

3 DAILY LIFE

People with mental health problems and their carers should live as fulfilled a life as possible, with additional support when needed to help them achieve this goal.

National Service Framework: key action 9

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

People with mental health problems ...may require help to access and maintain good quality housing. [paragraph 14.2]

Each local authority area are to ensure there is a range of housing options with appropriate levels of support available for people with mental health problems by end 2009/10. They should work in tandem with Registered Social Landlords (RSLs) – Housing Association – and the private rented sector to fulfil this aim. [key action 9 paragraph 15.1]

Is supported housing effective? What evidence is available regarding tiered levels of support?

What are service users perspectives on supported housing?

See Section 6.5 alternatives to admission and supporting people after discharge from hospital

There was limited UK primary research available regarding supported housing, and programmes to address homelessness for mentally ill people.

The statements

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3.1 Supported housing

Effectiveness of supported housing

3.1a Dedicated schemes whereby people with severe mental illness are located within one site or building with assistance from professional workers have potential for great benefit as they provide a 'safe haven' for people in need of stability and support. This, however, may be at the risk of increasing dependence on professionals and prolonging exclusion from the community. Whether or not the benefits outweigh the risks can only be a matter of opinion in the absence of reliable evidence. There is an urgent need to investigate the effects of **supported housing** on people with severe mental illness in a randomised trial.ⁱ

- i. Chilvers R, Macdonald GM, Hayes AA. Chilvers R, Macdonald GM, Hayes AA. Supported housing for people with severe mental disorders. *The Cochrane Database of Systematic Reviews* 2002, Issue 4. <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000453/frame.html> [accessed 29/07/05]
(Type I evidence – systematic review of randomised controlled trials evaluating the effectiveness of supported housing compared with outreach support schemes or 'standard care' for people with severe mental disorder/s living in the community. No studies met the inclusion criteria. Literature search to 2001.)

The statements

3.1b Research in **supported housing** for psychiatric patients has so far been neglected. Large scale surveys on structure, process, and outcomes across a variety of housing schemes may be useful in the future to identify some of the key variables influencing outcomes.

There is considerable diversity of models of supported housing and inconsistent use of terminology to describe them. In terms of outcomes, it seems that functioning can improve, social integration can be facilitated, and residents are generally more satisfied in supported housing compared with conventional hospital care. Little information is available on the factors that mediate outcomes and on skills required by staff. ⁱ

Service user perspectives of housing

3.1c The majority of clients had long-term mental health problems and were supported by a range of professionals. **Floating support** was flexible in responding to individual needs. A number of themes of relevance to inter-professional working emerged from the data. These included: floating support as a community resource, links with other agencies and confidentiality, information sharing and risk management. Floating support workers worked closely with professionals from health, social care, voluntary and educational services. Although the scheme's contribution to client care was highly valued, a number of barriers to effective interagency working were evident. This study highlighted the need for discussion and presented a forum for developing an ongoing **collaborative process** to address the specific issues which emerged in focus group discussions. ⁱ

Caveat: The sampling strategy and methods of data analysis have not been described in this study.

The evidence

- i. Fakhoury WK, Murray A, Shepherd G, Priebe S. Research in supported housing. *Social Psychiatry & Psychiatric Epidemiology* 2002; **37(7)**: 301-315
(Type III evidence – systematic review of 30 studies (cross-sectional, uncontrolled follow-up, observational studies and 1 non-randomised controlled trial) evaluating the effectiveness of supported housing for residents with severe and enduring mental illness. Literature search limits were not reported.)

- i. Sharples A, Gibson S, Galvin K. 'Floating support': implications for interprofessional working. *Journal of Interprofessional Care* 2002; **16(4)**: 311-322
(Type IV evidence – qualitative and quantitative study exploring the impact of a 'floating support' scheme provided by a local housing association in the UK. Focused conversational interviews were conducted with 11 clients (mean age 37.4 years, 65% male) of the scheme. 4 focus groups were also held with 15 people: 3 floating support workers, their line manager, and representatives from a community mental health team, social services team, a drop-in centre, housing association, a volunteers bureau, the local college and counselling service.)

