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Understanding *what matters* in the Shared Lives support model

A rapid literature review to develop a logic model

shared lives plus

DEEP: A to ben bid bont

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Executive summary

Background

Shared Lives (SL) is a distinctive model of social care support that operates primarily in the United Kingdom (UK). It has a long genesis and there are similar support models in operation around the world.

As part of a research project exploring a SL day support arrangement, we sought to draft a logic model describing the SL support model. Logic models help explain how a support model works and what outcomes are produced. Previous logic models for the SL support model have been scheme specific. There have been no previous attempts to understand the SL support model and its outcomes by combining findings from all the relevant literature on SL and similar support models.

Method

To draft a SL logic model, we conducted a rapid evidence review. Eligible support models included in the review shared the key components of SL:

- Citizens and paid carers are matched
- Citizens are supported in the paid carers own home and included in their family and/ or community life
- Paid carers only support a limited number of citizens at any one time
- Citizens receive support from the same paid carer over time

Included studies had to contain outcome data (i.e., findings about what impact was achieved) for SL or a similar support model and could be conducted anywhere in the world (although they had to be published in English). We included grey literature reports as well as peer review published papers.

Findings

Sixteen papers and reports were eligible for inclusion, although just over half of these studies were assessed as having a high risk of bias. The SL logic model synthesised from the study findings included the following key components:

Inputs: recruiting paid carers with the right qualities

Activities: matching citizens and paid carers based on similar interests and dispositions

Outputs: relational care, including support provided in a family environment

Outcomes: multiple short-term outcomes reported for citizens with support needs and paid carers

Discussion

The evidence on which the SL logic model is based has limitations. Future research is needed to address gaps in the evidence and missing voices. Future research is also needed to strengthen the evidence for positive outcomes through comparative studies with other support models and standardised outcome measures.

Despite the limitations in the literature, some confidence can be placed in the SL logic model given its resonance with the wider literature and previously developed

SL scheme specific logic models. Confidence can particularly be placed in the inputs, activities and outputs detailed for SL as these were drawn from relevant qualitative evidence.

Contents

Background

Worldwide, social care policy makers need insight into what constitutes meaningful support that helps citizens with complex needs achieve good wellbeing. This is seen in the social care policy in Australia, Germany and Sweden that seeks to empower citizens to access support options that meet their desired outcomes (Robertson, Gregory & Jabbal, 2014). A similar agenda is laid out in Scotland in the Health and Social Care Delivery Plan (Scottish Government, 2016) and the England Care Act (Department of Health and Social Care, 2014).

A particular interest in current social care policy is how to provide good support in people's own communities and homes. This can involve home help (or domiciliary care), but it can also involve helping people to access activities and amenities in their local community. If people are supported in their local community, this can delay care home placements, reduce health and social care service use, and save money (National Institute for Health and Care Excellence, 2015). For example, in Sweden, policy talks of strengthening the capability and opportunity for people to participate in society (Government Offices of Sweden, 2020). In Japan, policy focuses on providing community-based support through in-home help and day services (Usui & Palley, 1997) and in New Zealand there is an emphasis on helping people with support needs to remain in their own home and community (Timmins & Ham, 2013). Policy makers in Asia similarly focus on community-based support, which is culturally appropriate in the Asian context and more feasible than residential care in a rapidly ageing population (Help Age International, 2015). Countries in other continents also have a long history of supporting citizens within the community: in Italy many older citizens are cared for in the family home with the help of home care workers (Naldini & Saraceno, 2008). The devolved nations in the United Kingdom (UK) also emphasise care at or close to home (Health and Social Care Board, 2013; Scottish Government, 2016; Welsh Government, 2018).

In Wales, where this review and associated project were undertaken, the Social Services and Wellbeing (Wales) Act (Welsh Government, 2014) promotes outcomes focused wellbeing goals including the opportunity to participate in recreation, domestic, family, and personal relationships, and the opportunity to contribute to society. The Well-Being of Future Generations (Wales) Act (Welsh Government, 2015) has an ideal of a resilient and cohesive Wales, where communities support each other and are well connected, and the Healthier Wales plan lays out a commitment to using community assets (Welsh Government, 2018).

Shared Lives (SL) is a model of social care that operates in 'the local community' (Fox, 2015). It offers support with activities of daily living and importantly has a focus on helping an individual re-engage with and remain part of their local community.

The SL model

SL can be dated to the fourteenth century (Eckert, Namazi & Kahana, 1987). At its core is the idea of 'relational care', that is providing support through the interpersonal relationships that are created and then sustained.

Dickinson (2011) distilled the core features of the SL model currently operating in the United Kingdom (UK) as:

- Citizens with support needs are matched with a paid SL carer based on similarities in their dispositions and interests
- Citizens with support needs are included in the SL carer's family and community life
- SL carers support a limited number of citizens at any one time
- SL carers often support the same citizen(s) for a long time (for years in many instances)
- Although SL carers are paid and receive training and supervision, they remain self-employed (Brookes & Callaghan, 2013)

The SL model was first employed to support citizens with learning disabilities, but it is increasingly recognised as a model for citizens with a variety of support needs (Callaghan, Brooks & Palmer, 2017) including people with mental or physical health problems, people living with dementia, people with physical disabilities, people experiencing homelessness and people who misuse substances (Fiedler, 2005a). As the SL model has become more prevalent, various support arrangements have been developed (Brookes & Callaghan, 2013) including:

- Long-term care, where the citizen and SL carer live together, and support is provided over a long period of time
- Short breaks, where the citizen stays overnight on regular occasions in the home of the SL carer
- Day support, where citizens receive regular support during the day
- Rehabilitation or intermediate support, which is provided for a more finite period
- Outreach support, where the SL carer provides support primarily in the citizen's home

In the UK, the SL model can be delivered by both the statutory and the independent/ third sector (Bernard, 2005). These services are regulated, helping to maintain the coherence of the model, and services can access guidance and advice from the charity Shared Lives Plus (SLP).

