HOUSING FOR LONDONERS WITH MENTAL HEALTH NEEDS
A review of recent developments

Kathleen Boyle and Chris Jenkins
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Executive summary

This working paper forms part of the King’s Fund Inquiry into mental health. It seeks to:

• analyse the supply of housing for people with mental health needs in London
• compare the current situation with that of five years ago
• comment on whether the supply is currently meeting needs
• identify priorities for future development of services.

Findings

The volume of specialist housing provided by housing associations for Londoners with mental health needs has remained static in the past five years. Since the working age population has grown by 6 per cent over the same period, the supply of supported housing has declined per capita.

No comparable information is available on how the supply of non-housing association provision has changed in the past five years.

Much of the specialist housing was funded via capital programmes relating to the closure of large mental health hospitals, such as Friern Barnet and Claybury. The majority of this provision is in small group homes. Although immensely successful in enabling individuals to live in the community, new residents now regard the quality and style of this provision as poor and unattractive.

There has been some refocusing of the housing supply. There are 10 per cent more housing association-owned mental health schemes today than there were five years ago, but they are on average smaller than the earlier ones, so the number of units of housing has increased by only 0.1 per cent. The focus has changed to provide more self-contained housing, but progress has been slow, with the proportion of shared housing falling from 64.6 to 60.8 per cent.

Limited numbers of new models of housing provision have been developed. These include:

• successful schemes to provide alternatives to hospital admission
• women-only housing
• specific schemes for people from black and minority ethnic groups.

Distribution of supply is largely concentrated within the inner London boroughs, reflecting the scale of local need in the inner city areas. A number of outer boroughs have an under-supply of community-based provision, particularly if they were not part of a former hospital closure/re-provision programme.

For people with mental health needs, there is therefore an element of the ‘postcode lottery’ as to whether appropriate provision exists locally. Overall, the supply of specialist housing is inadequate, the range of housing options is poor and the quality of the housing available is variable (including much poor-quality provision). Despite the changes to homelessness legislation, access to mainstream housing, whether private or social sector, is shrinking rather than increasing. For people with mental health
problems, there is a further risk that some progressive housing-policy initiatives, such as Choice Based Lettings, will make access to secure, social housing more difficult, rather than less so.

The number of places available for letting within specialist housing has fallen sharply (by 26 per cent in five years) as the average length of occupancy has risen. This results from two factors:

- The needs of those occupying the specialist housing have increased.
- Move-on accommodation (permanent, ordinary housing) has become more difficult to access as a consequence of the decline in social housing in the capital by some 50,000 houses, and the high cost of owner occupation or private renting.

Existing supported and generalist provision is housing people with more complex needs than five years ago. Tenants are more likely to have a dual diagnosis. There is no evidence that funding, staffing, or training have kept pace with this increase in the complexity of need. There appears to be little recognition in strategic documents of how the client group has changed, or whether the existing housing and support models remain appropriate.

Although the complexity of need has increased generally, providers of supported housing are reluctant to accept the most complex and difficult clients. This means that for those suffering severe and enduring mental illness, particularly those with dual diagnosis, finding housing with support remains difficult.

The Government’s ‘Supporting People’ policy initiative will fundamentally affect the future of housing for people with mental health problems, and the sector stands currently in a state of great uncertainty. The new policy will greatly improve the co-ordination of planning, funding, and monitoring of the sector. It will also bring risks to providers (since funding will be less secure) and to commissioners (especially where services are not within their own geographical boundary). Its success will depend on whether it is adequately funded.

Current housing and support priorities within health and housing agencies are focused in two areas:

- services for people with complex needs, including dual diagnosis
- services that offer support to people in their own homes (usually known as ‘floating support’ services).

The use of the term ‘supported housing’ is rapidly becoming unsuitable as a generic term to describe such a wide range of provision. As increasing numbers of clients receive floating support, it is inaccurate to call this ‘supported housing’. It may be more appropriate in future to refer to ‘housing support services’, some of which may be located in supported housing.

The Supporting People funding changes have prompted an (undocumented) rush in establishing new floating support services for many client groups. These offer tremendous potential, and will significantly add to the desired continuum of care as clients re-integrate within their communities and receive tailored support services to match the care from community mental health teams, assertive outreach teams and crisis intervention teams. As yet, there are only a few examples of housing support being integrated into any of these team models, but this would seem an obvious next step for local services.
Strategically, whole systems working between health and social services continue to develop. However, in many boroughs, housing – both at provider and enabling levels – remains largely outside the loop of mental health care in terms of service planning and strategy. Despite references in the National Service Framework and various government papers on mental health services, housing receives scant coverage by the Department of Health. In the development of Supporting People, health agencies were conspicuous by their absence from the Government’s early descriptions of local partnerships.

**Recommendations**

This working paper identifies a number of action points. These are encapsulated in the following nine recommendations, addressed to Central Government, London’s local government (including the Association of Local Government) the NHS, and private and not-for-profit providers of housing and support. The recommendations fall under the two headings of service development and systems development.

**Service development**

- To agree the priorities to be addressed by providers in offering specialist accommodation and appropriate support, and to ensure that funding from Supporting People, health and social services is co-ordinated, and is sufficient to meet the identified needs of high-care clients with complex needs and dual diagnosis.

- To analyse the current specialist stock and identify the scale of remodelling and new building required, to consider how limited social capital funding can best be used, and to supplement this through Public-Private Partnership (PPP) and Private Finance Initiative (PFI) funding.

- To assess the full economic and social cost of unnecessary acute and secure provision and identify the potential savings from housing-based alternatives. Savings achieved through reducing the need for secure and acute beds should be reinvested in new community-based services.

- To work with black and minority ethnic communities and agencies to develop models of good practice in meeting the needs of black and minority ethnic groups in many London boroughs.

- To improve support and funding to address the causes and consequences of homelessness in the capital, both as a symptom and a contributory cause of mental illness In particular, to support those agencies working with single homeless people, often with drug abuse and mental health needs, who are outside the health system.
Systems development

• To produce a single database of mental health provision, incorporating the new Supporting People database, registered care, and other health and social services provision, and to use this to develop mental health and housing strategies to feed into future Supporting People planning.

• To agree how service planning across the capital will operate under Supporting People, and in particular to urge the eight boroughs judged ‘excellent’ under the Audit Commission’s new Comprehensive Performance Assessment to continue to work in partnership with others.

• To develop strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models.

• To improve working with local authority housing departments, particularly in estate management and allocations and homelessness, both to improve access to normal housing and to help provide better services, in order to prevent unnecessary homelessness through tenancy failures.
Introduction

This study was commissioned by the King’s Fund as part of its Mental Health Inquiry. Its 1997 study of London’s mental health considered briefly the role of housing within care and support services for people with mental health problems. This study recognises that housing is central to mental health services.

The brief

The authors were commissioned to study:

- the extent to which the supply of specialised housing for people with mental health problems in London has improved over the last five years
- the extent to which the needs of people with serious mental health problems for affordable, appropriate housing in London are being met
- the impact that any shortcomings in the supply of supported accommodation in London are having on the use of acute hospital beds
- housing strategies being developed by local authorities and NHS bodies, working with housing providers (including social landlords) to provide accommodation for people with severe and enduring mental health problems
- how far financial support provided to assist with the costs of housing and related support in London is enhancing or hindering the ability of people with mental health problems to secure and maintain ownership or tenancy of a home
- examples of innovative practice in London, facilitating access to suitable accommodation and enabling individuals to keep their homes.

The research methodology

This brief posed a number of challenges, not least because the work was undertaken during a time of considerable change. Within the supported housing sector, there are no standard definitions of types of provision, and no central database of specialist projects. New Supporting People databases were being compiled as the draft of this paper was being prepared, but this study came too early for the authors to rely heavily on these, since they could not be confident of the quality of the data provided.

The lack of data on the supply of housing for people with mental health problems was compounded by a lack of data on needs. These inadequacies applied to data on the current situation, as well as to trends within the last five years. The authors were therefore wary of relying too heavily on statistical analysis, and agreed the following approach with the King’s Fund:

- maximum possible use of published statistics
- postal questionnaire to key commissioners within social services departments, primary care trusts and mental health trusts, with telephone follow-up
- a more in-depth analysis of six boroughs (Hillingdon, Islington, Newham, Bexley, Southwark and Wandsworth), including interviews with commissioners and providers
- analysis of housing strategies and Supporting People strategies where available.
Statistical sources

Statistics on the supply of housing were taken from the Office of the Deputy Prime Minister’s website (www.odpm.gov.uk), and on hospital activity and registered care from the Department of Health website (www.doh.gov.uk). Information on individual registered care homes was collected from each of the London offices for the National Care Standards Commission.

