All questions used in this survey were initially piloted with a multi agency project board that had service user representation. The crisis house question was posed with a definition of what a crisis house is.

2.4 Survey themes

Each theme area mirrors those used in the design and implementation of the service user questionnaire and individual participant interviews. The theme measures used to evaluate the range of attitudes from the three sectors have been designed to enable comparison. Theme areas are described on page 8.

1. Training

The fundamental purpose of this theme area is establishing if participants feel additional training would be necessary for the aims of the strategy and accommodation pathway to be met.

The focus and use of cues centre upon existing skills and knowledge, support planning and the skills staff feel a service user has and the available training opportunities open to service users that promote independence.

2. Two Crisis House

The theme underpinning question two relates to the need for a crisis house as an underpinning service in the accommodation pathway.

The focus and use of cues were used to determine the type service required, how it should be delivered and who should have access to a crisis house.

3. Barriers

Identifying barriers is another key theme integral to unlocking the potential within existing services.

The question and cues used all focus on identifying the knowledge partner agencies have about each other, time, resources, attitudes and confidence as possible barriers to increasing and sustaining independent living.

4. Support

The focus of this themed question is in how targeted support can enable positive risk taking to be used to promote move on and sustainable independence.

The question and cues used all relate to the range of presenting needs service users have in addition to their poor mental health. Identifying key support needs like dual diagnosis, medication in the community and ex-offenders and then mitigating the risk posed with targeted support like specialized staff teams co-located and access to a range of non mental health specific services.

3.0 Research

3.1 Implementing the Research

It was planned from the outset that all the services listed in table 1.1 would need to participate in this survey to ensure a clear comparison could be made between service users and service providers.

Fourteen focus groups were planned and successfully implemented with the full range of service providers from Supporting People funded services, inpatient and community psychiatric services. The exception to this was the Outer City Primary Care Liaison Team whose service user profile was considered the same as the Inner City Primary Care Liaison Team who participated in this research. It was therefore agreed with the project board that only one of these teams would need to participate.

Each focus group interview was undertaken by two or more facilitators. One of whom acted as interviewer while the other recorded the information attained from the process.

The data attained from each of the fourteen focus groups was recorded in the form of a transcript and provided with an identify number. This was undertaken to ensure the anonymity of participants as they were advised during the interview process that their views and opinions would be recorded anonymously.

While it is important that the anonymity of each service provider and their participants are protected it is of equal importance that service sectors and individual services are compared and evaluated against each other. Therefore transcripts one to six have been recorded as all the residential inpatient and rehabilitation services, numbers seven to ten are the community voluntary sector services and eleven to fourteen are community psychiatric services. Please see appendix 4 for reference.

3.2 Evaluating the Research

Following this process the focus group transcripts were then subjected to a process of coding. This process requires the allocation of numbers and letters to be attributed to a set of statements and comments made during each of the interview processes (Robson, 1993: 253). Coding the transcripts in this way enables a realistic and comparable measure to be made between the views and opinions provided by each of the focus groups.

This method of coding is used to enable a point of reference and means of identifying support for a particular view between individual services and service sectors.

All the transcripts were coded in accordance with their responses to the questions posed during the interview, the context in which statements were made and when particular reference was made to one or more of the cues employed during the interview process.

All the coded transcripts are then processed and presented as a set of results.

4.0 Results

The results have been presented as a series of four sections, mirroring the order in which the questions were posed during the implementation of the research. Each section is then broken down again into a series of five sub-sections, again mirroring the order in which the cues were used during the implementation of the research.

For the purpose of standardisation all the results from the focus groups are ordered by service sector. This allows a clear comparison to be made between the different service sectors, which are then used to inform the findings and recommendations.

4.1 Section One (Training)

Question One: What additional training will be needed and where should it be targeted to increase service user move on, or enable service users to sustain their independence in the community.

4.1.1 Staff Skills and Knowledge

This prompt was used during the interview to ascertain if participants felt staff within their service and or other services have the right type and level of knowledge and skill to support service users to move on or live a more independent lifestyle.

Inpatient and residential rehabilitation services

Participants from the six focus groups in this service sector formed a consensus that external service providers, particularly those in the community voluntary sector required additional training in a number of areas. These include developing a better understanding of mental health and differing types and levels of need and triggers that result in people becoming unwell, risk management, sharing information and dual diagnosis which includes mental health coupled with a learning disability and or substance misuse.

Agreement between the six focus groups on gap's in their own knowledge and skill base as an area for training, points to the need for training in a number of areas. These include welfare rights training, specialist training in accessing welfare benefits, housing benefits and grants to assist in enabling service users to move on.

A further training need was recognized that services exist outside the inpatient and residential rehabilitation service sector that participants had no knowledge. This was reinforced by the notion that preparing service users to move on is often

more difficult than it should be because of this lack of knowledge of what is available and how it might be accessed.

Community and voluntary service sector

Participants from this sector felt they needed more training around mental health generally, particularly in understanding conditions and behaviours associated with an individual's mental health. Training on how to modify or support some behaviour's associated with mental health. Training that includes different ways of engaging hard to reach clients and service users living in the community.

Community psychiatric services

Some participants felt services within the community and voluntary service sector would benefit from training that raised awareness of wider mental health issues, this it was proposed would reduce stereo types and prejudices associated with mental health. They also felt the community and voluntary services needed training around assessing need and promoting independent living so providers could train service users to better sustain their independence or move on.

Some focus groups also felt the community voluntary sector providers would benefit from recovery focused training.

4.1.2 Psychological Therapies

This prompt was used to assess to what extent psychological therapies would have, if service providers were trained to deliver them.

Inpatient and residential rehabilitation services

The majority of participants expressed the need for psychological therapies to be available in the community. Most focus groups agreed that psychological therapies help service users to move on or sustain their independence. As such therapies should be delivered in the community by service providers working with those who might benefit.

Therapies should be controlled in their delivery but supported housing staff or voluntary and community sector providers should be provided with the training to deliver these within the community.

Some focus groups felt they should be provided with the skills and training to deliver some psychological therapies.

Community and voluntary service sector

Focus group participants in this sector are generally sceptical about delivering

psychological therapies and expressed the need to be cautious about being trained to deliver psychological therapies. They expressed the need to be cautious as they generally felt that their role within supported housing had changed recently leaving them with little or no capacity to develop the role further.

Some participants felt delivering therapies would change the relationship they have with service users to the detriment.

One group of participants did however feel that delivering psychological therapies from supported housing might be helpful in achieving move on and sustaining independence. They did however balance this with a commentary that therapies might best be delivered by specialist workers.

Community psychiatric services

All the focus group participants in this sector were agreed that psychological therapies are needed to assist and enable service users to sustain their independence in the community or move on from supported housing.

This view was moderated by the current availability or lack of access to psychological therapies as a resource. The need for psychological therapies was further illustrated by participants who stated that individual service users who had low level needs can develop a higher level of need if psychological therapies are not widely available or accessible to community services.

Focus groups also linked the need for psychological therapies to be made available to people accessing the crisis house and those using voluntary sector services.

4.1.3 Service Users Have the Skills

This prompt was used during the interview to ascertain if participants consider service users to have the necessary skills to be able to move on from inpatient and residential rehabilitation services, supported housing and or sustain their independence in the community.

Inpatient and residential rehabilitation services

Focus group participants identified the training they currently provide service users in the form of budgeting, managing personal and shared environments and job seeking. However, one of the focus groups strongly argued that service users would be more motivated and feel better able to move on if they knew what services were available to them. Training that provides this level of awareness and facilitates this level of understanding will better equip service users for move on and provide them with an understanding of what is available and what is

expected of them.