Similar support models

There are similar support models to SL in most parts of the world (Callaghan et al., 2017). For instance, in America there are a range of models which include elements of SL (Eckert et al., 1987) including board and care, family care homes, adult foster care and sheltered care homes. However, several of these models are not regulated so there is less consistency in their core features. Adult foster care is more likely to be regulated, but foster carers can support up to five adults and they do not always provide care in their own home. In addition, although personal care and housekeeping are provided other aspects of care may be provided by outside agencies (Kane, Kane, Illston, Nyman & Finch, 1991) and interactions between foster carers and people with care and support needs can be limited (Eckert et al., 1987). These are significant differences from SL where relational support is fundamental, and the support provided by the SL carer is holistic.

In Australia Host Family Day Respite and Host Family Overnight Respite services have similarities with the SL model. Although limited to day support and short break type arrangements, in this model host family workers provide support in their own

homes, support only a small number of citizens and are carefully selected (though the criteria for selection are not stated) and receive training and support from the service organisation (Shanley, 2006).

To summarise, although there are similar support models to SL, in practice these models often have key differences to SL.

The reason for undertaking a rapid evidence review

This rapid evidence review was undertaken as part of a Health Care Research Wales Social Care Grant project (grant reference: SCG-19-1608). The wider project conducted a Social Return on Invest (SROI) evaluation of a SL day support service called TRIO, which was operating in North Wales. SL day support is becoming an option for more people (SLP, 2020) and due to the impacts that COVID-19 social distancing regulations have had on traditional day centre provision (Shared Care Scotland, 2020), this is an apt moment to evaluate the value of this type of arrangement. Reviewing existing evidence is recommended as a first step in evaluating complex interventions (MRC, 2019). Similarly, the first step in demonstrating a support model's value is to communicate its outcomes and how these are achieved. This can be accomplished through creating a logic model. The rapid evidence review was undertaken to draft an initial logic model for TRIO, informed by the wider evidence about how the SL support model works and what outcomes it produces.

Logic models show the investments, activities, outputs, and outcomes of support models. They can also consider how contextual factors might influence how a support model works or if there are any assumptions about how the model of support works. Creating a logic model for the SL model has value beyond the study. It provides transferable learning for social care policy and practice development, both nationally and internationally. It better enables comparison with other models of support (Gaugler, 2020; Kirk, 2020) and informs service commissioning and delivery.

When we searched the literature to see if we could base our study on an existing logic model for SL, we found that the published logic models for SL were scheme specific and previous literature reviews exploring the outcomes of SL were either dated or not peer review published (Callaghan, Brookes & Palmer, 2015; Dagnan, 1997; Fiedler, 2005; Harflett & Jennings, 2016; National Development Team for Inclusion (NDTI), 2019).

A rapid evidence review undertakes a systematic search of the literature but omits some stages of the full systematic review process to complete the review within a short time-period. This type of review is often used to inform policy, update previous reviews and to explore new emerging topics (University Libraries, 2022). Our selection of this type of review to build a logic model was pragmatic: we needed to quickly pull together the relevant literature to inform the remainder of the project. A rapid evidence review was also appropriate as, as detailed above, there are existing reviews of the SL support model on which we could build, and the SL support model remains an emerging area of research.

Review question

The primary review question was *What outcomes are reported for stakeholders of the SL support model and what are the reported mechanisms of action?*

The primary outcomes explored were physical and mental health and wellbeing/ quality of life for the citizen with support needs. Secondary outcomes considered impacts for unpaid carers, SL carers, other professionals, and the local community. The review defined unpaid carers as family members or friends who provide unpaid care to an adult (Welsh Government, 2014).

Method

The rapid evidence review protocol was registered on Prospero; CRD42020211948 (https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=211948). The review was approved by the Bangor University School of Medical and Healthcare Sciences (Post-reg) ethics and research committee (reference: 2020-16793).

Search strategy

We used the SPICE(S) framework (Booth, 2006) to decide what terms to use when searching the literature. The SPICE(S) framework suggests considering if you need search terms to cover five concepts:

Setting: This was not needed, as we included all types of SL arrangements
Perspective: This was not needed as we were interested in all perspectives
Intervention: SL or Host Family support or Family Care or Adult Placement or Family Placement Scheme were the search terms used (Host Family support includes key features of the SL support model and the other terms are previous names used for the SL support model)
Comparison: This was not needed as we not comparing the SL support model to other models
Evaluation: We included all types of evaluation

Peer reviewed literature on SL is scarce so four bibliographic databases were searched (inception to 4th January 2021):

- CINAHL (EBSCO)
- Social Science Premium Collection (ProQuest)
- PsycInfo (ProQuest)
- Web of Science (Clarivate)

Terms were searched in the database title and abstract fields. Box 1 illustrates the CINAHL search strategy.

Box 1: CINAHL search strategy

1. Title field: “Shared Lives” OR “Family Care” OR “Adult Placement” OR “Family Placement Scheme” OR “Host Family Respite”

2. Abstract field: “Shared Lives” OR “Family Care” OR “Adult Placement” OR “Family Placement Scheme” OR “Host Family Respite”

3. #1 OR #2

4. Retrievals limited to English Language

We also searched for grey literature reports (i.e., reports that were not peer-review published) in Google and on the SLP website. As we were undertaking a rapid evidence review and time was limited, we did not search for PhD reports. When a relevant paper or report was retrieved, we undertook citation searches and reference list screening to try and identify further relevant literature. Once we had compiled a list of retrieved literature a representative from SLP (KM) checked there were no obvious omissions in the included literature.

Review inclusion and exclusion criteria

All SL arrangements (and similar support models) for adults were eligible to be included in the review. These arrangements could support adults with any type of support need. To ensure all the papers and reports included were describing a model of support like SL, the support model described had to include the following features:

- Citizens and paid carers are matched
- Citizens are supported in the paid carers own home and included in their family and/ or community life
- Paid carers only support a limited number of citizens at any one time
- Citizens receive support from the same paid carer over time

Other models did not need to use the same employment arrangements as SL, but paid carers needed to be selected for the role, trained and to receive supervision.

Studies had to be published in English, as there was insufficient time for translation, but they could be conducted anywhere in the world. Studies could use any method, but the paper or report had to contain data (evidence) about the SL model outcomes.

Search process

Searches were conducted by one reviewer (LP), but GT independently screened ten percent of the titles and abstracts for eligibility. Interrater agreement on eligibility was 94%. Seven papers could not be obtained within the available timeframe. Available full text papers were independently screened by LP and GT and interrater agreement was 98.5%. The two disagreements concerned whether the support model described had sufficient similarity to SL and whether there was sufficient data in the paper. Reference to the paper and discussion led to both these papers being excluded.

