


# Supporting people to live well: A multimethod study of Shared Lives (adult placement)

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## Abstract

**Background:** Shared Lives (adult placement) is a model of community-based support where an adult who needs support and/or accommodation moves into or regularly visits the home of an approved Shared Lives carer. It is an established but small-scale service used mainly by adults with learning disabilities. However, little research has been conducted about whether and in what ways this model can support people to live well.

**Method:** This article presents findings from outcome measures focused on well-being for a sample of 39 people supported by Shared Lives in England. Fifteen semistructured interviews were also conducted by peer/coresearchers to supplement the quantitative data. Data collection took place between June 2017 and September 2018.

**Findings:** Findings indicated that people using Shared Lives generally had good outcomes across all of the measures. All of those interviewed identified areas of their life where Shared Lives had made a positive difference, particularly with relationships and activities.

**Conclusions:** Limitations to the research mean that more work is needed to fully understand the role Shared Lives plays in supporting people to live well and in comparison to other forms of community support.

## KEYWORDS

adult placement, community support, learning disabilities, multi-methods, outcomes, well-being

## Accessible summary

- It is important that people with learning disabilities have choices and control over where they live.
- Shared Lives is a service that is mainly used by adults with learning disabilities, people are matched with a carer and they live with or visit them.
- Shared Lives appears to support people to have good lives or live well.
- Most of the people supported by Shared Lives in this research were comfortable and happy.
- Shared Lives should be included as one of the support options offered to adults with learning disabilities and their families.

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## 1 | INTRODUCTION

Across the world, various terminology is used to identify developmental disabilities, including learning disability, learning difficulty, intellectual disability/developmental disorder and developmental/cognitive delay. For the purposes of this article, we use the term 'adult with learning disabilities' as this is a term in common use in the United Kingdom. There are approximately 1.4 million adults with learning disabilities in the United Kingdom, over 900,000 in England, 50,000 in Wales, 30,000 in Northern Ireland (Public Health England, 2016) and 23,000 in Scotland (Scottish Commission on Learning Disability, 2017). People with learning disabilities can vary widely in the support they need, and some may never use learning disability support services. Local authorities are experiencing around 3% growth in demand from new service users who have learning disabilities or are within the autism spectrum and require help and assistance each year (Local Government Association, 2016).

There has been a commitment from the government and leading organisations across the health and care system to improve care and support for people with learning disabilities, for example, through the Transforming Care programme (Department of Health, 2012). There has been a focus on moving away from residential care toward commissioning supported living arrangements in the community (Local Government Association, ADASS & NHS England, 2015). It is important that adults with learning disabilities have more choice and control over where they live. However, there are still gaps in the evidence about the combination of services and support adults with a learning disability might require and their views on what works for them. Anecdotal evidence points to the potential benefits of supported living over residential care, but there is a recognised need for high-quality research evidence to guide the commissioning of different housing and support options to meet the needs of adults with learning disabilities.

The focus of this article is one particular form of supported living, Shared Lives (previously known as adult placement). Shared Lives schemes and carers provide three main kinds of support. There are live-in arrangements where a person who needs extra support lives with a Shared Lives carer and their family and receives care and support from them, as well as becoming part of each other's circle of friends, family and community. This is the most common form of Shared Lives support; in 2020/21, it was estimated that over 5717 arrangements were live-in (Shared Lives Plus, 2022). Shared Lives day support enables a person to receive support from their Shared Lives carer during the day, and the carer's home is used as a base for community activities. Lastly, short breaks where a person stays with a Shared Lives carer can range from one night to several weeks. People who live with a family carer may also access Shared Lives short breaks, as an alternative to traditional forms of respite. Adult or family placement-type services have been used for many years with different client groups and in most parts of the world, particularly Northern Europe and the United States, although terminology and definitions vary (Schofield, 2009).