The statements

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3.1d The results reinforced the importance of both **private and common spaces in supportive housing**. Both teams designed spaces which included a mix of private and community spaces. Both teams expressed concerns with safety and security and both designs attempted to deal with these issues in interior and exterior spaces. Both teams also stressed the importance of offering a diverse range of units of various sizes. Both teams also considered the idea of flexible space to be important, so that the changing needs of residents could be accommodated. Key differences in the design solutions, between teams, included their preferred scales of social interaction and differences in the access they provided to individual living spaces.ⁱ

Caveat: Participants received a \$50 honorarium.

3.1e There is a need for greater **consumer participation** with **mental health nurses** and policy makers, in the development of **housing services** that both protects consumers but, at the same time endorses their individuality and autonomy. Results show the 3 themes of: (1) clients wanting to feel safe and secure in their home; (2) not wanting to live with other people with mental illnesses; and (3) wanting to live a normal life despite having a mental illness. Subjects rejected congregated housing based on 3 perceptions: (1) that it was set up in order for **mental health services** to more easily manage them; (2) that it identified them as former psychiatric patients, causing stigmatization; and (3) that it represented failure to be able to lead a normal life. ⁱ

See also Sections 2.1 – 2.2 for consumer involvement with mental health services

- i. Johnson, LC. The community/privacy trade-off in supportive housing: Consumer/survivor preferences. *Canadian Journal of Community Mental Health* 2001; **20(1)**: 123-133

(Type IV evidence – intensive planning session of consumers of supportive housing invited to spend a weekend in a charrette workshop to design an ideal supportive housing environment. 20 current or recent residents participants from supportive housing programmes in Canada (ranging from young adult to middle aged) were divided into 2 teams based on either community or privacy themes.)

- i. Warren R, Bell P. An exploratory investigation into the housing preferences of consumers of mental health services. *Australian and New Zealand Journal of Mental Health Nursing* 2000; **9(4)**: 195-202

(Type IV evidence – qualitative study conducting semi-structured interviews with 10 clients (aged 23-55 years) of an Australian community mental health service with diagnoses of either schizophrenia or bipolar affective disorder.)

The statements

3.1f Narrative responses revealed 4 integrative themes: (a) loneliness, (b) making do with socially and structurally inferior housing, (c) a desire for more understanding, and (d) a concern with an individual's sense of **integration into a community**. Prevalent throughout the analysis of the residential experience of tenants in **supported housing** was their gratitude for their housing and their general sense of satisfaction and optimism – in spite of social and structural concerns with housing that was often not affordable. Participants also expressed a general desire to develop understanding, particularly of mental health issues with **landlords**, other tenants and the community at large.

Overall, there was a strong desire to fit-in with the community at large, in apartment buildings and neighbourhoods that exhibit diversity. A prominent theme was that residents of housing which is almost exclusively occupied by **low-income households** did not identify with their communities. Residents also spoke against living in housing that is dedicated to people with serious mental illness.¹

Caveat: The sampling strategy and sample characteristics have not been fully reported. Participants were paid \$10.

The evidence

- i. Walker R, Seasons M. Supported housing for people with serious mental illness: Resident perspectives on housing. *Canadian Journal of Community Mental Health* 2002; **21(1)**: 137-151

(Type IV evidence – qualitative study of supported housing residents in Ontario, Canada. 14 single men, 14 single women and 3 couples (mean age 41 years) were interviewed.)

National Service Framework: key action 9b

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Services are to be provided for homeless people which identify and meet their care and support needs, and which are comparable in quality of care to those who are housed. [Key action 9 paragraph 16.1]

What are the needs of homeless people with mental health problems?

See Sections 5.2 for information on the needs of homeless people with mental health problems

National Service Framework: key action 9c

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Teams admitting people to hospital...are to work with housing and advice agencies to ensure that people will not be homeless following discharge, and that their housing conditions will not undermine their recovery. [Key action 9 paragraph 16.2]

How can homelessness following discharge be prevented?