A need for multi agency training was advocated as a means of training service users in the various skills required to live independently or semi independently in the community. The same group of participants also advocated for co-located staff specialist in certain areas to provide this training to service users.

Community and voluntary service sector

A number of focus groups cited training as essential for service users occupying inpatients and the residential rehabilitation services. The focus of the training should be preparation for independent living and making the transition from inpatients and residential rehabilitation to supported housing.

Focus groups likewise cite the need for educating service users in what supported housing offers and what a service user might expect from supported housing in the longer term. The focus of the training needs to be realistic about the long term housing options available to service users from the start, one group said.

Preparation for independent living should start when service users are still accessing inpatient services.

Community psychiatric services

Service users need to be better prepared for the transition from younger person mental health services to adult services. Service users should be better supported and made aware of the challenges they face as young people with mental health issues and when they live independently in the community.

4.1.4 Support Plans

This prompt was used during the interview to establish if participants feel staff in other service sectors have the right skills and have received the necessary training to deliver effective support or care plans.

Inpatient and residential rehabilitation services

A range of focus groups hold the view that they provide and deliver effective care planning. This view however does not extent to supported housing providers. Supported housing providers in the community have shown an ability to deliver, but have according to these participants failed to deliver the kind of positive outcomes required. The rational for this was developed around support plans failing to reflect the care plan assessments service users receive when accessing inpatient and residential rehabilitation services. Participants felt support plans in the community voluntary sector should reflect the care plans developed with

service users as part of their move on plan.

Another focus group felt community voluntary sector services should start, or at least develop their support plan with the service user and inpatient provider before the service user makes the transition from inpatient services to supported housing. This it was felt would enable a more positive transition to take place and support plans would then better reflect the needs of the service user. Failing to do this results in the service user repeatedly going through an assessment process.

Inpatient services develop care plans that include service user training in preparation for independent living. This however is quite often different from the training and support plans service users receive when they enter supported housing in the voluntary and community sector.

Focus group participants generally expressed the need for care plans to be reflected in supported housing (community voluntary sector services) support plans, this it is proposed would consolidate the move on process.

Community and voluntary service sector

A large group of participants from a range of services acknowledged the need for an improvement in the links between care plans (Care Plan Assessment) and the housing related support plans they use. This is identified as a training issue for supported housing providers and mental health professionals in the inpatient and residential rehabilitation services. Participants recognised that their own services and those in the inpatient service sector do not have a shared understanding of the assessment and case management processes.

Like the focus group participants from the inpatient services the voluntary sector focus groups advocated a need for supported housing support planning to start prior to a referral being made from inpatients to supported housing. This it is adjudged will enable the care planning to merge with the support plan delivered by the supported housing service.

A secondary training need identified by focus groups within this sector points to the need for staff in inpatient and community voluntary and community psychiatric services to receive training on data protection and the freedom of information act. As sharing information between services about service users can prevent a service user accessing the right move on pathway.

Community psychiatric services

Focus group participants in this sector identified the community and voluntary supported housing sector as needing to re-focus their support plans to better reflect a recovery focus that includes tackling social exclusion.

They also believe medication needs should be reflect in housing related support plans.

4.1.5 Service User Access to Training

This prompt was used during the interview to ascertain if providers felt service users had access to different types of training opportunities that might help or enable them to move on or better sustain their independence.

Inpatient and residential rehabilitation services

A consensus between participants in all of the focus groups in this sector suggested service users do not have access to the most appropriate training opportunities.

Focus groups advocated the need for service users to receive training in the following areas: welfare benefits, basic life skills, self esteem and confidence building, dealing with anxiety, strategies for dealing with loneliness and developing links with the local community, shopping and budgeting, vocational training and general independent living skills.

Some focus groups stated that service users, while resident with inpatient services, should be provided with information on what accommodation pathways exist and how they might access them. This it was stated would promote independence by raising the awareness of service users and their carers.

Community and voluntary service sector

Focus groups in this sector highlighted the need for service user training to be completed before they leave inpatient services. Making the right kind of training available to service users before they leave inpatient and residential rehabilitation services better prepares service users for moving on and into supported housing in the community.

Independent workshops made widely available to service users from a range of service sectors would better prepare service users for independence.

Some supported housing providers use externally developed 'training packages' of housing units. These are a help to both service users and providers in developing and preparing service users for move on.

Service users accessing inpatient services should receive training that includes the practical skills they will need when they return to the community, this provides the foundation which supported housing workers can then pick up and develop.

Community psychiatric services

Focus groups in this service sector believe service users and providers would find it extremely profitable if services with the right kind of experience in training service users were to share this with other service sectors.

Life skills and independent living skills were identified as the most important training opportunities that should be made available to service users in all service sectors.

4.2 Section Two (Crisis House)

Question: how important do you think crisis accommodation might be in helping service users move on or sustain their independence in the community?

4.2.1 Extra Help (& need for a crisis house)

This prompt was used during the interview to ascertain the need for a Crisis House and determine the extra support a service user may require when accessing the Crisis House.

Inpatient and residential rehabilitation services

All the focus group participants from this sector supported the need for a Crisis House.

Participants felt having a Crisis House in Plymouth was a positive development and would stop clients being admitted to acute services. The same group felt that the service should be operated and staffed 24 hours per day providing access to medical staff.

To effectively support service users with the kind of help and extra care they need crisis house staff should be people with an experience of working with mental health client's in crisis. The skill mix should include male and female, qualified nurses, unqualified support workers and Occupational Therapists.

The Crisis House should have an area made available to females only.

Another group of participants felt the crisis house should be gate kept by the City's Assertive Outreach Team and Home Treatment Team, this would, it was suggested help regulate access.

Participants specified the extra help service users may require in the Crisis House as being counselling, training in money management, personal hygiene,

cooking and personal care, all of which should be offered in the Crisis House as additional to the support service users should expect.

Community and voluntary service sector

All the focus group participants from this sector supported the need for a Crisis House.

Focus groups in this sector view the crisis house as an opportunity to move away from the model of traditional hospital care where everything is done for the service user. The Crisis House could act as the antithesis of this model of care by using therapies that enable and support independence.

The Crisis House could provide Social Workers with the opportunity to embrace the middle ground between hospital and community care and therefore avoid moving service users living in the community into B & B as part of a respite package.

The Crisis House could offer support to carers in situations where a care package has broken down and a service user may need to access the crisis house.

Community psychiatric services

All the focus group participants from this sector supported the need for a Crisis House.

Focus group participants collectively agreed that the Crisis House should be staffed 24 hours which should include qualified nursing staff. The service should be backed up with access to counselling, support with medication that includes taking personal responsibility for managing medication. Additional training should also be offered that relates to personal responsibility.

One focus group stated that the Crisis House service should link with the client when they return to their home or place of residence, thereby linking follow up support with community based services.

4.2.2 Access to the Crisis House

This prompt was used during the interview to ascertain what groups of service users should have access to the Crisis House and if service user confidence is likely to increase among those who have access to move on.

Inpatient and residential rehabilitation services

Participants from this sector generally felt that the Home Treatment Team and Assertive Outreach Service should gate keep access to this service.

Personality Disorder was cited as needing or benefiting from having access to this type of accommodation.

Crisis accommodation would help throughput from inpatient and rehabilitation services and would be beneficial to clients moving on from services across this service sector.

Crisis accommodation as an option to service users would provide them with the confidence to move on from inpatients if they knew they had access to it when they needed it.

Community and voluntary service sector

All the focus groups in this service sector expressed a range of concerns that relate to access. While one group stated that mental health services (tPCT) should gate keep the Crisis House they like other participants felt that this may result in the Crisis House becoming an assessment centre or prioritised for clients accessing Home Treatment or the Assertive Outreach Service.