The main group supported by Shared Lives are adults with learning disabilities, estimated in 2020/21 as 5817 people, accounting for 67% of the total number of people using Shared Lives (Shared Lives Plus, 2022). It is difficult to get accurate information about the actual

number of people supported by Shared Lives schemes as recording systems vary from locality to locality. From a sample of schemes responding to the annual State of the Sector survey conducted by Shared Lives Plus (Brookes et al., 2018), numbers per scheme ranged from seven to 506 with an average of approximately 89.

Shared Lives arrangements are provided by approved individuals or families who are self-employed (Shared Lives carers) working in partnership with a Shared Lives scheme. In 2021, there were approximately 122 schemes in England, a third operated by local authorities and the remainder in the independent sector (Shared Lives Plus, 2022). The Shared Lives scheme is responsible for recruiting carers and taking them through an assessment and approval process. Shared Lives carers are self-employed but work under the direction of the Shared Lives scheme. The scheme receives referrals for support from Shared Lives and works with the individual, their family and their case manager/social worker to find a Shared Lives carer who can provide them with tailored support and also the right lifestyle and opportunities. The Shared Lives scheme is responsible for supporting and monitoring each arrangement. Shared Lives arrangements are formed using a matching process. The process involves participants getting to know each other, before making any commitment. Shared Lives support may be commissioned by the local authority or National Health Service, funded using personal budgets, housing benefit (for the accommodation element) or people using their own funds. In the case of independently run schemes and most local authority schemes, the registered provider receives payment for the care provided and pays the Shared Lives carer. It is difficult to estimate the support needs of people in Shared Lives placements as the ability of a scheme to meet more complex needs is very much dependent on the skills of the Shared Lives carers available.

While it still forms a small part of social care provision Shared Lives consistently performs well in inspections by the Care Quality Commission (CQC), the UK's regulator of health and social care services. In 2020/21, 96% of schemes were rated as being either 'good' or 'outstanding' outperforming other community care services (Shared Lives Plus, 2022). Shared Lives has been compared favourably to other care and support options on some key indicators of personalisation, such as inclusion, flexibility, choice and control (NAAPS, 2010). There is some evidence of high levels of satisfaction among users (Fiedler, 2005; NAAPS & IESE, 2009) alongside cost-savings, particularly for people with learning disabilities (NAAPS & IESE, 2009; Social Finance, 2013). Research studies have suggested that people being supported value being treated as an individual, being part of a family and taking part in household tasks (Dagnan & Drewett, 1988; Robinson & Simons, 1996; Ware, 1987). As part of the Shared Lives Plus annual survey of schemes, 80 Shared Lives carers indicated that Shared Lives arrangements had helped people develop independent living skills and increased their social participation (Shared Lives Plus, 2014).

Similar models of support exist internationally and there is a large body of literature in the United States about adult foster care (that could be considered an equivalent to Shared Lives), but not specifically related to people with a learning disability. It is also known as adult placement or family care in Europe. In Canada, there have been studies of home-share where a person with a learning disability lives in an arrangement similar to

Shared Lives, and these have explored the views and experiences of people receiving support, home-share providers and family members (Hole et al., 2012). There has also been a comparison of outcomes between different forms of community support including the Canadian 'family model' from the perspective of support staff and family members. Stainton et al. (2011) found better outcomes for information and planning, access to and delivery of support, community connections, satisfaction and overall perception for this and group homes (the exception was choice and control). However, this is an area where there has been a limited amount of formal research and systematic evaluation, particularly of Shared Lives. This research aimed to answer whether Shared Lives was achieving its aim of supporting people to live well.

## 2 | METHODS

### 2.1 | Study design

Data collection took place between June 2017 and September 2018 in the context of austerity but before the coronavirus disease 2019 (COVID-19) pandemic. To identify the support needs met by Shared Lives, we used both quantitative and qualitative approaches, a series of outcome measures and semistructured interviews (a third strand focused on the experiences of Shared Lives carers). The study had ethical approval from the Social Care Research Ethics Committee, support from the Association of Directors of Adult Social Services and research governance approval from participating councils. It benefited from the guidance of an advisory group involving practitioners, Shared Lives users and carers, family carers and academics.

