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SUPPORTIVE HOUSING FOR PEOPLE
WITH SEVERE MENTAL ILLNESS IN ASTURIAS: RESTRICTIVE ENVIRONMENT OR OPEN TO THE COMMUNITY?

VIVIENDAS SUPERVISADAS PARA PERSONAS
CON TRASTORNO MENTAL SEVERO EN ASTURIAS: ¿AMBIENTE RESTRICTIVO O ABIERTAS A LA COMUNIDAD? [1]

MORADAS SUPERVISIONADAS PARA PESSOAS
COM DOENÇA MENTAL GRAVE EM ASTÚRIAS: AMBIENTE RESTRITIVO OU ABERTO PARA A COMUNIDADE?

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ABSTRACT: Community care model and philosophy of psychosocial rehabilitation as engine key recovery personal, social and employment of people with severe mental disorder is assumed from the psychiatric reform process begun in Spain in 1985. In this sense, the accommodation is an essential component to the extent that there is sufficient evidence to assert that the provision of adequate accommodation represents a critical condition to ensure community care, becoming one of the most important programs of social support. The aims of the study are to evaluate housing supervised for people with severe mental disorder in Principado of Asturias in its aspects of infrastructure and the inner workings of the same. This uses the *Environmental Index (AI)*, and the scale of opportunity to the *Basic Everyday Living Schedule (BELS)*, as well as the information provided by the residential programs and key informants of the same. Housing obtained from half a score in the environmental index of 17,29 on a maximum of 55, giving it a more open than the institutional, although far environments functionality yet of the supervised homes of other residential programs. In short, outcomes provide a level of considerable independence to carry out basic and social skills of the users, but true danger of institutional environment in its daily operation, in aspects such as the network of users, formed largely by the staff of the housing, time who is residing in them or their low participation and social integration is denoted.

KEYWORDS: Social Pedagogy; Mental Diseases; Housing; Communities; Social integration; Social education.

RESUMEN: A partir del proceso de Reforma Psiquiátrica iniciado en España en 1985 se asume el modelo de atención comunitaria y la filosofía de rehabilitación psicosocial como motor clave para la recuperación personal, social y laboral de las personas con trastorno mental severo. En este sentido, el alojamiento es un componente esencial en la medida que existe evidencia acumulada suficiente para afirmar que la provisión de un alojamiento adecuado representa una de las condiciones críticas para garantizar la atención comunitaria, convirtiéndose en uno de los más importantes programas de apoyo social. *Métodos*. El objetivo del estudio es evaluar las viviendas supervisadas para personas con trastorno mental severo en el Principado de Asturias en sus aspectos de infraestructura y el funcionamiento interno de las mismas. Se utiliza la escala *Índice Ambiental (IA),* y la escala de oportunidad de *Habilidades Básicas de la Vida Diaria (BELS),* así como la información aportada por los programas residenciales y los informantes clave de los mismos. *Resultados*. Las viviendas obtienen de media una puntación en el Índice Ambiental de 17,29 sobre un máximo de 55, lo que le confiere una funcionalidad más abierta que los ambientes institucionales, aunque lejos todavía de las viviendas supervisadas de otros programas residenciales. En síntesis, los resultados otorgan un nivel de independencia considerable para el desempeño de las competencias básicas y sociales de los usuarios. *Discusión*. Se denota cierto peligro de ambiente institucional en su funcionamiento diario, en aspectos como la red social de los usuarios, formada en gran parte por el personal de las viviendas, el tiempo que llevan residiendo en ellas o su escasa participación e integración social.

PALABRAS CLAVE: Pedagogía social; Enfermedad mental; Vivienda; Comunidad; Integración social; Educación social.