The authors attempted to collect extracts from the Supporting People databases of individual boroughs, since these would provide the most complete picture of the sector, but only 15 of the 33 boroughs were able to provide these. Instead, they relied on a summary table produced by the Association of London Government, which had been compiled earlier in the year on the basis of returns submitted by the boroughs.

The supported housing database of the Housing Corporation provided data on housing associations, but staff there did not have capacity to interrogate the database for comparisons with five years ago. The Supported CORE databases, which show lettings activity across supported housing owned by housing associations, provided the most reliable statistical data, but covered only a proportion of the sector. Since CORE was the only set of consistently produced statistics, this was used for analysing how the sector has changed over the last five years. The CORE analysis was commissioned from the National Housing Federation.

Overall, the quality of available statistical information was poor. There were no standard definitions of different types of housing and support for people with mental health problems. Supporting People provided the first opportunity to study a good proportion of the sector, but this research was undertaken too early to benefit from the new databases being collated. Several Supporting People lead officers would not release the data.

Even when the Supporting People information is gathered, the databases will not be complete, as they will not contain registered care homes, health-funded projects or intensive support projects other than those funded via Supporting People. Information about health-funded projects is particularly sparse, and any comparison with the situation five years ago is impossible because of the large-scale reorganisation that has taken place.

It would be very useful if housing and care providers were to adopt an objective of developing, and accurately maintaining, central databases of supported accommodation within each local authority area.
The government agenda

Supported housing for people with mental health problems is affected by many different government policies. The two key current initiatives are the National Service Framework for mental health and the Supporting People programme. However, as the list at the end of this section shows, a great many other policies are also having an impact within the sector. It is also important to refer back to the key policy of Housing and Community Care.

Housing and Community Care

In 1997, the Department of the Environment and Department of Health and published *Housing and Community Care: Establishing a Strategic Framework*. The document sets out key characteristics for Joint Mental Health Strategies. These remain relevant and vital points today. These characteristics included:

- agreement between health, social services and housing that services for people with a mental illness are a priority for the medium and long term
- development of a defined range of care, support and housing options from several independent sector providers who can provide a wide spectrum of care support within housing settings
- joint agreement on the most effective way to use all sources of capital and revenue funding
- commitment to joint commissioning
- maximum use of floating support so that as wide a range of care as is practicable is available within the patient’s own home.

Department of the Environment and Department of Health (1997), p 12

This document has helped shaped the agenda and the development of services over the past six years. However, the fact that these same items remain urgent issues today suggests that only limited progress has been made in improving strategic planning and effective partnership working.

The National Service Framework and housing

The National Service Framework (NSF) for Mental Health sets out the key standards for services for people with mental health needs. It contains relatively few references to housing. However, the NSF comments:

*Service users themselves believe that adequate housing and income, and assistance with the social and occupational aspects of daily living are among the most important aspects of care and reduce disability.*

Department of Health (1999), p 45

The NSF also highlights the impact of poor housing on mental health and emphasises the need for partnership approaches and the involvement of housing agencies in providing necessary support. Two specific requirements arise from the NSF:
to identify within the care programme approach (CPA) the housing status of clients and to ensure the care plan addresses their housing needs.

- to estimate, within the housing strategies of local authorities, the gaps in the service and the needs for accommodation and support for people with a mental illness.

Although CPA plans may capture information on housing status and need, in practice it has proved difficult both for social services and for health to record this in any form of accessible database. This data would make the second of the tasks easier to achieve, as needs data remains poor across most local authority areas. It is unclear as to what extent the requirement to identify housing status is translated into more positive action and planning.

By necessity, the housing strategies of local authorities cover the entire range of housing within the area of the authority. Specific references to individual ‘special needs’ groups are inevitably limited. Although the recent development of Supporting People strategies has allowed a greater focus on ‘special needs’ provision, the scale of supported housing in many areas is such that there is limited opportunity for any in-depth analysis of individual client groups to be carried out by the Supporting People teams.

Other than in those areas where specific client research and strategies have been developed, or where needs are comparatively low, specific coverage of the needs of people with mental illness is limited.

To properly address the intent of the NSF, health, social services and housing agencies need to address the issue of accommodation as a specific project within service planning. Good examples of this are:

- Islington, which has conducted a thorough accommodation review
- Tower Hamlets, which is continuing planning and commissioning work it began in 2000 via a mental health and housing strategy
- Harrow, which is completing a local mental health and housing strategy.

Standard Five of the NSF states:

*Each service user who is assessed as requiring a period of care away from their home should have:*

- *timely access to an appropriate hospital bed or alternative bed or place, which is:*
  - in the least restrictive environment consistent with the need to protect them and the public
  - as close to home as possible.

Department of Health (1999), p 45

The NSF highlights the issues faced by acute services when inadequate housing or community-based accommodation is available. Lack of 24-hour-staffed accommodation, the potential of crisis intervention housing, ethnic and gender specific projects and an overall lack of supported housing in many areas of the country are all emphasised (Department of Health 1999, p 51).

This working paper suggests that the required degree of partnership between care and housing or housing support agencies is not yet in evidence across the board, to enable commissioners to successfully plan for increased and more diverse provision.
Subsequent good practice guides and NSF implementation advice have emphasised the importance of housing that:

- meets the needs of diverse communities and of certain groups, such as women
- addresses more complex needs
- adopts new models of provision, such as crisis intervention housing.

These particular areas of provision are addressed in this working paper, but overall they remain in limited supply.

**The ‘Supporting People’ funding programme**

Supporting People is a new funding system for the provision of housing-related support services. In April 2003, existing sources of funding from the Housing Corporation, probation, and, in particular, housing benefit will be transferred to a single ‘pot’ administered by local authorities. The overall national fund will be cash-limited, subject to the normal central government controls on local authority expenditure. The design and principles of Supporting People are, nevertheless, a cause for considerable optimism among many commissioners and provider agencies.

Support services will increasingly be linked within a whole systems approach to a local strategy. The potential for improved service delivery, integrated social care, health and support and housing services is immense, and will accelerate the growing partnership role between housing agencies and social and health services.

Equally importantly, Supporting People offers the opportunity to provide services to support and enable individuals to live independently without being a resident of a particular property or housing project. This divorce of the service from the scheme allows services to be designed for, and adapted to, individual needs. Furthermore, the fact that the support funding is no longer linked to tenure means that floating support services can be developed as client-based, rather than property-based, services.

The current mission statement of Supporting People, as set out by the Office of the Deputy Prime Minister, describes the programme as ‘a working partnership of local government, service users, and support agencies.’ (Source: www.spkweb.org.uk)

However, this statement fails in one specific sense: namely, that it does not include health service commissioners or providers as specific, named partners. In the context of those with mental health needs as well as many others, the role of primary care trusts and mental health trusts will be significant in future partnership arrangements.

**Local strategies**

The supported housing sector has tended to grow organically, driven by opportunity – particular funding initiatives – and the energy of the voluntary sector. Supporting People will increasingly harness capital and revenue resources in a more strategic manner to reflect local priorities and needs.

By the end of September 2002, each local authority was required to produce a shadow Supporting People strategy. These strategies provide details of current provision and identify priorities for future developments, based on local needs. They are termed
‘shadow strategies’ in recognition of the fact that further work will be required before full five-year strategies can be finalised later in 2003.

Most shadow strategies have relied on existing plans and strategies. This approach has immediate limitations, since few authorities (for example) have detailed housing strategies for each of the client groups. Few have accurate figures for needs, and information on ‘unmet needs’ is particularly hard to come by. There are a number of methodologies for quantifying accommodation needs (for example, the ‘Pathways’ model, developed by Lynn Watson (1993) which quantifies the number of new accommodation units that a local area will need for a specific client group), but no one model has gained widespread acceptance, and attempts by the Office of the Deputy Prime Minister to devise a national needs model have foundered. It is, therefore, unsurprising that data on needs are sparse, but this does nevertheless raise questions about the quality of the planning process.

**Service development**

There is a tremendous potential for service development within the Supporting People framework. Three examples can usefully illustrate this:

- de-registration of group homes
- floating support to homelessness schemes
- crisis intervention.