### 2.2 | Outcome/well-being measures

Six Shared Lives schemes across England recruited participants and collected data on our behalf. Staff from each scheme were asked to

invite people accessing their services to complete a small number of outcome measures. This was done through a face-to-face, structured interview with scheme staff during a routine visit. This format was chosen rather than a self-completion questionnaire, as it allowed staff the opportunity to clarify questions and adapt wording where necessary. There were show cards for questions about choice, community, emotional health, occupation, family life, physical health and social life. Full guidance for staff carrying out the interviews was incorporated into the interview schedule.

Information was collected including, age, gender, support needs and information about the placement/arrangement. A number of measures were used to assess the well-being/quality of life of people being supported by Shared Lives. These measures described below were My Shared Life; ICEpop CAPability measure for Adults (ICECAP-A); Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS); overall quality of life; and physical health.

#### 2.2.1 | My Shared Life

This outcome measurement tool was developed by the authors for Shared Lives Plus in 2015 through a review of existing outcome tools and frameworks, and the literature on measurement (Callaghan et al., 2015). Consultation also took place with Shared Lives schemes, carers and people being supported. It includes six areas of well-being including some questions from the Adult Social Care Outcomes Toolkit (ASCOT) (Smith et al., 2018) about occupation and participation and control over daily life. This measure does not provide an overall score but instead looks individually at the different aspects of how a placement impacts a person's well-being. Questions cover family and personal relationships, involvement in the local community and physical and emotional well-being. The remaining questions are based on a similar format to ASCOT, where there are four 'outcome states' each reflecting how well a person's needs are being met in that area (see Box 1). The top two responses reflect a person having no unmet

#### BOX 1 Outcome states for the My Shared Life Measure

Outcome state	Definition	Example question in My Shared Life
Ideal	The individual's wishes and preferences in this aspect of their life are (or would be) fully met	I see the people I like as much as I want, it is great
No needs	The individual has (or would have) no or the type of temporary trivial needs that would be expected in this area of life of someone with no impairments.	I see the people I like sometimes, it is ok
Some needs	Some needs are distinguished from no needs by being sufficiently important or frequent to affect an individual's quality of life.	I see the people I like but not enough, it could be better
High-level needs	High-level needs are distinguished from some needs by having mental or physical health implications if they are not met over a period of time. This may be because of severity or frequency.	I do not see the people I like at all and feel lonely

Adapted from the Adult Social Care Outcomes Toolkit guidance (Smith et al., 2018)

needs in that area, with the top answer indicating that their situation is ideal, that is, I see the people I like as much as I want, and it is great. The final two responses indicate that there are unmet needs in this area of the person's life, that is, I see the people I like but not enough, it could be better, and I do not see the people I like at all and feel lonely.

### 2.2.2 | ICECAP-A

This tool is linked to Amartya Sen's capability approach which defines well-being in terms of an individual's ability to 'do' and 'be' the things that are important in life. It was developed by the University of Birmingham for use with the general adult population and a set of UK index values has been estimated using a best to worst scale. Studies of the validity of the ICECAP-A have been conducted with the general population and patient groups (Al-Janabi et al., 2012). The responses to this measure can be calculated to create a score between one and zero, where a higher score indicates a better state of well-being.

### 2.2.3 | SWEMWBS

This scale aims to monitor the mental well-being of the general population. It was developed by the University of Warwick, working with the University of Edinburgh and NHS Health Scotland. This is a seven-item version of the 14-item scale, and has been validated in the UK and Italy (Tennant et al., 2007). Scores range from seven to 35 and higher scores indicate higher positive mental well-being.

Two single-item measures were also included, one about overall quality of life and the other about physical health.

## 2.3 | Qualitative interviews

Managers and staff from the six Shared Lives schemes distributed information to households. All potential participants received an invitation letter and information about the study (including in an easy-to-read format). Individuals or households contacted the research team directly if they wished to participate (we do not know how many households were contacted in total). Interviews were arranged at a time and location that was convenient to respondents.