RESUMO: Introdução. Do processo de reforma psiquiátrica iniciada em Espanha em 1985, assume-se o modelo de atenção da comunidade e filosofia de reabilitação psicossocial como um fator-chave para a recuperação pessoal, social e de emprego das pessoas com doença mental grave. Neste sentido, a vivenda é um componente essencial na medida em que não é suficiente acumulado evidências para afirmar que a provisão de morada adequada é uma das condições essenciais para garantir cuidados na comunidade, tornando-se um dos mais importantes programas de apoio social . Métodos. O objetivo do estudo é avaliar a habitação supervisionado para pessoas com doença mental grave no Principado das Astúrias, e os aspectos de infra-estrutura do funcionamento interno do mesmo. Use o Índice de escala Ambiental (AI), ea escala de Competências oportunidade Básicas de Vida Diária (BELS), bem como as informações fornecidas pelos programas residenciais e informantes-chave do mesmo. Resultados. As propriedades obtidas pelas avaliações médias no Índice Ambiental de 17,29 de um 55 possível, dando-lhe mais funcionalidade aberto a ajustes institucionais, embora ainda longe das casas dos outros programas residenciais supervisionadas. Em resumo, os resultados fornecem um nível de independência considerável para executar habilidades básicas e sociais dos usuários. Discussão. Denota-se algum perigo de ambiente institucional em suas operações diárias, em áreas como a usuários de redes sociais, formados em grande parte por funcionários da Habitação, quanto tempo eles tenham residido eles ou à sua fraca participação e integração social.

PALAVRAS-CHAVE: Pedagogia social; Doença mental; Vivenda; Comunidade; Integração social; Educação social.

Introduction

Historically, the concept and attention towards mental disorder has experienced several changes caused by major changes in management impelled by the present times. In this sense, social concern about people ingoing this problem has evolved through the transition between the terms *"mad"* (whom requires isolation and reclusion due to his presupposed dangerousness), *"diseased"* (susceptible to sanitary attention) and *"citizen"* (López Álvarez & Laviana-Cuetos, 2007), which emphasizes their consideration as persons entitled to rights and duties, which they face multiple difficulties to exercise, derived from their illness and its consequences in terms of personal incapacity, but also from social barriers attached to the stigma. In this sense, this new conception was brought to Spain through the Psychiatric Reform of 1985, which started a process of deinstitutionalization and embraced the communal attention model as a main tenet, based on new rehabilitation approaches grounded on the paradigms of recovery and well-being (Handbook of Clinical Practice for Psychosocial Intervention in Severe Mental Illness, 2009). Therefore, concepts such as "integral and integrated attention" have been introduced, which intend to cover the deficit and social disadvantages produced by the impact of mental illness in patients (Gómez-Beneyto, 2007, 2011). Thus, the community becomes a founding value in the intervention framework. This supposes a change endorsed by the participation of different agents, specially social and education ones whose key work concern is social emancipation and transformation, and that is where education is most directly connected to community development (Varela Crespo, 2010).

1. Communal attention model

Since the closure of the major institutions, the lives of persons with severe mental illness has developed within their familiar disposals or in their own houses, and, with that, their needs have become more and more closer to normality, that is, adjusting to the core of needs of the healthy population: need to receive an education, to work, to gain their own living, to relate to other people, to occupy their free time and, surely, to receive adequate treatment (Gómez-Beneyto, 2007, 2011). Definitely, this means to allow these persons to recover their life projects. In this point, psycho-social rehabilitation is of great importance, for in order to obtain self-independence it is necessary to count on a series of supports that should facilitate each step towards recovery. This process is forwarded by learning procedures and the provision of social support, that mediate the developments of personal skills in the different aspects of personal evolvement (Camino Vallhonrat, Hernanz Vaquero & Bosch Vilac, 2010). Attention for persons with severe mental illness requires the integration of distinct levels of attention and different types of intervention that form an inseparable whole, and which integrate in new objectives: autonomy, life quality, personal well-being, social participation as part of the concept of personal recuperation.

The Principality of Asturias, as stated in the 2011-2016 Mental Health Program of the Principality of Asturias, coordinated by Amelia González López (2011), adheres to the communal attention model, following to European guidelines accorded in the European Union's Green Paper on Mental Health (2006), the Convention on the Rights of Persons with Disabilities in New York, December 13th, 2006, as well as the national model developed in the Strategy for Mental Health of the National Health System (2007) and the recently published 2001-2016 Strategy for Mental Health of the National Health System (Gómez-Beneyto, 2011). Therefore, the framework chosen for this intervention recognizes in persons with mental illness all the rights and responsibilities of a citizen, with actions directed towards the normalization and complete integration in society, avoiding their exclusion.

2. Housing attention for persons with severe mental illness

Embodied with this philosophy of practice, different socio-sanitary applications and programs which facilitate social integration for persons with severe mental illness began to grow. One of these programs is the housing program referred to previously, in which different models and structures of housing are offered. In this sense, housing attention is one of the last echelons of normalization desired by persons will mental illness, at the same level as programs of employment in social support programs, which must be appropriately conditioned according to the sanitary aspect of the community model so to effectively promote integration. Thereby, the work of rehabilitation would become somber without the housing tenet to assure a minimum of safety and reliance (Gómez, 2002). Without stable and quality houses, the communal teams can not function. They are so important, that Shepherd and Murray argue that *"the house should be the center of community psychiatry"* (Macpherson, Shepherd & Edwards, 2004, p. 180).

