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GOALS OF NEW LONG-STAY PATIENTS IN SUPPORTED HOUSING: A UK STUDY

WALID K.H. FAKHOURY, STEFAN PRIEBE & MANSUR QURAISHI

ABSTRACT

Aim: This study assessed the goals 'new' long-stay clients aim to achieve by being in supported housing (SH), compared the goals stated by clients and staff, and tested whether subgroups of clients can be identified on the basis of their goals, quality of life and psychopathology.

Method: Interviews were conducted with 41 clients and 39 staff of supported houses in London and Essex, UK. Descriptive, content and cluster analyses were used to analyse the results.

Results: Clients' most frequently reported goal was moving to independent housing, followed by staying healthy, and increasing living skills. A comparison of goals reported by clients and staff showed poor or no agreement between them. Cluster analyses identified two clusters of clients. Cluster A ($n = 23$) contained those with no stated goals (or with the aim of staying healthy), lower quality of life, and more psychopathology; cluster B ($n = 18$) included those with an aim to move to independent housing, better quality of life, and less psychopathology.

Conclusion: In the UK, more staff training may be needed to identify and achieve the goals of the 'new' long-stay clients. For a subgroup of these clients, SH may still be a long-term care setting; while for another subgroup, new forms of rehabilitation in SH and better opportunities to leave SH may have to be developed. More conceptual and practical efforts are needed to manage the transformation of many settings from homes for life to transitional places where residents receive specific interventions.

INTRODUCTION

Over the past 30 years in North America and Western Europe, there have been major changes in mental healthcare provision. The shift from institutionalised to community care, combined with the closure of many psychiatric hospitals, led to a significant number of patients with multiple needs being placed in the community and requiring adequate housing, whether with or without support (Fakhoury & Priebe, 2002). This has consequently led to a growth in the variety of residential settings for these patients, including supported housing (SH) settings (Fakhoury *et al.*, 2002a).

The literature provides extensive data on SH clients' characteristics and outcomes. Studies point out that compared to those living in semi-supervised or independent accommodation,

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clients of SH are often older, less educated and unemployed (Friedrich *et al*., 1999; Fakhoury *et al*., 2002a), suffering from schizophrenia (Middleboe *et al*., 1998; Friedrich *et al*., 1999), and have problems with self-care (Livingston *et al*., 1992; Sood *et al*., 1996) and neurocognitive functioning (Wykes & Dunn, 1992; Brekke *et al*., 1997). The outcomes of SH are reported to be positive, with clients showing improved functioning, increased social integration, and better quality of life (Fakhoury *et al*., 2002a).

However, while there is a consensus on the profile of a SH client, there is as yet no universal agreement of what SH is and what philosophy it embraces (Fakhoury *et al*., 2002a). In addition, the existence of a considerable diversity of SH models – more so in the US than in Western Europe – makes the agreement on a single definition problematic (Fakhoury *et al*., 2002). However, it was the American 'National Institute of Mental Health' (NIMH) that first attempted to define 'supported housing'. The NIMH viewed it as 'an approach that focuses on clients' goals and preferences, uses an individualised and flexible rehabilitation process, and has a strong emphasis on normal housing, work, and social network' (NASMHPD, 1987). Although this definition may be too broad (Fakhoury *et al*., 2002a), and may not be used to classify different types of settings (Lelliott *et al*., 1996)), it is of importance conceptually because it considers goals of clients as an integral component of the SH approach.

In the UK, concerns have been repeatedly expressed that the range of existing SH settings is insufficient or of a poor quality (Audit Commission, 1998), and this, in turn, suggests that SH care may not be addressing the goals of its recipients. Currently, supported houses provide either semi-supervised or fully-supervised living arrangements for patients with mental illness, with some level of mandatory mental health services. Managers of SH settings are currently faced with the challenge of accommodating the 'old' long-stay clients (Fakhoury & Priebe, 2002), and with dealing with the increasing number of 'new' long-stay clients (Fakhoury *et al*., 2002a), two different groups of clients with different goals. The 'old' long-stay clients are those who have been hospitalised for a long period of time, and moved into SH early in the process of de-institutionalisation. These clients have been the focus of many studies into SH (Trieman *et al*., 1998; Fakhoury *et al*., 2002a; Priebe *et al*., 2002). The 'new' long-stay clients, on the other hand, are those currently presenting to the service – often with multiple needs and co-morbid alcohol/drug problems – competing for limited places in SH, and many over-staying in acute admission wards (Shepherd & Murray, 2001). Defining goals and working to achieve them may help clients, especially the new long-stay ones, to move out of SH. To examine the clients' goals, we conducted an exploratory study, using both qualitative and quantitative methods, of 'new' long-stay clients and staff in SH settings in two areas in England. More specifically, the study aimed to address three main questions:

1. What are the goals of 'new' long-stay clients residing in SH?
2. Is there an agreement between clients and staff on the goals of clients?
3. Can distinct groups of clients be identified based on their goals, quality of life and psychopathology?

METHODS

Setting and sample

SH settings in East London and Essex (Southeast region in England) were approached between August 2000 and December 2001. The managers in these houses were asked to identify clients who met the following criteria: not being in an inpatient setting for a length of time exceeding five years at any single period of time (to exclude 'old' long-term hospitalised patients); speaking English fluently; having a primary diagnosis of schizophrenia or related psychotic disorder (ICD 10 = F20–F29); and being under the age of 65. Out of the 17 SH settings approached, 11 identified clients who met the inclusion criteria. These settings belonged to different providers. Of the people living in these settings, 72 were identified. However, 20 (28%) refused and 11 (15%) were deemed too ill to take part in the study. The remaining 41 were interviewed (response rate of 57%). Thirty-two clients (78%) were recruited from 8 settings in London, and 9 (22%) from 3 settings in Essex. In addition, 39 staff were interviewed. The staff group included client care co-ordinators and the housing care managers of settings where clients were recruited.

Study instruments

Clients were interviewed in their place of residence using a specially constructed semi-structured interview schedule. The interview lasted between 20 and 40 minutes and was designed to elicit both qualitative and quantitative data pertaining to the clients' current stay in SH. On the qualitative level, the interview covered the goals clients had identified while at the residence. On the quantitative level, the interview covered, among other things, the clients' psychopathology and quality of life. Psychopathology was measured using the 24-item Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962). Quality of life was assessed using the Manchester Short Assessment of Quality of Life Scale (MANSA), whereby clients rated their satisfaction with life as a whole and in major life domains on 7-point scales ranging from 1 (could not be worse) to 7 (could not be better) (Priebe *et al.*, 1999).

Information was also obtained from care co-ordinators, through face-to-face interviews, on each client who had taken part in the study. This included information about the client's goals (staff were asked to list three main goals they thought the client aimed to achieve).

Data analysis

Data was analysed using SPSS 10.1 for Windows. Descriptive data was reported in terms of frequency and number count and in means and standard deviations (*SD*) where appropriate. Pearson's chi-square test for categorical data, Spearman's rho for continuous data, and one-way ANOVA were used in comparing variables.

Answers to the open question related to goals were subjected to content analysis (Bowling, 1997). Both staff and clients were asked the same question (for the client: *'while you are living here what would be the three main goals you would like to achieve?'*; for staff: '*while the client is living here what would be the three main goals he/she would like to achieve?*'. Information on these was recorded on the questionnaires. A list of all the individual answers given by clients and staff regarding goals was then compiled. Two researchers used the list separately

to categorise the goals. The categories were then compared, agreed upon, and for reliability purposes, checked again by an independent researcher.

The categories were then used to identify the most commonly reported goals of care and to compare goals reported by clients and staff. Stated goals were paired (i.e. each client's response was paired with the response given by the member of staff who answered the questionnaire about that specific client) and the two sets of responses were analysed using Cohen's Kappa (K) of agreement.

A hierarchical cluster analysis was run using complete linkage (furthest neighbour) in order to identify whether the clients could be classified into groups. It was felt that key variables to this classification of clients were their stated goals, quality of life, and their psychopathology level, and hence, these variables were subjected to clustering. Inclusion of socio-demographic variables such as age and gender was tested and found not to affect clustering. The number of clusters was determined by viewing the resulting dendrogram in order to identify well-separated groups.