Interviews were semistructured and covered: what the Shared Lives carer helped with; what life was like before Shared Lives; how life had changed; independence and control; friends and relationships; and good and not so good things about Shared Lives. Questions were a mix of closed and open-ended (see Box 2). The peer or coresearchers requested these be written out as a script with easy-read prompts. At the end of the interviews, participants were given a £10 high street voucher to thank them for participation. Interviews lasted between 20 and 45 min.

Three people with lived experience of Shared Lives conducted the interviews. Peer (their preferred term) or coresearcher was a paid

### BOX 2 Interview questions for people who live with their Shared Lives carer

- 1) How long have you lived with your Shared Lives carer?
- 2) How many Shared Lives carers have you had?
- 3) What does your Shared Lives carer help you with?
- 4) What was your life like before you were with your Shared Lives carer? (prompt) Who did you live with? (prompt) What services or other support did you use?
- 5) How has your life changed since you have been supported by your Shared Lives carer?
- 6) Is there anything about your life now you would like to change?
- 7) Do you feel you can do the things you want to do?
- 8) If you wanted to have friends around, would that be OK?
- 9) Do you have a boyfriend or girlfriend? (prompt) If you wanted them to stay at the house with you would that be OK?
- 10) If you decided to move out, would you know how to arrange this?
- 11) Do you and your Shared Lives carer get on well together?
- 12) Who is the person you talk to most about things that are important to you?
- 13) Who would you talk to if you were worried about something?
- 14) Please could you tell me what the best things are about living with your Shared Lives carer?
- 15) Please could you tell me anything that is not so good about living with your Shared Lives carer?
- 16) What score out of 10 would you give the support you get from your Shared Lives carer?
- 17) Is there anything else you would like to tell us?

role and there were a series of sessions in preparation for this covering what makes a good interviewer and interviewing techniques. The sessions included role-play and easy-to-read materials were provided in a folder. Support for the peer or coresearchers to conduct the interviews was tailored to their needs and preferences.

## 2.4 | Analysis

Scores to individual questions and responses from the outcome measures were analysed using IBM SPSS Statistics. Overall scores were calculated and descriptive statistics were produced.

The recordings from the semistructured interviews were summarised in a format that agreed with the coresearchers to enable

them to feed into the analysis. Thematic network analysis (Attride-Stirling, 2001) was used to analyse the data; this involves six steps: coding the material; identifying themes; constructing thematic networks; describe and explore thematic networks; summarise thematic networks; and interpret patterns. Peer researchers were involved in the first two stages, coding and identifying basic themes.

### 3 | FINDINGS

#### 3.1 | Outcome measures

Data were collected for 39 people supported by Shared Lives, across six schemes. All respondents had a learning disability or autism, a small number also had mental health issues (two) or physical disabilities (1). People had mild to moderate learning disabilities and the capacity to consent to take part was required. The majority of respondents were female (62%). Ages in the sample ranged from 17 to 87 years old (with an average of 37 years old), and the majority were single never married (77%) and White British (95%). Most participants reported that their main type of Share Lives arrangement was a long-term or residential arrangement (46%), with a smaller number using Shared Lives for short breaks or respite (31%). One person indicated 'other' as their main type of Shared Lives arrangement, noting that they were currently using an interim placement. However, they also used short breaks as well as Shared Lives for rehabilitation. One-fifth of the sample (20%) did not report their type of Shared Lives arrangement. Eight of the respondents answered the questions alone, nine had a Shared Lives carer present and 18 had someone else present (information was missing for four participants). Nine of the 39 respondents completed the measures themselves the remainder received some support or prompting from a Shared Lives practitioner or carer.