Data extraction

LP extracted data from each included paper and report to enable us to characterise the literature. We extracted information about participant characteristics, study

design, reported outcomes and mechanisms. A template extraction form guided the process and GT independently extracted data for 10% of studies. Interrater agreement was 93% and disagreements were resolved through recourse to the paper or report.

Risk of bias assessment

A study has a risk of bias when its design or how it has been conducted means that it is likely to give misleading results. If biases in the papers and reports included in a review are not explored, then a review might draw erroneous conclusions.

LP and GT independently looked for risk of bias in the included papers and reports. We primarily used the Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist. This checklist has been developed and piloted by review experts. It was selected as it is widely used, and many of the studies included in the review employed qualitative research methods. For studies employing mixed qualitative/ quantitative methods the Mixed Methods Appraisal Tool (MMAT: Hong, Pluye, Fàbregues, Bartlett, Boardman, Cargo, Dagenais, Gagnon, Griffiths, Nicolau, O'Cathain, Rousseau & Vedel, 2018) was used. For other designs, such as surveys, appraisal tools were sourced from the Centre for Evidence Based Management (2019), whose checklists are based on a synthesis of existing guidance.

Regardless of the tool used we concentrated on nine areas that could lead to a risk of bias:

1. Was there a clear research question and did the study have clear aims and objectives?
2. Was the study design appropriate?
3. Were the study methods appropriate?
4. How were participants sampled (chosen) and recruited?
5. What analysis was undertaken and how was this conducted?
6. Were the stated findings clearly evidenced?
7. Was the study conducted in an ethical way?
8. Was the learning from the study transferable to other contexts?
9. Did the researcher consider how they might have influenced the study and its findings (reflexivity)?

Sometimes the appraisal tool used did not cover all these areas and any items not covered were considered 'neutral' when deciding if there was risk of bias. So that we could consider the overall risk of bias in the literature included in the review we categorised each paper as illustrated in box 2.

Box 2: Risk of bias categorisations

Low risk of bias	No weak areas
Moderate risk of bias	No more than one weak area
High risk of bias	Two or more weak areas

Interrater agreement regarding risk of bias was 80% and disagreements were resolved through discussion.

Synthesis

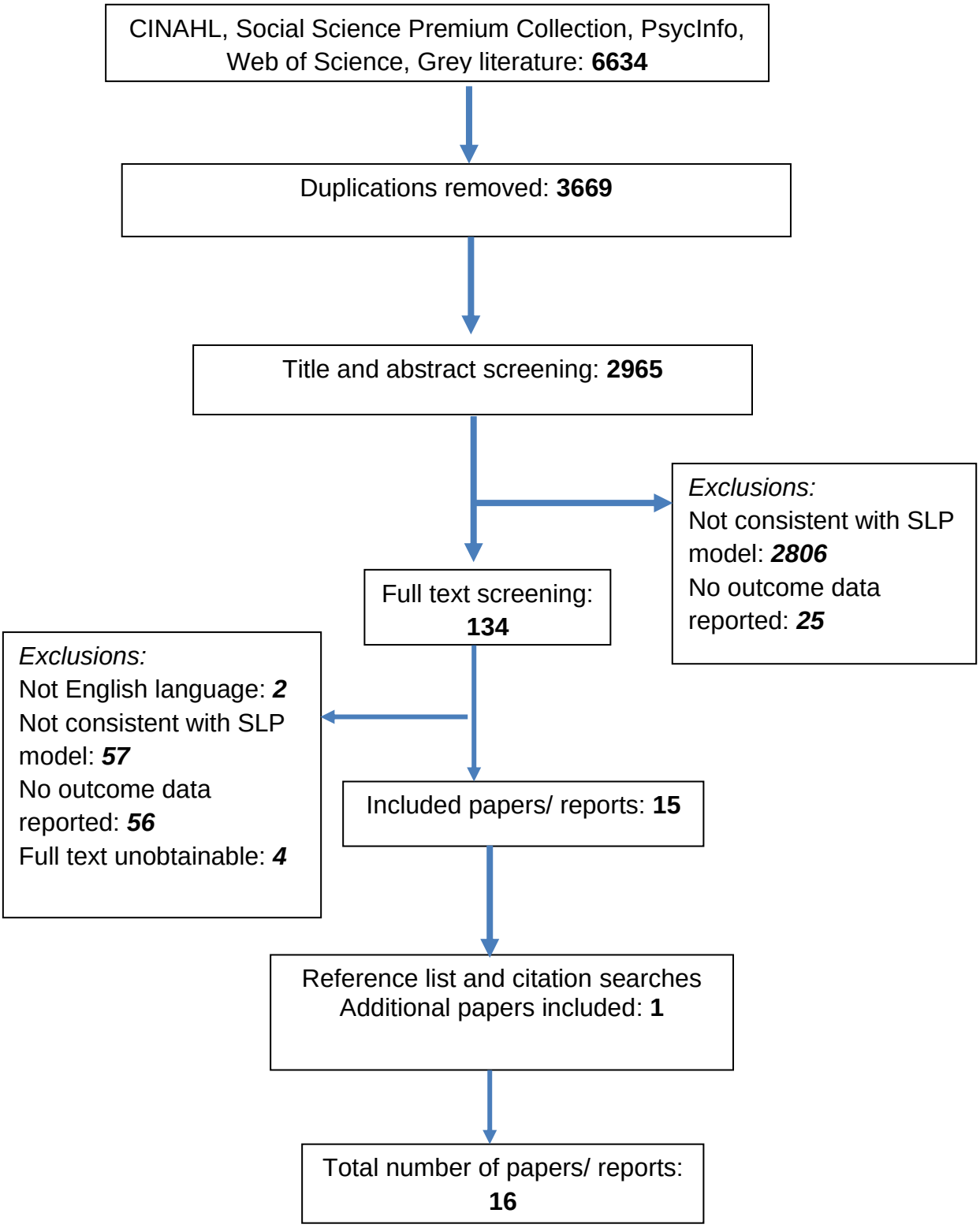
A narrative synthesis was undertaken. This is an appropriate form of analysis when the literature employs different study designs and investigates different outcomes. The findings were organised according to the logic model components of inputs, actions, outputs, outcomes (short, medium, and long-term), context and assumptions. Studies with a high risk of bias were not excluded, instead the strength of evidence for each logic model component was explored.

