HERO

housing: an educational european
road towards civil rights

HOUSING AND MENTAL HEALTH
QUALITY INDICATORS TOOLKIT FOR LOCAL COMMUNITIES
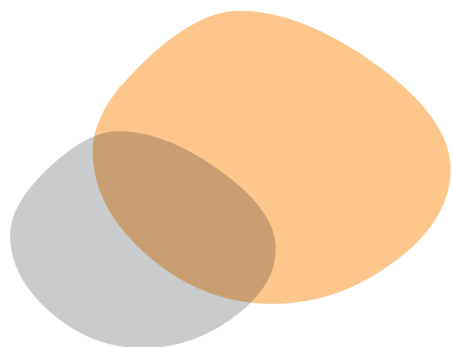
COORDINATED BY **ASL ROMA 2**

www.housing-project.eu

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Introduction

Flori Degrassi
Director General - ASL Roma 2
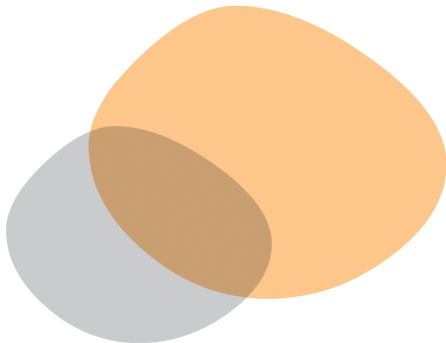
I am pleased to introduce "Housing and mental health. Quality Indicators Toolkit for local communities" the first publication of HERO. A project resulting from an authentic exchange of experiences with the Housing scheme, it aims at detecting indicators of quality that can be considered European guidelines for future initiatives in mental health recovery.

Hero is the first ASL ROMA 2 Housing project for the mental health system to have received European recognition under the Erasmus+ program.

With this initiative, the HERO partnership aims to explore this important subject through joint efforts among a number of different countries.

The project is fully incorporated into the "Mental Health Action Plan 2013-2020" promoted by the WHO, and is part of the United Nations Sustainable Development's objective 3, "Good Health and Well-Being". I would also like to highlight the valuable contribution of HERO to the exchange among citizens, service users and their family members, mental health workers, stakeholders and social workers, in building an integrated path toward a quality of life based on well-being and social inclusion, as opposed to stigma and marginalization.

I believe that this first tangible product of the HERO project, promoted and coordinated by the Department of Mental Health of ASL ROMA 2, will arouse the interest of people from diverse disciplines, who are involved in carrying through the Housing system scheme for mental health users.

I wish good luck to everyone who, in the five European countries where the project is being implemented, is working to its realization.

Partners
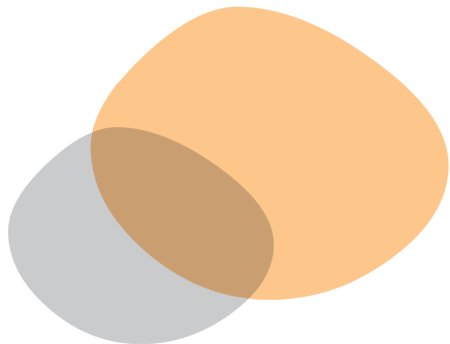
SISTEMA SANITARIO REGIONALE
ASL ROMA 2

HERO APPLICANT, WITH THE MENTAL HEALTH DEPARTMENT
I T A L Y
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AND THE PARTNERS

FONDAZIONE INTERNAZIONALE DON LUIGI DI LIEGRO onlus
I T A L Y
www.fondazionediliegro.com

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PEPSAEE
PanHellenic Association for the Psychosocial Rehabilitation & Work Re-Integration
G R E E C E
www.pepsaee.gr

I.

HERO context
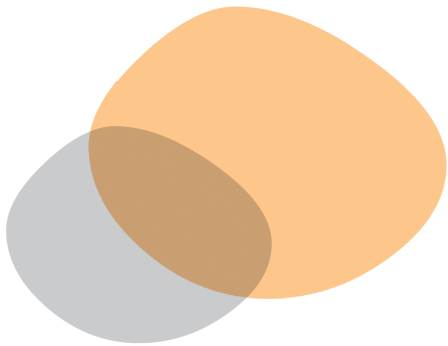
The safeguard of mental health is becoming increasingly important in the world. In the past few years, the World Health Organization has launched a number of initiatives to raise awareness about the various degrees of disability that can be generated by mental illness.

Mental well-being has been defined as essential to general health according to the WHO. Good mental health generates personal fulfillment, the ability to cope with ordinary everyday tensions, professional behavior and productivity, and a positive contribution to the community. To give this subject the attention it deserves, all over the world there is still much work to be done. Many things must change if we are to reverse unfavorable trends and end human rights violations and discrimination against people affected by mental disorders and psycho-social disabilities. This global action plan recognizes the essential role mental health plays in reaching our overall health objectives. Based on a lifelong approach that aims to achieve equality through universal health coverage with a focus on prevention, the plan revolves around four core principles: an effective leadership and governance in the field of mental health; the availability of integrated, comprehensive mental health and social services that meet the needs of the community; the implementation of prevention strategies; and the dissemination of in-depth information through the gathering of more scientific evidence and promotion of research. The objectives of this action plan are certainly ambitious, but the WHO and its Member States are fully committed to achieving them. (Mrs. Margaret Chan, Director General, World Health Organization, Presentation of "2013-2020 Action Plan for Mental Health"). The action plan is complementary
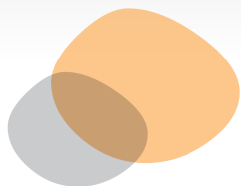
to the "Quality Right toolkit" by the WHO, where the standards supporting Housing are defined in according to the five topics of the UN "Convention on the Rights of Persons with Disabilities":

1. The right to an adequate standard of living and social protection;
2. The right to enjoyment of the highest attainable standard of physical and mental health;
3. The right to exercise legal capacity and the right to personal liberty and the security of person;
4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse;
5. The right to live independently and be included in the community.

HERO is a project that revolves around places: *Urban environments are constantly subject to change, and they are interconnected. In these places, the only fixed concept is the idea of transition* (Esther da Costa Meyer, 2012). Housing is an English word which indicates the act of inhabiting and the 'ing' suffix evokes the idea of progress: this means that inhabiting is not a fixed concept, but rather implies change and evokes a path, a neighborhood and a city where relationships are built among people who know one another or who are meeting for the first time.

Neuro-scientific research reveals that the brain is an organ that lives and grows through relationships: *The idea of mind and by extension of selfhood that I want to bring forth through the notion of extended self is that of a self that is located neither inside nor outside the brain/body, but is instead constantly enacted in-between brains, bodies and things and thus irreducible to any of these three elements taken in isolation. (Malafouris, 2009).*

We believe that mental health cannot be achieved in one single place. After speaking with Ronald Laing – as reported in "Crimini di pace" (1975) – Franco Basaglia wrote: *Laing … now proposes again (…) the building of an "asylum" which responds (…) to the need of a shelter to protect those who experience a "different" existence. This should be a place where "different" people are able to express themselves without limitations and where they learn to live with their differences. As much as Laing incites us to resist and fight within the institutions, we encourage him to try and prevent the "asylum" from becoming another kind of institution, as it will inevitably be integrated into the social and economic area in which it will be built … Although this project focuses on the individual, it does not feature any in-depth analysis of the political and social environment in which the individual is to be assimilated.* It is not correct to presume that there can be a place where patients can be cured without
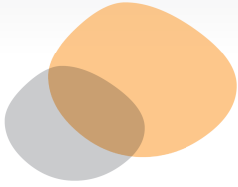
any social and political intervention: Health lies in diversity, in new possibilities, in one's faith in a different future.

Between 1950 and 1960 many European clinicians and politicians carried forward the idea that mental treatment did not require a long stay in a mental hospital … They were opposed to the old-fashioned psychiatric wards as they considered them "Anti-therapeutic". However, their approach was quite naïve, as it aimed at changing the structures and not the methods. (Robert Hinshelwood, 2001 Director of the London Therapeutic Community "Cassel").

If the structures were too large, smaller buildings were built; If they were remote from the center, they were moved into the city. However, this didn't work. Even in the smaller centers the so-called "new chronicity" persisted.

HERO proposes something different: It allows one to live with and in spite of his or her suffering, with awareness of one's differences, and to be integrated into a network of relationships formed in places designed to improve mental health (community, apartments with customized facilities, etc.) and are based on social resources (cultural centers, theatres, recreational centers, etc.), on therapeutic activities within the facilities (such as multiple family groups) and offsite groups (such as "Hearing Voices," music events, sports events, etc.), on work (according to personal abilities and opportunities). They promote volunteering services to help overcome the difficulties of establishing relationships and communication with people who are generally considered "unpredictable" and "different." Of note is that these places are interconnected, accessible, habitable and modifiable. They are places where everyone feels welcome, respected, not judged or stigmatized, and can become aware that mental health (and not only that) is a status that can be obtained if everyone is involved, because it involves everyone.

We are convinced that the surrounding territory must be strictly connected to the "places" where patients are staying: these places should always be considered in relation to the surrounding environs.

As early as 1994 Marc Augé affirmed that *"It is necessary to overcome the restrictive notion of whole cultures as independent entities forced to co-exist"*. We should be building a system to find a new language that is not the sum of different languages, but rather one that produces a new culture inspired by social well-being and psychic health. **This is our goal.**

II.

The target reader
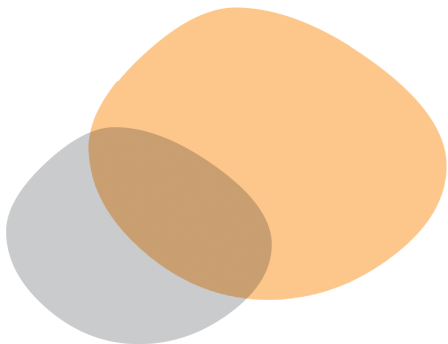
The eBook is a contribution to the spreading of our experiences and ideas on Housing for people with mental health problems.

The target reader is anyone who has directly or indirectly experienced mental health issues as well as anyone who works in this field.
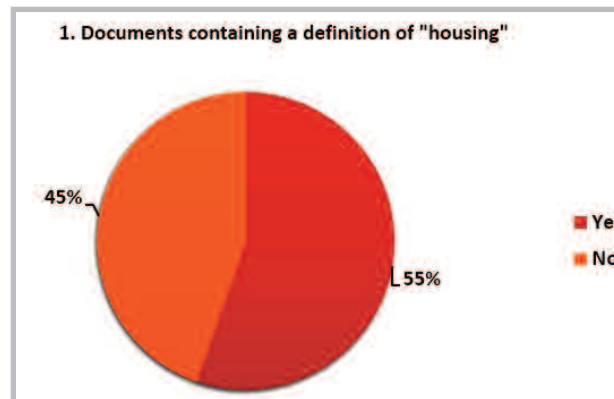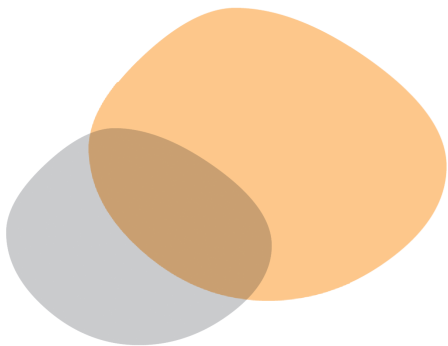
The eBook's aim is to clarify what Housing means in the mental health field, its origins, its current development, its limits and its great potential.

Readers could get to know Housing and find out how they can actively get involved to make our society more and more inclusive.

III.

Housing definition

1. Documents containing a definition of "housing"

45%

55%

Yes

No

International literature offers many terms to define the places, the projects and the nature of the pathways designed to house people with psychic disabilities.

A few articles explore the difficulties raised by shared terminology; To overcome any confusion which may be generated by such difficulties, a number of schemes have been offered that are thought to match real situations.

Common ground:
Regardless of the names given to the places where people live, it is noteworthy that these places are located along two main axes at the extremes of which we find the words:
• Autonomy – Dependence;
• Protection – Lack of restrictions.
Some authors claim that along these routes, help and support of different kinds and sizes can be provided.
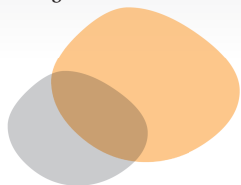In other terms, they suggest two complementary actions:
• Encourage patients to move from institutions to normal homes;
• Stimulate general acceptance of and support for frameworks in which disabled people can become integrated in society.