2.1. Supportive housing for persons with severe mental illness effects

Many studies have shown positive effects in users enrolled in supervised houses and the residential programs regarding to their clinical status (Fakhoury, Murray, Shepherd & Priebe, 2002; López Álvarez et al., 2002; Sörgaard et al., 2001), personal and social functioning (Fakhoury et al., 2002; Hansson et al., 2002; Sörgaard er al., 2001); life quality (Hansson et al., 2002; López Álvarez et al., 2005c; Mares, Young, Mcguire & Rosenheck, 2002; Piat & Sabetti, 2011); along with a shortening in sanitary resource usage (Lascorz, Serrats, Pérez, Fábregas & Vegué, 2009).

All the more, Ogilvie (1997) affirms that living in a bad residential environment increases the number of necessary services and shortens life quality, hence it reduces the user's satisfaction and creates more needs. Nevertheless, living in an appropriate housing facility betters social functioning, and if one transits from an appropriate housing facility to a non-appropriate one there is a deterioration of these factors, in such a way that these aspects indicate a clear relation between quality in housing and quality in social functioning. On the other side, the inclusion of persons in a not appropriate residential facility may reinforce a series of negative effects such as risk of institutionalization, with the appearance and maintenance of impoverished and stereotyped personal conducts and scarce social contact (Ogilvie, 1997). In this respect it should be mentioned that, if traditional custodian models are associated in general to worse results (Sörgaard et al., 2001), users are not homogenous in regard to their necessities. For this reason, different groups of users benefit from different kinds of functionality, some developing better in environments with more personnel and low need for activity and interaction, while in other residents an "excess" in personnel leads to the diminution of positive results in terms of autonomy, participation and development of social networking (Fakhoury et al., 2002).

3. Housing attention in Asturias

The evolution of residential facilities in Asturias has had a discontinuous history. On one side, the nineteen-eighties represented a moment of creation and of putting forward many disposals, within the global emphasis of reform process. Thus, in 1987 existed two protected floor in Avilés; a protected home, called "La Casita", for five plazas; a helps program for heterofamiliar houses; "inns with twenty-five plazas in Oviedo and a help program for houses for ten persons in Gijón" (García González, 1988, p.732). In 1993, up to 30 protected squares and the "La Casita" protected house could be counted, increasing to 6 protected floors with 17 occupied squares and one tutored home, capable for 7 persons in 1998 (Health Service of the Principality of Asturias [SESPA], 1998).

Since the beginning of the nineteen-nineties, housing attentions goes through stagnation and retrocedes, since despite the important roll this disposals played, gradually interest in there use decayed

(García González & De las Heras, 1998), with the disclosure of a few floors, also due to problems in financing. Today there are, functioning, "ten supervised houses for a total of thirty-two squares" (González-López, 2011, p.28), although the studies' sample is composed of seven housing facilities. The housing administration is combined, since Asturian Foundation for Attention and Protection to Persons with Disabilities and/or Dependences (FASAD) does the intervention in six houses, the SILOÉ Foundation manages three flours, and one accommodation is managed directly by services of Mental Health.

Thereby, a vital aspect in sight when to evaluate this kind of housing facility is to learn its daily functioning, which offers relevant information as to how community attention is understood within the supervised houses that make part of the public mental health network in Asturias. This also allows the diagnosis of what kind of residential model is intended and makes it possible to analyze the differences of concept and residential programs between the distinct foundations or services that sponsor and supervise the housing facilities.

4. Method

The investigation brought forward in these pages is part of a broader research which evaluates supervised houses for persons with severe mental illness in the Principality of Asturias. Its objectives are to analyze the main characteristics of the housing facilities and the basic and social functioning of their users, along with their social community support, their life quality, and their attitudes and rates of satisfaction with regard to the house. The specific results revealed here are derived from the internal functioning of the houses, which is regarded the last steps towards accomplishing the process of psycho-social rehabilitation of the users, needing attention in the pedagogical level for its development, intervention and evaluation.