Participants thought that mitigating these concerns could be achieved by implementing a clear and agreed process that sets out a clear criterion for access from the full range of service providers in this sector.

It was also stated that service users from this sector want a service that provides middle ground between Glenbourne (inpatients) and the community. They stated that they know this from the evidence attained via service user questionnaires.

Community psychiatric services

Participants felt having access to crisis accommodation from the community services would prevent clients needing residential or inpatient services. They also felt that service users or people accessing the full range of services from within the community should have access to the Crisis House.

4.2.3 Five Days Maximum Length of Stay

This prompt was used during the interview to ascertain if the maximum length of stay in the Crisis House should be 5 days.

Inpatient and residential rehabilitation services

Three focus groups felt that a 5 day stay in crisis accommodation was too long, they advocated a period of not more than 24 to 48 hours as a maximum. 24 to 48 hours it was asserted was long enough for most service users to reduce their crisis and move back to their normal place of residence. This would help avoid blockages and enable more people to access the crisis service.

Another focus group agreed with this but felt some service users might need up to a week so a bit of flexibility was required. The same participants felt that if the crisis service did not have a maximum time limit this would leave it open to abuse. However, the remaining three focus groups agreed that 5 days to a week was the most appropriate time period.

Community and voluntary service sector

One focus group from this sector agreed that 5 days should be the maximum length of stay, but this was tempered with the view that flexibility should be used as some service users may need more time.

Participants from the rest of the focus groups in this sector were divided on the need for a time limit or what it should be. Participants from one focus group felt there should be a time limit of 5 days but others within the same group stated that their situation could be chronic so should be longer while others thought no time limit should be imposed at all.

Another group felt that crisis accommodation would not be needed if a cut off point after 5 days was imposed on service users. Participants from the same group stated that a 5 day cut off should be implemented; others however felt that time should be determined by the environment a service user was living in and the suitability of them returning prematurely to that environment which might result in further crisis. This theme was continued with other participants stating that a crisis house could have the opposite effect on clients in that they might not wish to live independently so abuse the facility if no time limit were imposed.

Participants from another group did agree that 5 to 7 days should be a maximum period of occupation but others felt this to be inflexible and should instead be determined by the needs of the client.

Community psychiatric services

A general consensus can be drawn from the focus groups in this sector that 5 days should be the maximum period a service user should access the Crisis House. However, the same participants also emphasised the need to be flexible as one or two nights might be adequate for some service users who just need to calm down. While some others felt 7 days should be considered suitable

because of the varying nature of the situations they find themselves, this was challenged by participants within the same group who stated that this might encourage service users to settle.

4.2.4 Support (within Crisis House)

This prompt was used during the interview to ascertain what types of practical support might be needed when service users access the Crisis House.

Inpatient and residential rehabilitation services

Participants from this service sector identified a range of practical support needs that they felt were very important. The focus of this support should be around welfare benefits and welfare rights, daily living skills such as personal hygiene, cooking, money management, maintaining accommodation and communication.

One group felt that additional support should include domiciliary care as service users accessing the Crisis House will have different backgrounds and levels of support need. Alongside this carer and community involvement should include CPN input into crisis accommodation which would promote move on and independent living.

Community and voluntary service sector

One group felt that practical support would be best administered by a mixture of staff with differing skills. They will need to be able to administer medication, manage the operation of the building and provide practical support that should include cooking, managing money, preventing neglect (personal hygiene) and help and advice on general health and housing issues.

A number of focus groups from this service sector identified the need for domiciliary care; however one group felt that this was not necessary as they said this removes some of the independence from the client.

Support should likewise include an extension of the work the Crisis House does with service users into the community once they move back to their normal place of residence.

Community psychiatric services

Some participants want crisis accommodation to avoid the type of practical support provided in hospital environments as everything is done for service users, they believe that the ethos of the Crisis House should be contrary to this.

They also felt that the construction of good support plans are essential if the patient is to be informed about the type of support she/he can expect.

4.2.5 Access from Supported Housing Providers

Inpatient and residential rehabilitation services

A range of focus group participants stated that supported housing providers should have access to the Crisis House. Access to the Crisis House should be based on and determined by individual need. This it was asserted would impact on the number of people requiring admission to the inpatient services.

Some participants suggested that consideration should be given to allow Devon Partnership client's access to the Crisis House. However, another group felt that given the number of beds available it is essential that these are prioritised and patients or service users from the supported housing sector should be placed carefully to avoid conflict with other service sectors.

Community and voluntary service sector

One focus group from the Supported Housing sector felt that it would be really positive to have access to a Crisis House, so service users are able to step out and back again into their accommodation when they need to. This however was tempered by a view that inpatient services will always be needed for some clients whose needs will be greater than a Crisis House can provide. They also feel the Crisis House could provide a fast track into inpatients if a service users health deteriorated.

Participants from other focus groups in this service sector were of a similar view that supported housing providers should have access to the Crisis House, identifying Crisis Accommodation as an alternative to inpatient services.

Participants within one focus group suggested that the Crisis House should be managed and operated independently.

Community psychiatric services

A strong argument was made by two focus groups that supported housing should have access to the Crisis House. They also advocated a need for the Crisis House to be managed and operated on a multi-agency, multi-disciplinary basis. This would prevent the service being perceived as just another hostel, but would provide the type of access needed.

Groups also see the Crisis House in this context as offering a valuable opportunity to 'give time out' to service users from a range of service sectors in the community. The Crisis House was also described as a valuable tool in the armoury of service providers in the community.

4.3 Section Three (Barriers)

Question: What barriers might prevent service users from moving on?

4.3.1 Accommodation Options

This prompt was used during the interview to ascertain if there are enough accommodation options available to enable service users to move on, or better sustain their independence.

Inpatient and residential rehabilitation services

Service providers in this section have shown a profound lack of knowledge about what services exist in the community.

However, a consensus was reached between these focus groups that there was a need for step down supported housing or stage two services identified on the accommodation pathway provided during the focus group interviews.

Community and voluntary service sector

Focus group participants in this service sector feel the greatest barrier to service users moving on from supported housing is the private rented market, or private landlords. The reasons provided for this relate to the stigma attached to mental health and housing benefits as the majority of landlords will not accept people who are in receipt of Housing Benefits.

Rent and deposits are also barriers to moving on from supported housing and into the private rented sector. Rents are generally set to high for many people leaving supported housing to access. Likewise deposits are set to high and properties in the private rented sector that are accessible are at the lower end of the property market.

Not enough housing stock exists within Plymouth City Council or Residential Landlord portfolio's that is suitable, or accessible. A lack of choice and the ghettoisation of service users with a background in mental health is also a problem when allocations are offered.

Focus groups from this sector supported the need for step down or stage two services to be developed.

Community psychiatric services

A poor knowledge of housing options is also a clear barrier within this service sector. Nevertheless a need for stage 2 or step down high support services

should be developed. This recommendation was based on the model of an accommodation pathway provided to focus group participants.

The same focus group also felt that an inability to move a service user forward or backwards in supported housing prevented move on.

4.3.2 Service Users Wish to Live Independently

This prompt was used during the interview to ascertain if staff working across the three service sectors believe service users have positive attitudes to move on and independent living.

Inpatient and residential rehabilitation services

Participants felt that some service users have a very positive attitude to move on, while others were fearful.

Community and voluntary service sector

It was suggested that some service users have an unrealistic expectation of what move on options are available so can express a desire to move on. However, some clients do not wish to move on as some will require additional support for a longer period time.

Participants stated that not enough support exists in the community at the moment for many of the service users who have longer term needs. However, other participants said that this should not affect the service user's attitude or ability to move on because other types of support exist that provides a structured day and practical support.