Different stories
Case literature features two major categories of projects, laws and financing. They provide

different responses to the Housing needs of people with experience of mental health issues.

• The HOUSING FIRST model revolves around the concept of having a home as a right for everyone, even a priority requirement. Only after obtaining/having/choosing a home, the person who lives in it (these descriptions often coming from people who had been homeless), can attend to his or her health, psychiatric, social and legal needs. In all these cases, authors underline the importance of separating the concept of 'Housing' from those of 'care' and 'rehabilitation.' Therefore, the project "Housing as Housing," guaranteeing the patients' free choice is seen as strengthening their sense of responsibility and avoiding any feelings of dependence on institutions.

2. Documents referring to a "housing first" approach
35%
65%
Yes
No
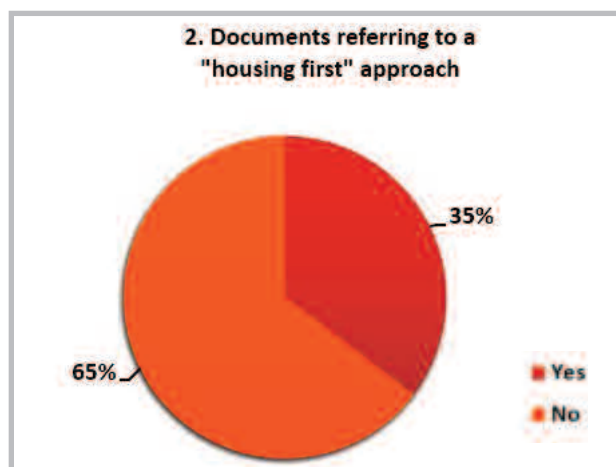
• The model inspired by HOUSING STEP-BY-STEP is based on the process of de-institutionalization for the patients who are hospitalized in psychiatric wards, and aims at a gradual decrease of assistance through "continuum of care" in structures where independence is gradually increased and custody gradually loosened up.

These models originate from different conceptual and historical standpoints. The first is generated by the need to face the problems of the homeless, while the other rises from the will of overcoming any iatrogenic issues of institutions. However, since then, they have undergone further developments. A sound contribution to the terminology has been given by some authors, which distinguishes three main categories:

CUSTODIAL HOUSING: Healthcare staff who are always available, in control, and ready to care for resident patients.
SUPPORTIVE HOUSING: Groups – Apartments with resident staff performing rehab programs with resident patients: The staff decides the arrangements as to "where and with whom".
SUPPORTED HOUSING: Independent homes, chosen by those who live there, and non-re-

sident staff with facilitating functions. Residents have free rein in decision-making.
It is seen that in these definitions, especially in the US, the parameters considered important and variable refer mainly to decision-making powers, the functions of the staff, and the varying role of the user.
Nevertheless, in the Anglo-Saxon world, there are different meanings for the same terms: in UK the definition of Supported Housing also includes characteristics of Supportive Housing, where the staff is present 24 hrs/day.
Case literature features critics to the methods but they are often controversial as they favor as the best model the one under whose definition they fall. An example of this is given by two opposing concepts: 'Supported Housing' (based on the idea of "Housing First," and providing flexible support to the person living in the same apartment) vs 'Continuum Approach' (inspired by the 'step by step' concept, with users moving to apartments provided with different supports according to their mental health conditions).
Within the varied concept of Supported Housing, some articles report such definitions as: Residential Care, Floating Outreach, Homes with Assistance, Homes with Facilitations.
Here follow the general standards taken into account when distinguishing among Housing types: Type of owner (property, rental, family owned, owned by institutions providing the assistance, etc.)
• Provision of centralized services;
• Personal privacy is guaranteed;
• Assistance provided (upon request, on appointment, frequent support, steady surveillance, etc.).

IV.

A need for shared indicators
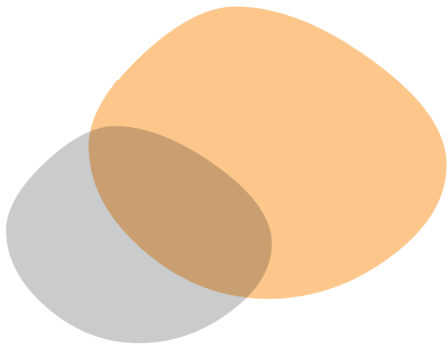
The collective experiences of the HERO project partners have revealed the need for a shared language. The first ten months of work conducted by the HERO team has confirmed this necessity. Indicators vary substantially in the different EU countries, reflecting their peculiarities. Nevertheless, it is necessary for those involved in housing projects to agree upon a number of common indicators to be able to easily compare information about on-going activities and results achieved, both on a national and European level.

Today this appears to be likely achievable. The indicators mentioned in this eBook will pave the way to a survey that we hope will improve the housing projects in European countries.

V.

Selecting the indicators
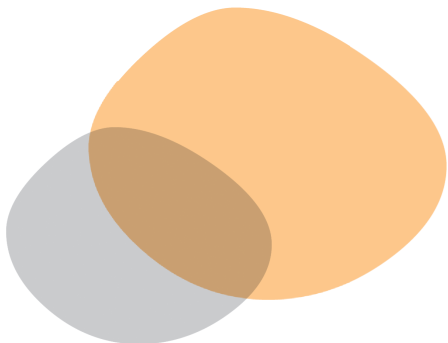
Choosing the indicators for Housing projects has not been an easy task. We were helped by the survey conducted in partnering countries, a survey which has integrated the analysis of case literature with the experiences reported by the main stakeholders of the Housing projects.

We also think that indicators can be used to Improve Housing projects through flexible yet codified routes and create services based on individual factors.

Analysis of case literature has provided the necessary tools to turn a private problem into a resource which can be shared.
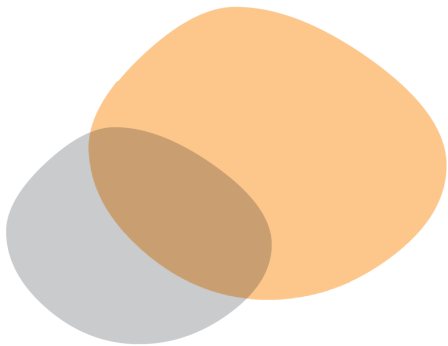
We have detected about 150 indicators which are divided into ten key-areas.

VI.

The infomation gathering approach
Key-areas
Review and focus

To detect macro areas of analysis of Housing literature and focus groups, the Department of Mental Health of the ASL ROMA 2 multidisciplinary team has carried out:

• Explorative focus groups within the Hero team, to share their years of experience in this field;
• A "core drilling" of specialized literature, with the analysis of about ten scientific articles, featuring both theoretical and practical field experiences in several countries, mainly focusing on mental health but also delving into other fields of Housing such as projects for the homeless.

Le aree-chiave sono nate dal confronto di The key- areas were generated by compared experiences among partners and by a specific analysis of case literature. They provide a reference point for bibliographic review work and focus groups.

The compilation and analysis of the information collected allowed the ASL ROMA 2 team to obtain the building/detection of key-areas of information to be used at a later stage, for focus group content analysis carried out in the various countries involved in the project, and for analyzing a wider range of international articles and scientific files.

The Hero project uses the key-areas to integrate the information collected by those directly involved in the Housing project (focus group) with the information based on case literature. The approach is based on personal experiences that echo other international cases on the subject.

These key-areas represent the areas considered most relevant– both theoretical and practical – for successful Housing outcomes. For the same reason, they have been considered as a benchmark for the development of quality indicators.

In view of the following detection provided by the focus groups of the different countries involved in the project and through the analysis of sixty-five international articles and files on 'Housing,' the scientific-pragmatic relevance of the key-areas is considered solid.

The data drawn from case literature have been integrated so as to allow the assessment of the indicators' degree of usefulness and level of appropriateness to different contexts and targets.

Resultantly, a new key-area has emerged: that of policies guiding the work in this field. These policies feature significant constraints and considerable resources, starting from the provision of homes. In the future, the project team will issue a publication focusing on the analysis of the policies. It is a vast topic that requires the implementation of many other resources.

A. Focus group.
General information.
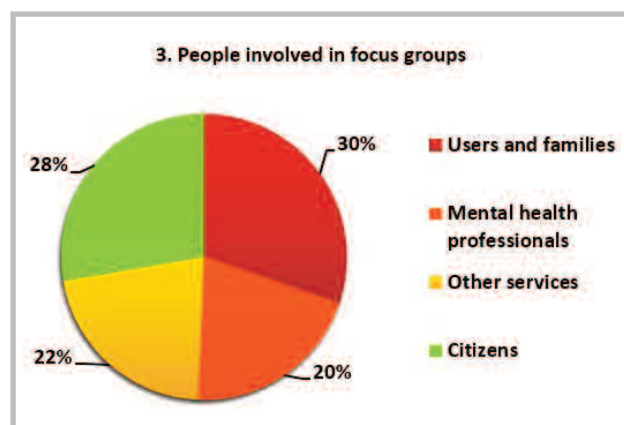
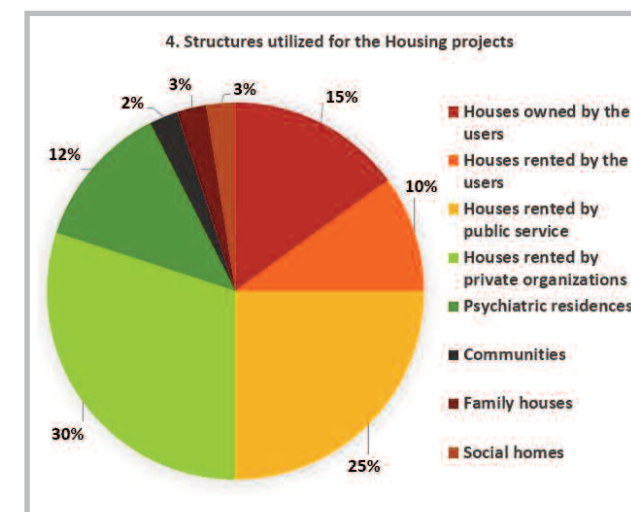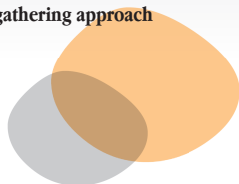Twenty-five focus groups were put together among the partnered countries - Italy (Rome), Greece (Athens, Korydallos), Croatia (Zagreb), Belgium (Gent, Lier, Bornem) and United Kingdom (Liverpool) - thus involving 249 people including mental health professionals, other stakeholders, users and their families and citizens.

Some people involved in the focus groups, are engaged in a Housing project. The people engaged in a Housing project were asked about the type of Housing.

The Housing projects, in which those people have been involved, are mainly supportive and supported. In Italy, in one case, also the custodial approach is reported. In Belgium also mobile support, new format and different models are reported. In Croatia and United Kingdom all the approach – custodial, supportive and supported – have been utilised.

3. People involved in focus groups

- Users and families — 30%
- Mental health professionals — 20%
- Other services — 22%
- Citizens — 28%

4. Structures utilized for the Housing projects

- Houses owned by the users — 15%
- Houses rented by the users — 10%
- Houses rented by public service — 25%
- Houses rented by private organizations — 30%
- Psychiatric residences — 12%
- Communities — 2%
- Family houses — 3%
- Social homes — 3%

B. Review.
General information.

Sixty-five international papers, published in the last thirty years, were analysed thoroughly.

6. Year of publishing

- 1990-1994
- 1995-1999
- 2000-2004
- 2005-2009
- 2010-2014
- 2015-2017

5% 3% 12% 22% 26% 32%

8. Documents reporting on a specific housing project

34% 66%

- Yes
- No

5. Type of documents

- Papers
- Reports of a research
- Reports of a project
- Guidelines
- Chapters in a book
- Official policy documents
- Editorials

1% 2% 3% 5% 6% 25% 58%

7. Language of the documents

3% 8% 12% 77%

- English
- Dutch
- Italian
- French

9. Countries of the housing case studies

Nr. of mentioned case studies

USA, Canada, UK, Italy, Netherlands, Belgium, Sweeden, Europe, Ireland, Denmark, Australia, New Zeland, Germany, Not mentioned

VII.

Ten key-areas: creating a language which can be shared within the housing projects
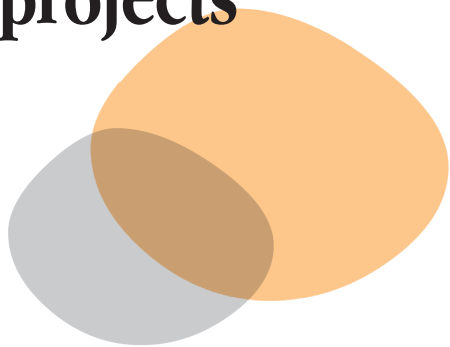
The HERO project aims at promoting a common language which can be shared by everyone involved in Housing projects for people with psychosocial disabilities.