Findings

Overview of the included literature

Figure 1 shows the process of the rapid evidence review.

Figure 1: PRISMA flow chart illustrating the review process



Most of the 16 studies included employed interview or survey methods. Three studies used mixed qualitative/ quantitative methods (Harflett and Jennings, 2016; Mitchell-Smith, Caton & Potter, 2020; NDTI, 2019), but only two papers included standardised outcome measures (Braun and Rose, 1987; Callaghan et al., 2017). Standardised outcome measures can aid comparison across studies. Just over half of the papers (56%) had a high risk of bias, with only four papers categorised as having a low risk of bias (see Table 1). Reflexivity was seldom considered in qualitative papers and across all study designs, papers often did not describe the analysis undertaken in sufficient detail to fully understand and replicate the process undertaken.

Table 1: Summary of included papers

Paper/ Report	Country	Design	Model	Arrangement type	Primary need addressed	Whose perspectives are included (sample size*)	Who outcomes are reported for	Risk of bias categorisation
Mitchell-Smith et al. 2020	England	Mixed methods	SLP	Long term care	Care leavers	Care leavers (65), SL carers (11) Other professionals (13)	Care leavers	Low
SLP, 2019	Scotland	Interviews	SLP	Day services Short breaks	Dementia	Citizens LWD (6) SL carers (9) Carers (6) Other professionals (5)	Citizens LWD SL carers Carers	High
NDTI, 2019	England	Mixed methods	SLP	Intermediate care	Physical health needs	Citizens with physical health needs (3) SL carers (5) Other professionals (4)	Citizens with physical health needs SL carers Other professionals	Low
Callaghan et al., 2017	England	Survey	SLP	Long term care Day support	Old age	Older adults (150)	Older adults	Low

Paper/ Report	Country	Design	Model	Arrangement type	Primary need addressed	Whose perspectives are included (sample size*)	Who outcomes are reported for	Risk of bias categorisation
				Short breaks Outreach				
Brookes et al., 2016	England	Qualitative questionnaire	SLP	Long term care Outreach	Old age	Older adults (136)	Older adults	High
Harflett & Jennings, 2016	England	Mixed methods	SLP	Long term care Day support Short breaks	Mental health	Citizens with mental health needs (10) SL carers (14) Carers (7) Other professionals (11)	Citizens with mental health needs SL carers Carers Community	High
SLP, 2015	UK	Survey	SLP	All but most long-term care	Most learning disability	SL carers (200)	Citizens with learning disabilities SL carers Other professionals	High
SLP, 2014	England	Survey	SLP	Long term care Short breaks	All- not specified	SL carers (80)	Citizens attending SL arrangements	High

Paper/ Report	Country	Design	Model	Arrangement type	Primary need addressed	Whose perspectives are included (sample size*)	Who outcomes are reported for	Risk of bias categorisation
Bell & Litherland, 2013	England	Survey	SLP	Most attended short breaks Some attended Day support Long term care	Dementia	Citizens LWD (5) SL carers (29) Carers (14)	Citizens LWD SL carers Carers Other professionals	Moderate
Boldy et al., 2005	Australia	Survey	Host family respite	Day support	Dementia	Carers (31)	Citizens LWD Carers	Moderate
McConkey et al., 2005	Northern Ireland	Qualitative interviews	SLP	Long term care Day support	Learning disability	SL carers (35)	SL carers	Moderate
McConkey et al., 2004	Northern Ireland	Qualitative interviews	SLP	Day support Short breaks	Learning disability	Citizens with learning disabilities (20) SL carers (30) Carers (25)	Citizens with learning disabilities SL carers Carers	High
Dagnan & Drewett, 1992	England	Primarily qualitative interviews	Family placement	Primarily long-term care	Learning disability	Citizens with learning disabilities (6) SL Carers (20)	Citizens with learning disabilities	High

Paper/ Report	Country	Design	Model	Arrangement type	Primary need addressed	Whose perspectives are included (sample size*)	Who outcomes are reported for	Risk of bias categorisation
Dagnan, 1994	England	Qualitative interviews	SLP	Long term care	Learning disability	SL Carers (20)	SL Carers	High
Dagnan & Drewett, 1988	England	Qualitative interviews	Family placements	Primarily long-term care	Learning disability	Citizens with learning disabilities (8) SL Carers (10)	Citizens with learning disabilities SL Carers	High
Braun & Rose, 1987	America	Survey	Family care	Long term care	Old age	Carers (31)	Older adults	Low

Abbreviations: NDTI = National Development Team for Inclusion; Citizens LWD = Citizens Living with Dementia; SLP = Shared Lives Plus; UK = United Kingdom

Note: *Sample size provided for SL group in comparison studies.

The publication date range was 1987-2020, reflecting the long genesis of the SL support model. The literature covered all SL arrangements, although outreach arrangements were only included in two studies (Brookes, Palmer & Callaghan, 2016; Callaghan et al, 2017) and were not considered separately in any analysis. Three support models retrieved through the searches met eligibility criteria: SL (all UK based), one instance of Family Care (America: Braun & Rose, 1987) and one instance of Host Family Respite (Australia: Boldy, Davey & Crouchley, 2005).

Key support model features	**SL**	**Family Care (Braun & Rose, 1987)**	**Host Family Respite (Boldy et al., 2005)**
Citizens and paid carers are matched	Yes	Yes	Yes
Support provided in the paid carers home	Yes	Yes	Yes
Paid carers support a limited number of citizens	Yes	Yes	Yes
Citizens receive support from the same paid carer	Yes	Yes	Yes
Paid carers are selected, trained, and receive support	Yes	Not explicitly stated	Yes
Additional model features	-range of arrangements -range of needs supported -SL carers are self-employed	-Long-term care arrangement -Older adults needing support with activities of daily living supported -Employment model not stated	-Day support arrangement -Supporting people living with dementia -Implied that paid carers were employees

Across all the studies, the predominate support needs were old age, dementia and learning disabilities. The total sample sizes were:

- 428 citizens with support needs (age range (when reported) 16-90 years, both men and women participated but when stated nearly all were white British)
- 114 unpaid carers (when stated, reported to be parents, siblings, spouses, children, other relatives, and non-relatives who were not otherwise specified)
- 453 paid carers (predominately female, reported age range 26-69 years and most had considerable experience of providing support)
- 33 other professionals (when stated, reported to be workers in statutory services)

Narrative synthesis

The SL logic model drafted from the review findings is presented in Figure 3 and the synthesis below discusses the nature, extent, and strength of the supporting evidence.