It is, thus, an investigation oriented towards change, improvement and social transformation, for which "the evaluation may contribute helping democratic institutions to select, supervise, improve and give meaning to programs and social policies" (Mark, Henry & Julnes, 2000, p.3). Nevertheless, it is a participative investigation, fundamentally descriptive and uses a single card. The method chosen for field work is "quanti-qualitative" (Barrón, Bas Peña, Crabay & Schiavoni, 2010, p.86), using a number of researches, documental analysis, and field notes during the investigation. The technical source of information is interviews, the main methodological resource used for evaluation. This is because psychosocial rehabilitation has individuality as its core characteristic, concerning particularities of the evaluated persons and the contexts where they interact or may come to interact. These circumstances make interviewing the best method for requesting information during rehabilitation (Fernández, González Cases, Mayoral & Touriño, 2003).

The sample selection was made through a non-probabilistic sampling, conveniently incorporating all studied population in the Principality of Asturias: all seven supervised houses for persons with severe mental illness and its users. Four of them managed by FASAD, two by SILOÉ and one by the Mental Health services of house's zoning placement.

For a concrete analysis of the material two information resource instruments were specially used:

a) Environmental Index. This scale was adapted, with many additional questions, from Wykes Hospital and Hotel Practices Profile of 1982 (Jordá & Espinosa, 1990, 1991). Its objective is to value the level of an individual's autonomy in his residential environment and evaluate its quality and activities it features. The scale is divided in subsections with the following headings: activity, pertinence, food, health and hygiene, resident skills, services and surrounding environment. It has been designed to be used in hospitals as well as in any kind of housing with personnel assisting residents with mental illness. It has a total of 55 items with yes or no answering options. The scoring of a 55 maximum, which is more than the level of "restrictiveness" or "restriction", as seen in the instrument's original version (Jordá & Espinosa,

1990; Maestro Barón et al., 2001; O'Driscoll & Leff, 1993; Rickard et al., 2002), seems to measure, in a general sense, the higher or lower functional proximity of these items to the institutional contexts or environments (López Álavres et al., 2005b). Nonetheless, it has shown to be an adequate questionnaire for measuring the adjustments needed between the patients' needs and the residential installations. This should help forward persons with severe and persistent mental illnesses to installations better adapted to their needs (Corbiere, Lesage, Reinharz & Contandriopoulos, 2001). This interview was made for the persons in charge of housing facilities for persons with SMI.

b) Basic Everyday Living Schedule. Originally elaborated by Julian Leff, BELS is an instrument designed to evaluate specific skills of everyday coexistence in persons suffering from long scale mental disorder (Leff, Trieman & Gooch, 1996). It is administrated to a key informer, in this case someone from the housing personnel, and explores four fundamental functioning areas: 1) self-care, 2) domestic skills, 3) community skills, and 4) activities and socials relations. It allows to point out the subjects' performance or updated achievements and his opportunities to act independently in each area. The questionnaire is made of 26 items. Each one of them is divided in two scales, an achievement opportunity scale and a skill performance scale. In this case, the chance scale shall be used, in three levels in order to determine the standards of opportunity the person has to do his activities independently: total opportunity of independence (2 points), some opportunity of independence (1 point), no opportunity of independence (0 points). In Spain, there is a study on reliability made with samples of 77 chronic mental patients housed in flours and protected homes located in Granada and Sevilla (Jiménez et al., 2000). The results of the analysis in regard to reliability show, in general, a good global concordance in opportunity scale (0,791 medium score) as well as in the performance scale (0,743 medium score).

The interviews are done individually in the supervised houses object of this study. Therefore, authorization is obtained from all agents involved in this research, from the Mental Health services and the entities responsible for managing the houses, to the user's informed consent. Applications are made by one only trained interviewer, in order to avoid possible deviations and interpretations. Documents from Mental Health Services and programs of residential attention from the managing entities are also analyzed.

5. Analyzing and interpreting the results

5.1 Aspects of Infrastructure

First, we shall present the analyzed houses' aspects of infrastructure, such as the number of squares in each dispositive, the type of dormitories, an aspect the user's consider very important for intimate reasons, as well as its location and the nearby serviced provided.