Community psychiatric services

One focus group stated that service users generally do not know where they are in terms of their housing status or the process needed to access appropriate accommodation. It is therefore difficult for service users to hold a positive view about move on or sustaining independence.

Service users also lack the confidence but may have a positive attitude to move on.

4.3.3 Service User Confidence

This prompt was used during the interview to ascertain if staff teams believed service users are more likely to have the confidence to embrace move on if they knew when things went wrong or they became unwell they could increase their support again.

Inpatient and residential rehabilitation services

All the focus groups from this service sector supported the idea that service users should be able to move up and down a staged accommodation pathway that provides increased or decreased levels of support, that are needs based.

One group of participants described this part of the discussion as a 'mixed bag'. Some service users cannot move on due to a lack of accommodation so they slip back in terms of their recovery and are then no longer ready for transition, while others will move on. However, service users do have the potential to move on and will over time attain the ability to live independently but will from time to time demand the security and nursing care available from the inpatient units.

Increasing support and decreasing support over time can be difficult for some service users as they become institutionalised however building structured transitions tailored to each person means the process of move on can not be rushed.

Another focus group outlined a similar set of barriers to move on but stated that confidence to move on was a major factor for service users. The general consensus among this group was that having the right kind of support networks or pathways would overcome this barrier to moving on and into community services.

One focus group emphasised the need to be able to move in both directions of the accommodation pathway (between stages one and three) so service users can access more support when required.

Some participants did express the view that staged move on that enables service users to increase and decrease their support needs through an accommodation pathway would work. They also stated that there should not be an expectation that everyone can move through this model. The group also stated that some people should be able to just stay in residential inpatient services permanently without the pressure to move on being imposed.

Participants from another focus group cited past experiences of supported housing in the community as a barrier to service users moving on from residential inpatients. This however was tempered by the view that having stage two services, as described in the accommodation pathway, would increase the number of clients who are able to move to move on and others decrease their length of stay in a residential inpatients unit.

Community and voluntary service sector

Some participants from this sector felt that the confidence of service users to move on would increase if they knew they could move back to supported housing

if things did not work out. However, the majority of focus groups within this service sector felt the proposed accommodation pathway was confusing and might result in conflicts in terms of different provider aims.

The same groups also identified certain areas of Plymouth as causing clients to feel nervous, which might act as a barrier to move on.

They also expressed concern that supported housing providers were only able to provide support for two years, which made some of the older service users nervous about moving on.

Community psychiatric services

Participants within this sector felt it was extremely important that service users are able to move backwards and forwards, i.e. increasing or decreasing their support when required.

They also feel that the contracts between service providers in the community voluntary sector should be clear, ensuring all providers know that service users can move backwards and forwards. They added that service users can become stressed around the time people leave their accommodation so will need to be aware of where they are going.

4.3.4 Knowing what is Out There

This prompt was used during the interview to ascertain if operational staff and managers know what support services are available in the community, where they are and how they would access them.

Inpatient and residential rehabilitation services

Focus group participants generally agreed that there is a lack of knowledge about what accommodation services are available. Some participants stated that they rely on Social Workers to find accommodation for service users who need to move on, providing the caveat that the options available are limited to the knowledge of the Social Worker.

Some participants stated that they have little or no confidence in the supported housing currently available, which coupled with the lack of knowledge about what services are available and a history of poor access to those they are aware of has been a barrier to independent living.

Supported housing it was asserted retain a criteria that excludes people with a history of arson or those with a forensic background, present as high risk, or at of suicide or violence. This has been a historic barrier to move on from inpatients and into supported housing.

Focus groups from this sector also stated that apart from not knowing what services are available the greater barrier to move on was the time it takes for supported housing providers to accept a referral given the long waiting times and demand on existing services, this can often mean providers pick and choose. They also identified a need for female only services and were not aware if any existed.

One focus group stated that service users presenting with enduring mental illness currently do not fit with any of the available accommodation options outside the residential rehabilitation services. This group also stated that those service users who have the ability to move on are often unable to do so because the housing on offer is unsuitable for the individual's needs. Not having the right type and level of support can prevent the service user from wishing to move on because they feel vulnerable.

The remaining focus groups concurred with their peers that the underlying barrier to move on is the lack of suitable housing and their service users' experience of supported housing. They conceded that service teams do not have the necessary housing knowledge to know what services are available. These groups also cited a lack of resources as barriers to move on.

Community and voluntary service sector

Focus group participants in this sector identified the need for staff within the inpatient and residential rehabilitation services to receive training around supported housing, particularly around knowledge and understanding of what supported housing is available and how to access it.

The same focus group of participants also stated that to successfully work with clients in this sector staff do not just need to understand the mental health issues they also need to understand supported housing. Staff and providers working within the community and voluntary service sector also need to understand the inpatient and residential rehabilitation services better to know who to refer to when service users need to move back from the community.

The biggest knowledge gap that acts as a barrier to move on from supported housing is knowing what private rented sector accommodation is available and having the resources to access it.

The remaining focus groups discussed the difficulty in accessing private landlords and the need to be trained to identify and work with landlords to access move on accommodation in the community.

Community psychiatric services

One group of participants in this sector agreed that a lack of knowledge around supported and general needs accommodation exists. They stated that because a lack of knowledge exists as to what supported housing agencies exist the agencies they do use “cherry pick”, leaving some service users with few options. Because no clear accommodation pathway exists at the moment no clear links can be made to what housing resources are available. Therefore staff working in this sector need to discover the parameters of choice through experience.

The same group of participants felt because of the lack of knowledge around housing issues and what is available service users will quite often end up being housed in one area, which can work to the detriment of both the service user and the local community. A lack of knowledge about people with mental health often results in service users being inappropriately housed, which affects their dignity and for many they become fearful and afraid. The group felt that what constitutes housing should be re-thought and training and knowledge about housing is an important issue for all personnel involved, particularly getting the balance between housing and mental health needs.

A number of focus groups identified issues relating to the private rented sector and the lack of knowledge about this sector.

Some participants continued to focus on supported housing. These groups felt supported housing providers exclude service users who have a history of chaotic behaviour. These individuals will often end up by passing supported housing all together and go straight from inpatients into independent living, which is not the most suitable solution to their housing need. The groups felt that these clients would get the maximum benefit from supported housing, but as is usually the case they end up occupying inappropriate accommodation in the community, particularly younger service users.

One focus group said joint working between agencies and service sectors needs to be adopted as it feels like agencies are fighting each other at times. Training staff who work in a range of housing schemes are not trained well enough; staff who work in the community psychiatric services often see these people as unskilled. The criticism focused on the ability of staff working in these services to see the bigger picture and the way to address this knowledge gap will be through training.

4.3.5 Time

This prompt was used during the interview to ascertain if operational staff have the time or capacity to help service users with their housing and accommodation needs.

Inpatient and residential rehabilitation services

Focus group participants in this sector provided a range of responses that related to time factors as barriers to move on.

Some participants felt front line staff spend a lot of time developing an awareness of housing and accommodation services. This work bites into the time staff have in dealing with mental health issues. One focus group felt this work should be taken on by a social worker, or someone who has expert knowledge around housing and accommodation issues.

Another focus group felt front line workers are not made part of the decision making process concerning the placements of clients, but did recognise a shortage of available resources, which can itself act as a time constraint. This was illustrated by some participants as manifesting itself in the application form and interview process which is extremely time consuming when moving service users on and into the supported housing sector. It is also felt that supported housing providers increasingly expect residential inpatient staff to sort out a service users welfare grants and housing and welfare benefits before they move on and into supported housing. Again, this it is felt is a time constraint on them as a resource. The same participants also recognised the pressure on the community voluntary sector to fill their vacancies rather than spend time ensuring compatibility between service and service user.