#### 3.2 | My Shared Life

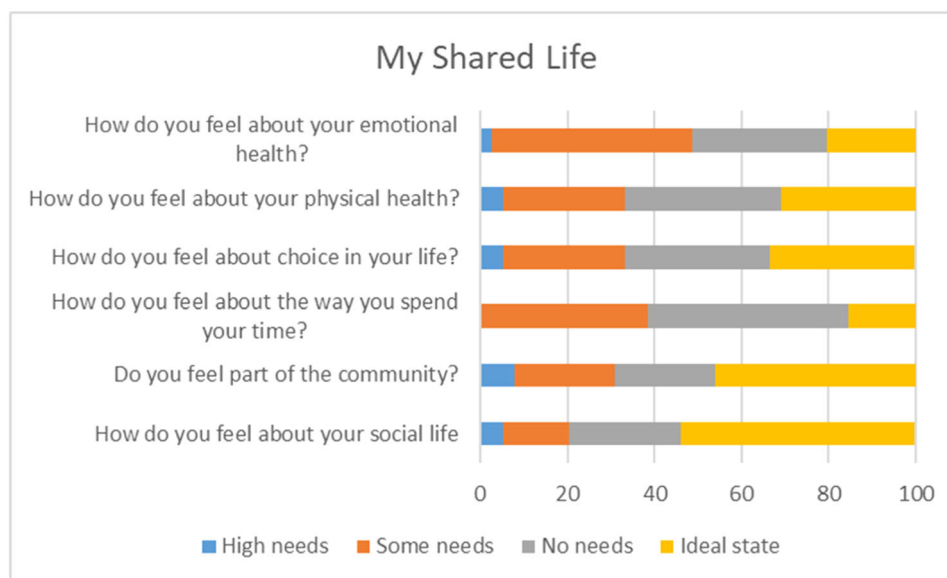
As seen in Figure 1, the results of the My Shared Life measure indicated that outcomes for participants were best in terms of social and community life, with a high proportion reporting that these areas of their lives were ideal. The majority of respondents felt that they saw the people that they liked as much as they wanted (ideal state, 54%), with a further 26% feeling OK about the amount they get to see people (no unmet needs). A similar pattern can be found in the responses to whether participants felt part of the community, although a higher proportion of the sample did not feel they were involved enough (23%). The area with the highest proportion of high or some unmet needs was emotional health, where nearly half of respondents (49%) said that they sometimes or often feel down.

None of the participants felt that they did not do any of the things they liked with their time, although 38% felt they would like to do more. A small number of participants took part in training (5%), education (18%), paid work (13%) or volunteering (15%); however, the majority reported not being involved in any of these (56%).

#### 3.3 | ICECAP-A

The mean score for the ICECAP-A of the total sample was 0.807 (SD = 0.139), where scores ranged from 0.43 to 1.00. This suggests that the majority of respondents reported a high level of well-being in the areas of stability (feeling settled and secure), attachment (love, friendship and support), autonomy (being independent), achievement (and progress) and enjoyment (and pleasure).

Only one person reported no capability for one of the items, which was stability, indicating that they were unable to feel settled and secure in any area of their life. This person was in a long-term placement. Table 1 below shows the number of people who responded positively and negatively to each attribute.



**FIGURE 1** Stacked bar chart to show responses to My Shared Life items. [Color figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com)]

**TABLE 1** ICECAP-A responses.

Attribute	%	
Feeling settled and secure	<i>n</i> = 39	
I am able to feel settled and secure in all areas of my life	11	28
I am able to feel settled and secure in many areas of my life	21	54
I am able to feel settled and secure in a few areas of my life	6	15
I am unable to feel settled and secure in any areas of my life	1	3
Love, friendship and support	<i>n</i> = 39	
I can have a lot of love friendship and support	21	54
I can have quite a lot of love friendship and support	15	38
I can have a little love friendship and support	3	8
I cannot have any love friendship and support	-	-
Being independent	<i>n</i> = 39	
I am able to be completely independent	6	15
I am able to be independent in many things	17	44
I am able to be independent in a few things	16	41
I am unable to be at all independent	-	-
Achievement and progress	<i>n</i> = 38	
I can achieve and progress in all aspects of my life	11	29
I can achieve and progress in many aspects of my life	14	37
I can achieve and progress in a few aspects of my life	13	34
I cannot achieve and progress in any aspects of my life	-	-
Enjoyment and pleasure	<i>n</i> = 39	
I can have a lot of enjoyment and pleasure	20	51
I can have quite a lot of enjoyment and pleasure	12	31
I can have a little enjoyment and pleasure	7	18
I cannot have any enjoyment and pleasure	-	-

Abbreviation: ICECAP-A, ICEpop CAPability measure for Adults.