**De-registration of group homes**

It had been anticipated that a significant number of small registered care homes would de-register. This would enable tenants to seek funding from transitional housing benefit, which would then be transferred to Supporting People.

In reality, by early 2003, few schemes had de-registered. This has been attributed to the short timescale available for completing a complex process that involved redefining the service and gaining agreement from the Care Standards Commission. However, there will be further de-registrations in the future as service commissioners re-evaluate registered schemes in which the relative inflexibility and higher costs are inappropriate for what are effectively shared houses. Supporting People offers the chance to change both the funding system and the legal status of these schemes to create more flexible, client-focused services and, in the process, free existing health revenue funds that could then be used for revenue support to housing and community-based services.

**Floating support to homelessness schemes**

Many clients with mental health needs are failing to get either mainstream or specialist housing. For a significant percentage, the only available accommodation is in hostels for the single homeless. At present, few such hostels have the specialist staff skills or necessary funding to provide the specific support that clients require.

Floating support models offer the opportunity for specialist mental health agencies to work with single homeless agencies in providing support to clients. Specialist mental health support could be offered to people living within homeless hostels, as well as to those completely outside the supported housing system. This could prove a highly
effective bridge to outreach and community mental health teams for the clients concerned.

Crisis intervention

Several models of housing-based crisis intervention accommodation have been developed in London, and have been the subject of two recent assessments – see Mental Health Foundation (1996) and Sainsbury Centre for Mental Health (1999). By offering short-term housing and high levels of support and clinical care, these schemes actively prevent hospitalisation. Most clients greatly prefer such community-based support to assist with short-term crises. The maximum length of stay in the schemes varies from two to six weeks. Although Supporting People funds are not necessarily available for clients within the schemes, they allow open-ended support from non-clinical staff to continue after clients return to their own homes, offering a continuum of care.

Contracting and performance monitoring

It is hoped that Supporting People will lead to greater flexibility in services, greater choice of housing options for individuals and improved standards of support. A detailed quality framework is under construction, and this will underpin Supporting People contracts. Contracts are expected to become increasingly focused on outcome and quality, as well as reflecting the ‘best value’ approach that is a requirement for local authorities. Several authorities have made their intentions clear in this respect.

The introduction of a uniform quality framework is to be warmly welcomed. It has been developed following consultation with commissioners and providers, but ultimately its usefulness will depend on how it is implemented by commissioners. There is a particular concern that if the requirements are too administratively unwieldy, smaller agencies may struggle to meet the requirements. There is a danger that the diversity and ingenuity of the sector will be weakened if small agencies do not survive. Some agencies will require support to cope with these changes.

Affordability

One of the great advantages of Supporting People is that people in short-stay accommodation (where the intended length of stay is less than two years) will not be charged for their support. Under the previous system, which was housing-benefit driven, if anyone took up work, they would be charged for the support they received, and would see little or no benefit from working. Under Supporting People, those in long-stay accommodation will not be charged if they receive housing benefit. Where people in long-stay accommodation do not receive housing benefit, they can apply for a means test to have their support charge reduced.

The means test is subject to local authority discretion, since it is linked to locally-determined charging systems for domiciliary care. The guidance from the Office of the Deputy Prime Minister states that earned income should be discounted when undertaking the means test. There is therefore increased potential for people with mental health problems to work, without seeing their earnings used up to pay for support charges. While this is certainly an advantage for people in short-stay projects,
it is difficult to be certain about whether long-stay accommodation will also become more affordable until the means tests are in place.

The National Service Framework for Mental Health makes much of keeping pathways to work open (see for example, Standard One, Mental health promotion). Supporting People provides an opportunity to make work a financially viable option for people who need support. It would be a missed opportunity if means testing undermined this advantage.

Uncharted implications

Supporting People represents a seismic change to the funding of the sector, and its implications will take many years to become apparent. This section raises a number of questions about unintended, but potentially negative, effects of the policy. These are discussed in more detail in Appendix 1, but are noted briefly here.

Funding out-of-borough placements

Funding for Supporting People services will be transferred to the local authority in which the service is located, irrespective of which agency or authority referred the people to the service. The authority in which the scheme is based may well regard the funding as 'theirs', to be spent on 'their' population. Schemes serving a number of local authorities will be faced with persuading their home borough to fund places for people from other boroughs. Many people have moved about a great deal, and have no local connection. These 'rootless' people may be particularly disadvantaged.

Local authorities as well as providers face challenges from the new system. Out-of-borough placements may become unavailable, or much more expensive, if the home borough decides to use all the places for its own 'home' tenants. Boroughs currently relying on large numbers of out-of-borough placements will be particularly hard hit.

Cross-authority procedures

The Supporting People policy recognises the inter-dependency of the provision of the boroughs through its cross-authority procedures for projects working with single homeless people and those escaping domestic violence. There are no formal procedures for cross-authority working in mental health, and it will therefore be possible for one borough to impose changes without the consent of neighbouring boroughs.
Action points

- There should be a clarification and strengthening of cross-borough arrangements for mental health. One option would be to insist on consultation with any authority that has more than 10 per cent of the places in a given scheme.
- In addition, further research should be commissioned to monitor the effect of Supporting People on mental health provision in the capital. The factors described above mean that there are greater uncertainties for local authorities and for mental health projects in London than for other client groups.

Local authorities with flexibilities and freedoms

A further major challenge to the success of Supporting People is the very recently announced flexibilities awarded to those local authorities that received three stars under the Audit Commission’s comprehensive performance assessment. In London, eight of the 33 boroughs achieved this: Camden, Westminster, Hammersmith and Fulham, Kensington and Chelsea, Wandsworth, Bexley, Corporation of London, and Kingston. These boroughs account for 25 per cent of mental health Supporting People services, and 37 per cent of provision for single homeless people in London.

Action point

- The eight London Boroughs, given the new flexibilities, should remain within the nationally agreed policies and procedures for Supporting People for at least the first three years of the programme, to allow the programme to become established and stabilised.

Impact on future developments

Half of the current housing association provision for people with mental health problems is owned by just 10 housing associations, nine of which are large general-needs providers. If supported housing becomes more risky, governing boards may well seek to reduce their exposure by cutting back or stopping developments in the supported field. If general needs housing associations were to take a risk-averse view of Supporting People, the consequences could be serious.

The future role of the Housing Corporation

Under Supporting People, the Housing Corporation will continue to allocate social housing grants to housing associations toward the capital costs of new supported housing. This represents a new complication as previously the Housing Corporation awarded capital and revenue as a single package. It is as yet unclear how the Corporation’s prioritisation of capital bids will mesh with the boroughs’ prioritisation of revenue bids.
The broader housing agenda

Housing, and social housing in particular, is under a great many pressures at present. Other areas of the housing agenda that are likely to impact on supported housing include:

- **the Homelessness Act 2002**, which increased duties on local authorities to assist vulnerable homeless people
- **new ways of allocating social housing**, under which local authorities are allowed to take into account any behaviour of a person that affects her/his suitability to be a tenant, and whether they have a local connection
- **local letting policies**, under which local authorities may choose a variety of criteria for deciding who will be offered housing in a particular area
- **choice-based lettings**, under which properties are publicly advertised and people apply to live in them
- **anti-social behaviour strategies**, and the new powers for housing associations to apply for anti-social behaviour orders
- **proposed reform of housing law**, under which people could lose their security of tenure if they behave in an anti-social way
- **tenant incentive schemes**, under which ‘good’ tenants are rewarded with a higher level of service
- **regeneration schemes**, which, although they result in improvements to the local area, can reduce the amount of housing available (because empty properties are needed for those decanted while their area is regenerated) and can result in areas becoming ‘gentrified’ and less accepting of people with support needs
- **housing for key workers**, which is much needed, but not currently extended to those working within the supported housing sector.

(These policies are analysed in Appendix 2.)

The paradox of social housing in London is that although it is in such high demand, there are areas of extreme unpopularity. The ‘right to buy’ has concentrated social housing into smaller pockets in less popular areas, and has resulted in a higher concentration of people with support needs being housed in these zones. The poor reputation of some areas of social housing has resulted in an increasing focus on tackling anti-social behaviour, incentivising good behaviour, and changing lettings policies to increase choice and create more balanced communities.

The challenge throughout is to ensure that people with mental health problems and other support needs are not labelled as a ‘problem’ that needs to be targeted.