What are acceptable housing conditions that will support recovery?

3.2 Preventing homelessness once discharged from hospital

3.2a This study suggests that **involuntary outpatient commitment (OPC)** may provide a short-term reduction in the **risk of homelessness** among a subgroup of treatment-reluctant individuals with severe mental disorders combined with severe functional impairment. Involuntary OPC was associated with a significant decrease in the risk of homelessness during the first 4 months following hospital discharge for participants with severe functional impairment at baseline (OR 0.015, 95%CI 0.0003–0.7369). This suggests that OPC may have reduced the risk of homelessness by approximately 90% for this subgroup of participants. OPC did not appear to affect risk of homelessness among participants with mild-to-moderate functional impairment. Co-occurring substance abuse, treatment nonadherence, and outpatient services intensity were found to be strongly associated with episodes of homelessness.ⁱ

Caveat: The difference between the groups for participants with severe functional impairment was not significant at the 8- and 12-months. It is unclear whether an intention-to-treat analysis was used. The results may have limited applicability to a UK setting.

3.2b The findings suggest that **providing housing** for persons who have **severe and persistent mental illness** improves cognitive functioning but that independent living may diminish executive functioning. Overall neuropsychological functioning improved significantly across the full study sample (Hotelling's $T^2=67.68$, $df=20, 66$, $p<.01$, $n=86$). This change was also reflected in the overall impairment score ($t=2.80$, $df=90$, $p=.006$). Executive performance, measured by the Wisconsin Card Sorting Test (WCST), decreased significantly among persons assigned to independent apartments (3.2 compared with 2.4, $t=2.41$, $df=37$, $p=.021$) and increased, but not significantly, among those assigned to group homes (2.5 compared with 2.8). The effect of housing type on WCST scores was statistically significant ($F=5.70$, $df=1, 82$, $p=.019$).ⁱ

Caveat: Demographic details of the sample have not been reported and participants were paid for their participation. It is unclear if an intention-to-treat analysis was used.

- i. Compton SN, Swanson JW, Wagner HR, Swartz MS, Burns BJ, Elbogen EB. Involuntary outpatient commitment and homelessness in persons with severe mental illness. *Mental Health Services Research* 2003; **5(1)**: 27-38

(Type II evidence – secondary analysis of data from a 1-year randomised controlled trial of 204 involuntarily hospitalised patients in Durham, North Carolina (mean age 39 years, 50% male). Following hospital discharge, patients were assigned to be released or maintained under involuntary outpatient commitment (OPC). OPC, in which a judge orders patients to adhere to treatment, is designed as a less restrictive alternative to hospitalisation for persons with severe mental health problems at risk of becoming dangerous.)

- i. Seidman LJ, Schutt RK, Caplan B, Tolomiczenko GS, Turner WM, Goldfinger SM. The effect of housing interventions on neuropsychological functioning among homeless persons with mental illness. *Psychiatric Services* 2003; **54(6)**: 905-908

<http://psychservices.psychiatryonline.org/cgi/reprint/54/6/905> [accessed 29/07/05]

(Type II evidence – randomised controlled trial of 112 persons with serious persistent mental illness who were stable residents of homeless shelters in Boston, USA. Participants were assigned to group homes or independent apartments. Measured outcomes included substance use, medication dosage and case-manager-reported medication compliance. 18 months follow-up.)

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- 3.2c The **critical time intervention** programme is not only an effective method to reduce **recurrent homelessness** among persons with severe mental illness but also represents a cost-effective alternative to the status quo. Over the study period, the critical time intervention group and the usual services group incurred mean costs of \$52,374 and \$51,649, respectively, for acute care services, outpatient services, housing and shelter services, criminal justice services, and transfer income. During the same period, the critical time intervention group experienced significantly fewer homeless nights than the usual care group (32 nights versus 90 nights). For each willingness-to-pay value the additional price society is willing to spend for an additional nonhomeless night greater than \$152, the critical time intervention group exhibited a significantly greater net housing stability benefit, indicating cost-effectiveness, compared with usual care.
- Caveat:** The results may have limited generalisability to a UK setting.