Thereby, the flour in Asturias have an average of 1,06 squares, that in some cases may be enlarged if free apartments are available. In the room modality, 94% of the floors are occupied by the users in individual accommodations. Still, the places chosen for implementing the houses are distributed in a majorly urban area and a reasonable enclave, easy access to shopping facilities, cafés, community centers, movie theaters, etc. (Table 1)

Table 1. Supervised housing location and surroundings

		Supervised housing
Location	Urban	85,7%
	Rural	14,3%
Surrounding area		
Services in the surrounding environment at a walking distance	Commercial shops	100%
	Bares y cafés	100%
	Community centers	85,7%
	Movie theaters	85,7%

Reference: Self made.

Table 2. Housing internal functioning

Factors	Specific issues	Supervised housing
Restrictive rules	Restriction towards going out at night	7 (100%)
	Fixed wake-up time	7 (100%)
	Fixed time to return home	7 (100%)
	Prohibition to smoke in the rooms	7 (100%)
	Scheduled visiting	4 (57,1%)
	Limited TV watching hours	4 (57,1%)
	Fixed eating hours	4 (57,1%)
	Fixed bedtime	3 (42,9%)
	Restriction towards bar frequency	2 (28,6%)
	Fixed bath time	2 (28,6%)
	Prohibition to have matches, lighters	1 (14,3%)
	Restriction towards going out during daytime	0 (0%)
	House front door closed	0 (0%)
	Prohibition to possess blades, knives, scissors	0 (0%)
Autonomy limitation	Limited medicine ingestion	7 (100%)
	Limitations towards door locking during bath time	4 (57,1%)
	Possibilities of personnel entering the rooms without asking for permission	4 (57,1%)
	Limitations to have owned furniture and ornamental articles	2 (28,6%)
Privacy limitation	Having to inform where going to when leaving the house	2 (28,6%)
	Limitation to possess personal money	1 (14,3%)
	Limitation to make coffee or tea	0 (0%)
	Limitation to cook light meals	0 (0%)
	Limitation to keep locked belongings	0 (0%)
	Personal belongings supervised by personnel	0 (0%)
Participation	Participate in planning and preparing meals	7 (100%)
	Weekly meetings between patients and personnel	4 (57,1%)
Global Index (Maximum restriction: 55)		**Average: 17,29**

Reference: Self made.

In general, the table reflects a relative *"normalization"* in functioning, with a *global index* average value of 17,29 (DT=2,49), even though with internal functioning variations from the managing entity, and an improvement in numbers of cases of restrictive rules, since parts of the data impress for the differences in respect of what should be considered "home environment", more appropriate for this kind of housing. Thus, the major restrictions are found in timing, getting out of the house, or limitations in regard to medication, a very important issue for the functional well-being of persons with severe mental illness, which is why all flours choose to keep direct control over medication provision and ingestion.

On the other hand, house doors stay open in the housing complex, without restriction as to going out during the day and there are not many limitations in regard to basic aspects of life such as the resident's autonomy and privacy, despite some limitations indicate that some places are more institutionalized than homelike, such as having to inform the personnel when leaving the house (28,6 % of the flours). Nevertheless, a surprising circumstance found is that in 57,1% of the houses the personnel entered the users rooms without asking for permission, although this statistic may give a false impression, since it is not properly due to limitation in the user's privacy, but to the trust and confidence built between personnel and residents in a family-like environment. Moreover, meetings are held between personnel and users on a weekly basis in 57,1 % of the floors, although this aspect can present mixed dimensions: the meetings are institutionally formal, but seem to be very useful to regulate many aspects of collective living and to resolve details in the houses' internal environment.

At last, the investigation of functioning aspects in the housing facilities in complete with the application of the BELS opportunity scale, which describes the possibility each resident has to develop certain daily skills in his/her house and which is value according to his/her capacity to accomplish (Table 3).

The data reflected in the last table point out and complete the issues studied in the houses' environmental index. In this sense, it can clearly be observed that patients may freely leave the house during the day, since the houses function on an open regime. Thereby, the users are free to choose their free-time activities, to leave and return to the houses and engage in all kinds of social contact and relations with persons from their surrounding environment. Likewise, most activities involving self-care are not restricted, nor are the opportunities to exercise their performance in domestic or communal skills.

The scale presents, in general, open housing facilities, with moderate restrictions in information expressed by the environmental index, as in the *waking and getting up* item, or in the return home at night item, in which despite being an open facility, resident are expected to inform personnel or ask for permission to go out and establish an agreement on when to be home.

The other variables that patients do not have complete freedom in regard to are the ones regarding medication, food purchase, use of assistance services and the capacity to manage their own money or budget, even though this restriction, moderate or significant, rely more on the user's level of performance, his/her capacity to independently perform these activities, than on the rules established by the floor or the residential program he/she is subscribed to.