Indicators have been grouped into ten key-areas, which compose a Housing project.
The key-areas and their indicators represent the first step towards a systematic knowledge of Housing projects.
The following key-areas are the ones which showed up the most in our research, but this is not an exhaustive list.
HERO has selected the following key-areas:
1. EVALUATION PROCESS OF USER SKILLS
2. LOCAL CONTEXT RESOURCES
3. CASE MANAGER / ORGANIZATIONAL STRUCTURE AND NETWORK OF THE HOUSING MENTAL HEALTH SERVICES
4. EVALUATION OF THE REPRESENTATIONS, PERCEPTIONS, MOTIVATIONS AND SATISFACTION OF USERS
5. FLEXIBILITY/CLINICAL GOVERNANCE / COMMUNICATION AND COORDINATION
6. RESPONSIBILITY AND DECISION MAKING OF USERS

7. VOLUNTEERING SYSTEM AND CIVIL SOCIETY
8. LIFE LONG LEARNING
9. RESOURCES FOR HOUSING
10. IMPACT EVALUATION

Every ten key-area contains the outcome of the analysis conducted by literature and focus groups. Each key-area reflects a specific list of indicators. We remember that indicators have been detected through a bottom-up method added to a top-down one. They are not theoretical indicators but they were generated by the real needs of users and by those who take part to the project more or less directly. We also remind that they have actively contributed to the work conducted on Housing indicators. Four HERO target groups have been selected: Users and their families; Local health services; Workers from non-health agencies; Residents.

VIII.

Key-areas and indicators

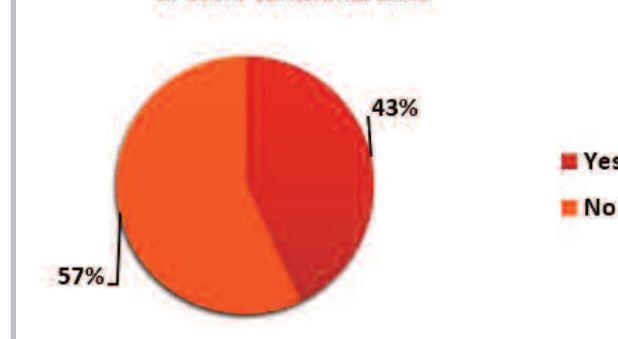**Summary of the information taken from the review and the focus groups**
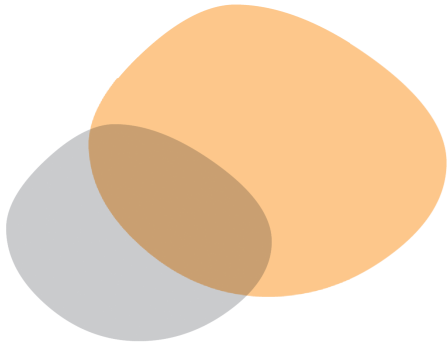
1. EVALUATION PROCESS OF USER SKILLS

A central element reported on in case literature is the assessment of user competency and need in reference to Housing projects. The evaluation is nevertheless affected by the differences between a "Housing first" approach and an approach based on growing levels of autonomy achieved through a "continuum."

1.1 Documents describing an evaluation process of users' functional skills

43%
57%

■ Yes
■ No

In the first case, the purpose is to understand the type of support needed to ensure the maximum degree of independence for users in order for them to obtain the highest degree of satisfaction and perceived best quality of their life, beginning with separating the concept of 'dwelling' from 'curing'.

In the second case, the goal is to encourage the choice of the best possible accommodations in terms of the type of structure, the degree of support provided, and the categorization of the other residents, to the extent that this is possible. Unfortunately, it is difficult to provide an adequate range of solutions to meet the many and varied user needs, as well as the sheer volume of requests in relation to the resources as they become available.

The need has been emphasized to carefully analyze why users – and/or their family members – are prone to choosing more or less independent Housing situations.

According to the analyzed cases, a number of aspects need to be assessed, the combination of which provides a variety of user profiles and the various related needs:
• Intellectual functioning level as measured by I.Q..
• Adaptive capabilities.
• Ability to deal with everyday life: intellectual skills (comprehension of spoken and written language, capacity to manage money, understanding of a time table); social skills (interpersonal contact, sense of responsibility), basic and practical skills, all to assess the level of help needed to carry out day-to-day tasks.
• Social interaction, based on the principle that each participates according their own ability.

• Physical and mental health.
• Social and economic environment, social network, social and economic condition.

1.2 Documents reporting on specific stages for users' functional skills' evaluation

Yes 25%
No 75%
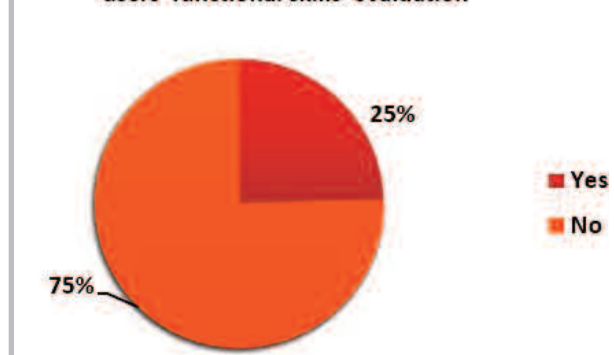
Another aspect to be taken into account regards the level of satisfaction reached by users, their family members and staff. In particular, it has been observed that the most significant levels of subjective satisfaction have been assessed in cases of recovery more than in instances of remission of symptoms.

While the necessity for an initial assessment is acknowledged, there is no consensus on the frequency of monitoring, but generally speaking it varies from every two weeks to every three to six months.

Assessment and monitoring services are mainly carried out by Mental Health Services as well as by supporting organizations.

The need for structures and homes reserved for users is considered as a specific function of the local authorities implementing local policies.

Regarding the usefulness of monitoring, including competences and user satisfaction, in view of the programming of interventions, numerous studies claim that it is preferable to set up support systems rather than customized Housing solutions, be-

cause in the latter there is a greater chance that such solutions are too restrictive or assistance-oriented.

According to some studies, the traditional psychiatric approach to Housing does not provide adequate tools for an independent life, which can only be obtained within an independent environment, as the traditional method tends toward a total control of the lives of users.

The perception of life quality is linked to numerous factors, including length of stay in the same home, the sense of stability it provides, good social integration and more generally speaking, the characteristics of the neighborhood.

Some authors highlight the importance for users to access psychological support and establish relationships with contemporaries to become experienced in daily life skills as well as relational ones.

It is interesting to observe how many focus groups participants, underline the necessity for an adequate assessment of the motivation and the skills necessary to be able to live with other people. The issue revolves around self-determination, and ability to control their own lives, especially with respect to the choice of people to live with.

1.3 Documents listing specific structures/organizations which have reported on users' functional skills evaluation

- 25% — Yes
- 75% — No
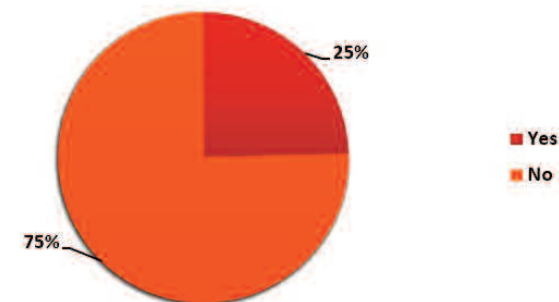
1.4 Whether a specific method or tool is used for these evaluations

- 25% — Yes
- 75% — No
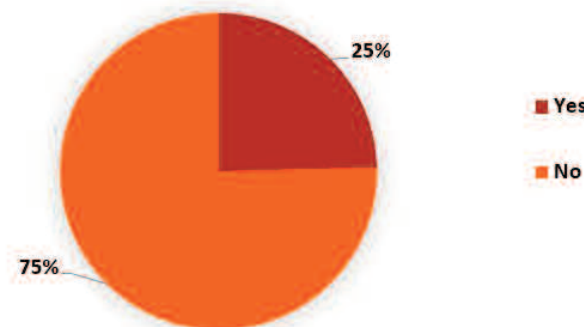
1.5 Type of method/tool used for these evaluations

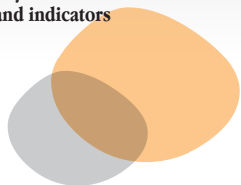|	
HoNos Health of the Nation Outcome Scales	Lehaman's Quality of Life scale
VADO Valutazione di Abilità Definizione di Obiettivi	RIBW
WHOQOL-BREF	SAMSHA/CMHS SMI survey
LSP Life skills profile	PHI The Physical Health Index
CAN Camberwell Assesment of Need	Social Network Assessment at the initial interview (T1)
WHO-DAS II Disability Assessment Scale II	Participants completed an Adaptation to Community Living Assessment
POE - COPES	Housing Environment Assessment at the one-year follow-up interview (T2)
MANSA - PGCMS	Madison Assertive community treatment programme
QUIS Quality of Interaction Schedule	Lancashire Quality of Life Profile LQOLP
SOM Short Observation Metod	Brief Psychiatric Rating Scale BPRS
Special form created in Ireland	Global Assesment Functioning Scale GAF
NCA Needs-for-Care Assessment	External Integration Scales
IQ	Social community integration asses
RS score	SF 12 Consumer experiences of stigma questionare
AAMR - model for support's systems evaluation	

Mental health professionals claim that a critical situation arises when – instead of encouraging an assessment – choices are based mainly by the need to "place" users, regardless of the availability of appropriate solutions.
Residents with no prior experience with Housing among others may tend toward a preoccupation with the new "neighbors" and become concerned about their tranquility and security due to the stereotype of the unpredictable and potentially aggressive nature of the mentally disabled.

EVALUATION PROCESS OF USER SKILLS
INDICATORS

1. Is there a preparatory USERS phase planned before activating a Housing project?
2. Is collaboration with users planned in case of future cohabitation?
3. Will an intervention team be operational to handle crises?
4. Is collaboration with families planned?
5. Will social and relational abilities be promoted?
6. Do Housing facilities have pre-established periods of residence?
7. Are users' personalities taken into account for cohabitation?
8. Are users' needs, potentials and expectations taken into account?
9. Can users be involved in the planning of their daily lives?
10. Do users have the option of choosing their home?
11. Is non-professional support encouraged?
12. Do Housing programs favor young people?
13. Is there a "healthy curiosity" from neighbors?
14. Is there a de-institutionalization program on behalf of the Psychiatric Hospital?
15. Are there regular meetings among the key figures involved in the Housing project to provide updates on users' skills?
16. When users access the Housing project for the first time, are their abilities assessed within a networking framework?
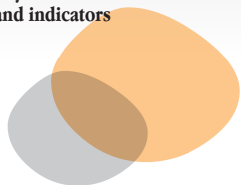
2. LOCAL CONTEXT RESOURCE

According to case literature, homes, environment and neighborhood have an impact on mental health. Living in inadequate places is associated with ill-suited behaviors while better accommodations are linked to lower levels of psychologic suffering; If people are proud of their own environment and Housing facilities, they will treat them much better. There are studies that offer assessment scales conducted by trained personnel for Housing facilities and neighborhoods.

**2.1 Documents describing an evaluation process for the environmental resources**

- 31% Yes
- 69% No
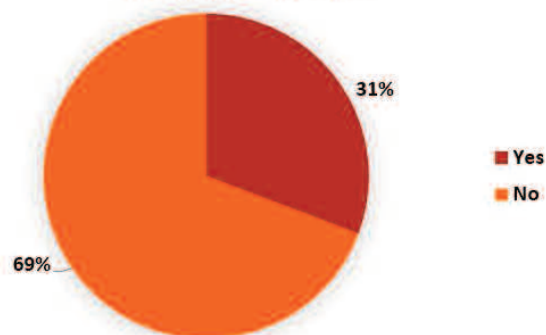
2.2 Documents describing specific method/tool used for the evaluation of the environmental resources

- 17% Yes
- 83% No
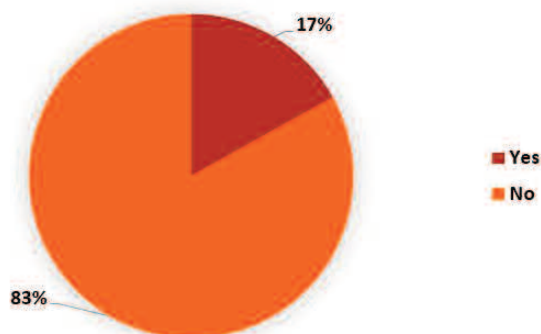
One assessment criterion regards people's wishes and feelings about their homes, whether they feel safe, if their house has all the necessary equipment, and what their level of satisfaction is. The house location should be taken into consideration as it can influence independence, safety, social inclusion and sense of belonging.