RESULTS

Characteristics of residents

Of all the residents interviewed, 76% (31) were men. The average age was 39 years ($SD = 9$), with a range from 21 to 64. Sixty-eight percent (28) reported having a 'white' ethnic background. The majority (83%) had completed secondary education, and almost two-thirds (63%) of the residents had relatives living nearby. Almost half (48%) had visits from their relatives/friends at least once a month. There were no statistically significant differences between residents on the basis of the location of the SH setting.

As for the sample as a whole, the average BPRS score was 41.0 ± 12.2 and the average MANSA mean score was 4.4 ± 0.9, with a significant negative correlation between clients' scores on the two scales ($r = -0.39$, $p < 0.05$). An analysis of the MANSA specific domains' scores showed that the clients reported the highest satisfaction score with regard to housing and personal safety. Physical health and lack of employment were the areas where least satisfaction was reported. Satisfaction with housing was the only MANSA domain that was statistically significantly correlated to psychopathology, with those with less psychopathology being more satisfied with their residence ($r = -0.33$; $p < 0.05$) (see Table 1).

Goals of supported housing

Content analysis showed that the main goal identified by the clients who were interviewed was moving to independent housing, with 22% of people identifying this as their foremost goal. Increasing work skills (including going back to study) (20%), staying healthy (mentally and physically) (17%) and increasing living skills (17%) were other most cited 'main goals'. Reducing dependence was the main goal for 5% of those interviewed, and increasing daily structure was the main goal for 2%. However, almost a fifth (17%) of those interviewed were unable to identify any goals whatsoever.

A comparison of the goals reported by clients and those reported by staff for the same clients showed poor or no agreement between staff and clients. This was true for all reported

Table 1
Clients' characteristics

	Total Sample $N = 41$ **Mean ± *SD***
Age (years)	39.9 ± 9.5
Gender (men)	75.6%
Hospital admissions	
0–5 admissions	41.5%
6+ admissions	58.5%
BPRS score	41.0 ± 12.2
MANSA score	4.4 ± 0.9
Life in general	4.5 ± 1.9
Housing	5.5 ± 1.4
Work	4.1 ± 1.9
Finance	4.6 ± 1.4
Social contacts	4.4 ± 1.7
Leisure activities	4.8 ± 1.7
Personal safety	5.1 ± 1.7
Living arrangement	4.5 ± 1.7
Sex life	4.4 ± 2.6
Family relationship	5.0 ± 1.9
Physical health	4.0 ± 1.8

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

goals. The highest kappa value was +0.20 (values less or equal to 0.20 reflect poor agreement) and pertained to the goal of staying healthy (see Table 2).

Clients' clusters

As far as grouping clients in terms of stated goals, quality of life, and psychopathology, two clusters emerged with no significant differences between the two in terms of gender, age, and setting location. Cluster A comprised of 23 clients and cluster B of 18 clients. Clients in the two clusters reported having different sorts of goals. All the people who did not report any goals at all were in cluster A while all those who mentioned a wish to increase their social contacts outside of the residential setting, or wanting to do further education, were in cluster B. There were also other significant differences between the two clusters, with the majority of people who reported wanting to move to independent housing and to increase work skills being in cluster B. The only goals where there were no differences between the two clusters were regarding the desire to stay healthy, increasing living skills and becoming more independent (see Table 3).

As far as quality of life and psychopathology are concerned, clients in cluster A had significantly higher scores on the BPRS and reported being significantly less satisfied with their living conditions. Clients in cluster B, on the other hand, had lower scores on the BPRS and reported being more satisfied with their living conditions. None of the people in Cluster A were in any kind of voluntary/paid employment, while there were two people in Cluster B who worked a few hours every week. The analyses also showed that there were significant differences between the two clusters with regard to the specific domains of MANSA. Compared

Table 2
Agreement between client and staff on goals of stay in supported housing

Goal			Staff		Cohen's Kappa
			Yes *n*	No *n*	
Increasing daily structure					
	Client	Yes	1	2	+0.07
		No	6	21	
Increasing living skills					
	Client	Yes	1	6	−0.22
		No	9	14	
Increasing work skills					
	Client	Yes	2	10	0.00
		No	3	15	
Moving to independent housing					
	Client	Yes	6	3	+0.16
		No	10	11	
Reducing dependence					
	Client	Yes	1	2	−0.12
		No	8	20	
Staying healthy					
	Client	Yes	5	4	+0.20
		No	7	14	

to clients in cluster B, those in cluster A were significantly less satisfied with their housing, physical health, mental health, and with life in general (Table 3).