**Action point**

- Research needs to be carried out to study the effect that the changes in housing and homeless legislation and government priorities have had on the ability of people with mental health problems to get ordinary housing.
The supply of housing in London

Wider pressures within the general housing market heavily influence the supply of housing for people with mental health problems. Many people are supported through floating support services offered in ordinary housing, and those in specialist provision aim to return to more ordinary housing in the longer term. The ability of providers is heavily influenced by the availability of staff, which is in turn affected by the housing market. This section analyses the significant reduction in the supply of social housing in London and comments on how this affects the ability of people with mental health problems to get ordinary housing.

Declining investment in new housing

There were reductions in the development of social housing in the late 1990s as the funding available to the Housing Corporation was reduced. Overall, new housing under development by housing associations fell from 31,000 in 1994 to 18,000 in 1998. At the same time, sales of existing local authority homes under the ‘right to buy’ legislation continued to reduce available housing.

In the general housing market of 1997, prices were continuing to rise and recover from the effects of the property slump and negative equity of the early 1990s. Property repossessions were reducing, as were overall numbers of homeless families in short-term accommodation and bed and breakfast.

There was a view that as the housing market picked up and the homelessness statistics improved, housing was not an issue for a new government, which was more focused on the health service and education.

Single people, however, were increasingly excluded from the social safety net under revisions to the homeless legislation, which came into effect in 1998. The changes were not rescinded until the new Homelessness Act of 2001 provided a new framework for entitlement.

Subsequently, not only has the housing market continued to rise but it has done so increasingly quickly, and this has had an impact on lower income groups, including many people designated as key workers, unable to secure housing in either the rented sector or the owner-occupied sector at prices they can afford. This has begun to attract additional investment into social housing, a greater focus on areas of high demand, such as London, and a re-balance of the family and single-person accommodation being planned.

Reductions in overall provision of social housing

This section analyses how the quantity of housing in London has changed as a combination of new building and the demolition and sale of social housing. It also looks at how housing priorities have changed and how choice has been reduced as a result of demand outstripping supply.

New building
The overall number of new, permanent dwellings built in London in 2001/02 was 29 per cent higher than in 1996/97. This was entirely due to private-sector building, as the number of houses built by housing associations and local authorities fell by 38 per cent, to a new 10-year low.

This private-sector boom was more marked in London than elsewhere in the country. In England as a whole, 4 per cent fewer new houses were begun in 2001/02 than five years previously. This total hides a modest increase of 7 per cent in private sector building, and a slump of 51 per cent in social housing new starts.

**Fig 1: Permanent dwellings started by tenure (London)**

Table 1, opposite, shows the enormous impact of the ‘right to buy’. Since substantial amounts of housing have been transferred from local authorities to housing associations, these two categories are analysed together, rather than separately.

The total supply of housing in London has therefore increased by 150,000 dwellings over the last decade, with the numbers of owner-occupied and private rented dwellings increasing by 100,000 each and the number of social rented dwellings decreasing by 50,000. In percentage terms, the social housing sector has fallen from 29.3 per cent of all households to 26.1 per cent over this period.

Given that housing associations and local authorities have built some 47,000 new dwellings in London in the same time period, this shows the total amount of social housing lost to other sectors to be nearer 100,000.
Table 1: Number of dwellings in London (000s)

<table>
<thead>
<tr>
<th></th>
<th>Owner-occupied</th>
<th>Rented privately or with a job or business</th>
<th>Rented from housing asscn or local authority</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>1,673</td>
<td>387</td>
<td>852</td>
<td>2,912</td>
</tr>
<tr>
<td>1993</td>
<td>1,651</td>
<td>459</td>
<td>839</td>
<td>2,949</td>
</tr>
<tr>
<td>1995</td>
<td>1,657</td>
<td>496</td>
<td>829</td>
<td>2,982</td>
</tr>
<tr>
<td>1997</td>
<td>1,700</td>
<td>488</td>
<td>826</td>
<td>3,014</td>
</tr>
<tr>
<td>1999</td>
<td>1,738</td>
<td>488</td>
<td>815</td>
<td>3,041</td>
</tr>
<tr>
<td>2001</td>
<td>1,773</td>
<td>491</td>
<td>803</td>
<td>3,067</td>
</tr>
<tr>
<td>Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991–2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ODPM (2002a), p 4

Changing priorities in the sector

There has been a significant shift towards the provision of family housing rather than single-person accommodation. In 1991, almost 43 per cent of all new starts were one-bedroom units. By 2001, this had fallen below 20 per cent.

This is of particular significance for people with mental health needs, particularly those with a severe and enduring mental illness. The greater the degree of mental health need, the higher the percentage of single people living in private and social rented housing. A study by the Office of National Statistics, *The Social and Economic Circumstances of Adults with Mental Disorders* (ONS 2002), found that nearly 50 per cent of people with neurosis, and more than 60 per cent of those with psychosis, lived in rented accommodation, compared with one-quarter of people with no disorders. In the group with a probable psychotic disorder, 43 per cent were living in a one-person family unit – almost three times the proportion of those with no mental disorder (15 per cent).

The lack of single-person accommodation has also reduced access to move-on accommodation for people leaving specialist schemes. Supported housing has suffered from a ‘silting up’ in the last five years, and this is examined in the section on lettings within supported housing over the past five years.

Housing choice

The impact on supply of the right to buy, coupled with the increasing difficulty of entering the owner-occupation sector, has reduced housing options available to people in need of social housing. The *Survey of English Housing* (Office of the Deputy Prime Minister 2002c) asked people who had moved into, or within, the social housing sector in past five years how much choice they felt they had. The results were illuminating, with 56 per cent of people in London saying they were offered no choice at all.
Table 2: Choice offered in home allocation, by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Enough choice (%)</th>
<th>Not enough choice (%)</th>
<th>No choice at all (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>42</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>Midlands</td>
<td>43</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td>London</td>
<td>31</td>
<td>13</td>
<td>56</td>
</tr>
<tr>
<td>Rest of south</td>
<td>37</td>
<td>13</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: ODPM (2002c), p 51

New lettings

Between 1996/97 and 2000/01, new lettings of social housing in London were reduced by 31 per cent, from 83,600 lettings to 57,700. Fig 2, below, shows that the reduction was experienced by existing tenants transferring within their own landlord or to another social landlord, and new tenants, whether statutory homeless or not.

Fig 2: New social housing lettings in London

![Graph showing new social housing lettings in London](image)

Source: ODPM (2002a), p 104

As the statistics in Fig 2 demonstrate, the total supply of social housing only reduced by 3 per cent in this time, so the 31 per cent reduction in new lettings must be mainly due to people being unwilling, or unable, to move. This gives a picture of a social housing market in which demand outstrips supply, people have very few choices, and housing mobility is increasingly restricted.
Rent levels in London

Rent levels in one-bedroom flats in London increased by between 10 and 15 per cent in the three years from 1997/98 to 2000/01 (figures are most easily compared for these years.)

Table 3: Average rent levels in London (£ per week)

<table>
<thead>
<tr>
<th></th>
<th>1997/98</th>
<th>2000/01</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing association rents</td>
<td>54.03</td>
<td>59.81</td>
<td>+10.7</td>
</tr>
<tr>
<td>Local authority rents</td>
<td>46.43</td>
<td>52.33</td>
<td>+12.7</td>
</tr>
<tr>
<td>Private rented</td>
<td>94.52</td>
<td>108.70</td>
<td>+15.0</td>
</tr>
</tbody>
</table>


Table 4: Most and least expensive one-bedroom rents in London in 2000/01

<table>
<thead>
<tr>
<th></th>
<th>Most expensive</th>
<th>Least expensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing association rents</td>
<td>1. Redbridge</td>
<td>1. Bexley</td>
</tr>
<tr>
<td></td>
<td>2. Barnet</td>
<td>2. Lewisham</td>
</tr>
<tr>
<td></td>
<td>3. Harrow</td>
<td>3. Islington</td>
</tr>
<tr>
<td>Local authority rents</td>
<td>1. Westminster</td>
<td>1. Havering</td>
</tr>
<tr>
<td></td>
<td>2. Redbridge</td>
<td>2. Waltham Forest</td>
</tr>
<tr>
<td></td>
<td>3. Harrow</td>
<td>3. Newham</td>
</tr>
<tr>
<td>Private rents</td>
<td>1. Islington</td>
<td>1. Greenwich</td>
</tr>
<tr>
<td></td>
<td>2. Kensington and Chelsea</td>
<td>2. Newham</td>
</tr>
</tbody>
</table>


Some patterns are discernible. The most expensive housing association and local authority rents tend to be in the outer London boroughs, with the most expensive private rents in the central boroughs. The cheapest housing association and local authority rents are more evenly spread across London, but with a slight tendency to be in the outer boroughs. The cheapest private renting is in outer London.