- 3.2d Providing **housing combined with mental health services** is an effective approach to **reducing shelter use** among mentally ill persons who have a history of homelessness. Heavy users of the shelter system were more likely to be placed in New York/New York (NY/NY) housing. In the 2-year post-placement period, persons who received a NY/NY housing placement used, on average, 128.2 fewer shelter days than those in the control group. In 1996, the NY/NY housing initiative reduced the average nightly census in New York City shelters by an estimated 4.6 %.ⁱ

The evidence

- i. Jones KJ, Colson PW, Holter MC et al. Cost-effectiveness of critical time intervention to reduce homelessness among persons with mental illness. *Psychiatric Services*. 2003; **54(6)**: 884-890
<http://psychservices.psychiatryonline.org/cgi/reprint/54/6/884> [accessed 29/07/05]
(Type II evidence – randomised controlled trial with cost-effectiveness analysis of 96 participants from a psychiatric programme in a men’s public shelter in New York. Participants were assigned to either the critical time intervention or to usual services. Costs and housing outcomes were examined over 18 months.)
- i. Metraux S, Marcus SC, Culhane DP. The New York–New York housing initiative and use of public shelters by persons with severe mental illness. *Psychiatric Services* 2003; **54(1)**: 67-71
<http://psychservices.psychiatryonline.org/cgi/reprint/54/1/67> [accessed 29/07/05]
(Type IV evidence – analysis of an integrated dataset using computerized service records on housing, shelter use, and health care services. The dataset consisted of 3,167 persons who received New York–New York (NY/NY) housing placements, which provided mental health services, and a matched control group of persons with mental illness who used shelters but did not receive housing placements. The study examined changes in the use of shelters in New York City by mentally ill persons with a history of homelessness who received housing placements through the NY/NY housing initiative between 1990 and 1999 and the impact of the initiative on the overall demand for shelter beds in the city.)

The statements

The evidence

3.2e The Pathways **supported housing programme** provided a model for effectively housing individuals who were **homeless** and living on the streets. The programme's housing retention rate over a 5-year period challenged many widely held clinical assumptions about the relationship between the symptoms and the functional ability of an individual. Clients with severe psychiatric disabilities and addictions were capable of obtaining and maintaining **independent housing** when provided with the opportunity and necessary supports. After 5 years, 88% of the programme's tenants remained housed, whereas only 47% of the residents in the city's residential treatment system remained housed. When the analysis controlled for the effects of client characteristics, it showed that the supported housing programme achieved better housing tenure than did the comparison group.ⁱ

- i. Tsemberis S, Eisenberg RF. Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services* 2000; **51(4)**: 487-493
<http://psychservices.psychiatryonline.org/cgi/reprint/51/4/487> [accessed 29/07/05]

(Type III evidence – experimental study of 241 individuals (mean age 41.12 years; 66.8% male) housed between January 1993 and September 1997 by the 'the Pathways to Housing Supported Housing Programme', New York. Tenure was compared to a citywide sample of 1,600 persons (mean age 41.35 years, 72% female) who were housed through a linear residential treatment approach during the same period.)

3.3 Housing conditions

3.3a The strongest finding from the literature on housing as an input and an outcome was that living in **independent housing** was associated **with greater satisfaction with housing and neighbourhood**. The review has not demonstrated which housing attributes or factors are critical to a mentally ill person's capacity to live independently, it has not described the types of **residential alternatives** that are most effective for persons with serious mental illness, it has not identified specific housing attributes that can be systematically associated with the best type of residential settings and it has not produced any agreement on the most appropriate way to conceptualise and measure the effectiveness of the housing setting.ⁱ
Caveat: Although the quality of included studies is discussed, no formal method of appraisal was reported.