DISCUSSION

This study, the first of its kind to focus on goals of clients of SH from both clients' and staff perspectives, provided valuable information on what goals clients aim to achieve from their stay in SH. The analyses showed that clients had different goals, with most of those who stated a goal wanting to move to an independent accommodation or to stay healthy. However, almost a fifth had no clearly stated goal for care. There also appears to be little or no agreement between goals that clients have identified for themselves, if they had any, and goals that staff reported for the same clients. There is evidence in the literature showing low agreement between staff and clients when it comes to staff perceptions of clients' needs (Middleboe *et al*., 1998). Our analysis indicates that there is also divergence in views regarding clients' goals. This may be due to staff lack of understanding of what clients aim to achieve from staying in SH, or alternatively, to the clients unrealistic expectations of what they could possibly achieve. Also, the low agreement may have resulted from poor communication, so that staff and clients have little idea about each others' views. In any case, a meaningful and constructive discussion between staff and clients as to what the short- and long-term goals are in the individual case is needed throughout a client's stay in SH. Given that staff and clients spend much time with each other in housing schemes, there should be sufficient opportunities for such a dialogue. This may lead to either a better agreement between staff

Table 3
Comparisons between cluster A ($n = 23$) and cluster B ($n = 18$) on goals, psychopathology and quality of life

	Cluster A $n = 23$	Cluster B $n = 18$	Test (degrees of freedom)
Goals			
Going back to study	$n = 0$	$n = 2$	–
Increasing daily structure	$n = 3$	$n = 1$	$\chi^2 = 0.49$ (1)
Increasing living skills	$n = 7$	$n = 5$	$\chi^2 = 0.00$ (1)
Increasing social contacts	$n = 0$	$n = 2$	–
Increasing work skills	$n = 5$	$n = 11$	$\chi^2 = 8.0$ (1)**
Moving to independent housing	$n = 2$	$n = 10$	$\chi^2 = 12.2$ (1)***
Reducing dependence	$n = 2$	$n = 2$	$\chi^2 = 0.13$ (1)
Staying healthy	$n = 6$	$n = 5$	$\chi^2 = 0.99$ (1)
BPRS score	48.0 ± 11.7	32.1 ± 5.0	$F = 28.7$ (1,40)**
MANSA score	4.1 ± 0.8	4.8 ± 0.7	$F = 8.4$ (1,34)**
Life in general	3.8 ± 1.8	5.3 ± 1.7	$F = 6.75$ (1,39)**
Housing	4.9 ± 1.7	6.2 ± 1.9	$F = 9.06$ (1,39)***
Work	4.0 ± 1.9	4.3 ± 1.9	$F = 0.15$ (1,39)
Finance	4.6 ± 1.7	4.6 ± 1.2	$F = 0.001$ (1,36)
Social contacts	4.4 ± 1.6	4.4 ± 1.9	$F = 0.01$ (1,38)
Leisure activities	4.6 ± 1.9	5.2 ± 1.5	$F = 1.25$ (1,39)
Personal safety	5.0 ± 1.9	5.3 ± 1.5	$F = 0.39$ (1,39)
Living arrangement	4.4 ± 1.6	4.4 ± 1.9	$F = 0.00$ (1,39)
Sex life	4.8 ± 2.6	3.9 ± 2.5	$F = 1.16$ (1,38)
Family relationship	4.6 ± 2.0	5.4 ± 1.7	$F = 1.99$ (1,39)
Physical health	3.4 ± 1.6	4.8 ± 1.7	$F = 7.58$ (1,39)**
Mental health	4.0 ± 1.6	4.9 ± 1.4	$F = 3.39$ (1,39)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

and clients on the goals or an explicit disagreement in which staff as well as clients are fully aware of their different views. It may be assumed that the chances to implement goals are substantially higher when staff and clients agree on what these goals are. Staff should also ensure that these goals are based on current information about existing services/settings that the clients could access after leaving their current residence. This process may facilitate a move toward more suitable services for some clients and may even facilitate a more seamless transition out of the supported setting for others. This, of course, requires staff to have adequate training, not only in effective communication with clients, but also in providing a service that is based on the philosophy of SH. The evidence from the literature suggests that, so far, staff training issues have been neglected, with little research invested into knowing what tasks should be performed and what skills are needed for effective working in these settings (Fakhoury *et al.*, 2002a).