All the focus groups from this service sector strongly supported the move on pathway as a means of reducing time and increasing the move on opportunity. However, some participants feel the time each service user spends in a service is not always conducive to their recovery as it is too short.

Participants also stated that the hours or time allocated to service users in the community by supported housing providers is significantly less than that provided by the inpatient services.

Community and voluntary service sector

Some focus groups in this sector saw time as a support constraint, citing the hours of support available in the supported housing sector as considerably less than that provided in the inpatient services.

Participants in this sector linked opposing time constraints as affecting the different service sectors like inpatient and community psychiatric services. The result of this affects cultures and attitudes, particularly between service sectors when one service is trying to move a service user on and into another service sector.

Move on from supported housing and into the community also has a number of impacts on time and resources for this service sector. Focus groups cited these in the way service users are able, or unable to access local authority accommodation. The local authority provides a panel for people who present with mental health needs. A focus group stated that a service user goes before the panel and cannot get housed as they are considered well at the time and those who are granted move on accommodation are usually unwell and unable to live independently.

The majority of focus groups in this service sector state that the local authority needs to allocate more appropriately and take better account of a client's wishes.

Community psychiatric services

One focus group felt time was a barrier in terms of how much an individual worker within the sector was supposed to know and how much they can know about complex issues like housing and housing related support.

Another focus group linked the issue of time to the processes related to referring clients to different housing and accommodation schemes. They said it takes a lot of the workers time to make referrals to different places, which can be a particular issue when one client who is continually referred to a number of services. The group asked if one process should be used as this would save time.

To help move on in housing and accommodation services in the community some participants stated that if the work with the patients they undertook continued after the client had moved on and into supported housing this would promote better continuity in the move on process and help patients at the same time. This it was felt could be provided by training supported housing providers, which would reduce the time all the service sectors spend processing referrals.

4.4 Section Four (Support)

Question one: *What type and level of support do you think service users will need to help them move on?*

4.4.1 Medication

This prompt was used during the interview to ascertain if service users living in the community who are in receipt of prescribed medication need support.

Inpatient and residential rehabilitation services

One focus group felt that helping service users with their medication once the service user has moved on will continue to mean service users are dependent

and in need of care. However, the same group also said living independently with support around medication could help service users to move on from inpatients and residential rehabilitation.

This view was shared by a number of other participants but one group felt that with any accommodation pathway that included step down services providing the accommodation should be able to provide adequate mental health support. This they stated should include medication, links to community services and support with physical needs, domiciliary care and daily living skills in addition to housing related support.

The best way to achieve this, another group stated, was by taking a multi-agency approach. The group felt that a multi-agency approach was the best strategy and this would embrace the idea of co-locating staff. Support for this approach was voiced by another group who stated that not everyone who moves on from residential inpatient care needs supervision with their medication. However, like previous groups they felt that support and assistance with medication should be provided when required otherwise an individuals health would deteriorate. In some cases service users moving on should receive support from the Assertive Outreach Service.

Community and voluntary service sector

One group of participants felt clients/service users would be able to manage their medication and self medicate if appropriate training were provided while they were accessing inpatients and residential rehabilitation services. This group described this as part of the preparation for living in the community. They were likewise of the view that this work should be undertaken prior to referrals being made to community services.

However, another group of participants from this sector felt that their services needed to provide clients with support to take medication. This included holding, dispensing, picking up prescriptions and monitoring prescribed medication. This group also stated that these are key elements in a clients move on process. The aim should be to encourage clients to become increasingly independent so that they become self medicating, but this will take time it was asserted.

Community psychiatric services

Focus groups within this sector made strong references to the accommodation pathway. They stated that it is essential for clients to be able to move on or live a more independent lifestyle, but they will have to be compliant with their medication to prevent relapse. Staff should also ensure clients pick up their prescriptions and monitor compliance with prescriptions as this would greatly increase recovery.

One focus group emphasized medication as a real issue. Participants stated that patients require support from their GP as well as support providers in the community this includes ensuring blood tests are undertaken, which they say has not worked well historically.

4.4.2 Access to drug and alcohol treatment

This prompt was used during the interview to ascertain if service users who present as dual diagnosis or those who present with alcohol and drug issues need extra or specialist support.

Inpatient and residential rehabilitation services

Focus groups from this sector expressed the view that there is a need for all services to better understand the role drugs and alcohol play in mental health.

Participants support the view that all services should expect clients to have a dual diagnosis. Drug and alcohol issues are prevalent to the work services undertake, services in this and other sectors should be able to understand and work with both mental health and substance misuse.

One group of participants felt that drug and alcohol issues cannot be separated out from mental health and are significant problems for 90%-95% of clients. Services across the accommodation pathway should reflect recognition of dual need. They also said access to waiting lists for drug and alcohol treatment is extremely important.

One focus group identified the need for staff from other specialist service providers to be co-located alongside housing advice workers, which would provide services in the accommodation pathway with a skill mix of qualified support staff relevant to the support needs of service users.

Community and voluntary service sector

A large group of participants felt that mental health services should only work with clients with a dual diagnosis where the client has demonstrated a commitment to stability. Otherwise the impact on the other residents in a supported housing project is too great.

Community psychiatric services

Participants from this sector all recognise the need for dual diagnosis to be considered alongside a service users mental health.

One group of participants said that a lot of crisis situations that happen are often related to the misuse of drugs and alcohol. Service providers across the

accommodation pathway should be provided with the knowledge and training required to deal with issues related to dual diagnosis. The group also felt the best way to achieve this would be by developing a multi-agency approach to the problem. They added that patients will more than often present with a multiple number of needs like illicit drug problems, which may then bring on mental health issues which the group felt would be best dealt with by a multi-agency (co-location) approach being taken.

Some participants felt the issue of dual diagnosis should be dealt with on a positive basis that offers an individualistic analysis of need. This would help determine a client's personal choice and the type of supplementary course of treatment they felt they needed.

4.4.3 Ex-offenders

This prompt was used during the interview to ascertain if service users with an offending or forensic background should have access to supported housing.

Inpatient and residential rehabilitation services

Focus groups from this sector felt service users with the full range of needs should have access to supported housing, regardless of personal history.

Community and voluntary service sector

Most supported housing providers hold the view that referrals into their services should be considered on a case by case basis.

One focus group did however state that if a service user had a forensic history their need should be handled by the City's Forensic Team; this would make case management easier.

Community psychiatric services

Some participants expressed concern that providers in the voluntary community sector would be unable to work effectively with service users who have a forensic history, or offer the level of support required without additional support.

Another group expressed the same set of concerns and stated that service providers in the community voluntary sector will use historic risk issues as a predictor of current risk, which in turn is then used as a barrier to accessing supported housing.

However, another focus group felt very positive about the accommodation pathway as they thought it would offer a wider choice for service users, which

they felt can be beneficial to clients with diverse needs, particularly those with a forensic history which might incorporate a learning disability.

4.4.4 Co-located Housing Staff

This prompt was used during the interview to ascertain if mental health services in the community psychiatric and inpatient services should have co-located staff who are expert in housing advice and housing related support. Conversely should supported housing providers in the community voluntary sector have co-located staff that are trained Psychiatric Nurses.

Inpatient and residential rehabilitation services

All the focus group participants from this sector support the proposal that staff expert in housing advice and housing related support should be co-located within their service sector.

One group of participants set out the benefits of co-location by stating that the opportunity to have co-located staff would be really positive. Mental health staff co-located in supported housing would mean clients could receive support with medication, gain an understanding of service users mental health needs and prevent relapse and re-admission to inpatient services.

They felt co-locating housing staff in residential units would increase the skills and knowledge available to clients who are ready to move on. These staff could attend planning reviews so move on planning starts earlier.