Figure 3: SL logic model

Inputs	Activities	Outputs	short-term outcomes	Medium term outcomes	Longer-term outcomes
Scheme management Obtaining referrals SL carer recruitment	Support Training Matching Placement preparation	*Within each arrangement SL carers provide:* Stability and consistency (e.g., a long-term service) Relational care (e.g., care provided in a family environment) Person receives individual attention The care provided is flexible to changing needs Practical and emotional support is provided	*Citizens with support needs*		
			Connected Improved contact with own family Choice Meaningful activities Satisfaction Confidence Self-esteem	Enhanced independence Skills Progression in activities Mental health Quality of life and wellbeing Health outcomes	Prevention Reduced demand on statutory services Concern regarding loss of access to maintenance care
			Unpaid carers		
			A break Confidence in care New/ maintained connections Satisfaction	Reduced stress	More able to continue caring
			SL Carers		
			Learning Desired occupation Maintaining interests/ connections Companionship New activities Satisfaction Self-esteem Confidence Burden	Wellbeing Maintenance of proximal outcomes	Maintenance of proximal and medium-term outcomes
			Other professionals		
			Timely discharge from statutory services		
			Community		
				Reduced stigma Less service access barriers	Increased integration More equitable service access

Inputs and activities

Inputs are the investments made in a service. This includes managing a service, recruiting paid carers, and obtaining enough referrals for a scheme to be viable. Activities are what a scheme does with the investments to run the service. This includes supporting paid carers, providing training, setting up placements and organising a matching process. The literature highlighted that recruiting the right people to be paid carers, i.e., people with the necessary qualities and commitment to person centred support was important. Other important aspects included supporting paid carers, and providing a matching process are particularly important for good outcomes in the SL model.

Considerable comment was made about the characteristics that SL carers need. Other professionals, carers and citizens with support needs all suggested that SL carer qualities were an important factor contributing to outcomes. Noted qualities included kindness, a caring nature and genuineness (McConkey, McConagie, Roberts & King, 2004) as well as an ability to be 'on the ball' (NDTI, 2019).

There was comparatively little comment on financial inputs (investments) for citizens or SL carers. Some SL carers have reported financial insecurity and poor pay (NDTI, 2019), but others report receiving a good income (SLP, 2019). SL carers did comment on the impediments caused by the time needed for registering and training as a SL carer as they are not paid during this period (McConkey et al, 2004; McConkey, McConagie, Robets & King, 2005). SL carer income can be also affected by long waits for referrals (NDTI, 2019). In Bell and Litherland's (2013) study, which primarily examined day support and short break arrangements for citizens living with dementia, some unpaid carers (who were self-funding this support) thought that the cost of these arrangements was high. Unpaid carers of adults with learning disabilities expressed similar views about the costs of self-funding SL in McConkey et al, (2004).

Half of the included studies discussed the matching process. If an adequate match was not found, a clash of lifestyles or personalities could be challenging for SL carers. However, if the SL carer saw the citizen improve in their functioning over time this could help the SL carer cope with the initial mismatch (NDTI, 2019). The studies also indicated that the matching process could be challenging for schemes to undertake due to time pressures (e.g., Mitchell-Smith et al, (2020) or due to having a small pool of SL carers (NDTI, 2019). In addition to the matching process, pre-placement preparation, involving graduated meetings and visits, was identified as important in two studies (Mitchell-Smith et al, 2020; NDTI, 2019). These studies considered long term care and intermediate arrangements: similar preparation was not identified for short break and day support arrangements.

Outputs

Outputs describe the activities of paid carers. This is how the care and support are provided in the arrangement day to day. Relational care is a defining feature of the SL support model. Although Dagnan and Drewett (1988) found some emotionally distant relationships between SL carers and citizens with learning disabilities, other studies attested to the importance of relational care. The dated nature of the Dagnan and Drewett study and its high risk of bias suggests this discrepant finding should not be afforded high significance.

Seven studies reflected on the SL carer creating a family experience for the citizen. Important aspects of this family experience were the family environment (Mitchell-Smith et al, 2020), involvement in the life of the family (Harflett & Jennings, 2016) and the citizen feeling included and valued by the SL carer's family (NDTI, 2019). However, it could be challenging for SL carers to introduce citizens into their family (Dagnan, 1994). For instance, it could take effort to establish positive family relationships (Dagnan & Drewett, 1988) and some SL carers were wary about introducing citizens with certain support needs (e.g., mental health support needs) into their home (Harflett & Jennings, 2016). Overall, the literature suggests providing a family experience is important with evidence coming from citizens with all types of support need. However, it should be noted that the current literature has not examined the outcomes of outreach arrangements (where SL carers provide support in the citizen's own home) separately from other arrangements. Given the different set-up of this type of arrangement, it is possible that different mechanisms (outputs) are important.

Personalised care, where practical and emotional support are tailored to the wishes and needs of the citizen, is another defining feature of the SL support model. Personalised care was considered important in short break and day support as well as in long-term care arrangements (e.g., Harflett & Jennings, 2016). The importance of providing practical and emotional support was highlighted in one study with a low risk of bias (Mitchell-Smith et al, 2020) and one study with a moderate risk of bias (Bell & Litherland, 2013). However, this theme was also reflected in two papers with a higher risk of bias (Brookes et al, 2016; Harflett & Jennings, 2016). Personalised care was not always only just provided to the citizen with support needs. Bell and Litherland (2013) identified that when working with citizens living with dementia, providing support to their unpaid carers was also important. This included providing them with a break from their caring role and taking time to listen to unpaid carer concerns and sharing information about the individual with support needs.