Another aspect in which some kind of restriction is noted is the *use of assistance services* variable, both sanitary and social (doctor, dentist, social security, etc.). It is expected that house dwellers mark there appointments with complete independency, even though, in many cases, the personnel does it for them. Notwithstanding, the personnel is always attentive to patients concerns and usually knows all of their appointments, as much as they support and supervise them in all those daily questions, despite the residents total independence.

Table 3. Percentage of users with regard to the levels of opportunity to perform activities independently

Areas or activities	Supervised housing		
	Significant restriction	Moderate restriction	No restriction
Independent movement	0%	0%	100%
Waking and getting up	0%	28,6%	71,4%
Dress him/herself	0%	0%	100%
Return home at night	0%	100%	0%
Eating	0%	0%	100%
Medication	23,8%	61,9%	14,3%
Personal hygiene	0%	0%	100%
Clothes	0%	0%	100%
Incontinence	0%	0%	100%
Behavior while in the bathroom	0%	0%	100%
Food preparation	0%	0%	100%
Simple food preparation	0%	0%	100%
Grocery shopping	28,6%	9,5%	61,9%
Shopping	0%	0%	100%
Laundry	0%	0%	100%
Personal space care	0%	0%	100%
House and public area care	0%	0%	100%
Using public transport	0%	0%	100%
Using assistance services	19,1%	23,8%	57,1%
Using public services and areas	0%	0%	100%
Using personnel money or budget control	0%	23,8%	76,2%
Daily occupation	0%	0%	100%
Free time activities	0%	0%	100%
Sociability	0%	0%	100%
Consideration and concern for others	0%	0%	100%
Emergency assistance provision	0%	0%	100%

Reference: Self made.

Conclusions and discussion

First of all, Asturias presents a low average of adequate housing facilities available, if compared to housing rates from other Autonomous Communities such as Andalucía, Madrid or Castilla-La Mancha. Following this tendency, the distribution of housing resources in Asturias, of 2,04 homes for 100.000 inhabitants, is by all means insufficient if compared to the housing rates for every 1000.000 inhabitants proponed by the Spanish Neuropsychiatry Association. In this case, the consensual document established a minimum of 20 and an ideal of 50 squares for every 1000.000 inhabitants. Although this may be considered an ideal scene and, given today's reality, it estimates a number of "reasonable minimum of 10 squares and goal of 20" (AEN, 2002, p. 59). Despite the fact that other reference programs such as from the Community of Madrid (Florit Robles, Cañamanes Yelmo, Collantes Olmeda & Rodriguez González, 2007), estimate a minimum of 6 squares for every 100.000 inhabitants. However, the 2011-2016

Mental Health Plan of the Principality of Asturias, estimates the housing necessity in different grades of support or supervision, in approximately 14+-3 squares for every 100.000 inhabitants. Along with this average, the plan point as an objective to maintain functioning 19 supervised houses or floors with different intensity levels of care that will provide shelter for 95 users, as well as the creation of 3 mini-houses with 76 squares (González-López, 2011)

Besides, if compared to other European countries, the situation worsens considerably. Of course, none of the numbers of studies made in Copenhagen, Amsterdam, London or Verona (López Álvarez et al., 2004) may overcome this research's spectrum and no evidence has been shown that the evolution of social-cultural factors develop in the same direction, nor with a predictable rhythm (López-Álvarez et al., 2005b). Along with this, almost no user looks forward to sharing a housing facility and is commonly features an element of discontentment; in fact this may bring consequences to their coexistence and social support, since a series of studies from Baum and collaborators (Evans, Wells & Moch, 2003) show that the design of shared rooms has negative effects on the social support of the residents, if compared to user in individual rooms.

On the other hand, the situation of the present facilities, in terms of *access to community services*, seems to show locations in normal residential surroundings, which helps with integration and improves the life quality of the users, as shown by many studies (Contreras Nieves et al., 2007; De Girolamo et al., 2004, 2005a; Mares et al., 2002; Rickard et al., 2002; Shepherd & Murray, 2001). Certainly, the use patients do of these services is very low, as shown by the low scores in community participation and integration.