In some boroughs, the price differences between the sectors are extreme. Islington, for example, is the third cheapest borough for renting from the local authority (£55 in 2000/01), but the most expensive area for private renting (£178).

People’s housing options are therefore governed strongly by the borough in which they find themselves. The housing market bears little relationship to the economists’ ‘perfect market’, where customers have full knowledge of all prices and move to purchase at the cheapest price. While people move within areas of London (for example, Southwark to Lewisham or Westminster to Kensington and Chelsea), they are less likely to move all the way across London to seek housing in Bexley because Redbridge is too expensive. Social housing lettings policies often require a local connection as a way of managing the great demand they face, and this severely restricts movement within London.

The high levels of private sector rents put much of London out of reach of all but the most highly paid. They reduce the likelihood of anyone moving on from specialist accommodation into a private flat. It is possible to receive housing benefit to cover
the costs, but whether or not private landlords are willing to accept people on benefits depends on whether they are able to find other tenants who are not dependent on benefits. This is not entirely due to prejudice against the type of person they expect to be receiving benefits; there is a major financial disincentive to housing a benefits recipient: the period of time it takes for a housing benefit claim to be settled.

Outlook for supported housing

It is unlikely that planned increases to the social housing programme will generate a great deal of new supported housing schemes. Nor will there be anything other than a modest increase in housing available for move-on accommodation for existing projects.

Housing support will need to be addressed from within existing local resources, and it seems likely that service developments will be of more significance than the physical development of new schemes. This is already being reflected in the growth of floating support services.

The finance for identified new schemes, particularly for those with severe and enduring illness, will require capital finance from a broad range of sources, including untraditional forms of finance for supported housing, such as the Private Finance Initiative and Public-Private Partnership. Private-sector involvement in the development and management of schemes may also increase, broadening the role played within the residential and nursing sectors.

There is real uncertainty about whether the capital funding needed for improvement and remodelling of older schemes will be available.

The need for investment

Capital investment in new provision has to be needs led. At present, there is insufficient data collected in a consistent way across London to allow accurate projections of need. Information on specialised accommodation requirements tends to be anecdotal, focusing on the type of provision gap that exists locally, and is linked primarily to issues around unnecessary hospital admission or delayed discharge from acute beds.

Investment planning needs to address:

- existing provision – its suitability, desirability and appropriateness of service
- access to self-contained housing and the capacity of ‘floating support’ services to provide flexible, open-ended support as required
- local needs assessments that can help quantify specific gaps in provision; for example, the need for high-care, 24 hour-staffed accommodation and for crisis intervention accommodation
- the needs of local communities in terms of ethnic and gender-specific provision
- the balance to be achieved between service-based solutions and new housing provision.

Nevertheless, the existing evidence identifies a need for delayed discharge and lengthening stays in specialist provision. There are also concerns over:

- levels of shared housing and poorer quality schemes
- the overall lack of provision in certain outer London authorities
• the lack of community-based housing options open to those in low and medium secure units – with costs ranging up to £120,000 per year compared to high care housing at some £20,000 a year total cost.

The case for capital investment as well as service solutions is clear even if the level required is not.

Many vulnerable client groups face the same issues. The scenario above applies to a greater or lesser extent to people with learning disabilities, frail older people, refugees and asylum seekers, young people leaving care and those with a physical disability. Overall levels of funding to meet all those needs are simply not available through the social housing grant system, which is struggling to address the overall shortage of affordable housing in London.

Private finance is being used to meet the needs of some vulnerable groups. PFI-based schemes have been developed in Lewisham, Redbridge and Hammersmith and Fulham, for example, to meet the needs of frail older people. Mental health provision will need to make its case for PFI credits and for PPP arrangements, and the nature of these schemes is that strong evidence of continuing need and therefore revenue flows is required.

Whether investment is planned via a strategy to address vulnerable peoples' needs across the board or by client group, the specific needs of people with mental health needs, particularly those with a severe and enduring mental illness, need to be quantified. In addition, the relationship with secure provision needs to be established and the form of partnership between providers and commissioners further developed.

In certain areas, the gaps in provision are major, and it is critical that the balance between service-led solutions and specialist provision is correctly identified. Other elements that need to be identified are the most appropriate form of accommodation, the range and type of provision, including issues as to tenure diversity (for example, shared ownership) and the capacity of local partners to develop this.

We have indicated that there are high levels of pressure on housing associations to meet a wide range of needs. This is combined with a degree of uncertainty among many as to their continuing role in specialist housing provision. The housing association sector in London is robust and diverse. However, the agenda it faces is enormous. Given the role the private sector plays in many areas of care and accommodation, it is important that its experience and resources is available and that it is also included in the planning of services and accommodation.

Whether individual areas focus on service-led solutions or accommodation-led solutions, revenue funding is equally critical. Supporting People can only represent a small proportion of this funding. De-registration of some schemes will free a certain amount of existing revenue by accessing housing benefit to cover accommodation costs, and it is important that any such savings are retained within the service. But these too will be limited, and health will be the major revenue contributor. At present, health budgets are paying for unnecessary hospitalisation, including delayed discharge from acute beds. The lack of community-based alternatives means that people are housed in more expensive secure units for longer than necessary. These costs need to be quantified, and consideration given to spending these funds more cost-effectively on community-based mental health services.
Action points

- Health authorities and local authorities should work to develop strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models.

- Requirements for capital funding should be based on a recognition that private finance will be required in some if not all areas.

- The private sector should be involved as a partner both in planning new provision and in its development.

- The full economic and social cost of unnecessary acute and secure provision should be assessed and potential savings from housing-based solutions identified. Savings achieved should be ‘ring fenced’ for revenue support to community services that reduce the use of, and periods spent in, secure and acute beds. This should be achieved to a level that is determined by clinical needs rather than supply issues.
The supported housing sector
1997–2002

This section of the working paper analyses the supported housing sector – that is, housing specifically set aside for people with mental health problems, and also ordinary housing within which a floating support service is provided. It tracks how the sector has changed over the last five years and analyses whether these changes have kept pace with changing needs.

Population data

The 2001 census data provides far more accurate data than previous mid-year estimates. Since this study relates to accommodation for adults with mental health problems but excludes age-related mental health problems, statistics have been used for the age ranges 15–64 for men and 15–59 for women as the best proxy available for the group being studied.

Table 5: 2001 census data for London (000s)

<table>
<thead>
<tr>
<th>Age</th>
<th>1996</th>
<th>2000</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men aged:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–29</td>
<td>789</td>
<td>843</td>
<td>+6.8</td>
</tr>
<tr>
<td>30–44</td>
<td>900</td>
<td>1,006</td>
<td>+11.8</td>
</tr>
<tr>
<td>45–64</td>
<td>702</td>
<td>735</td>
<td>+4.7</td>
</tr>
<tr>
<td>Total 15–64</td>
<td>2,391</td>
<td>2,584</td>
<td>+8.1</td>
</tr>
<tr>
<td>Women aged:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–29</td>
<td>782</td>
<td>792</td>
<td>+1.2</td>
</tr>
<tr>
<td>30–44</td>
<td>867</td>
<td>927</td>
<td>+6.9</td>
</tr>
<tr>
<td>45–59</td>
<td>578</td>
<td>606</td>
<td>+4.8</td>
</tr>
<tr>
<td>Total 15–59</td>
<td>2,227</td>
<td>2,325</td>
<td>+4.4</td>
</tr>
<tr>
<td>Total (men and women)</td>
<td>4,618</td>
<td>4,909</td>
<td>+6.3</td>
</tr>
</tbody>
</table>

Source: ODPM (2002a), p 63

The population of the age group under consideration in London grew by 6.3 per cent between 1996 and 2000. All other things being equal, a growth of at least this scale of specialist housing would have been required to keep pace with needs.