Action at the community level is proposed to increase tolerance for diversity and disability, and to increase the frequency and quality of contact among neighbors. In the requisite assessment, stakeholders play an important role. The relationship among stakeholders, volunteers and mental health professionals can help tackle the forthcoming problems.

2.3 Documents describing interventions done with neighbors, shopkeepers, active citizenship, etc.

- 5% Yes
- 95% No
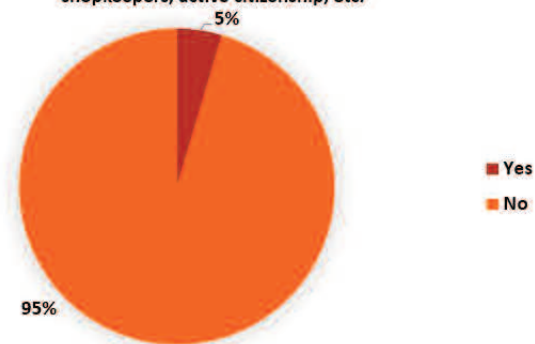
A house close to shops, services, means of transportation and leisure opportunities helps to increase social inclusion.
People live better and feel safer in communities and within a supportive network. Some texts suggest that it is important to avoid areas affected by a high crime rate or with low social cohesion and weak social capital.

Therefore, the majority of the studies conducted stress the supportive role played by community hangouts (grocery stores, coffee shops, restaurants, movie theatres, libraries and places of worship), community support (becoming accepted by the community), safety (low crime rate) and a residential environment where there are few other people affected by mental disabilities.

2.4 Frequency with which specific enviromental resources are pointed out
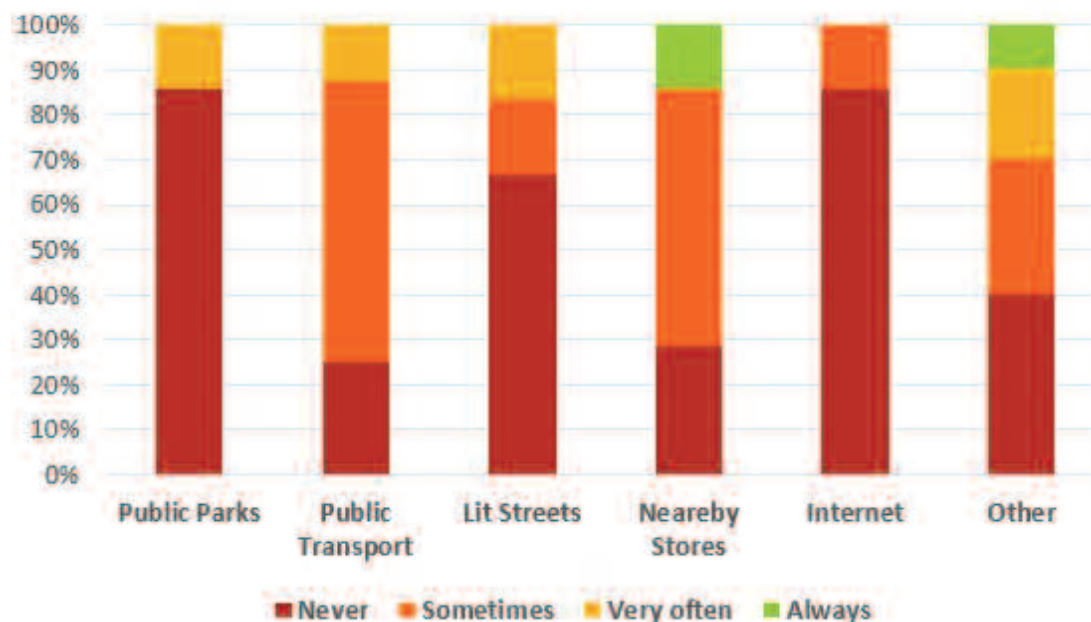
A minority of authors state that the exposure of mentally disabled people to crowded places like green spaces may increase anti-social behavior.

The users' well-being is helped by a low level of noises, minimal traffic, good exterior and interior lighting, sidewalks, access to transportation and easy access to services.

These opportunities – states case literature – encourage the gaining of life experiences and can reduce the users' dependence on caregivers. Also important are issues of privacy, coherence in building design and the presence of private outdoor spaces.

2.5 OTHER SPECIFIC RESOURCES POINTED OUT

- Building outdoor space
- Drivability
- Services
- Community center
- Contact point general medicine
- Pedestrian Zone
- Public security
- Housing quality
- Access to public supportive services.
- Landlords
- Safe environment
- Nearby public supportive services (e.g. hospitals)
- Lighting
- Availability of transportation and services

Focus groups reveal that according to mental health professionals the "Friendship Club" is important, even though users do not often participate.

Some municipalities and local authorities offer support services (pharmacies, supermarkets, restaurants) and in general they underline the opportunities that these can offer, as well as the importance of volunteers' support. Users' properties can become resources for others as well, thanks to reasonable rents and in some cases, they facilitate relationships with the neighborhood, although prejudices are still very strong.

Therefore, the preparation of the surrounding environment should be accurate and it would help if mental health professionals knew the place. The starting point is the users' desire for freedom of choice regarding where and with whom they want to live.

During focus groups, residents underline the importance of proximity and knowledge to counteract prejudice by encouraging interaction in the local community. To this end they suggest innovative projects such as collaborations with universities to involve students in shared Housing. Meeting and social places are more difficult to be found in big cities where frequent security problems may hinder integration.

Within their respective focus groups, mental health professionals from diverse institutions underline the importance of being able to count on volunteers, students and neighbors. However, people have to want to volunteer their time and support, and it would be helpful to find ways to encourage them in this choice, as their impact can help users feel less lonely. Furthermore, it is necessary to promote awareness to encourage inclusion from as many people as possible. Family physicians – in collaboration with the mental health service - can help in this process.

Key-areas
and indicators
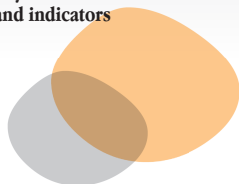
2.6 Documents describing an evaluation process for the relational resources in the community

- Yes 34%
- No 66%
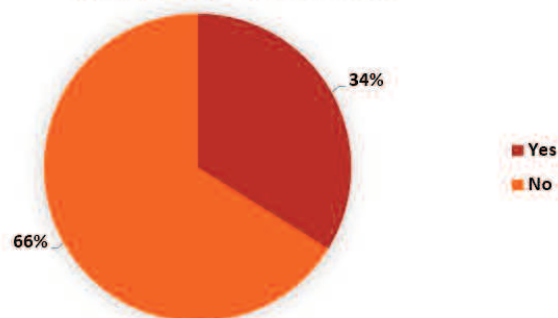
2.8 Documents describing integrations between housing projects and job inclusion projects

- Yes 17%
- No 83%

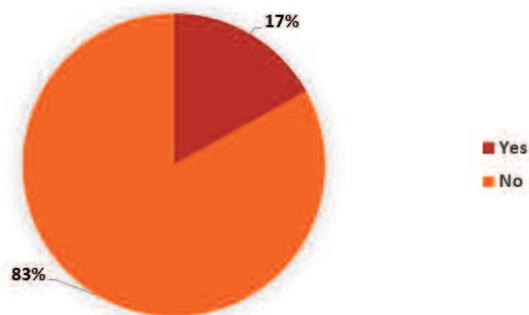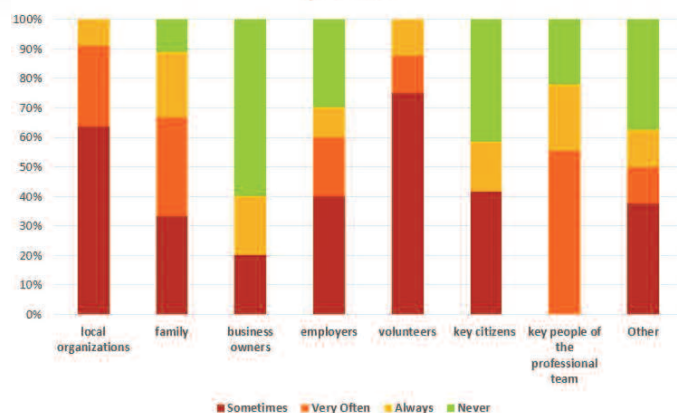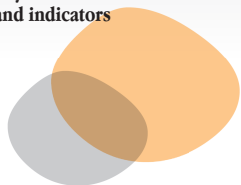**2.7 Frequency with which specific relational resources in the community are pointed out**

Legend: Sometimes, Very Often, Always, Never

Categories: local organizations, family, business owners, employers, volunteers, key citizens, key people of the professional team, Other
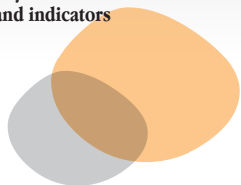
Users and family members who took part in focus groups have highlighted that a pattern of improvement in the neighborhood and in the territory, could encourage understanding and communication. The apartment should be linked to public transport and should be located in an area with shops and green spaces. Meals and activities should also be taken into consideration. The efficacy of external contacts will also be assessed in the Housing projects. According to users, employment plays a fundamental role in their independence and improvement of their abilities. A job allows them to establish a relationship with the environment, as an alternative to domestic isolation, and it becomes an opportunity that should be approached with a degree of caution: Some users describe difficulties and crises when they become too exposed to social life.

Tenants may not be able to subscribe to the objectives or comprehend the meaning behind the activities offered by the professionals involved in their community life. In this way users feel that their needs have been misunderstood and in some cases they now require more psychiatric help. Families, and especially parents, are important resources for users, but professional staff should provide more help to family members who are often overwhelmed. Essential environmental resources (libraries, public parks, cafés, meeting places) should be present in the areas where Housing projects are underway.
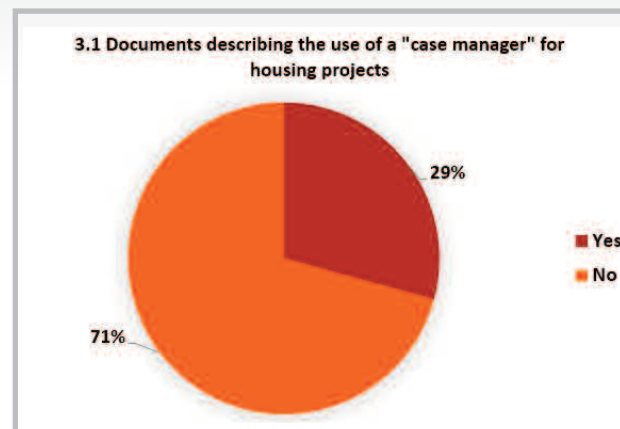
LOCAL CONTEXT RESOURCE
INDICATORS

1. Is the apartment located close to public transport?
2. Is the apartment located close to shops and/or shopping malls?
3. Are there meeting places in the area (for example homeowners' associations, libraries, cultural, religious, political and union associations, etc.)?
4. Are there movie theatres, museums, sports and recreational centers in the area?
5. Are there green spaces (parks, etc.)?
6. Are there security guards (e.g. police stations, police barracks, law enforcement patrols)?
7. Are there working opportunities in the area?
8. Is there a local project to support employment for Housing project users?
9. Does the local public administration privilege and support employment (for example: "social restaurants" and other professional initiatives aiming at including users)?
10. Do mental health professionals try to reduce stigma through the development of local resources?
11. After the implementation of Housing projects, are relationships with the area resources maintained?
12. Are families involved in Housing projects?
13. Are the neighborhood's elderly residents encouraged to establish relationships with users aiming at mutual support?
14. Are Housing project users involved in neighborhood initiatives?
15. Is there a possibility to involve university students who live or study in the area?
16. Will neighborhood relationships be encouraged?
17. Will the differences between small town and big city Housing projects be taken into account?
18. Will the differences between living in a wealthy area or in a working class district be taken into account?
19. Are there fears or concerns among the neighbors about users' abilities?
20. Are there any prejudices that prevent users from becoming socially included?
21. Is there a relationship established with local media?
22. Are there places for socializing?