In the SL model, support is provided by a consistent SL carer. The literature suggests that one important output of SL is the stability this affords. This was viewed as important for care leavers (Mitchell-Smith et al, 2020), citizens with mental health support needs (Harflett & Jennings, 2016) and citizens living with dementia (SLP, 2019). A consistent SL carer was also noted to be important regardless of the arrangement considered, with evidence drawn from long-term care, short break, and day support arrangements (Harflett & Jennings, 2016). It was also apparent that the responsiveness and flexible nature of the SL support model is additionally important as it enables SL carers to accommodate changing needs (Brookes et al, 2016; NDTI, 2019). However, most of the evidence regarding the importance of flexibility came from studies with a high risk of bias.

Outcomes

Outcomes are the positive or negative impacts that people experience after engaging with a support model. We decided to group outcomes into those experienced in the:

- Short term (i.e., more immediately)
- Medium term
- Longer term (i.e., after some time has elapsed)

This was informed by the observation in Mitchell-Smith et al, (2020) that some immediate outcomes need to be experienced before longer-term outcomes can be achieved. For instance, if citizens gain confidence and self-esteem through the SL support model, they are more likely over time to experience better mental health, wellbeing, and quality of life.

The literature identified outcomes for five recipient groups: citizens with support needs, unpaid carers, SL carers, other professionals, and the local community. However, most studies focused on citizens with support needs and SL carers.

Short-term outcomes
Seven main outcome areas were identified for citizens with support needs. 'Feeling connected' was the most reported outcome with 11 studies contributing evidence, including three of the papers with a low risk of bias (Braun & Rose, 1987; Mitchell-Smith et al, 2020; NDTI, 2019). Evidence also came from Host Family Respite (Boldy et al, 2005) and Family Care (Braun & Rose, 1987). Citizens could feel more connected in multiple ways. For instance, they could feel connected with the SL carer's family and community. They could develop new or maintain existing friendships. SL could also improve the connection between the citizen and their own family. For instance, family relationships could improve (Harflett & Jennings, 2016) or the family could benefit from the 'break' provided by the SL carer as the unpaid carer could step aside from their caring role and find 'relief' for a short period of time (McConkey et al, 2004; Mitchell-Smith et al, 2020).

There was substantial evidence that many citizens engaged in meaningful activities with the support of the SL model. Citizens could engage in a wide range of pursuits (McConkey et al, 2004) and feel stimulated (Bell & Litherland, 2013). The emphasis varied according to the needs being supported. For example, meaningful activities included doing new things for citizens with learning disabilities, but it incorporated maintaining or resuming interests for citizens with mental health support needs (Harflett & Jennings, 2016) and citizens living with dementia (SLP, 2019).

Generally, citizens reported high satisfaction with the SL model. For instance, Callaghan et al, (2017) found that 68% of older adults expressed satisfaction with their SL arrangement and Dagnan and Drewett (1988) found that all the citizens with learning disabilities they interviewed, who were in long-term care arrangements, said they preferred SL to their previous placements which operated other support models, such as residential hospitals and hostels.

For unpaid carers, having 'a break' was noted to be an important outcome, especially when their friend/ relative was accessing short break or day support arrangements (e.g., McConkey et al., 2004). This outcome was noted by unpaid carers supporting citizens living with dementia, learning disabilities and mental health support needs. It seemed to be important that unpaid carers had confidence in the care provided in the SL model and for some unpaid carers the good relationship they formed with the SL carer was a further positive outcome (e.g., Bell & Litherland, 2013). The paper on the Host Family Respite model reported high unpaid carer satisfaction (Boldy et al., 2005). However, only four studies provided evidence about

unpaid carer outcomes and the total sample of unpaid carers informing the SL logic model is therefore small (N:77).

SL carer outcomes were also often wellbeing related. Some SL carers talked of achieving a positive balance in lifestyle, work satisfaction and income (SLP, 2019). Others talked about the rewards of seeing citizens improve over time (Dagnan, 1994; Harflett & Jennings, 2016). Some SL carers described gaining companionship through their relationship with the citizen, although many of these SL carers worked in long-term care arrangements with citizens with learning disabilities. In the older studies, SL carers directly said their work fulfilled their own social needs for companionship (Dagnan & Drewett, 1988; Dagnan, 1994), but this was not a stated outcome in more recent papers.

The nature of their work in the SL model was an important outcome for many SL carers (e.g., NDTI, 2019). SL carers working in all arrangements reported high work satisfaction. SL carers found the work interesting (NDTI, 2019) and the SL model offered possibilities that were not available in other support models (Dagnan & Drewett, 1988). For instance, some SL carers liked being self-employed (SLP, 2019) and others enjoyed working in a model that promoted independence (NDTI, 2019). Interestingly, however, learning opportunities in the SL model seemed less important, as these were only mentioned as a positive outcome by SL carers in two studies (Bell & Litherland, 2013; Harflett & Jennings, 2016). SL carers also reported some negative outcomes. Evidence from one moderate risk of bias (McConkey et al, 2005) and two high risk of bias studies (Dagnan & Drewett, 1988; Dagnan, 1994) identified SL carer burden. However, it should be noted that all these SL carers supported citizens with learning disabilities and most provided long-term arrangements.

Other individuals less directly involved in the SL model do not seem to experience significant outcomes. However, four professional respondents working in other services said that with the help of the SL arrangement they were able to discharge the citizen with support needs in a timely way from other support services (NDTI, 2019).

Medium term outcomes

There was substantial evidence that citizens with support needs improved in their wellbeing. Callaghan et al, (2017) found that the SL model contributed to a statistically significant improvement in citizen quality of life compared to a variety of comparison social care services including home care, other forms of day support and residential care.

There were indications that citizens with learning disabilities gradually acquired new skills, although all the evidence for this outcome came from papers with a high risk of bias. Citizens with physical and mental health support needs and older adults could similarly improve in their self-care. For instance, on the Sunderland Enablement Tool, 13/16 citizens with physical health issues in intermediate/ reablement arrangements showed better self-care abilities (NDTI, 2019). Further, Braun and Rose (1987) found that unpaid carers were more likely to report their older relative/ friend had improved in their physical functioning after receiving family care than if they had received nursing care. However, on objective measures of physical

functioning, the two models of support did not differ. Additionally, an intermediate/ reablement arrangement for citizens with physical health problems reported improved health outcomes (NDTI, 2019). Outcomes related to improved functioning have not been reported for day support arrangements (with the exception that Harflett and Jennings, (2016) reported wellbeing outcomes based on combined data from long-term care, short break, and day support arrangements).