Description of the sector

There is no single comprehensive database that describes the supported housing sector. The authors have therefore drawn on three databases: the Housing Corporation database, and the two Supported CORE databases (lettings and schemes).
Sources of data

The Housing Corporation database contains details of mental health projects that receive a supported housing management grant. This contains 4,371 units in 435 groups of projects. This represents approximately 80 per cent of the units that appear in the Supported CORE database. (Information on number of projects in the two databases cannot be compared, since projects are grouped together for supported housing management grant purposes, and reported separately in CORE.)

The Supported CORE resource is made up of two databases, one containing details of schemes, and the other of lettings. The major limitation with the databases is they only list those schemes owned by housing associations that have more than 250 units in total. However, they are the only available data source that allows comparisons to be made with the situation five years ago, since their data have been collected on a consistent basis.

Housing Corporation database

The Housing Corporation database tells us the following about the mental health sector:

- Of the 4,371 units funded by supported housing management grants, 786 (18 per cent) are floating support.
- 709 units are in registered care homes, 2,874 are in non-registered projects, and data on 788 units is missing.
- 72 different housing associations provide accommodation with additional support.
- Four of these are black and minority ethnic-led associations.

Table 6: Major players in supported housing in London

<table>
<thead>
<tr>
<th>Name of housing association</th>
<th>Number of units</th>
<th>Number of boroughs worked in</th>
</tr>
</thead>
<tbody>
<tr>
<td>London and Quadrant Housing Trust</td>
<td>295</td>
<td>10</td>
</tr>
<tr>
<td>Metropolitan Housing Trust</td>
<td>265</td>
<td>8</td>
</tr>
<tr>
<td>Notting Hill Housing Trust</td>
<td>253</td>
<td>6</td>
</tr>
<tr>
<td>Circle 33 Housing Trust</td>
<td>228</td>
<td>6</td>
</tr>
<tr>
<td>Community Housing Association</td>
<td>195</td>
<td>3</td>
</tr>
<tr>
<td>Peter Bedford</td>
<td>194</td>
<td>1</td>
</tr>
<tr>
<td>Family</td>
<td>155</td>
<td>6</td>
</tr>
<tr>
<td>Paddington Churches</td>
<td>151</td>
<td>4</td>
</tr>
<tr>
<td>East Thames</td>
<td>143</td>
<td>3</td>
</tr>
<tr>
<td>Hyde Housing</td>
<td>141</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: King’s Fund (2003)

Table 6 lists the organisations that own the buildings used by London's supported housing sector, rather than those that provide the support service. Since much supported housing is built with mixed funding, it also shows which organisations are investing in the sector, and it is noticeable (but not surprising) that nine out of the ten largest providers of supported housing are all general-needs housing associations (Peter Bedford being the largest specialist).
Supported CORE

Analysis of the Supported CORE database shows the following trends:

Table 7: Data contained in the schemes database

<table>
<thead>
<tr>
<th></th>
<th>1996/7</th>
<th>2001/02</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of mental health schemes</td>
<td>1,005.0</td>
<td>1,106.0</td>
<td>+ 10.0</td>
</tr>
<tr>
<td>No. of units in mental health schemes</td>
<td>5,358.0</td>
<td>5,419.0</td>
<td>+ 0.1</td>
</tr>
<tr>
<td>No. of units per scheme</td>
<td>5.3</td>
<td>4.9</td>
<td>-8.2</td>
</tr>
<tr>
<td>Total no. of schemes in London – all client groups</td>
<td>4,425.0</td>
<td>4,804.0</td>
<td>+8.6</td>
</tr>
<tr>
<td>Total no. of units – all client groups</td>
<td>33,659.0</td>
<td>35,772.0</td>
<td>+6.2</td>
</tr>
<tr>
<td>No. of units per scheme – all client groups</td>
<td>7.6</td>
<td>7.4</td>
<td>-2.6</td>
</tr>
</tbody>
</table>

Source: Supported CORE schemes database (2002)

Table 7, above, shows that the London supported housing sector has 8.6 per cent more schemes now than it did five years ago, and that the mental health part of the sector has grown faster than the average, with 10 per cent more schemes than before. However, the average project size has shrunk slightly in the sector as a whole, and significantly in the mental health sector. There has therefore been only a marginal increase in the number of units for people with mental health problems.

While this no doubt reflects improvement in practice, with smaller, more ordinary housing replacing larger-scale provision, it shows that although the investment in this part of the sector might have improved quality, it has not increased supply at all for people with mental health problems.

Tracking changes over the past five years

The schemes database allows analysis of individual projects that have opened or closed within the past five years. This analysis is shown in Table 8, overleaf. This analysis shows the difficulty of relying on scheme-based information without also studying the number of units. Ealing shows 14 new supported housing schemes developed in five years, but nine of these are one-bed units at the same location.

Overall, there has been disappointingly little movement in some of the boroughs. Havering reported no new developments or closures at all. In Harrow, one 10-bed project was closed, and nine individual one-bed units opened, with no other changes or developments in five years. Sutton has opened a new 10-bed project. Wandsworth has closed three projects of six, four and seven beds respectively, while its new services have largely comprised individual one-bed units.
Table 8: Schemes opening or closing between 1996/97 and 2001/02

<table>
<thead>
<tr>
<th>Borough</th>
<th>1996/97 schemes</th>
<th>Schemes closed by 01/02</th>
<th>Schemes opened by 01/02</th>
<th>Net change in schemes</th>
<th>Net change in units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>+1</td>
<td>20</td>
</tr>
<tr>
<td>Barnet</td>
<td>42</td>
<td>13</td>
<td>27</td>
<td>+14</td>
<td>115</td>
</tr>
<tr>
<td>Bexley</td>
<td>11</td>
<td>4</td>
<td>6</td>
<td>+2</td>
<td>53</td>
</tr>
<tr>
<td>Brent</td>
<td>40</td>
<td>4</td>
<td>5</td>
<td>+1</td>
<td>218</td>
</tr>
<tr>
<td>Bromley</td>
<td>39</td>
<td>1</td>
<td>3</td>
<td>+2</td>
<td>150</td>
</tr>
<tr>
<td>Camden</td>
<td>50</td>
<td>12</td>
<td>8</td>
<td>-4</td>
<td>341</td>
</tr>
<tr>
<td>Croydon</td>
<td>17</td>
<td>5</td>
<td>3</td>
<td>-2</td>
<td>76</td>
</tr>
<tr>
<td>Ealing</td>
<td>19</td>
<td>1</td>
<td>14</td>
<td>+13</td>
<td>126</td>
</tr>
<tr>
<td>Enfield</td>
<td>22</td>
<td>1</td>
<td>6</td>
<td>+5</td>
<td>59</td>
</tr>
<tr>
<td>Greenwich</td>
<td>29</td>
<td>4</td>
<td>9</td>
<td>+5</td>
<td>123</td>
</tr>
<tr>
<td>Hackney</td>
<td>39</td>
<td>3</td>
<td>9</td>
<td>+6</td>
<td>420</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>49</td>
<td>8</td>
<td>5</td>
<td>-3</td>
<td>256</td>
</tr>
<tr>
<td>Haringey</td>
<td>62</td>
<td>0</td>
<td>14</td>
<td>+14</td>
<td>293</td>
</tr>
<tr>
<td>Harrow</td>
<td>18</td>
<td>1</td>
<td>9</td>
<td>+8</td>
<td>51</td>
</tr>
<tr>
<td>Havering</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>+5</td>
<td>38</td>
</tr>
<tr>
<td>Hounslow</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>+3</td>
<td>44</td>
</tr>
<tr>
<td>Islington</td>
<td>55</td>
<td>3</td>
<td>8</td>
<td>+5</td>
<td>345</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>28</td>
<td>9</td>
<td>6</td>
<td>-3</td>
<td>198</td>
</tr>
<tr>
<td>Kingston</td>
<td>16</td>
<td>5</td>
<td>1</td>
<td>-4</td>
<td>74</td>
</tr>
<tr>
<td>Lambeth</td>
<td>61</td>
<td>6</td>
<td>1</td>
<td>-5</td>
<td>339</td>
</tr>
<tr>
<td>Lewisham</td>
<td>59</td>
<td>14</td>
<td>18</td>
<td>+4</td>
<td>258</td>
</tr>
<tr>
<td>Merton</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>51</td>
</tr>
<tr>
<td>Newham</td>
<td>18</td>
<td>1</td>
<td>2</td>
<td>+1</td>
<td>115</td>
</tr>
<tr>
<td>Redbridge</td>
<td>24</td>
<td>1</td>
<td>9</td>
<td>+8</td>
<td>136</td>
</tr>
<tr>
<td>Richmond</td>
<td>17</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Southwark</td>
<td>54</td>
<td>11</td>
<td>24</td>
<td>+13</td>
<td>296</td>
</tr>
<tr>
<td>Sutton</td>
<td>40</td>
<td>1</td>
<td>6</td>
<td>+5</td>
<td>99</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>15</td>
<td>1</td>
<td>4</td>
<td>+3</td>
<td>142</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>47</td>
<td>17</td>
<td>17</td>
<td>0</td>
<td>174</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>66</td>
<td>11</td>
<td>18</td>
<td>+7</td>
<td>276</td>
</tr>
<tr>
<td>Westminster</td>
<td>34</td>
<td>5</td>
<td>2</td>
<td>-3</td>
<td>295</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,005</strong></td>
<td><strong>151</strong></td>
<td><strong>252</strong></td>
<td><strong>+101</strong></td>
<td><strong>5,358</strong></td>
</tr>
</tbody>
</table>