3. CASE MANAGER/ORGANIZATIONAL STRUCTURE AND NETWORK OF THE HOUSING MENTAL HEALTH SERVICE

3.1 Documents describing the use of a "case manager" for housing projects

29%
71%
- Yes
- No

3.2 Documents describing specific professionals in charge of Case Management

9%
91%
- Yes
- No

Case Management is a psychiatric method which has proven to be particularly successful compared to assertive models. Actually, it reduces the need for hospitalization and it improves the results of the treatment and enhances the sense of well-being linked to Housing projects; According to some authors the method should be made available also to people affected by serious mental disorders.

A Case Manager (CM), as reported in the Review, carries out counselling activities, tries to resolve any crises which may occur, visits the users in their homes, manages their check-ups and tests, oversees their medicine schedule, upd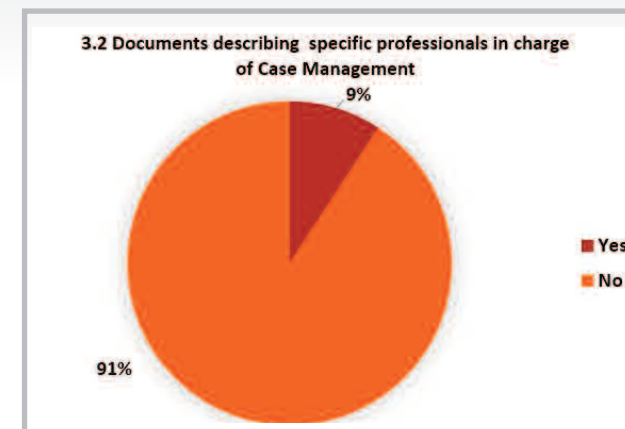ates their clinical profiles and if they are affected by other illnesses, helps them get in touch with their general physician or other specialists.

A problem ensuing in this working method is the risk of becoming a sort of employee who only makes appointments. The Clinical Case Manager is a role that aims at overcoming this problem because apart from making appointments he/she" accompanies" the patient.

A step forward is represented by Intensive Case Management (ICM) with a team available 24 hours a day and providing at least 6-hour reports a week.

In the United States, the ICM has turned into the Assertive Community Treatment (ACT) which, in addition to 24-hour availability, offers training in independent living.

In the Housing scheme, the Case Manager is also considered as "Housing Supporting Staff" and in some cases, as "Housing Supporting Assertive Community Treatment (ACT) Staff".

Case literature has shown that it is difficult to define health or social workers, because some authors say that the CM can also be a non- professional (volunteer, stakeholder, etc.), while ACT is a 24-hour health care team specialized in critical situations. Other authors, on the other hand, consider the CM strictly as a health professional with specific training.

3.3 Professionals who take up the role of case manager

1. Psychologists
2. Mental Health Professionals
3. Social workers
4. Community team members
6. Others

Focus groups particularly underline the importance of CM training and supervision as they are expected to tackle problems generated by psychic disorders, to advise about personal care, to carry out motivational interviews and to support families.
Of extreme importance are the following elements: Knowledge of territory, schedule of events (cultural, sports and recreational events, etc.) that promote social inclusion.
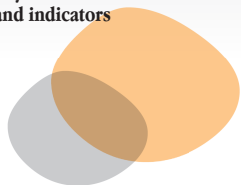Furthermore, the CM should be informed about health facilities and how to access them. Therefore, the CM should be able to provide individual, social, health, and working assistance. He needs to both support the social cognition - which means the capacity to de-codify the inputs generated by the social environment, the capacity to process social information and plan a suitable behavior pattern to increase social inclusion - and to collaborate with mental health services to share the "recovery" plan and project with health services providing assistance with overcoming addiction, finding a job, tackling critical situations 24 hours a day, and with services providing financial support and with local administrations.

The Housing supporting team should be separated by the health support team but should work closely with it to become aware of the recovery plan and be able to share it.

3.4 Documents containing information about housing processes regulated in a centralized way
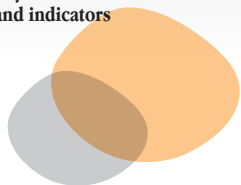
9%

91%

Yes
No
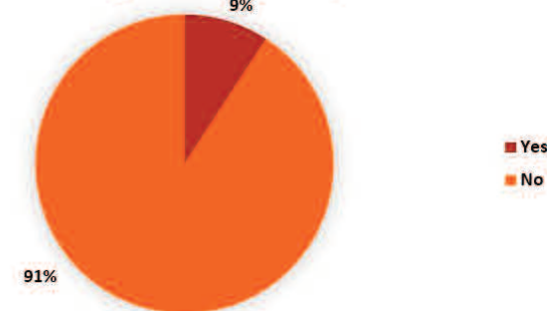
There is a high demand for quality assessment and for monitoring the Housing procedure even if a more suitable tool has not been detected yet. Generally speaking, there's a growing request for quality of life assessment tools (i.e.: Life Skill Profile – WHOLQOL, etc.).

CASE MANAGEMENT
INDICATORS

1. Will Housing coordinators undergo training/education?
2. Is there a case management in order to support users and their families?
3. Is social integration encouraged?
4. Do case management efforts encourage users' social skills?
5. Is there a case management in order to keep in touch with the local administration on Housing issues?
6. Is networking encouraged?
7. Is the cohabitation monitored?
8. Is there a case manager familiar with all the program's phases who shares information with the Housing project workers?
9. Will there be a connection between different services located in the same area (for example: daily healthcare centers, health service centers)?
10. Is the case manager an institutional function?
11. The case management is in charge of the quality of services for the users and their families?

4. EVALUATION OF THE REPRESENTA-TIONS, PERCEPTIONS, MOTIVATIONS AND SATISFACTION OF USERS

Case literature highlights how, in general, people with experiences of mental health issues prove to be very competent in weighing the benefits and disadvantages of different life choices.

4.1 Documents indicating an evaluation process of the representations/perceptions of people with mental health disease

- 42%
- 58%
- ■ Yes
- ■ No
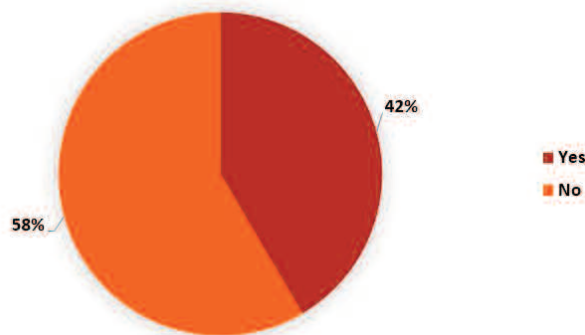
The following aspects are particularly relevant in determining the perceived quality of life of the user.

• Perception of the neighborhood's social climate.
This suggests that a wide range of initiatives should be promoted in the community to increase tolerance towards diversity and disability as well as to foster good relationships with neighbors.

• Possibility of choosing the most suitable type of home.
To some users, recovery means to be able to live on their own; To most users, it means to be able to live with significant others.
A better life quality is perceived by people who have been able to choose the Housing facility they prefer, as opposed to those who do not like where they live.

Case literature highlights that it is not possible to provide suitable accommodations for everyone. However, it is important to have a wide range of Housing and support services.

• Living independently.
Much of the research clearly shows that mental health users prefer to live in independent homes. They also prefer to live with a friend or a partner and not with other people affected by mental disorders (this point of view was confirmed also by testimonies collected from Focus Groups)

From the users' point of view, an independent life is preferable over traditional Housing schemes.

4.2 Documents containing information about an evaluation process concerning motivations, interests and objectives of people with mental health disease
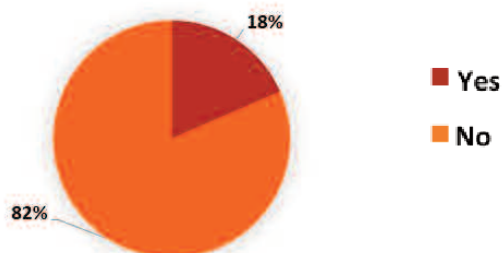

- 18%
- 82%
- ■ Yes
- ■ No

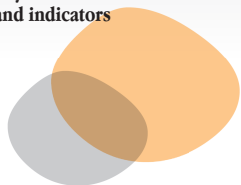• Available but not too intrusive support staff on site.

Generally speaking, a higher number of professionals involved increase the perception of a better life quality. However, users prefer to be supported by a 24/7 staff that does not reside on the premises with them.

According to the results obtained in the Focus Groups, it is clear that users expect the staff to be on site and be competent enough to detect and treat any kind of psychic discomfort which – if not mitigated – may become a hurdle to coexistence and eventually lead to the failure of the Housing project.

• Faculty of choice and degree of decision-making in the organization of their daily lives.

People who participate in Housing models where they can choose how to organize their daily lives and where they enjoy a good degree of privacy show a higher level of satisfaction with their accommodations compared to those who live in more constrained facilities with less freedom of choice.

At the same time – as was reported in Focus Groups – they expect and need to be helped to arrange their lives outside of the home, which as much as they are well organized, cannot represent the only element of satisfaction in their lives.

EVALUATION OF THE
REPRESENTATIONS, PERCEPTIONS,
MOTIVATIONS AND SATISFACTION
OF USERS
INDICATORS

1. Is there a system to detect the representations, perceptions, motivations and satisfaction of Housing project users?
2. Will users be able to perceive an interconnection among services?
3. Will users receive a prompt response if needed?
4. Do Housing project users believe they will receive proper assistance when they become older?
5. Do users think that Housing project goals have been reached?
6. Are furnishings and equipment perceived as functional and satisfactory?
7. Do users feel that their reasons for taking part in a Housing project have been considered?
8. Do neighborhood residents believe that people affected by psychic disorders have the same rights as the others?
9. Are users satisfied with their relationships with their neighbors?
10. Are there programs aiming at arousing interest and knowledge of Housing projects?
11. According to Housing project users, are objectives sufficiently shared?
12. Are Housing project users aware of their limits and their resources?
13. Do users have the possibility of arranging their own daily life at home?
14. Are users' wishes taken into consideration (where to live, with whom, etc.)?
15. Are users helped to develop adaptation and relationship skills?
16. From the users' point of view, are workers able to quickly grasp any criticality generated from cohabitation in Housing projects?

5. FLEXIBILITY/CLINICAL GOVERNANCE / COMMUNICATION AND COORDINATION

5.1 Documents containing information about the flexibility of the housing process

35%

65%

Yes
No
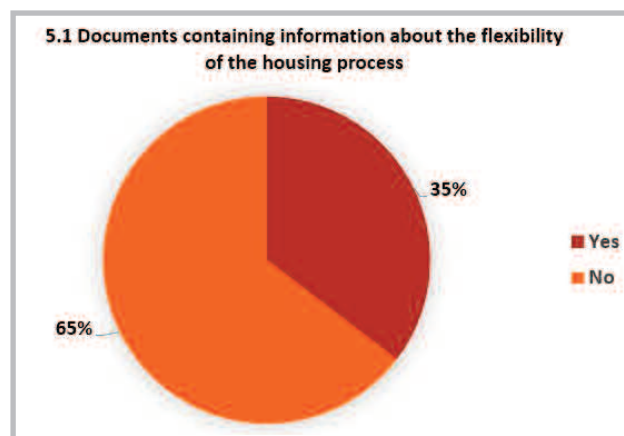
Results from the analyses conducted by focus groups indicate that flexibility represents a key concept concerning::
• The ability to create Housing programs by bringing together user and environmental resources in specific and creative ways, experi-

menting with innovative solutions involving a number of individuals (volunteers, social and healthcare providers, cooperative workers, support administrators, etc.), various methods of obtaining Housing facilities and various forms of sharing financial resources;
• The availability of staff and others to acknowledge and appreciate users' wishes and their personal resources, and respect each individual's process of transition, through which they become more independent and self-sufficient.

In particular, users and family members underline the positive results of projects that provide such flexibility, even with respect to rules established within communities and supportive homes (rules which are not the same for everyone because they are based on individual needs).

Some would like to go back to the old standards of a far less flexible mental health ser-
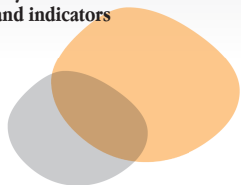
vice system, and would like to reverse the recent trend in which therapeutic interventions are based on users' real needs.

There is unanimous consensus among Housing, users and their family members and the social health services system on the need for communication, coordination and a common purpose.

Analysis of case literature reveals that quality Housing projects for mental health provide customized "packages" for each user, which are therefore flexible and not standard.

Flexibility is necessary because the quality of Housing is linked primarily to users' individual needs and not the houses they reside in.

Flexibility mainly refers to the degree of support to be provided according to the users' health conditions and needs: Services are provided and adapted according to the clients' needs and clients are not forced to move to different places to receive proper assistance.