The literature contains scarce information about medium term outcomes for unpaid carers and SL carers. Evidence that unpaid carers can experience reduced stress and anxiety came exclusively from short break and day support arrangements for citizens living with dementia (SLP, 2019). Similarly, evidence of improved SL carer emotional wellbeing came exclusively from papers with a high risk of bias (e.g., Harflett & Jennings, 2016). However, we observed that SL carers had often worked in SL for several years, suggesting that SL carers maintain their work satisfaction over time.

Longer-term outcomes

When we looked across the studies, many citizens with support needs had only recently joined SL when outcome data was collected. For instance, some had been in an arrangement for only a month. Consequently, there was less evidence for longer-term outcomes and much of this evidence about longer-term outcomes for citizens was contributed by SL carers. From the perspective of SL carers, citizens with mental health, learning disability or physical health needs required less input from statutory health and care services over time (e.g., NDTI, 2019). Interestingly two papers (Harflett & Jennings, 2016; Mitchell-Smith et al, 2020) highlighted the paradox that some citizens improved in their functioning to such an extent that their future funding eligibility and access to continued support was jeopardised. Less evidence was reported for citizens with other support needs, but one report referenced delayed admission to residential care following short break and day support arrangements (SLP, 2019).

A small sample of unpaid carers of citizens living with dementia (N:20) suggested that short break, day support and in one instance long-term care arrangements enabled them to continue in their caring role (Bell & Litherland, 2013; SLP, 2019). Similar longer-term outcomes were not reported by unpaid carers supporting citizens with other support needs. Finally, two papers with high risk of bias (SLP, 2015; Harflett & Jennings, 2016) suggested that the wider community may gain from the SL model in terms of less mental health stigma and reduced inequalities in health service access.

Context

Contextual factors are the features in the environment that influence how the SL support model can operate. The influence of local statutory services appeared to be a contextual factor that could either support or hinder SL arrangements. When the SL model had traditionally not been employed to support citizens with a particular need (e.g., care leavers aged 16-22), professionals working in statutory services could be unsure about how the SL model aligned with their statutory requirements. This was often due to having less awareness and understanding of the SL support model (Bell & Litherland, 2013; NDTI, 2019). Awareness, understanding, and perceived alignment of aims/ values influenced referrals to SL schemes and could

influence the extent to which other professionals offered help to the SL carers. For instance, SL carers often said they received insufficient information about the citizen from statutory services and this could be a barrier to successful matching and the provision of outputs such as personalised care (e.g., McConkey et al., 2005).

One further contextual factor is worthy of note. One low (Mitchell-Smith et al., 2020) and one high risk of bias (Harflett & Jennings, 2016) study identified that citizens with support needs cannot always chose their model of support due to a limited choice of services within their vicinity. A lack of choice and control can diminish positive outcomes (Botti & McGill, 2006) regardless of the support model because people cannot access the support that they would most like.

Assumptions

Two assumptions could be discerned from the literature. First, the SL support model is not universally beneficial. Six of the 49 citizens living with dementia receiving short break or day support arrangements tracked by Bell and Litherland (2013) had unsuccessful placements. Although a lack of positive outcomes was uncommon in the studies, it was reported on occasion for all types of support needs. It was also reported at least once in all types of arrangement. At present, however, there are no comparative studies that can indicate whether the success ratio in the SL support model is different to other support models.

A second assumption is that the costs of providing the SL model compare favourably with other support models. This makes the SL support model viable to commission. The literature includes example costs of providing the SL support model for citizens with various support needs including leaving care (Mitchell-Smith et al., 2020), mental health support needs (Harflett & Jennings, 2016), physical health problems (NDTI, 2019) and dementia (SLP, 2019). Example costs have also been reported for nearly all types of arrangement. When the costs of providing the SL support model have been compared with residential care (Harflett & Jennings, 2016) and hospital care (NDTI, 2019) the costs of the SL support model have been lower.

Discussion

The evidence base for the SL support model

The evidence on which the SL logic model was developed must be considered weak. Just over half the included studies were assessed to have a high risk of bias. Most of the evidence presented came from qualitative studies and non-standardised surveys. Qualitative studies provide rich insight into how a support model works from different perspectives and the outcomes experienced. However, they cannot quantify how often the reported outcomes are achieved. Very few of the included studies used standardised outcomes measures that would enable comparison across different studies and models of support. Similarly, very few studies compared outcomes of the SL support model to outcomes from other support models. Another area of caution is that the logic model was developed from studies that did not tease apart the findings from different arrangements. Most studies combined evidence from several types of arrangement meaning any differences between arrangements may have been overlooked.

The SL logic model was also developed based on studies undertaken exclusively in economically developed Western nations. All studies evidencing the SL support

model took place in the UK, with international evidence only coming from support models which included the key components of SL. Within the included studies, few participants were from ethnic minority groups. This means it is unclear whether a different logic model for SL support might be developed if data were collected in other cultural contexts. It also means that citizens from other ethnicities might report different outcomes following support from SL. This is an area of future research.

The studies included in the review tended to give limited information about the participants contributing data. This means that we cannot be confident that all citizen groups experience similar outcomes from the SL support model. For instance, there is no evidence in the studies about whether citizens who identify as Lesbian Gay Bi-sexual, Transgender, Gender Diverse, Intersex, Queer or Asexual (LGBTIQA+) experience similar outcomes from the SL support model. This information would be useful because in some areas of need, e.g., old age, these citizens can report poor experiences with other support models, such as residential care (Hafford-Letchfield, Simpson, Willis & Almack, 2017). Additionally, it cannot be ascertained whether different types of unpaid carer (e.g., spousal, adult child) or unpaid carers of different genders experience different outcomes. Furthermore, one 'voice' so far unheard in the SL literature is that of the family members of SL carers. We do not know, therefore, whether these additional stakeholders experience outcomes (positive or negative) from the SL support model. However, we acknowledge there is one PhD study by Brown (2015) which reports on how SL carer family members experience the SL support model. PhD studies were not included in the review, so this study has not informed the SL logic model.