- i. Newman, SJ. Housing attributes and serious mental illness: Implications for research and practice. *Psychiatric Services* 2001; **52(10)**: 1309-1317
<http://psychservices.psychiatryonline.org/cgi/reprint/52/10/1309> [accessed 29/07/05]

(Type I evidence – systematic review of 32 randomised controlled trials and observational studies examining the relationship between housing attributes and serious mental illness. Literature search 1975-2000.)

The statements

3.3b The lack of evidence linking **housing and health** may be attributable to pragmatic difficulties with housing studies as well as the political climate in the United Kingdom. In studies, however, that assessed the health impacts of Medical Priority rehousing, energy efficiency improvements, refurbishment, rehousing and area regeneration, improvements were found one month to 5 years after the housing improvements were completed. In one large, prospective controlled study the degree of improvement in **mental health** was directly related to the extent of housing improvement, demonstrating a dose-response relation. This consistent pattern of improvements in mental health would suggest that improving housing would generate mental health gains. In conclusion a holistic approach is needed that recognises the multifactorial and complex nature of poor housing and deprivation.^{i,ii,iii}

3.3c This study provides experimental evidence of **neighbourhood income effects on mental health**. Parents who moved to low-poverty neighbourhoods reported significantly less distress than parents who remained in high-poverty neighbourhoods. The intention-to-treat analyses showed, a significant group differences for distress symptoms; experimental parents were less likely than in-place control parents to report distress symptoms. For the treatment-on-treated (TOT) analysis, this effect was significant, suggesting that experimental parents who complied with treatment (i.e., moved) were less likely than in-place controls to report distress symptoms. This TOT effect represented an additional 20% reduction in symptoms compared with control parents.

Boys who moved to less poor neighbourhoods reported significantly fewer anxious/depressive and dependency problems than did boys who stayed in public housing.ⁱ

Caveat: The follow up at 3 years was 69.2%.

The evidence

- i. Thomson H, Petticrew M, Morrison D. *Housing improvement and health gain: a summary and systematic review*. Glasgow: MRC Social & Public Health Sciences Unit, University of Glasgow, 2002
- ii. Thomson H, Petticrew M, Morrison D. Health effects of housing improvement: systematic review of intervention studies. *British Medical Journal* 2001; **323(7306)**: 187-190
<http://bmj.bmjournals.com/cgi/reprint/323/7306/187> [accessed 29/07/05]
- iii. Thomson H, Petticrew M, Douglas M. Health impact assessment of housing improvements: incorporating research evidence. *Journal of Epidemiology & Community Health* 2003;**57(1)**: 11-16
(Type III evidence – systematic review of 18 experimental and non-experimental housing intervention studies. Literature search to 2000.)

- i. Leventhal T, Grooms-Gunn J. Moving to opportunity: an experimental study of neighbourhood effects on mental health. *American Journal of Public Health* 2003; **93(9)**: 1576-1582
(Type II evidence – secondary analysis of a randomised housing relocation programme in 5 US study sites. This study focuses on the New York City site following up 550/790 families (mean parental age 35.4 years; 93% female) allocated to 1 of 3 groups: an experimental group receiving housing vouchers and special assistance to move only to low-poverty neighbourhoods; a comparison group receiving housing vouchers under the regular geographically unrestricted programme (n=181); or a control group.)

The statements

The evidence

3.3d The prevalence of depression was associated with independently rated features of the **built environment**, independent of individuals' socio-economic status and internal characteristics of dwellings. After adjusting for socio-economic status, floor of residence and structural housing problems, statistically significant associations were found between the prevalence of depression and living in housing areas characterised by properties with predominantly deck access (OR 1.28, 95% CI 1.03-1.58; $p=0.02$) and of recent (post-1969) construction (OR ratio=1.43, 95% CI 1.06-1.91; $p=0.02$).ⁱ

3.3e **Neighbourhood renewal** in deprived areas is likely to have a role in **improving mental health** among local populations. More evidence about this relationship would help to inform how to approach neighbourhood renewal, including decisions about renewal priorities and whether to demolish or refurbish substandard housing.