Key-areas and indicators

Flexibility concerns:
• Intensity of the support to be provided according to different needs and projects;
• Housing rules (in supportive and supported homes) should not be the same for everyone but instead should be built according to individual needs;
• Personal objectives should be renegotiable over the course of the project;
• Length of stay: It is not possible to decide a priori because people with mental disorders handle changes with extreme difficulties and express a strong need for stability and continuity of cure;
• To be able to always listening to what users have to say about their needs and an ability to understand, and always welcome their point of view;
• To encourage users to choose from a range of options regarding their accommodations (including location and forms of payment),

whether they live alone, in a family or with roommates;
• Support of professionals based on the actual demand for help expressed by users who live in nearby houses (thus improving support);
• Introduction of a Health Budget through which flexible forms of support can be identified in different areas (home, work, social inclusion);
• Possibility to transfer support from specialist services to basic care, which is equal to all community residents.

Case literature presents two types of approach to mental health Housing projects. The first one is straightforward and traditional and matches the model based on the level of overall function and disability. As users gradually acquire the necessary abilities, they move to supportive Housing, until they are completely independent and can enjoy customized support. In the second approach, users are given responsibilities at the outset, as they are considered able to live independently. They are guaranteed flexible support, intensive if necessary, and always proportional to the needs of the moment. This second approach seems to be able to include people who would easily be excluded from the criteria of the first.

5.2 Documents containing information about the conditions that can inlcude or exclude a patient/user from a housing project
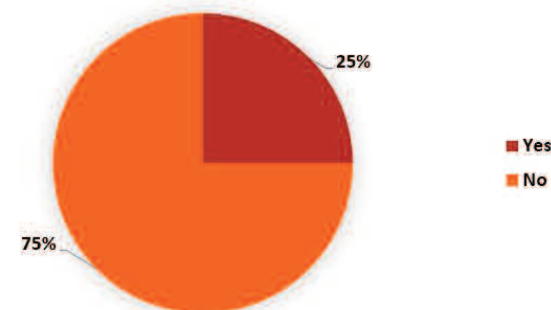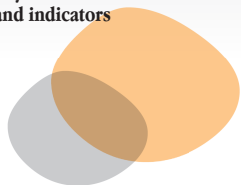
Clinical Administration
As with clinical research, Housing efficacy is measured by users' psychic well-being and improvement of quality of life. This assessment process should be part of the clinical management of the Housing to identify which actions produce the best results and to replicate them.
If the objectives of the Housing service are not clear and sufficiently specific, it is not possible to measure and assess the results and reproduce best practices.
Planning of individual rehabilitation projects should be the result of the collaboration and decision-making between users and support staff.
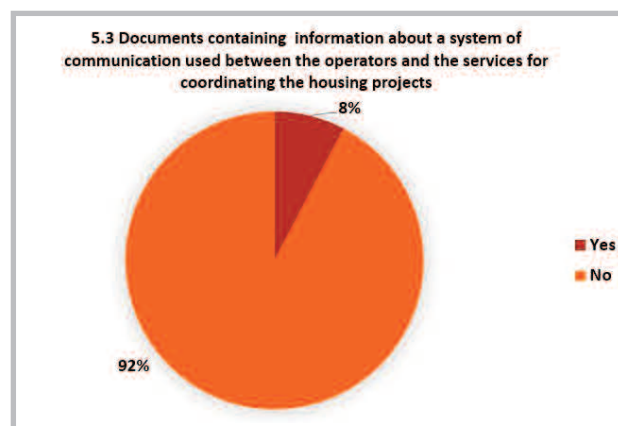
Communication/Coordination
Integration and communication between ser-

vices and Housing agencies are essential and to this end, proper training and education is essential for those who lead social and health services as well as for the staff involved in the support. There is a demonstrated need for clear procedures that regulate communication among the parties involved in the Housing process so as to create integrated projects and allow users to access a wide range of opportunities in the community.

In case literature, a central role is played by the partnership among users, families, service providers and administrators; open and mutual communication is promoted and common objectives are adopted. Users' opinions about their accommodations are considered important, in order to encourage their active involvement and sense of responsibility.
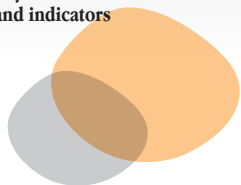
It describes an organization in which health service workers do not belong to the staff of mental health services who provide speciali-

5.3 Documents containing information about a system of communication used between the operators and the services for coordinating the housing projects

8%

92%

■ Yes
■ No

zed support, but it is absolutely necessary that they all work together to ensure effective services for users. A good communication and coordination system is essential and should take place through regular meetings, constant monitoring and detailed analysis of individual plans.

Often, when communication is lacking or it is perceived as an obligation, caregivers, especially informal ones, feel undervalued and

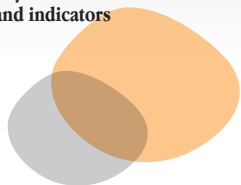need greater recognition. It is necessary that both service workers and informal caregivers (in-home nurses, cleaning staff, etc.) collaborate to avoid a protective or negative attitude toward users considering them as passive recipients of care in every area. Only in this way it is possible to handle the subject of Housing programs: Users should be encouraged to reclaim their roles as residents, as much as possible.
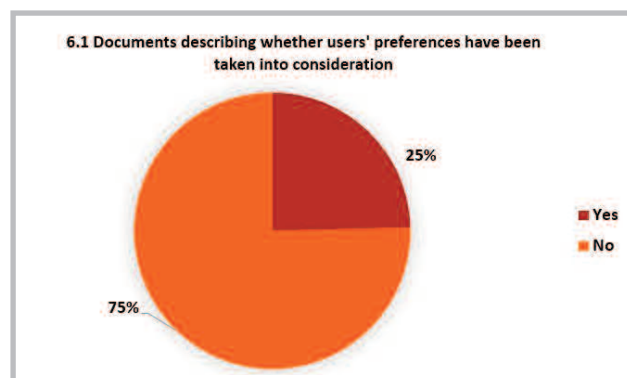
FLEXIBILITY/CLINICAL GOVERNANCE/COMMUNICATION AND COORDINATION
INDICATORS

1. Will there be initiatives to share personal experiences among Housing project users?
2. Will users and families share a therapeutic program?
3. Will there be a network connecting families, services, government, users and other stakeholders?
4. Will Housing facilities have flexible hours?
5. Will there be a "logbook" that can be accessed and used by users and workers?
6. Are Housing projects based on official guidelines or simply by implementation of good practices?
7. Do the actions undertaken suit users' real needs?
8. Do area resources share any channels of communication?
9. Will there be a team that follows and monitors users' needs, as well as their present and future level of independence and quality of life?
10. When a user owns a house and hosts another user, is there a contract to regulate the financial relationship between them?
11. Is there any professional support to daily life needs?
12. Is there an information system for the collection data on Housing projects?
13. Is there an organizational system to encourage coordination among Housing project key players?
14. Can the family doctor count on a supportive network for users?
15. Are there guidelines for Housing projects?
16. Is there a support program for facilitating the social inclusion of an individual user?

6. RESPONSIBILITY AND DECISION MAKING OF USERS

6.1 Documents describing whether users' preferences have been taken into consideration
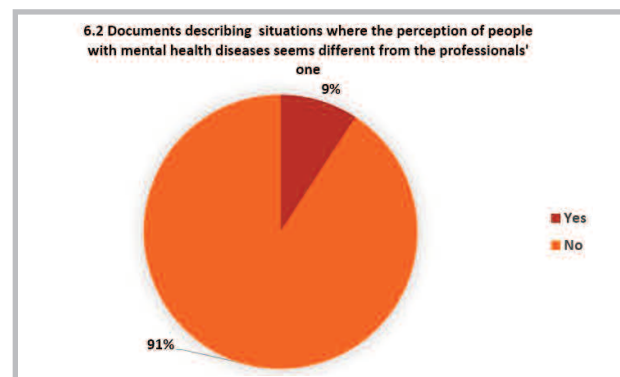
- 25%
- 75%
- ■ Yes
- ■ No

Literature features an important agreement – aiming at health and well-being – on the importance of being able to choose and control the fundamental aspects of one's life and above all to choose where one should live and the people with whom they live.
A number of studies reveal that the users of

mental health services consider the possibility of choice far more important than case managers do.

The latter tend to favor supportive homes while users prefer independent homes. Another interesting note is that cooperation between users and case managers allows us to find and create alternative Housing solutions, consistent with the idea that there is no worker who can understand a person's needs better than the person himself.

Accountability is also a value for Housing projects. This means that users are able to take responsibility for a rental contract.

This implies the necessity, for mental health workers and non- professional caregivers, to

6.2 Documents describing situations where the perception of people with mental health diseases seems different from the professionals' one
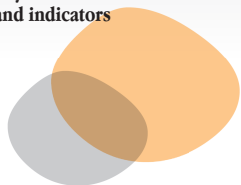
- 9%
- 91%
- ■ Yes
- ■ No

abandon the traditional protective attitudes toward users and not consider them as passive recipients of services in all areas of their lives, including training aimed specifically at recovery.

Naturally in focus groups these subjects have been highlighted mainly by users, who stress the importance of gaining experience, even running the risk of failing, to achieve a higher level of independence.
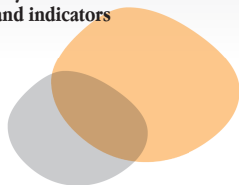
Workers and residents are both concerned about users' capacity to take on responsibilities, especially where Housing experiences are lacking and the existing structures still retain a custodial approach.
The majority of workers express concern about the difficulty for users to financially support their choices, and this represents a crucial matter.
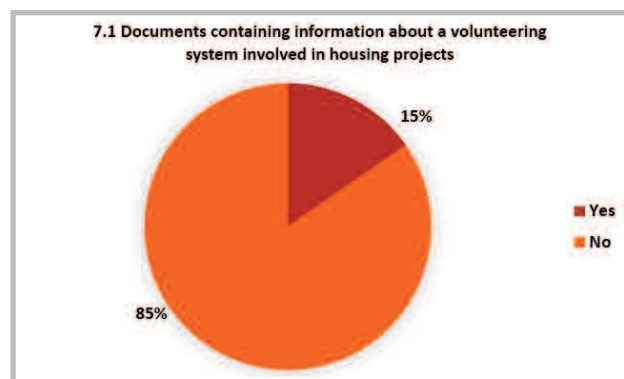
RESPONSIBILITY AND DECISION
MAKING OF USERS
INDICATORS

1. Can users make decisions and take on responsibilities?
2. Are decisions and goals shared with users?
3. Is home access regulated by standard procedures?
4. Can an ongoing Housing project be modified based on users' decisions?
5. Can users choose with whom they want to live?
6. Are users supported in the decisions they need to make to handle adverse events?
7. Is the diversity of each user's needs and abilities considered in terms of their decision-making ability?
8. Do users decide when they are together and when they are alone?
9. Do users have the possibility to decide how they want to spend their time?
10. Will a user be supported in case she/he decides to go back to her/his country?

7. VOLUNTEERING SYSTEM AND CIVIL SOCETY

7.1 Documents containing information about a volunteering system involved in housing projects

- 15% Yes
- 85% No

Volunteering is not given much consideration when research is conducted. However, coordination is recommended by an "experienced volunteer" as well as a close collaboration with health and social services.

A volunteer is a person who is informed about mental health and has been trained to support people affected by mental disorders and help them become socially integrated. The experienced volunteer appears to bring more "experiential" knowledge rather than that of formally trained operators.

Volunteering activities are supervised by territorial services; Volunteers join together to build an informal support network.

Volunteers are trained to raise awareness among residents who are reluctant to rent out their apartments and express solidarity in an inappropriate way, availing themselves of private spaces dedicated to people with mental disorders.

Case literature seems to reflect that if volunteering is scarce, it is even more so with mentally challenged patients.

Volunteering implies that there are people who dedicate part of their free time to support other people in need. However, this support is characterized as "giving to" and "doing something for" other people. Regarding mental health, the aspect of volunteering that requires one to stand with users affected by mental disorders becomes extremely difficult when volunteers are not given clear objectives and may perceive their activity as meaningless.

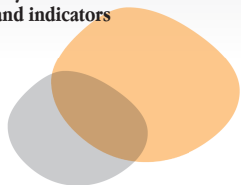The effort to scale up mental health volunteering should take into consideration the volunteers' needs. So in developing volunteering initiatives the goal to be set is not one of "giving" but "organizing".