1 The schemes opening and closing were virtually all one-unit schemes – most probably floating support where the address changed.
2 The large decrease was due to three large, high-care projects closing.
3 Nine of these were adjacent individual flats.
4 Four of these were adjacent individual flats.
5 These included 24 units in the Living Space project.
6 These included 18 units in Hutchings House.
7 CORE also shows a new 117-unit scheme, but it is understood that this is a reclassification within the database rather than a ‘new development’, and has therefore been removed from the analysis.
8 CORE also shows closure of a 95-place scheme, but this was a reclassification rather than closure, and has therefore been removed from the analysis. These two large schemes account for the slight difference in numbers between this table and the previous one.
9 Virtually all of these consisted of one-bed floating support.

Source: Supported CORE schemes database (2002)
Changes in type of supported housing

There has been some progress towards reducing the number of people expected to live in shared housing, as shown in Table 9, below.

Table 9: Reductions in shared housing

<table>
<thead>
<tr>
<th></th>
<th>Net change in no. of units between 99/00 and 01/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-contained flat</td>
<td>+163</td>
</tr>
<tr>
<td>Self-contained flat with common facilities¹</td>
<td>+58</td>
</tr>
<tr>
<td>Self-contained house</td>
<td>+7</td>
</tr>
<tr>
<td>Bungalow</td>
<td>+1</td>
</tr>
<tr>
<td>Shared flat²</td>
<td>+3</td>
</tr>
<tr>
<td>Shared house or hostel</td>
<td>-125</td>
</tr>
<tr>
<td>Not known</td>
<td>+1</td>
</tr>
</tbody>
</table>

¹ Tenants in self-contained flats with common facilities will have their own bedroom, kitchen and bathroom, and will share some common areas (eg a living room, or laundry) with other flats in the same block. These are often called cluster flats or grouped flats.

² In shared flats, houses or hostels, tenants share kitchen and/or bathrooms. Small shared houses are commonly referred to as group homes, whilst larger shared projects are termed hostels.

Source: Supported CORE schemes database (2002)

Several boroughs have reduced their numbers of shared places, but this has mainly been achieved without any corresponding increase in self-contained units. Only three boroughs have reduced shared housing while expanding their overall provision:

- Hammersmith and Fulham (six shared places closed and 26 self-contained opened)
- Brent (10 shared places closed, and 20 self-contained opened)
- Bexley (22 shared places closed and 28 self-contained opened).

Overall, the proportion of shared housing fell only marginally, from 64.6 per cent to 60.8 per cent.

The fact that more and more people now find shared housing unacceptable, coupled with the increased level of needs of people being housed, suggests that much greater investment in remodelling or re-provisioning of shared housing will be needed to keep pace with changing patterns of need. At the current rate of progress, shared housing would be with us for decades to come.

Lettings

Although the number of units has remained steady across London, the lettings database shows a significant reduction in the volume of service. The numbers of lettings where the principal purpose of the scheme is mental health, and where the client has mental health as the primary or secondary support need, are shown in Table 10, overleaf.
Table 10: Number of lettings in mental health schemes

<table>
<thead>
<tr>
<th></th>
<th>1996/97</th>
<th>2001/02</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of lettings</td>
<td>630</td>
<td>465</td>
<td>-26.3</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)

This significant reduction in lettings could be accounted for either because the same projects are supporting people with significantly greater support needs, so that the average stay is necessarily longer, or because there has been a reduction in the availability of move-on accommodation resulting in silt-up of projects. Whatever the interpretation, this finding is stark – one-quarter fewer people with mental health problems were given accommodation with support in a mental health project in 2001/02 than in 1996/97.

Greater support needs

The lettings database suggests the reduction in vacancies is hitting those currently living independently the hardest, with the number of places offered to people leaving hospital, hostels, or other shared or temporary housing being maintained at a fairly steady level.

Table 11: Previous housing status of new residents

<table>
<thead>
<tr>
<th></th>
<th>1996/97</th>
<th>2001/02</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority tenant</td>
<td>59</td>
<td>21</td>
<td>-64.4</td>
</tr>
<tr>
<td>Housing association general needs tenant</td>
<td>22</td>
<td>14</td>
<td>-36.4</td>
</tr>
<tr>
<td>Private tenant</td>
<td>40</td>
<td>7</td>
<td>-82.5</td>
</tr>
<tr>
<td>Owning or buying</td>
<td>2</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>Living with family/friends</td>
<td>101</td>
<td>69</td>
<td>-31.7</td>
</tr>
<tr>
<td>Hostel/shared housing</td>
<td>129</td>
<td>116</td>
<td>-10.1</td>
</tr>
<tr>
<td>Approved probation/bail hostel</td>
<td>1</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>Self-contained supported housing</td>
<td>18</td>
<td>20</td>
<td>+11.1</td>
</tr>
<tr>
<td>Hospital</td>
<td>126</td>
<td>120</td>
<td>-4.8</td>
</tr>
<tr>
<td>Prison</td>
<td>1</td>
<td>1</td>
<td>*</td>
</tr>
<tr>
<td>Other temporary accommodation, including bed and breakfast</td>
<td>40</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>Residential care home</td>
<td>49</td>
<td>36</td>
<td>-10.2</td>
</tr>
<tr>
<td>No fixed abode</td>
<td>0</td>
<td>3</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>42</td>
<td>15</td>
<td>-64.3</td>
</tr>
<tr>
<td>Lettings where this information was given</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)

The figures shown in Table 11 would seem to support the hypothesis that it is those with the more severe needs (using hospital inpatient care as a very rough proxy for need) who are continuing to be housed. However, the commentary from mental health staff working within local authority areas suggests the picture remains variable.

The majority of providers operate acceptance criteria for new lettings that are based on their capacity, expertise and health and safety requirements. Most providers will carry
out a risk assessment of new referrals prior to acceptance, and although the higher levels of client needs may be more routinely accepted, exclusions of the most complex cases remain a fact. Many schemes will refuse to accept those with a history of arson, some will refuse those with a history of violence, and, if the client is within a programme for drug or alcohol abuse, many will only accept those with a dual diagnosis.

As one scheme manager commented:

_We don’t have hard and fast rules about exclusions. Really, we set our acceptance criteria to try and match our resources to needs. In most cases we will carry out a risk assessment and make a decision on an individual basis. But it is highly unlikely we would accept anyone with a history of arson. Violent incidents are less of an issue, but we have to consider staff safety as well as other residents. Drug users must be in a programme._

Housing association scheme manager, East London

Schemes such as the Nile Centre in Hackney do not accept clients with current drug-use problems, despite accepting high-needs clients who would otherwise face hospitalisation.

Changes in length of stay

Many of those interviewed as part of this study mentioned that supported housing had changed over the last five years, and that it now puts much more emphasis on more permanent housing for people with more complex needs. Analysis of the Supported CORE schemes database confirms this to be the case.

The evidence from case study boroughs in Table 12, below, shows that the emphasis recently has been on more permanent housing for people with complex problems. (Unfortunately data is not available back to 1996/97, so data here has been compared data with the Supported CORE schemes database for 1999/00 and 2001/02.)