Following the renewal work, improvements occurred in both adults' and children's levels of psychological distress. Between 1992 and 1997 there was a fall of 15% in adults with one or more mental health problems and, among the longitudinal sample, a decline of almost a half in adults having trouble with their nerves. Multivariate regression analysis showed these effects to be associated with improved community safety and a reduction in serious draughts within dwellings. A respondent who perceived the area to be unsafe is significantly more likely to report 1 or more mental health problems than a respondent who perceived the area as safe (OR 2.45, 95% CI 1.41-3.92; controlled for the effects of chronic respiratory ill-health, age 50 or older and serious draughts). After controlling for the other 3 variables, an adult living in a dwelling with serious draughts is significantly more likely than an adult living in a dwelling with no or minor draughts to report mental health problems (OR 2.28, 95% CI 1.41-3.69).ⁱ

Caveat: Sample sizes for tabulated results do not correspond to those reported in the study text.

- i. Weich S, Blanchard M, Prince M, Burton E, Erens B, Sproston K. Mental health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *British Journal of Psychiatry* 2002; **180**: 428-433

(Type IV evidence – cross-sectional survey of 1887 individuals (aged 16 year and over; 57.3% women) in 2 electoral wards within 1 north London borough, representing 76 housing areas. The built environment was rated independently, using a validated measure.)

- i. Blackman T, Harvey J. Housing renewal and mental health: a case study. *Journal of Mental Health* 2001; **10(5)**: 571-583

(Type IV evidence – longitudinal study of 415 UK households (n=749 adults, aged >16 years; n=253 children) interviewed prior to the implementation of a neighbourhood renewal programme (1992). 234 households (n=394 adults; n=131 children) were followed-up 5 years later after completion of the renewal work. Self-reported outcome data were collected for perceptions of the neighbourhood, symptomatic health including symptoms of psychological distress and lifestyle factors.)

National Service Framework: key action 10

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

For users in employment/ meaningful activity, support should be made available to help them maintain their employment. [Key action 10 paragraph 16.3]

What support can be offered to people with mental health problems to help achieve and maintain employment?

The statements

The evidence

3.4 Supported employment

3.4a Supported employment is more effective than Pre-vocational Training in helping severely mentally ill people to obtain competitive employment. At 18 months 34% of people in Supported Employment were employed versus 12% in **Pre-vocational Training** (RR (unemployment) 0.76, 95% CI 0.64 - 0.89, NNT 4.5). Clients in Supported Employment also earned more and worked more hours per month than those in Pre-vocational Training.

There was no evidence that Pre-vocational Training was more effective in helping clients to obtain competitive employment than standard community care.ⁱ

- i. Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental illness. *The Cochrane Database of Systematic Reviews* 2001, Issue 2
<http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003080/frame.html>
[accessed 29/07/05]
(Type I evidence – systematic review and meta-analysis of 18 randomised controlled trials to determine how effective pre-vocational training and supported employment were in helping people, with severe mental illness to obtain competitive (i.e. open) employment. The primary outcome was number of clients in competitive employment at various time points. Literature search to 1999.)

The statements

The evidence

3.4b Supported employment has the potential to meet the occupational needs of a large proportion of mental health service users, provided it is implemented along clearly-defined lines. For people who, at any point in time, do not require open employment, a range of more or less inclusive alternatives exist. Service users are more likely to get jobs and keep them if they are not impeded by poor social skills and negative symptomatology, but also if they have worked before, have positive attitudes towards work, are placed as soon as possible in a job of their choice, receive preparation targeted at work rather than general training, receive ongoing support in their job, actively participate in an occupational intervention and are not worse off as a result of working. **Vocational services** seem to be more effective at getting people into work when integrated with mental health teams. The **Individual Placement and Support (IPS)** model of supported employment has strong evidence in its favour, but it may not suit everyone at all times.ⁱ

- i. Schneider J, Heyman A, Turton N. *Occupational outcomes from evidence to implementation*. Durham: Centre for Applied Social Studies, University of Durham 2002

(Type I evidence – systematic overview of 245 occupational interventions for service users with severe mental health problems (meta-analyses, randomised and non-randomised controlled trials, prospective cohort, retrospective cohort and other observational studies and expert opinion were included). Literature search date not reported.)