The most successful volunteering experiences have an "objective" like organizing leisure activities in the hospital psychiatric ward or arranging art therapy sessions providing support to the therapist.
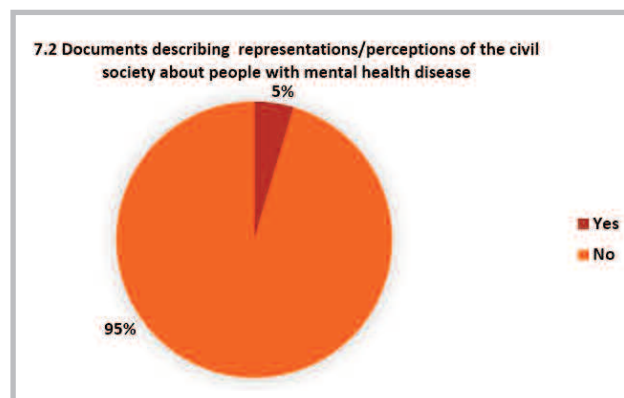
A person who provides company for patients affected by psychic disorder is subject to stress and may be unsure of the most "suitable words" to use, fearful as they are of being "wrong".

Often, services require these things and this is why volunteering efforts are so prone to failure.
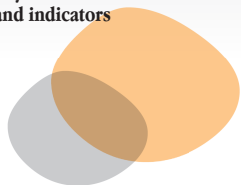
VOLUNTEERING SYSTEM AND CIVIL SOCIETY
INDICATORS

7.2 Documents describing representations/perceptions of the civil society about people with mental health disease

Yes 5%
No 95%

1. Will there be a trained mental health volunteer?
2. Does the Housing project include the possibility of promoting good neighborhood relationships?
3. Do Housing volunteers play a bridging role between professionals and society?
4. Are volunteers' activities in Housing projects subject to monitoring?
5. Will there be training / information on mental health issues to be provided to residents?
6. Is collaboration between workers and volunteers encouraged in Housing projects?
7. Are elderly people included in training programs designed to support users living in their neighborhood?
8. Do Housing projects support the initiatives of residents who live close to users?
9. Is the well-being of those who live in the users' proximity (neighbors, retailers, etc.) considered?
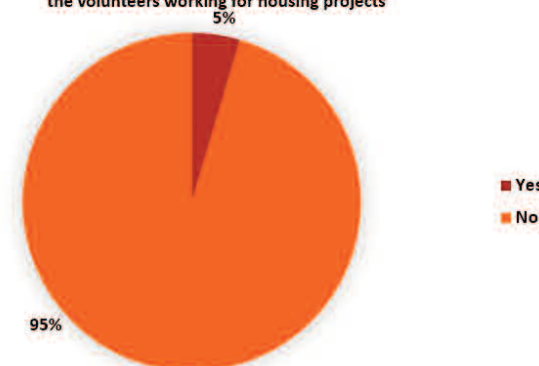
8. LIFE LONG LEARNING

8.1 Documents containing information about training provided to the professionals working on housing projects

- Yes
- No

14%
86%

8.2 Documents containing information about training provided to the volunteers working for housing projects
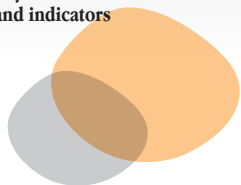
- Yes
- No

5%
95%
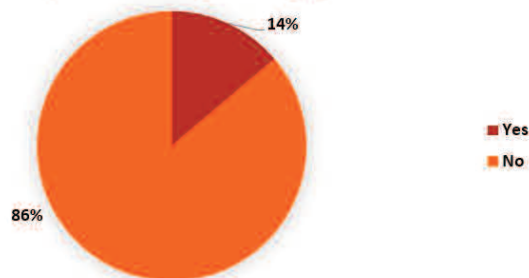
Case literature reports mainly on training experience for professionals. Training topics relate to the ability to select personnel specialized in Housing, the ability to identify user wishes and needs, the development of connection skills between different services and or between different roles and competencies. Supervision experience, assistance to clinicians and support to staff are also reported. There is less evidence of specific training in Housing programs on behalf of volunteers, local authorities and officers, users, families and residents. However, there is frequent evidence of the importance of specific wide-ranging training on the subject of Housing: to overcome prejudices, and for the development of collaboration among the different players (parents, workers, residents)
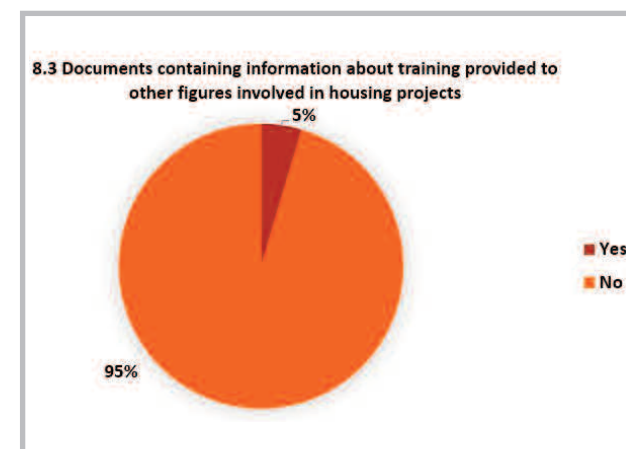
and institutions. Personal independence is often connected to human relations and financial self- sufficiency.
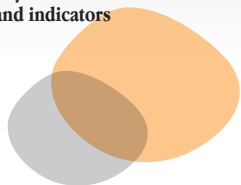
It seems that trained workers operate in situations that generally are not linked to the implementation of Housing programs. This problem is certainly debated but significant initiatives to solve it are still lacking.

The analysis derived from focus groups partly reinforces what emerged in Case Literature and expresses the participants' direct experiences. In this case, the need is also felt for wide-ranging training in the area of Housing, which involves everyone in civil society, more or less. User training experiences are also reported on how to reduce conflicts, manage critical situations, and organize daily life.

Training would help counteract and prevent stigma, share specific support techniques, knowledge and detection of resources by increasing the ability to establish relationships and collaboration among people who have different roles and tasks. Another important issue is the need for information about services provided according to the need of users, families and residents in general.


8.3 Documents containing information about training provided to other figures involved in housing projects

5%

95%

- Yes
- No

LIFE LONG LEARNING
INDICATORS

1. Are workers properly trained for Housing projects?
2. Do workers know the area?
3. Will workers be regularly supervised?
4. Will workers receive regular training?
5. Is there time management training for assisting users in skills related to how to organize and plan their day?
6. Are there information initiatives on how services for residents work?
7. Are there courses on mental health in schools?
8. Will users' families be trained and informed?
9. Will training be provided to anyone involved in Housing projects?
10. Will there be training/educational programs for those who are involved in Housing projects?
11. Are there training/educational programs for those whose task is selecting workers dedicated to Housing projects?
12. Are there local initiatives encouraging the development of social inclusion skills?
13. Is there training to develop the ability to work in a group and with groups?
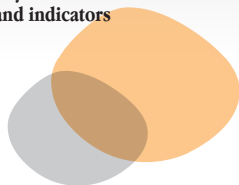
9. HOUSING RESOURCES

Case literature reveals that there are financial resources and funding agencies as well as a number of homes to be found: social Housing, private apartments where rental expenses may be integrated with public funding, apartments belonging to public or private companies or to the users and their families. In some cases social Housing is assigned to specific users.

It is emphasized that allocating a part of public funding quotas to Housing programs would be more cost efficient than the more expensive acute care services for non-independent patients services. In some cases it is possible to transfer funding from projects targeted to acute care projects to Housing projects.

Despite this, public funding has eroded, and so campaigns have been launched in support of Housing programs.

Many authors underscore the necessity to have a guarantee and a steady funding policy to support rentals for lodgers. In Italy family members often become financial guarantors for apartment owners.

In some cases a participation standard has been fixed for the expenses met by those who are involved. Workers may support users in the research of their own accommodation.

Basically there are two types of funding: One is allocated for users through their possible relocations and the other for projects that do not follow the individual but are tied to the associated Housing unit.

9.1 Documents describing financial supports for housing projects

26%

74%

Yes

No
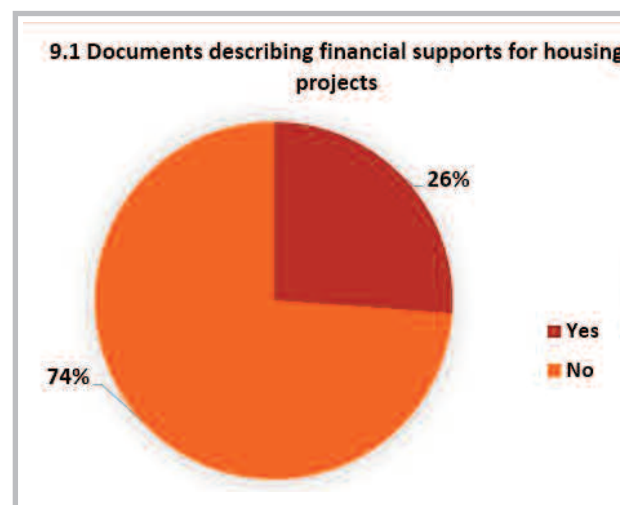
Over the course of focus groups, mental health practitioners emphasize the necessity for professional and financial resources and claim that public funding should supplement users' incomes. Workers complain about scarce flexibility and call on a more robust service network for mental health. Finally, they highlight that stigma make it difficult to obtain apartments from private individuals if there are not specific agreements with local authorities.
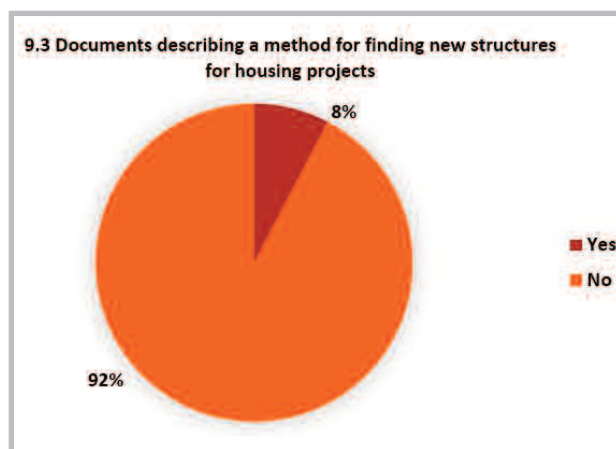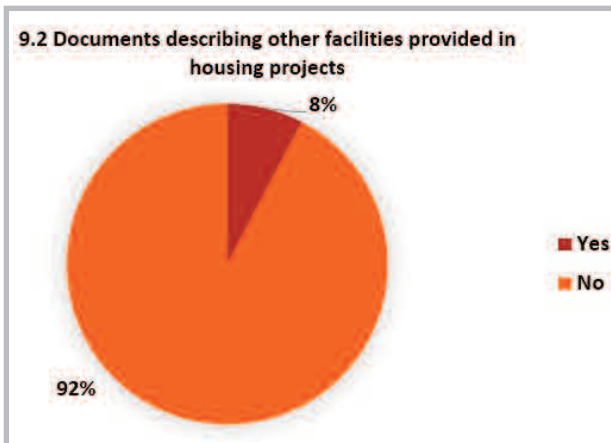
Workers who participate in the focus groups, although they come from other institutions, underline the importance of the relationships formed in the apartments and elsewhere: They aim at promoting solidarity and subsidiarity considering the specific characteristics of the various environments. It is necessary to provide independent apartments as well as common spaces to combat the element of loneliness. Necessity for support should not be underestimated. Each environment should find its own solution - there is no single solution for everyone, and there are different resources for each particular environment. Freedom of choice should be encouraged, avoiding too-specific places that could lead to segregation, even if Housing policies for the specific target are planned.

Various financing and support sources should be planned with methods that ensure that the sustainability of projects is linked to individual users. Of paramount importance is that these projects continue.

Strict and inflexible norms do not facilitate Housing programs. A legal base should be guaranteed to protect the different experiences. Finally it should be considered that this investment could become a financial burden on families.

In focus groups residents underline that the possibility of interacting with other users allows them to overcome possible fears or stigmas. Some reveal their own ignorance or absence of ideas in this area, even if they fundamentally think that the State should take charge of these issues. Others highlight the important role played by volunteers. Finally, users and their families who appear dedicated to them in the focus groups

9.2 Documents describing other facilities provided in housing projects

8%

92%

- Yes
- No

9.3 Documents describing a method for finding new structures for housing projects
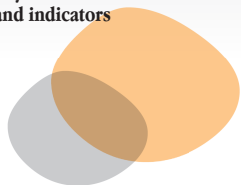
8%

92%

- Yes
- No

highlight the concept of choice: the importance of meeting someone and sharing the experience of community living, financially supported by their families. Other kinds of families are also involved, families who are not blood relatives but who help out when their own families cannot provide support. In some countries (Switzerland) the government takes care of everything including finding them a job according to their own abilities, thus relieving the immediate family. Another issue to be resolved is that people who have an apartment may not have money enough to maintain it.