Viewing the accommodation pathway the group felt stage two services would benefit the most from having trained mental health staff co-located.

A second focus group stated that access to a housing related support worker or housing advice worker would greatly benefit the residential rehabilitation services and increase the opportunity for the right kind of move on to take place. They felt that having a housing advice service linked to their team would be really helpful.

Importantly the same group identified a number of service users who they asserted would not be able to manage independent living unless the right level of support and package of care was available in the community. They expressed the view that if staff were co-located they would be able to move on more service users. Participants also stated that confidence would be improved if staff from the community voluntary sector were co-located in their service.

A different group of participants stated that residential services are dispersed across a large area. They said staff feel isolated and out of touch with what is going on in the City. They felt that they would benefit from access to a service directory or a co-located staff member who had a background in housing.

The group identified the age group of service users accessing their service as becoming younger and younger. The group felt these patients will need more appropriate housing advice to enable them to move on, they also felt stronger links to adolescent services was required. Furthermore, they made the point that staff did not have the knowledge to give housing advice to patients about their housing options, benefits, availability of services and processes like housing application forms and homeless approaches.

The same group cited the Spring Project as an effective model and way of working, as they are a voluntary sector service with a Psychiatric Nurse co-located. Other groups supported these views but also felt having co-located staff from the community voluntary sector and visa versa in the mental health services promoted integration and the process of normalisation.

Community and voluntary service sector

All the focus groups from this service sector support the concept of reciprocal co-location as a means of promoting move on and independence.

A range of participants from this sector stated that the Spring project provided an excellent model, which should be replicated across all the supported housing projects including homeless services. They said that supported housing staff benefit from the increased knowledge the mental health specialist brings. They also felt that the Psychiatric Nurse benefits because their knowledge of supported housing is increased and service users benefit because they receive a holistic service.

This group identified stage two services on the accommodation pathway as requiring co-located professional staff. This they contended would increase the advantage to service users in their move on by 100%. Co-location does need a clear role definition, they said, but the need to work in a multi-disciplinary way is paramount.

Other groups felt multi agency working is the way ahead, as a skill exchange would be a good option and opportunity to help service users in this sector with their medication issues. However, one focus group felt the model of co-location would be beneficial but community voluntary sector workers co-located with inpatients might be isolated.

Community psychiatric services

The idea of co-location received strong support from all participants in this service sector.

Some participants put forward the idea that services identified in the accommodation pathway should have enhanced support to prevent clients from having to use crisis services. This they stated could be achieved through co-location. Having skilled people with knowledge and links with the community voluntary sector would be very positive and really useful in reducing barriers and changing cultures. The same participants also felt a Psychiatric Nurse should be available within the single homeless supported housing sector.

Another focus group felt there was a definite need for a co-located worker who has links to other teams such as housing services; this was described as having routes into other worlds. Better links between Primary Care and the community it's contended is essential. A range of other participants cited the need for co-located service providers to deal with the complicated housing issues, forms and diverse range of housing applications and processes.

One group of participants also felt young people have a range of differing issues, which includes a different perception of what their own accommodation needs are and should be. A co-located worker will need to be honest with this group of service users as the reality is different from their perception.

4.4.5 Access to Supported Housing

This prompt was used during the interview to ascertain if people accessing mental health specific services and whose primary presenting need is mental health should have access to all types of supported housing.

Inpatient and residential rehabilitation services

Wide support for access to supported housing other than mental health specific services was advocated by a variety of participants. Specifically, access to accommodation based services in the homeless, ex-offender and substance misuse sectors were cited.

Participants stated service users with a high level of need could live in the community if the services in the accommodation pathway were better tailored to meet their specific needs.

Some participants felt that Devon Partnership Trust clients should have access to the supported housing identified at stages 2 and 3 on the accommodation pathway.

Community and voluntary service sector

Participants from this sector support the view that non specific mental health supported housing services should accept service users who have mental health issues.

The caveat to this however is a recognition that for these services to do so they would require additional support hours or be provided with the capacity to increase or decrease support when required.

Community psychiatric services

Participants felt that service users who had a history of mental health not only should have access to all the accommodation based supported housing services but it would be a necessity in view of the specific demands and needs individuals present.

5.0 Key Findings

Findings have been drawn from the evaluated statements and presented in the same way as the results in the previous section.

The key findings are presented by section and broken down into there individual sub sections. Each section is then summarised by merging the data attained from the individual service sectors to allow a clear set of findings from the research to be identified.

Individual service sectors have only been separated out where there is a distinguishable difference in attitude or belief between focus groups and service sectors.

5.1 Section One (Training)

5.1.1 Staff Skills and Knowledge

1. Focus groups from the community psychiatric, inpatient and residential rehabilitation services and the community voluntary sector strongly supported the need for training to be made available to community voluntary sector providers that include developing a better understanding of mental health, behaviours, risk and triggers that result in clients and service users becoming unwell.
2. The community psychiatric and inpatient and residential rehabilitation services also felt the community voluntary sector should have access to a range of training opportunities that will better enable them to promote move on and sustainable independence. These include risk management, information sharing, recovery focused training, understanding and managing dual diagnosis as a learning disability or as substance misuse as an association with poor mental health.

3. Inpatient and residential rehabilitation services identified a number of training needs that included, training in welfare rights, benefits and grants. However, it was acknowledged that a knowledge and skill gap existed that would require training to be made available that identified and mapped service providers within the voluntary and community supported housing sector.

5.1.2 Psychological Therapies

1. All three service sectors strongly support the need for psychological therapies to be available and accessible to their services.
2. Inpatient focus groups strongly advocated the need for training to be delivered to community voluntary sector so they can deliver psychological therapies. Community psychiatric services also support the view that the community voluntary sector should be trained to deliver psychological therapies. The voluntary community sector was generally more sceptical about this but one focus group expressed support for training in the delivery of psychological therapies, recognising this as integral to meeting the aims of independent living.
3. Psychological therapies should be made available and linked to the support available in the crisis house.

5.1.3 Service Users Have the Skills

1. Focus groups from both the inpatient and residential rehabilitation services and community and voluntary service sector provided a strong consensus that service users would benefit enormously from training while they still receive support from the inpatient and residential rehabilitation services. This could be addressed by taking a multi-agency approach to the training of service users prior to their transition from inpatient services to supported housing.
2. Young people with mental health issues need targeted training to better enable transition from youth and children services to adult services.

5.1.4 Support Plans

1. Community voluntary sector providers acknowledged the need for improved links between their housing related support plans and the care planning used by inpatient services. Supported housing and inpatient providers both identify this as a training need, which could be reciprocated.

2. Community voluntary sector providers also identified a need to develop their housing related support plans with service users prior to them being referred to their services. Inpatient services also felt that it was imperative that the transition from inpatient services to supported housing should be agreed with supported housing providers long before a service user moves on.
3. Information sharing and training in better understanding data protection and the freedom of information act would benefit all participants and better enable the sharing of information to inform support and care planning.
4. The community voluntary sector support plans and case management should better reflect recovery principles.

5.1.5 Service User Access to Training

1. Focus groups across the three service sectors expressed the view that not enough training opportunities exist for service users. They also advocated a need for practical training to be delivered that is both integrated and focused on promoting and maintaining independent living.
2. Service users and cares need to be made aware of the accommodation and move on pathways from inpatient services.
3. Service users should receive training for independent living prior to leaving inpatient services. This reduces the anxiety and practical difficulties service users experience when they step down from inpatient services and into the community based voluntary sector.
4. Some focus groups advocated the idea that providers would find it extremely profitable if services with the right experience in training service users were to share this with other service sectors.
5. Housing units developed and delivered within the community voluntary sector could be shared with inpatient and community psychiatric.