### 3.4 | SWEMBS

Scores on the SWEMBS were similarly high, with a mean of 24.52 (SD = 4.89) out of a possible score of 35. This is slightly higher than the mean score of the general population in England in 2016 (reference) ( $M = 23.5$ ,  $SD = X$ ). Scores on this measure ranged from 16.36 to 35.00. Table 2 illustrates responses to the SWEMBS.

**TABLE 2** Responses to the SWEMBS.

Items	%	
Feeling optimistic	<i>n</i> = 38	
None of the time	2	5
Rarely	4	11
Some of the time	14	37
Often	10	26
All of the time	8	21
Feeling useful	<i>n</i> = 37	
None of the time	-	-
Rarely	3	8
Some of the time	14	38
Often	11	30
All of the time	9	24
Feeling relaxed	<i>n</i> = 37	
None of the time	-	-
Rarely	5	14
Some of the time	7	19
Often	10	27
All of the time	15	41
Dealing with problems well	<i>n</i> = 38	
None of the time	1	3
Rarely	3	8
Some of the time	13	34
Often	13	34
All of the time	8	21
Been thinking clearly	<i>n</i> = 37	
None of the time	2	5
Rarely	3	8
Some of the time	12	32
Often	12	32
All of the time	8	22
Feeling close to others	<i>n</i> = 38	
None of the time	1	3
Rarely	2	5
Some of the time	6	16
Often	11	29
All of the time	18	47
Able to make up own mind	<i>n</i> = 38	
None of the time	1	3
Rarely	4	11
Some of the time	8	21

**TABLE 2** (Continued)

Items		%
Often	11	29
All of the time	14	37

Abbreviation: SWEMBS, Short Warwick Edinburgh Mental Wellbeing Scale.

### 3.5 | Single-item questions—quality of life and physical health

The majority of respondents rated their overall quality of life as so good it could not be better, very good or good (29 of 38 respondents, 76%). Two people indicated their quality of life was poor or very poor. To the question 'how would you rate your health in the past 4 weeks?', the majority rated it as excellent, very good or good (28 of 37 respondents, %). Two people indicated that their health was very poor.

### 3.6 | Semistructured interviews

Interviews were conducted with 15 people being supported by Shared Lives in three local authority areas. All interviewees had mild to moderate learning disabilities and the capacity to consent to take part was required. The majority were interviewed with someone else present but assistance with answering questions was only required in two cases.

Thirteen of the 15 participants were in long-term/residential placements. Interviewees had been supported by Shared Lives between 3 and 20 years, with the majority at least 5 years. Ten of the 15 interviewees had only one Shared Lives carer, the remainder had moved area once or twice and so their Shared Lives carer had changed.

All experiences could be placed in one or more aspects of the network in Figure 2. With regard to antecedents, interviewees gave similar responses and described their situation before Shared Lives as being 'not very good'. Participants referred to difficult situations such as experiencing family breakdowns. Interviewees described being in situations where they did not really speak or communicate with anyone and for two interviewees there were issues with emotional and mental well-being that had resulted in self-harm.

Never used to go out. Now can catch a bus to work.  
[female, lived with Shared Lives carer for 7 years]

Didn't speak a lot before, spent lots of time in the bedroom and self-harm. [female, lived with Shared Lives care for 4 years]

Interviewees also described difficulties with managing money and other areas of daily life. The interviewee's experience of Shared Lives included carers helping with a range of daily activities such as shopping, dressing, cooking and making drinks. The main areas of support mentioned were relationships (such as helping with family issues), money

and budgeting, doctor appointments and medication, and attending activities such as swimming. Interviewees described the best things about Shared Lives as being part of a family and socialising.