HOUSING RESOURCES
INDICATORS

1. Is there a 24/7 dedicated specialist?
2. Are there foster families who can share insights from their experiences with users?
3. Are there opportunities for people affected by different problems living together (mental health, drug addiction, migrants) to provide mutual support?
4. Is financial support planned for institutions in charge of finding homes (for example: local authorities, health facilities, etc.)?
5. Are there any commercial, sports or cultural event promotions or facilitations for users?
6. Will users be helped to handle their money, if necessary?
7. Are there any resources dedicated to deinstitutionalization that promote Housing projects?
8. Are users' associations encouraged?
9. Does local legislation encourage Housing projects?
10. Do public institutions help find homes for users?
11. Does the public administration facilitate the acquisition of Housing facilities for mental health users with specific measures?
12. Is there a guarantee that the costs for the home occupants do not change if one of them leaves the home?
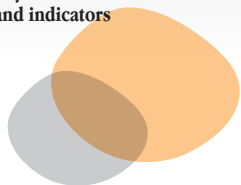
**Key-areas
and indicators**

10. IMPACT EVALUATION

10.1 Documents describing outcomes and impact evaluation of housing projects

35%
65%
- Yes
- No
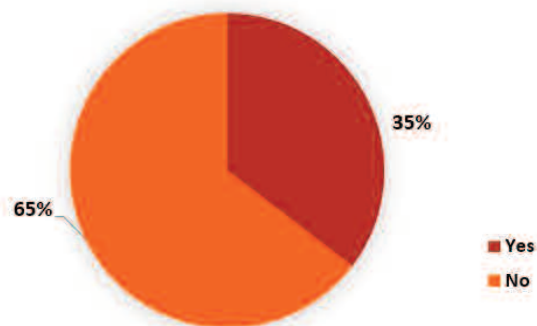
Numerous studies have been conducted on the impact of environment on quality of life. Several metrics have been used to assess the level of comfort, security, size of environments, respect of privacy, quality of workers' support, perceived life quality, daily activities, social relationships, adjustment to local community, social skills, functioning, etc. Certainly the support provided by services, psychic wellbeing and improvement of life style are strictly connected, as much as psychic well-being is linked to living in a community rather than in protected and restrained settings. Living in supported homes usually generates more positive effects than living in supportive apartments, with benefits in terms of well-being and costs, as the strain on hospitals and prisons is reduced. As a result of these researches, "Housing" can be defined as a system that is not about the structure itself but the relationship with the environment. Focus groups reveal the importance of "living out of" more than "living in" the apartments. Research has been conducted on the relationship between living spaces and outcomes, that is, how a place impacts people affected my mental disorders. Another important indicator is the relationship between the subjective perception of wellbeing and environment. To this aim, workers are encouraged to assess needs, abilities and difficulties of the users relating to the environment where they live, subsequently selecting the environmental tools able to meet needs and capacities. Focus groups reveal that Housing projects tend to provide health care services, while case literature reveals that the assessment of the Housing project's impact on mental health does not rely on any medical intervention but rather on subjective perception, characteristics of physical environment, social inclusion, and support during moments of crisis.

IMPACT EVALUATION
INDICATORS

1. Is there an agency qualified to assess the Housing system?
2. Will there be stakeholders who assess the impact of the Housing system?
3. Apart from Housing projects, are there other territorial initiatives aiming at inclusion?
4. Will the impact of Housing facilities on users and their families be part of the planned assessment?
5. Will there be regular surveys on costs/benefits of the Housing program?
6. Will residential facilities be assessed regularly?
7. Is there a system of periodic assessment of Housing projects?
8. Is quality of life monitored?

IX.

Use of indicators
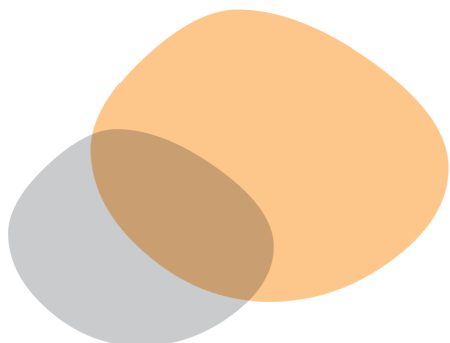
The tool kit is made up of ten key-areas; some indicators have been identified for each one. Indicators can be used at a local level to plan Housing projects, to set goals, monitor them and follow their implementation and progress.

They can also be used by social policies, to follow the progress of ongoing projects (also on local, regional, and national levels) and to achieve development and improvement. In-dicators can be used as guidelines for Housing projects, which are poorly chronicled despite the big demand.

The selected indicators explore different areas which are all involved in Housing projects requiring multidisciplinary skills (from organizations, families, users, residents and volunteers) focusing on shared goals such as health and life quality.

We estimate that the selected indicators can all be used in the different European countries.

However, the following categories:
1. Sourced of indications (Audience);
2. Data collection frequency;
3. Responsibility for the collection and management of data;
4. Responsibility for improving actions.

Are specific to each different country and should be provided to each indicator to enhance its effectiveness.

We think that the four categories should be selected by users of Housing indicators according to two main principles:

a) Mental health services and Housing management of a specific country (for example: de-institutionalization policy; number of supported/supportive Housing facilities, etc.);

b) Reasons to use indicators (for example: To start a Housing project, to monitor ongoing Housing experiences, to arise awareness in the local community, etc.)

We therefore suggest that the categories should be defined as it is shown in the table below.

The success of a Housing project is also based on the information provided, as this will enhance its planning, monitoring and improvement methods.

HOW TO USE THE INDICATORS

Indicator	Audience	Data collection frequency	Responsibility of data collecting and managing	Responsibility for improvement actions
	[Who provides information]	[How often data generated by the indicators are collected]	[People in charge for collecting and managing relevant data]	[Who is entrusted with actions aiming at improvement]

X.

Conclusions
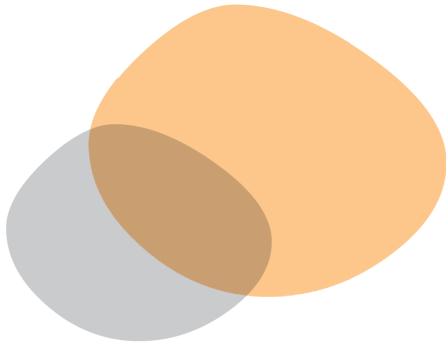
Recently (on March 28, 2017), the UN High Commission for Human Rights issued a report on the rights of people affected by psychic disorders and disabilities.

The report presents numerous opinions expressed by a vast representation of stakeholders. The introduction states that "Everyone, throughout their lifetime, requires an environment that supports their mental health and well-being; in that sense, we are all potential users of mental health services."

In a subsequent paragraph, the document states: "For decades, mental health services have been governed by a reductionist biomedical paradigm that has contributed to the exclusion, neglect, coercion and abuse of people with intellectual, cognitive and psychosocial disabilities." This observation reveals high criticality in mental health, a field that in the past few years has been characterized by reduced medical interventions, thus contributing to generate what today is improperly defined as "new chronicity."

According to the document, the widespread belief that mental diseases should be treated by doctors simply as medical problems totally neglects the "mental" aspect that attends them, and does not tackle the complexity of the matter.

Only recently has the WHO introduced the ICF system of classification (the International Classification of Functioning, Disability and Health), which takes into consideration the multiple and complex factors contributing to mental disorders: Mind, body, activity, participation, and environment. As stated in the UN document, "Diagnostic tools, such as the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), continue to expand the parameters of individual diagnosis, often without a solid scientific basis."
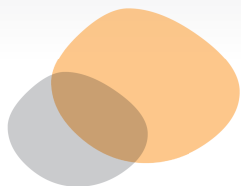
In compliance with the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," the effort of the group has been to take into account one of the most complex elements of psychic suffering: the concept of "Housing" intended as the act of dwelling.

The concept of dwelling, in both Italian and in English, implies a progression over time. However there are other elements apart from the notion of "time" to be considered. Some research is focused on life inside the various Housing facilities, analyzing and comparing them. According to architectural norms, inside is where the actual living takes place, while the outside reflects the social status of the one who lives there.

The indicators, which give the eBook its title and represent the synthesis of a survey that integrates bottom-up (focus groups) and top-down (case literature analysis) methodologies, are the starting point for HERO's constructive comparison of Housing experiences in various European countries. They will allow the HERO partnership obtain a formative curriculum on Housing projects for local communities. This is the goal of the partnership and it is supported by target groups of the project as well as by the most recent international testimonies on human rights and particularly on the rights of people affected by psychic disorders and disabilities.

We believe that the Housing process is both external and internal, as it encompasses the concepts of residence and environment, private and public areas, building and landscape, family relationships and social connections, individual skills and social opportunities, rights of citizenship and overcoming of new urban divisions (according to census and social class). Pope Bergoglio points out the beauty of cities where the architectural design includes areas that connect and create relationships and encourage mutual human recognition (Encyclical: Laudato sì, 2015, pp 139-140).

This view of Housing concerns the concept of "existence," as it is connected to and intertwined with existing as a person, a concept that cannot be reduced to a standard as it has been proposed until now by International Style, especially with regards to suburban areas because supporting a Housing project that brings well-being in mental health means creating well-being for everyone. In particular we should overcome the conceptual barriers dividing social relations. Just as the relationships within a space define its structure, space also influences the social relationships that take place within it. One has only to think about the sense of isolation and
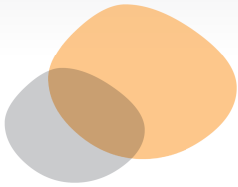
"silence" in the grand "salons" of mental asylums, then defined as "socializing spaces," and imagine how a simple change like putting the chairs in a small circle, "reducing" the large rectangular space, could have been able to miraculously "open people" to dialogue.

Another example is the "shopping malls" that follow the ideology of the "Bon Marché" in which the relationship takes place between exclusively "the customer and the object" and how the introduction of "little corners of play and music" can transform those places, making them more "friendly." The neighborhoods, the urban areas, the small centers, are the environmental elements supporting a relationship – places "open to diversity" that help change the perception of others as "different." They are aggregating places, with personal and public spaces that can be modified.

An environment is a place one belongs to, one's home, the place that hosts one's changing wishes over time.

The proposed model is therefore not to define better guidelines to help people with psychological problems but to build a system of relationships in which even people with psychic problems find it possible to live well with, and despite, their disability. If, as the UN report states, "we are all potential users of mental health services," then the goal is "to make possible" a satisfying life in which everyone is able to express their abilities and desires.

XI.

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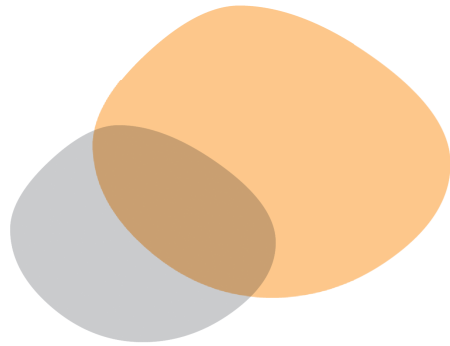
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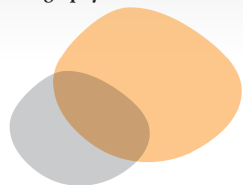
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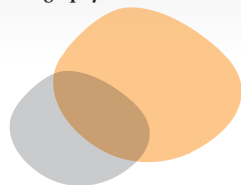
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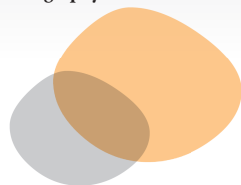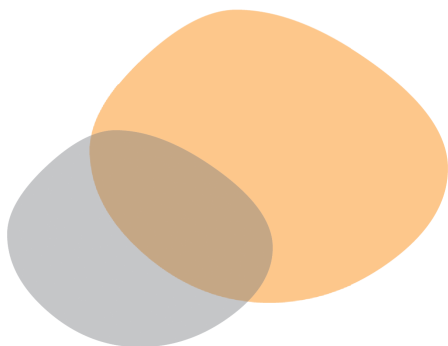
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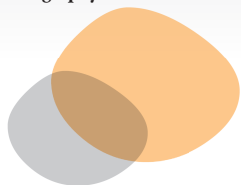
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