3.4c The findings illustrate the importance of choice of outcomes in evaluations of **employment programmes**. The incremental cost-effectiveness ratio estimates indicated that **individual placement and support (IPS) programmes** both cost more and produce more competitive employment; participants in the IPS programme worked in competitive employment settings for an additional week over the 18-month period at a cost of \$283 (\$13 an hour). When combined earnings were used as the outcome, data from the statistical analyses were insufficient to enable any firm conclusions to be drawn. No statistically significant differences were found in the overall costs of IPS and **enhanced vocational rehabilitation**.ⁱ **Caveat:** IPS subjects had a higher rate of hospitalisation before they entered the programme. There is insufficient data on participants baseline characteristics.

- i. Dixon L, Hoch JS, Clark R et al. Cost-effectiveness of 2 vocational rehabilitation programmes for persons with severe mental illness. *Psychiatric Services* 2002; **53(9)**: 1118-1124
<http://psychservices.psychiatryonline.org/cgi/reprint/53/9/1118> [accessed 29/07/05]

(Type II evidence - randomised controlled trial to determine differences in the cost-effectiveness of individual placement and support (IPS) and enhanced vocational rehabilitation (EVR). 150 unemployed inner-city patients in Washington DC, with severe mental disorders who expressed an interest in competitive employment were randomly assigned to IPS or EVR, and followed for 18 months.)

The statements

3.4d The **Individual Placement and Support programme** was more effective than the psychosocial rehabilitation programme in helping patients achieve employment goals. Achieving job retention remains a challenge with both interventions. Individual Placement and Support programme participants were more likely than the comparison patients to work (42% versus 11%; $p < 0.001$; OR 5.58) and to be employed competitively (27% versus 7%; $p < 0.001$; OR 5.58). Employment effects were associated with significant differences in cumulative hours worked ($t(211) = -5.0$, $p < 0.001$) and wages earned ($t = -5.5$, $p < 0.001$). Among those who achieved employment, however, there were no group differences in time to first job or in number or length of jobs held. Also, both groups experienced difficulties with job retention.ⁱ
Caveat: Subjects were given financial incentives to participate. Drop-out was high; by 24 months only 74% of the IPS group, and 60% of the comparison group were followed up. It is unclear whether an intention-to-treat analyses was performed.

3.4e The findings suggest that helping clients obtain work that matches their job preferences is an important ingredient of success in **supported employment programmes**. For clients in the **IPS programme**, those who obtained jobs that matched their preemployment preferences for type of work desired reported higher levels of job satisfaction than those in mismatched jobs (means = 3.11, 2.88, SD=0.43, 0.40 respectively, $t(22)=0.10$) and had longer **job tenures** than clients who obtained jobs that did not match their preferences (means=28.94, 15.12 weeks, SD=35.00,20.60 $n=31, 17$ respectively $t(46) = 1.72$, $p < 0.05$). For clients in the **PSR** or Standard programmes, job preferences were not related to job tenure or satisfaction.ⁱ
Caveat: The number of participants at follow-up, an intention to treat analyses, and whether the groups were similar at the start of the trial, have not been reported.

The evidence

- i. Lehman AF, Goldberg R, Dixon LB et al. Improving employment outcomes for persons with severe mental illnesses. *Archives of General Psychiatry* 2002; **59**: 165-172
(Type II evidence - randomised controlled trial of 219 outpatients (mean age at first admission 22.8 years, 57% male) with severe mental illnesses from an inner-city catchment area in Baltimore, USA. Allocation of patients was concealed, to either an Individual Placement and Support programme (IPS) or a comparison psychosocial rehabilitation programme. Participants were followed-up at 6 monthly intervals for 24 months.)