Given the literature limitations, what confidence can be put in the SL logic model developed?

As noted above, qualitative evidence is well placed to understand how a support model achieves impact. This means that we can be more confident in the inputs, activities and outputs detailed in the SL logic model. We can also have some confidence in the short-term outcomes for citizens and SL carers as these were evidenced from substantial data, some of which came from studies with a low risk of bias. This evidence came from all type of arrangement, plus the Host Family Respite and the Family Care model. Evidence also came from citizens with all types of support need. Additional confidence can be held in the suggestion that citizens experience some medium-term outcomes given Callaghan et al's (2017) comparative study reporting better wellbeing outcomes for citizens receiving the SL support model. Further, the inclusion of older literature and some international studies in the review provides some evidence that the SL support model (and support models containing all the key components of SL) can work across different policy and social contexts.

We can also draw some support for the SL logic model from the logic models developed for specific SL schemes. For instance, the logic model developed for a SL mental health scheme detailed similar inputs (recruitment of SL carers) and activities (support for SL carers). The outcomes detailed for citizens in this service included improved mental health and wellbeing (Harflett & Jennings, 2016).

Other support for the logic model can be derived from the wider literature. Many of the outputs detailed in the SL logic model correspond with what research identifies

as important regardless of the support model used. For instance, a review of respite services for citizens living with dementia and their unpaid carers concluded that person-centred, flexible, and responsive support providing meaningful activities was important (O'Shea, Timmons, O'Shea, Fox & Irving, 2017). Other researchers have also linked good outcomes to personalised support (Life Changes Trust, 2021; Miller, 2020; Whitmore, Caldwell, Peschin & Rosenberg, 2020). The output that is more distinctive for the SL support model, is that there was some evidence that the family environment in which support provided was important.

What does the SL logic model add to the literature?

Despite the limitations in the evidence on which it is based, the SL logic model developed through the rapid evidence review adds to the literature on the SL support model. It provides a summary of how the SL support model works and the outcomes report that can inform decision making by policy makers, commissioners, providers, paid carers seeking employment, unpaid carers, and citizens with support needs. Further, it contributes:

- A collation of all the evidence regarding the SL support model and similar support models
- An understanding of the current strength of the evidence for SL support model outcomes
- An understanding about how the inputs, activities and outputs in the SL support model can lead to positive outcomes
- Insight into evidence gaps and what future research is needed

Strengths and weaknesses of the rapid evidence review

The rapid evidence review retrieved literature reporting on outcomes (derived from qualitative, quantitative or mixed methods research) to ensure the logic model was evidence-based. However, this meant we excluded more discursive literature. This literature may have provided further insights concerning the inputs, activities, and outputs of the SL support model. For instance, such papers may have considered how SL schemes are delivered.

As stated in the method, a rapid evidence review is appropriate in emerging fields and when there is some existing work the review can build on. Our selection was also pragmatic: we needed to quickly review the literature to inform the remainder of the research project. Given these time restrictions we were unable to contact study authors to see if they could provide more information about the participants who had taken part in their study. If further information regarding samples had been obtained, we might have gained a better understanding of the range of people who have reported good outcomes from the SL support model.

Finally, it is challenging to consistently appraise risk of bias when including studies with different designs. We used appraisal tools that were appropriate for the studies included and employed a categorisation system that then allowed us to summarise the risk of bias across all the studies included in the review. However, if more time had been available, we could have created a more bespoke risk of bias tool, which we could have applied to all the included studies. This would have enabled more detailed intelligence regarding the relative strengths and limitations of different studies.

Implications of the SL logic model

The SL logic model contains information that is relevant to international social care policy and practice.

The SL logic model endorses the international policy focus on community-based social care support (Callaghan et al., 2017) as it explains how community-based support like that provided in the SL support model can achieve good outcomes. The logic model also details what the reported outcomes of this support can be. The logic model additionally suggests that many types of arrangement can be offered in 'the community' as evidence for the logic model was drawn from arrangements including day support, short breaks, intermediate/ reablement and long-term support.

In countries where the SL support model (or its close associates) are operating, scaling up the commissioning of these models could help realise the desired wellbeing outcomes detailed in national social care policy. As noted in the discussion, some confidence in the SL logic model can be drawn from the wider literature. This is because several of the activities and outputs identified in the logic model are not specific to a single support model. This implies that regardless of the exact support model, positive outcomes may result if policies promote relational support, person-centred support and holistic support that encompasses both practical and emotional support. Further research is needed to determine whether the output of 'support provided in a family environment' confers significant additional outcomes in the SL support model compared to support models that provide all the other outputs except this.

Paid carers derive work satisfaction from working in the SL support model. This is a support model that potentially could reduce staff turnover and promote interest in working within social care. This is important as recruitment and retention are recognised issues in social care in many countries (e.g., Holder, Kumpunen, Castle-Clarke & Lombardo, 2018). However, to maximise these benefits attention should be paid to how to commission arrangements so that SL carers can be paid to attend training and can be offered a financial safety net that enables them to stay 'in post' during lean referral periods.

The SL logic model can also inform provider practices. Routinely matching citizens and paid carers based on dispositions and mutual interests is rare outside of the SL support model. For instance, in residential care, key workers (who build a consistent relationship with a resident over time) are not always selected because they have similar interests to the resident. The rapid evidence review provides evidence that this form of matching is an important foundation for providing relational care and personalised support. It will be worthwhile for all providers to explore how they can meaningfully match citizens with paid carers regardless of the support model employed.

Conclusions

The development of the SL logic model was the first stage in a study exploring the added social value of SL day support arrangement. The logic model created summarises the evidence in the literature about how the SL support model works and what outcomes it creates. The rapid evidence review has contributed an

understanding about the strengths and limitations of the literature that can inform the SL logic model.

Some confidence can be placed in the SL logic model given its resonance with the wider literature and previously developed SL scheme specific logic models. Confidence can particularly be placed in the inputs, activities and outputs detailed for SL as these were drawn from relevant qualitative evidence. However, we need to be more circumspect about the outcomes of the SL support model due to the limitations of the literature on which these are based. Key evidence gaps have been identified for future research and future studies exploring the effectiveness of the SL support model need to use mixed methods, be comparative and to use standardised outcome measures alongside capturing narrative accounts.

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