5.2. Section Two (Crisis House)

5.2.1 Extra Help (need for Crisis House)

1. All focus group participants supported the need for a Crisis House in Plymouth.

2. The Crisis House should be open and able to accept referrals 24 hours per day 7 days per week, with a staff team skill and gender mix that includes qualified nurses and unqualified support staff.
3. Therapeutic support that includes counselling and therapies that enable and promote independence should be provided alongside training in money management, personal hygiene, cooking, personal care and managing medication.
4. Areas within the Crisis House should be female only areas and support should be offered to carer's as well as service users.
5. Follow up support should be available to service users who access the Crisis House once they return to their home or place of residence.

5.2.2 Access to the Crisis House

1. Service users from the full range of service sectors should have access to crisis accommodation.
2. The majority of focus group participants felt the Plymouth teaching Primary Care Trust should gate keep access to the Crisis House. However, clear processes have to be agreed between the Primary Care Trust and their partner agencies to ensure impartiality and fair access for clients using services in the community voluntary sector.
3. If service users across the range of services, particularly inpatient or residential supported housing services, knew they had access to crisis accommodation if things went wrong when they move on this would increase their confidence to do so.

5.2.3 Five Days Maximum Length of Stay

1. The majority of participants from all the focus groups determined that 5 days was the most appropriate time period for service users to access crisis accommodation. Some of the reasons provided for this were identified as a period of crisis only lasting 24 to 48 hours and if a time limit of more than 5 days was not imposed the facility would be abused. Furthermore ensuring the stay was short would avoid blockages and enable more people to access the Crisis House.
2. This was however balanced by the number of participants emphasising the need to be flexible. The reasons provided for this were defined as a need to consider a service users environment, differing levels of need, the time it takes some as opposed others to reduce their crisis.

5.2.4 Support (within Crisis House)

1. All the focus group participants identified a need for additional support in the form of practical non therapeutic support. This should take the form of welfare and benefits advice, personal hygiene instruction, support and instruction in cooking, money management, communication, maintaining accommodation and help and advice on general health needs and housing issues. Domiciliary care was likewise used to define the type of non therapeutic support that should be available in the Crisis House.
2. Some participants clearly supported the use of non therapeutic support but this it was asserted should not be used to create dependency but promote independence.
3. Non therapeutic support linked to care and support plans is seen as essential as is the work undertaken in the Crisis House being extended into the community as part of a package support.

5.2.5 Access from Supported Housing Providers

1. Focus groups across the three service sectors stressed the need for supported housing providers to have access to the Crisis House.
2. The Crisis House should act as a place where people can go when they need time out or respite.
3. Providing access from the supported housing sector to the Crisis House would have the effect of reducing demand on inpatient services.
4. The Crisis House should be developed and managed on a multi-agency, multi-disciplinary basis to ensure supported housing providers have appropriate access that is based on need.
5. The Crisis House would be a valuable tool in the armoury of service providers in the community.

5.3. Section Three (Barriers)

5.3.1 Accommodation Options

1. Focus groups across the three service sectors all advocated a need for stage two services to be developed.

2. A lack of knowledge about housing, supported housing and other types of tenure was identified as a major barrier among participants in the inpatient and community psychiatric services.
3. Access to the private rented sector prevents service users moving on because of the high rents and deposits, housing benefits and prejudices associated with people who suffer with poor mental health.
4. Social housing move on options are limited, which when coupled with a lack of choice and a history of poor allocations, service users with a mental health background have often found their opportunities limited.

5.3.2 Service Users Wish to Live Independently

1. Service users will generally have a positive view of move on but this is often based on an unrealistic expectation of the options available or lack of knowledge of what options are available.
2. Some service users might wish to move on but are fearful that they will not receive the level of support in the community they think they need. Confidence is also a barrier to move on despite service users having a positive attitude to independent living.

5.3.3 Service User Confidence

1. All the focus group participants supported the idea that service users should be able to move forward and backwards along a staged accommodation pathway that provides increased or decreased levels of support based on need.
2. Service users accessing the inpatient and residential rehabilitation services have the ability to move on some take longer than others and some will need to be able to move back before they are able to move forwards. Furthermore, having a staged accommodation pathway that provides structure will facilitate move on and will help to build the confidence service users need to be able to live more independently.
3. Focus groups identified confidence as a major barrier to move on but stated that the right kind of support networks and a clear accommodation pathway would overcome this barrier. Having a staged pathway through supported housing would decrease the length of stay service users spend in residential rehabilitation and inpatient services.
4. All accommodation providers will need to be clear that service users can move backwards and forwards on the accommodation pathway

otherwise it will become confusing. Service providers will likewise need to agree and be clear about the aims of the accommodation pathway otherwise this will have a negative impact on service user confidence.

5.3.4 Knowing hat is Out There

1. All participants strongly agreed that a lack of knowledge about general needs and supported housing exists within their services. The groups advocated a need for training across all the service sectors to rectify this.
2. Community psychiatric and inpatient service providers stated that they have little or no confidence in the supported housing sector. They also felt the main barriers to accessing supported housing, apart from a lack of knowledge about availability, are the waiting times, limited number of available places, resources, a service users history, no clear accommodation pathway and a poor understanding of supported housing and what it can provide.
3. The same groups of participants also acknowledged that the supported housing services they were aware of are either unable or unwilling to take many service users who are ready to move on because they feel unable to support their needs. The result of this is service users who could have benefited from supported housing end up living in inappropriate accommodation and quite often have to return to inpatient care.
4. Focus groups within the community voluntary sector identified a need for staff training within the inpatient and residential rehabilitation services. They stated that these services lacked knowledge and understanding of what supported housing is available and how to access it appropriately. They also highlighted gaps in their own knowledge, as a barrier.
5. One focus group said joint working between agencies and service sectors needs to be adopted as it feels like agencies are fighting each other at times.

5.3.5 Time

1. Participants from the inpatient and rehabilitation service sector felt staff spend to much time dealing with housing and accommodation issues as part of the move on process. Community psychiatric focus groups agreed with this and they likewise felt it was unrealistic to expect staff to have all the necessary knowledge associated with the complex

issues associated with housing and supported accommodation. They feel an expert in general needs housing and housing related support should be undertaking this work. This it was contended, would free more time for them to concentrate on their own areas of expertise.

2. Time constraints that impact on the capacity of staff within the inpatient and community psychiatric services are described as the various referral processes into supported housing, the application forms and interview processes that have to be undertaken. They assert that they are now required to undertake all the welfare benefit work prior to a supported housing provider accepting a move on referral from there service sectors. This staff identified as a time constraint on them as a resource.
3. Accessing the private rented sector and dealing with private rented accommodation issues was identified as a barrier to move on in its own right. Accessing property within the local authority also presents its own set of problems as housing allocations can sometimes result in people not ready for independent living be offered accommodation and others denied it for not being unwell enough.
4. Participants generally felt having a clear accommodation pathway will reduce time as a barrier and increase appropriate move on for service users. To help ensure this is successful some focus groups suggested that community psychiatric services and inpatient and residential rehabilitation services should continue to work with service users for a short period after they have been referred into supported housing. This it was stated would promote continuity, the move on process and save time in the longer term. Training was also advocated as a means of dealing with the barriers that impact on capacity.

5.4 Section Four (Support)

5.4.1 Medication

1. Focus group participants across the three service sectors were in collective agreement that service users who needed support with their medication should receive it.
2. Participants also agreed that support and assistance with medication should be provided when required rather than automatically to avoid dependence.
3. Some focus groups recommended that by taking a multi-agency approach to the problem of supervising medication, would enable more

service users to move on from inpatient services and into supported housing.