- i. Mueser KT, Becker DR, Wolfe R. Supported employment, job preferences, job tenure and satisfaction. *Journal of Mental Health* 2001; **10**: 411-417
(Type II evidence - randomised controlled trial of 204 unemployed clients (mean age 37.6 years; 72.5% male) with severe mental illness from Hartford, USA. Clients were assigned to either an Individual Placement and Support (IPS) model of supported employment, or a Psychiatric Rehabilitation Programme (PSR) or standard services (Standard) and followed for 2 years.)

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National Service Framework: key action 10

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

People with mental health problems and their carers have the same needs for friendship and social leisure/recreational and education/training/lifelong learning activities as any other person in the community. Some individuals may require additional support to access such opportunities. [Key action 10 paragraph 17.1]

How can social leisure activities of people with mental health problems and their carers be improved?

See also Section 1.3 and 1.9.

The statements

The evidence

3.5 Improving user/carers' social activities

3.5a Findings showed that the individuals who participated in the social recreation component of the programme, in varying frequency, reported significant improvements at 1 year follow-up than at intake. This was found in their self-ratings of loneliness, self-esteem, **social functioning, satisfaction with social relations and leisure activities** as well as general life satisfaction. People rated their satisfaction with leisure activities higher at the 1 year follow-up than at the time of intake ($t(35) = -2.50, p < 0.05$). Only a significant association between participation and changes in satisfaction with social relationships was found ($r = 0.33, p < 0.05$), so that people who participated in more programme activities, tended to report greater improvements in their satisfaction with social relationships.ⁱ

Caveat: Whilst 45 people enrolled, analysis is only based on those completing baseline and follow-up measures.

- i. Petryshen PM, Hawkins JD, Fronchak TA. An evaluation of the social recreation component of a community mental health programme. *Psychiatric Rehabilitation Journal* 2001; **24**: 293-298
(Type III evidence – longitudinal study of 36 participants (mean age 43.2 years, 61% female), with serious mental illness, enrolled in the social recreation component of a community-based mental health programme in Toronto, Canada. 12-months follow-up.)

3.5b Few differences were found between districts although there was some evidence of better objective outcomes for people in receipt of **integrated mental health services**. They socialised more, and seemed to have less difficulty accessing police and legal services. **Quality of Life (QoL)** seemed to be stable for the whole sample over time. In 6 months, general satisfaction with **leisure** increased (overall mean score 4.76 +/-1.08) and the number of people who had been in hospital fell (T1 31% compared to T2 17%).ⁱ

- i. Schneider J, Wooff D, Carpenter J, Brandon T, McNiven F. Community mental healthcare in England: associations between service organisation and quality of life. *Health and Social Care in the Community* 2002; **10**: 423-434
(Type IV evidence - observational study of 260 randomly selected service users in England (mean age 43.7 years, 53% male), from 2 'integrated' mental health trusts that worked closely with local social services and 2 'discrete' trusts that worked independently of local authority social services. 6-months follow-up.)

The statements

3.5c Key areas that were problems affecting participants quality of life were lack of personal achievement, lack of job, difficulty in forming and maintaining relationships, loneliness, health problems (both mental and physical), lack of leisure activities, personal safety and looking after self. 5 participants stated lack of **leisure activities** were a priority problem affecting quality of life. Involvement in 1 or more of the following leisure activities were listed by those who wished to do more in this area: cricket, bowling football (both playing and watching) and attending concerts. 2 of the interviewees indicated that it was their involvement in leisure activities that made their life worthwhile.ⁱ

The evidence

- i. Mayers CA. Quality of life: priorities for people with enduring mental health problems. *British Journal of Occupational Therapy* 2000; **63(12)**: 591-596
(Type IV evidence - qualitative study of 11 people (mean age 41.6 years, 10 male) with enduring mental health problems from 2 NHS trusts in the UK. Participants completed semi-structured interviews about daily activities and activities that they would like to do but felt unable to undertake. Participants also rated their quality of life and completed a quality of life checklist.)