The majority of interviewees said they got on well with their Shared Lives carer and would choose to speak to them if they needed to talk to someone or were worried about something. Two interviewees mentioned that occasionally there were arguments but felt that was just the usual situation for people living together.

Help you and discuss things together ... being part of a family. [female, 4 years]

Finally, the consequences of Shared Lives. All interviewees described their current situation as much improved and that Shared Lives had changed their lives. They felt they had a good life and there was very little that they would change about it.

It changed my life. Going to the gym, horse riding, woodwork, volunteering. [female, lived with Shared Lives carer for 3 years]

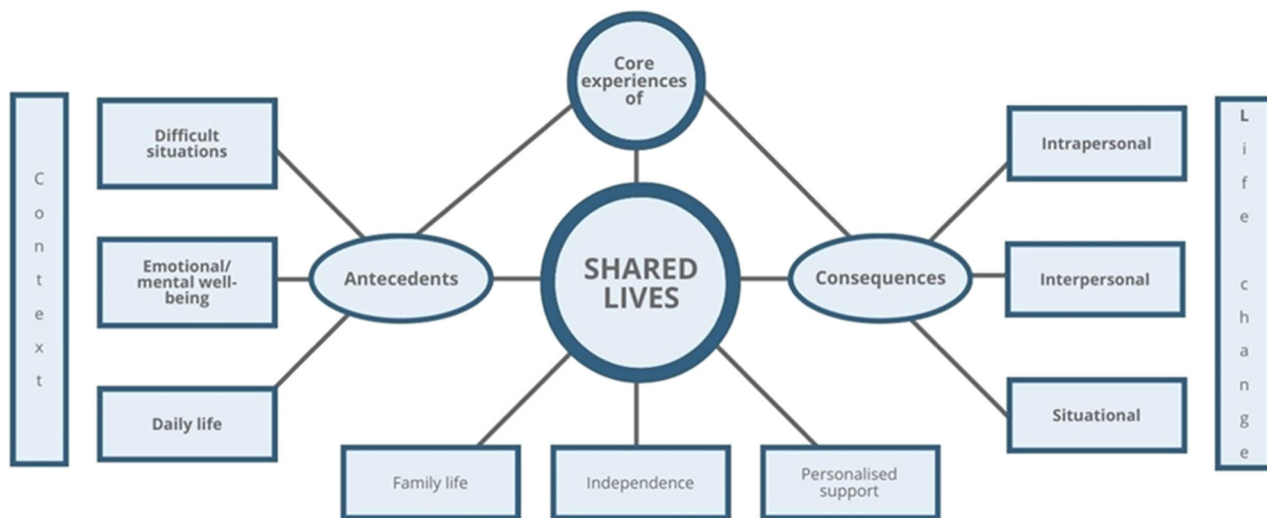
Interviewees highlighted the fact that Shared Lives support meant they were able to go out and do activities such as playing snooker, going to the cinema and out for meals. Four interviewees stated that Shared Lives support had been key to them volunteering, going to college and in one case gaining paid employment.

Carers are the best, like mum and dad. Changed my life .... was treated badly when young and carers have changed a lot for me. Been to college. Pleased with what they've done for me ... work at a care home. [female, 7 years living with Shared Lives carer]

### 3.7 | Discussion

The results indicate that people using Shared Lives generally had good outcomes across all of the measures. My Shared Life further supported this, with participants rating their social and community experiences, and key facets of Shared Lives, the most positively. This is perhaps not surprising when the premise of Shared Lives is that people become a part of the Shared Lives carer's family.