4. The need for co-located staff along the accommodation pathway was cited as the best way of achieving this aim.

5.4.2 Access to Drug and Alcohol Treatment

1. Focus groups across the service sectors support the view that there is a need for all services to better understand the role drugs and alcohol play in mental health.
2. A number of focus groups advocated the need for staff from a range of specialist services to be co-located. These groups felt the best way to deal with the issue of dual need was by developing a multi-agency approach to supporting the accommodation pathway.
3. Training should also be provided to services across the accommodation pathway that facilitates the sharing of knowledge and expertise to help providers work with service users presenting as dual diagnosis.

5.4.3 Ex-offenders

1. Participants believe service users with the full range of needs should have access to supported housing.
2. The voluntary and community sector's supported housing providers should be directly supported by the City's Forensic team. This it was felt would better enable these providers to manage the risk. It would also increase access and choice for service users which its felt can only be beneficial to the service user.
3. The community voluntary sector felt all referrals should be dealt with on a case by case basis.

5.4.4 Co-located Housing Staff

1. All the focus groups from all the service sectors support the concept of reciprocal co-location as a means of promoting move on and independence. Equally, all participants supported the accommodation pathway as appropriate to the facilitation of co-located staff, applying particular emphasis to the need for stage two services to have qualified Psychiatric Nurses.

2. Some focus groups felt having co-located workers expert in housing advice and housing related support in main stream mental health services promoted integration and the process of normalisation for service users at the earliest possible stage of their move on. Another group described having co-located staff as having routes into other worlds.
3. Multi-agency working is the way ahead, which would help increase the number of service users to move on from inpatient and residential rehabilitation services and into supported housing in the community.
4. A skill exchange that results in the co-location of staff between service sectors will benefit service users; develop knowledge between service sectors and breakdown barriers, change cultures and practices to the benefit of service users.

5.4.5 Access to Supported Housing

1. Wide support for access to supported housing other than mental health specific services was advocated by a variety of participants. Specifically, access to accommodation based services in the homeless, ex-offender and substance misuse sectors were cited.
2. Some participants felt that service users who had a history of mental health not only should have access to all the accommodation based supported housing services but it would be a necessity in view of the specific demands and needs these individuals present.

6.0 Recommendations

The recommendations listed here have been derived from the results and key findings summarised in the previous section. Recommendations are simply drawn as a comparative response to the need identified from the results of this piece of research.

Individual and detailed recommendations resulting from this research are provided in the main body of the accommodation strategy and can be found in chapter 8 under Conclusions and Recommendations and Chapter 9, The Future.

- 1. Training will need to be facilitated and provided by services from the voluntary community sector, community psychiatric and inpatient services on a reciprocal basis. Training will need to be targeted in the following ways to increase service user move on from inpatient services and better permit service users to sustain their independence in the community.**

- (a) Voluntary and community sector providers of supported housing should receive specific and targeted packages of training. This should include training around understanding mental health and associated behaviours, managing risk and triggers, recovery focused case management and managing dual diagnosis. The inpatient and residential rehabilitation services require targeted training that includes instruction in accessing welfare benefits, grants and training sessions that map and identify supported housing providers.
- (b) Psychological therapies should be accessible and available to service providers from the full range of service sectors. Staff members from the three service sectors should be provided with the necessary training to deliver selected psychological therapies within inpatient and community psychiatric services and where appropriate within community based supported housing services.
- (c) Service users should receive training when they access an inpatient service that focuses on their independent living skills and personal development, prior to moving on and into supported housing.
- (d) Housing related support case management and support plans should be better aligned with the care planning approach used by the inpatient and community psychiatric services. Training on how information is attained and used in support plans and care planning should be provided by services and between services on a reciprocal basis. All service sectors should receive training on information sharing, data protection and the Freedom of Information Act.
- (e) Service users will need more targeted training that focuses on their development and preparation for move on along the accommodation pathway and independent living. Services and individuals experienced in this type of work should provide other services and individuals with the necessary training.

2. Fourteen focus groups supported the need for crisis accommodation to be developed and arranged in the following ways:

- (a) To support and underpin the development of the accommodation pathway and meet the strategic aim of the accommodation strategy a crisis house will need to be developed. The service should provide the necessary therapeutic support and be delivered by a professional and well trained staff team.

- (b) Service users accessing the full range of services and service sectors will require access to crisis accommodation.
- (c) The maximum length of stay in the crisis house will be 5 days.
- (d) Practical, non therapeutic support should be available in the crisis house, which will need to take the form of domiciliary care and welfare and benefits advice and support with a range of presenting needs.
- (e) Supported housing providers from the full range of services will need to have appropriate access to the crisis house.

3. To overcome the barriers that might prevent service users from moving on from inpatient or residential supported housing managers and practitioners advocated the following:

- (a) To facilitate move on and ensure the accommodation pathway meets the needs of service users moving on from inpatient services and other supported housing providers, stage two services will need to be commissioned or procured to meet this need from existing supported housing stock.
- (b) All service providers will need to ensure service users are fully aware of the housing options available to them and level of support available from the accommodation pathway.
- (c) All service users should be able to move forward and backwards along a staged accommodation pathway that provides increased or decreased levels of support based on need. The focus of the pathway will need to provide confidence in service users that when they need to move backwards they are able in the same way they can move forwards. Service providers from the three service sectors will need a clearly worded protocol or agreement that enables this movement to take place.
- (d) Because a general acknowledgement among inpatient and community psychiatric services in the research recognized that they lacked any clear knowledge around the supported housing sector, and the supported housing sector acknowledged a limited knowledge of their partners practice as a barrier. Service providers from these sector's would benefit from a worker exchange to develop a greater understanding of each others practice, gain hands on experience and develop a culture of understanding and more effective risk management.

- (e) The model accommodation pathway will need to be implemented in full if the time qualified Nurses and Social Workers are to reduce the time they spend dealing with housing related issues. A need for a co-located staff member, expert in housing advice and welfare benefits to support the community psychiatric services will be required to increase capacity within existing services and increase performance related outcomes.

4. Service users will need a range of support mechanisms that should be applied in the following ways:

- (a) To enable some higher need service users to move on and into supported housing and sustain their independence in the community qualified personnel from the Mental Health Partnership will need to be co-located or allocate dedicated time to support service users with their medication. This will increase the level of access and availability open to service users who are more dependent on their medication. Community voluntary sector, supported housing workers should likewise receive training on how they can legally help service users manage their medication.
- (b) Service providers strongly advocated a need to develop a better understanding of the role drugs and alcohol play in mental health. A need to develop a multi agency approach that work's alongside the accommodation pathway will be necessary if the numbers of service users leaving inpatient services and moving into sustainable accommodation is to be achieved. A dual diagnosis worker, responsible for developing pathways into appropriate types and levels of treatment should be implemented to facilitate this effectively. Staff and workers from the three service sectors should be provided with training that enables them to increase the level of support they are able to offer service users who present as dual diagnosis (mental health & substance misuse).
- (c) Service users accessing the City's community forensic service should have access to the full range of supported housing services.
- (d) Reciprocal workforce co-location is essential in supporting the implementation of the accommodation pathway at a number of stages.
- (e) Service users presenting with a range of needs in addition to poor mental health will require access to non designated residential supported housing.

7.0. Implications Arising

The implications resulting from this research must recognise that participants are representative of all the services and teams responsible for the delivery of front line services and as such if the strategy that results from this work does not reflect their views and opinions it is unlikely this strategy will be effectively implemented.

The findings and recommendations derived from this research will inform the re-procurement of all the services in the community voluntary sector which are currently funded by the Supporting People programme.

The redistribution of resources and an increase in performance will be anticipated if the research recommendations are implemented through the strategy. This will impact on inpatient and residential rehabilitation services as well as the community psychiatric services.