The average scoring in the Environmental Index (17,26), presents a certain normalization with respect to restrictive internal environments if compared to the score obtained by the Home Houses of the Andalucian Public Foundation for Social Integration of Persons with Mental Infirmity (FAISEM) (Fernández Portes, 2008; López Álvarez et al., 2005b), with an average of 22,7 restrictions or limitations, although they are frankly better if the comparison is made with this programs supervised houses, that reaches an average of 13,2 limitation in autonomy of their users. Nonetheless, both programs are far away from the normalized environments found in this kind of residential facilities in London, with an average of 6,2 restrictive measures (Rickard et al., 2002). The Asturian residential model has, however, a number of different guidelines driven by the entities responsible for the houses supervision and support, similar in some cases to the residential improvements in Italy, with greater reliance in sanitary structure. In the same way, the diversity of situations found in each facility and the incongruity in the occasions between the scores on restrictive environment and its daily functioning are surprising. In this sense, there seems to be some lack of definition in the programs when objectifying the goals of the housing facility, that is, if they are to be skills and abilities training resources with intense support or houses with more specific support. This, in many occasions, leads professionals to take a more restrictive approach, stigmatizing the connotation of infirmity and dependency.

Along with this, the conformation of structure has shown to be the less favorable option, considering results from other studies on the differences of effectiveness in distinct types of housing facilities. In this study, Kallert, Leisse and Winiecki (2007) support that a daily life situation for patients should be maintained and fomented, regularly promoting social contact. This way, in order to avoid propagating re-institutionalizing phenomena (Priebe et al., 2005), health policies should promote subsidized housing investments and defend the improvement of autonomous functionality in patients with schizophrenia in their own houses.

There appears to be, however, a certain risk of institutionalization in the distinct residential programs, since, as conclusions from this research can show, the circle of social support is reduced to housing personnel and floor mates, creating a microcosmos that reduces communal participation. Another feature that may add to this concrete risk of institutionalization is the fact that 28,6 % of the residential program users' take more than two years living in the support floors. This period is considered the

limit established for, a priori, patients to exit the program and enroll in independent lodges, once these houses were built on the idea of entrainment and apprenticeship of their users which will serve as an anchor in the community, a vehicle for teaching and learning of all abilities and skills necessary for their insertion and communal participation. Therefore, facing the impossibility of finding alternative residential options, in some of the houses analyzed in this study, the status has changed from temporary to permanent. Despite these institutions' focus on rehabilitation and the increasing expectations of professionals, the low rates of communal integration or residential independency have been a common topic in programs from other countries, such as the US, Italy, and Great Britain (Piat & Sabetti, 2011). In this sense, it is necessary to create external activities, courses and training activities that are part of the patients interest, in which housing personnel play a significant roll. A study published in 2009 made by Bitter, Entenfellner, Matsching, Frottier and Frühwald, revises different researches that analyze this problem from 1997 to 2007, reaching the conclusion that the risk of trans-institutionalization continue real and did not find evidence of support models that are adapted to the individual needs of patients.

With all this, persons with severe mental illness can satisfactorily live in their communities with the adequate housing and support (Ogilvie, 1997; Kyle & Dunn, 2008), but need, however, the public policies to promote its excellence, guaranteeing that all the support they need are at their disposal, while observing and evaluating the whole process and interventions, in which the pedagogical aspect is key for obtaining social abilities and skills, which are specific to the users of Asturias, along with personal development and employment orientation and insertion. In this sense, we agree with Newman and Goldman (2008), in an article referring public policy implementation on mental health, in which they affirm that the general tendency on residential attention is to open facilities and then think what to do in them. Theses authors conclude that the experiences have shown that these persons' housing needs are, in many cases, prominent, that must give sense to an immediate satisfaction, although permanent solutions and efficient programs of intervention must be sought, accepting the construction of houses in order to attend the seriousness of this situation, developing persistently the future work, as put by Newman and Goldman (2008) in the article entitled *"Putting housing first, making housing last"*.

Therefore, the ultimate goal of residential services for persons with severe mental illness is to serve as starting point in order to obtain changes in the "client" roll, achieving a citizen roll through the housing facilities, along with education and work opportunities (Piat & Sabetti, 2011). That is the continuity of recuperation. From this point of view, the supervised houses do not promote recuperation, nor social participation or integration, nor the improvement of its consequences by itself just because it is a residential resource with lower level of supervision and more independent, but because it must reflect its user's choices and must accomplish the specific requirements for each individuals recuperation. According to this conception, the community must be the founding reference in educative action.

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