The item regarding emotional health had the highest number of respondents rating themselves as having high or some unmet needs, which does not support findings reported by Shared Lives Plus that 85% found their emotional health had improved through Shared Lives. This possibly could be attributed to the fact that Shared Lives carers can probably make a greater difference in mental well-being through practical assistance, for example, making sure finances are up to date, advice on relationships, organising a part-time job, which all contribute to mental health. However, this does not necessarily mean that emotional health will be supported by those activities.



**FIGURE 2** Core experiences of Shared Lives: thematic network. [Color figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

Over half were not engaged in training, volunteering or paid work which perhaps reflects the fact that this is a low percentage generally. In 2021, for example, people with a learning disability in paid work were estimated at 5.1% for England and volunteering at 6% (NHS Digital, 2021).

The scores from the ICECAP-A were positive overall. The majority reported feeling settled, safe and secure and having love friendship and support. The items measured by the ICECAP-A (attachment, security, achievement, enjoyment and independence) can be mapped across to the aims of Shared Lives of family life, setting personal goals, and enabling independence (NAAPS, 2010). SWEMWBS scores in the sample were slightly higher than those of the general population, suggesting that they had better levels of mental well-being (the low number of respondents meant however that meaningful statistical comparisons between the two populations could not be made). This is not consistent with previous research that indicated that people with learning disabilities have poor mental health and well-being. Some studies suggest the rate of mental health problems in people with learning disabilities is double that of the general population (Cooper et al., 2007; Emerson & Hatton, 2007; National Institute for Health and Care Excellence NICE, 2016). This could suggest that Shared Lives has a positive impact on this area of life. All of those interviewed identified areas of their life where Shared Lives had made a positive difference, particularly with relationships and activities.

There are limitations to this study. The original plan for the research was to gather data on a large number of referrals and create a comparison group so that we could look at changes in outcomes over time (and then combine this with cost information for economic evaluation). We had asked schemes to estimate their referral numbers for the previous year but a subsequent national slowdown in referrals meant numbers were significantly lower than predicted. In combination with this, four of the 11 schemes that agreed to participate dropped out of the research due to workload and other issues, most significantly a scheme that covered four local authority areas and claimed large numbers of referrals. Therefore, we could not compare the outcomes of people using other types of services to Shared Lives.

The research had a smaller than anticipated number of participants for both quantitative and qualitative aspects. Perhaps if researchers had been deployed in the local areas this would have meant less reliance on an already busy staff group to identify participants and take them through the raft of measures, larger numbers may have been recruited. Training and supporting the peer or coresearchers required a significant investment of time but this was outweighed by the benefits of their insights and the relationships forged.

The people who participated in the interviews were a self-selected group who may have been more positive about their well-being than those who did not take part. People with a learning disability are a diverse group and those with profound and multiple learning disabilities were not included in this research. The suitability of this kind of support for this group still requires further investigation.

A synthesis of the literature about adult placement (Fiedler, 2005) highlighted that very few studies had been conducted on service users' experiences of and satisfaction with the service. This situation has not significantly changed since then, there are some examples of research where this element is included but these have tended to involve a small number of participants. For example, NAAPS & IESE (2009) conducted focus groups including 23 service users, and Bell and Litherland (2013) also included a small number of service users and carers (five and 14, respectively) in a project exploring the use of Shared Lives for people living with dementia and their family carers. This research has attempted to elevate the voice and experiences of people supported through Shared Lives and make a first step in identifying where the benefits of the service might lie.

## 4 | CONCLUSIONS

The research illustrates that Shared Lives is clearly valued and has generated some, if limited, evidence to suggest it is supporting people to live well. Shared Lives as a model has shown resilience and flexibility at a time when the social care system is under pressure from



the effects of austerity and the Covid-19 pandemic, with increasing numbers until 2020/21. This research provides a starting point in exploring the benefits of Shared Lives for adults with learning disabilities, but further work is needed with larger samples to be able to make meaningful comparisons to those receiving other types of services and for economic evaluation.

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## CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

## DATA AVAILABILITY STATEMENT

Data that support the findings of this study are available from the corresponding author upon reasonable request.

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