The study identified two distinct clusters of clients according to their goals, quality of life and level of psychopathology. Clients in cluster A had a higher degree of psychopathology than those in cluster B. They also reported a lower quality of life, and were less satisfied with their life in general, with their housing, and with their health, both physical and mental. These findings, are not only consistent with those from other studies that reported a negative association between psychopathology and quality of life (Corrigan & Buican, 1995; Priebe *et al.*, 1998; Bengtsson-Tops & Hansson, 1999; Hansson *et al.*, 1999; Fakhoury

et al., 2002), but they also show that residents' goals may vary in line with differences in psychopathology and quality of life. Those in cluster A, for example, were significantly less likely than those in cluster B to want to move to independent housing or to increase their work skills. Some clients in cluster A, the more 'ill' group, were not even able to identify any goal. Future investigations, particularly longitudinal studies, may be needed to assess whether having clearly stated goals for care contributes to positive patient outcomes. If this is the case, then identifying these goals and working to achieve them should be part of routine client care assessment in these settings

It is worthwhile to mention that interviewed staff frequently commented that some of their clients should be moved to more independent and less restrictive housing settings, but that no such settings could be offered to them. Indeed, our analysis suggests that some clients, especially those in cluster B, may be healthy enough to move from supported to more independent living. However, the UK Audit Commission indicated that it is often difficult to find suitable settings for people to move on to from conventional SH settings (Audit Commission, 1998).

This study points to the importance of a conceptual debate on what SH is expected to provide for the 'new' long-stay patients. Traditionally, SH provided homes for life for mentally ill people who were perceived as in need of supervision. This has shaped the SH approach in caring for patients in the community. In this culture, identifying further goals and specific treatment packages are not needed as patients are admitted to these settings with the goal of them staying there. However, this situation has changed over the years with the emergence of a new client group who often want to move on to more independent housing after a while to ultimately achieve independent living. No data, however, exists on how long these people would need supported living for, or on what staff in these houses should specifically do to enable them to move towards more independent living. On the other hand, not all clients have clearly stated goals for care. This mix of clients, which is not exclusive to UK SH settings, for it has also been reported in other countries such as Germany (Kaiser *et al*., 2001) and Italy (De Girolamo *et al*., 2002), forces strategists to re-consider the aim of SH. Is it to rehabilitate patients to achieve independent living or to provide homes for life? Our findings suggest that there are two distinct types of 'new' long-stay patients in SH. A type for whom SH might still provide homes for life, and another type that would possibly benefit from both a more specific rehabilitative approach in SH settings and practical opportunities to move out of them into the community.

Finally, the analyses were conducted on a small sample, mainly because it was difficult to identify more 'new' long-stay patients in the catchment area who met the inclusion criteria and who were willing to participate in the study. Therefore, the study may not be representative and findings on the relative frequency of the two clusters identified should be taken with caution. Interviews were conducted in the SH setting and this may have biased the results in that patients were less likely to criticise their SH provider. Nonetheless, the study, being exploratory, and using both qualitative and quantitative methodologies, provided valuable information to guide further research on the subject. It may be seen as a strength of this small-scale investigation of goals of patients in SH that, while we intentionally set out to interview patients from diverse settings, common themes across these settings were identified.

CONCLUSION

This survey showed that, in the UK, there is a need for staff training to be able to communicate effectively with their clients and identify with them the goals they aim to achieve by being in SH. Alternatives to SH should also be provided to those who are ready to move on to less structured and more independent housing. On a conceptual level, new forms of SH – or alternative rehabilitative settings – should be developed, particularly for a subgroup of 'new' long-stay patients who would like to move to more independent living and who, because of their improved mental health, may be able to do so.

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