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Net change in no of units between 99/00 and 01/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium-stay units (more than one year, but move-on expected)</td>
<td>+9</td>
</tr>
<tr>
<td>Permanent</td>
<td>+212</td>
</tr>
<tr>
<td>Short-stay units (less than one year)</td>
<td>+39</td>
</tr>
<tr>
<td>Missing</td>
<td>-43</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)

Access to support

As shown in Table 10 (p 28), the number of people gaining access to supported housing has reduced sharply over the last five years. The following analysis was undertaken to identify whether any specific age, gender or ethnic group has fared better or worse than others.
**Age profile – new lettings**

The age profile of new lettings shows an increase in the number of 46–59 year olds being housed, with decreases for younger people, most especially those aged 25–38.

**Table 13: Age profile of tenants in new lettings**

<table>
<thead>
<tr>
<th>Age range</th>
<th>1996/97</th>
<th>2001/02</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 or 17</td>
<td>2</td>
<td>3</td>
<td>*</td>
</tr>
<tr>
<td>18–24</td>
<td>76</td>
<td>60</td>
<td>-21.1</td>
</tr>
<tr>
<td>25–31</td>
<td>160</td>
<td>104</td>
<td>-35.0</td>
</tr>
<tr>
<td>32–38</td>
<td>141</td>
<td>89</td>
<td>-36.9</td>
</tr>
<tr>
<td>39–45</td>
<td>90</td>
<td>75</td>
<td>-16.7</td>
</tr>
<tr>
<td>46–52</td>
<td>53</td>
<td>68</td>
<td>+28.3</td>
</tr>
<tr>
<td>53–59</td>
<td>37</td>
<td>39</td>
<td>+5.4</td>
</tr>
<tr>
<td>60–64</td>
<td>22</td>
<td>14</td>
<td>*</td>
</tr>
<tr>
<td>65–69</td>
<td>5</td>
<td>5</td>
<td>*</td>
</tr>
<tr>
<td>70–74</td>
<td>9</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>75–79</td>
<td>5</td>
<td>2</td>
<td>*</td>
</tr>
<tr>
<td>80+</td>
<td>5</td>
<td>0</td>
<td>*</td>
</tr>
<tr>
<td>Lettings where this information was given</td>
<td>96.0%</td>
<td>98.7%</td>
<td>*</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)  
* small numbers

**Gender profile – new lettings**

In 1996/97, 27.9 per cent of new lettings were to women, and 72.1 per cent to men. In 2001/02, the picture was similar, with 29.1 per cent of lettings being to women, and 71.0 per cent to men.

**Ethnic origin – new lettings**

CORE asks for information on colour and ethnic origin. The results show a significant shift towards supporting a higher proportion of black people of Caribbean, African, or Asian origin.
Table 14: New supported housing lettings by race and ethnicity

<table>
<thead>
<tr>
<th>Ethnic origin</th>
<th>1996/97 (%)</th>
<th>2001/02 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>24.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>4.5</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>4.4</td>
<td>2.0</td>
</tr>
<tr>
<td>White</td>
<td>66.8</td>
<td>60.3</td>
</tr>
<tr>
<td>Asian</td>
<td>4.2</td>
<td>6.7</td>
</tr>
<tr>
<td>Caribbean</td>
<td>9.8</td>
<td>14.8</td>
</tr>
<tr>
<td>African</td>
<td>4.7</td>
<td>8.0</td>
</tr>
<tr>
<td>South-east Asian</td>
<td>1.1</td>
<td>.0</td>
</tr>
<tr>
<td>British/European</td>
<td>66.1</td>
<td>50.5</td>
</tr>
<tr>
<td>Irish</td>
<td>4.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Other</td>
<td>4.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Combination</td>
<td>1.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Declined to give information</td>
<td>3.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Lettings where this information was given</td>
<td>98.8</td>
<td>99.1</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)

Impact on acute sector

Supported CORE shows that although the number of places offered within supported housing has fallen by 26 per cent, the number of places allocated to people leaving hospital has remained fairly constant, as shown in Table 15, below.

Table 15: Number of lettings in supported housing

<table>
<thead>
<tr>
<th>Year</th>
<th>1996/97</th>
<th>2001/02</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total lettings</td>
<td>630</td>
<td>465</td>
<td>-26.3</td>
</tr>
<tr>
<td>Lettings to people whose last settled base was hospital</td>
<td>126</td>
<td>120</td>
<td>-4.8</td>
</tr>
</tbody>
</table>

Source: Supported CORE lettings database (2002)

This does not tell us whether the supply of places is keeping pace with the demand, but does indicate that people leaving hospital have not seen their chances of being offered a place in supported housing reduced in the same way as have other sectors of the population.
Conclusions

The housing association sector is supporting fewer people with mental health problems than five years ago for two reasons:

- although the number of projects have increased, their average size is smaller
- fewer units become available in any one year.

Compared with the situation in 1996/97, people who received accommodation with support in 2001/02 were more likely to be:

- 46–59 years old, and less likely to be 25–38 years old
- black
- a resident in hospital, a hostel or shared housing
- nominated by the housing department or referred by social services.

The context – providers’ perspectives

This section offers some qualitative information and context to the raw data outlined above. It is based on interviews with Geoff Heath from Opendoor Housing Trust and Vicky Stark and Christine Storrs from Look Ahead Housing and Care, augmented with information from London and Quadrant Housing Trust and Hyde Housing.

Pressures and driving forces within last five years

The last five years have presented few opportunities for developing innovative mental health services. There has been pressure to devise services that can be funded from housing benefit, without putting further pressure on social services or health funding. There has been particularly acute pressure in pricing of registered care.

Providers interviewed had seen little pressure from statutory agencies to improve the models of service provided. One provider described having 40 registered care beds, built in the mid-1980s. Five years ago, the organisation had been sure that this model of service would not survive another five years. Now it seems likely that they will survive for quite a time to come, even beyond the introduction of the new Care Standards.

Although social services has not exerted pressure to increase the quality of support provided, they have been keen for providers to increase the volume of support. In the past, services tended to be either 24-hour cover or five-days-a-week, office-hours cover. The new emphasis has been on seven-day services with emergency off-site cover available 24 hours a day.

Changing needs

Providers have seen significant changes in the needs of the people they are asked to house. Far more people have dual diagnosis. For Opendoor Housing Trust, the major change in people referred through the homelessness route has been the increase in drug and alcohol abuse, while for those referred by social services or health, the major
increase has been in people with a forensic history, and people previously detained under the Mental Health Act and now on Section 117.

Look Ahead has seen a significant increase in the proportion of their tenants who have dual diagnosis, with a very sharp rise in the number of people with drugs problems. They had also noticed an increase in the number of people with personality disorders, for whom statutory agencies had no appropriate services. Both Hyde and London and Quadrant reported a general increase in people with higher needs and more complex problems. All providers emphasised the very different nature of the client groups they were now housing.

Supply and demand

When asked whether supply was keeping pace with demand, the providers felt that the supply was fairly static, with the same housing being used to satisfy a higher level of need than previously.

Opendoor had not seen a great increase in the volume of demand from the statutory services, but were clear that this was because of resource pressures. They reported a greater incidence of people who should have been cared for by statutory services being referred via the homelessness route because they had either slipped through the net, or had been deemed to have insufficiently high support needs. They quoted an extreme example of a person on a Home Office order (in other words, with severe mental health problems and a history of offending) who was referred to them simply as a ‘single homeless person with support needs’.

Opendoor reported that tenants were certainly staying longer in projects than they were five years ago. There was a feeling that the projects were now housing people, either long-term or even permanently, rather than supporting them for a short period and preparing them to move on. This was due to a combination of the higher needs of the tenants, and the difficulties with move-on.

London and Quadrant saw some evidence of oversupply of low-support provision, and under-supply of high-support provision, especially forensic services.

Remodelling

Pressure has been more likely to come from housing departments faced with housing people for whom social services accept no responsibility. This pressure is for an increase in schemes enabling independent living, and this has resulted in some remodelling of shared bed spaces into independent units. Opendoor, for example, has been involved in the development of 26 one-bed units in the last five years, of which 14 were improved older properties, and 12 were new build.

Look Ahead have been involved in a remodelling of a registered care home. This was originally a registered six-bed shared house, plus six independent registered flats, plus an outreach service in Westminster. The shared house residents were people previously in long-stay hospital, whereas the independent flats housed younger people, mainly with a dual diagnosis.
Look Ahead found that after people had been supported independently for a few years, they no longer needed to be in registered care, but had settled into their living accommodation and did not want to move. The six flats were therefore de-registered (and other provision increased elsewhere to compensate for the loss), and with the savings achieved, the outreach service was expanded.

Overall, the quantity of remodelling has been low. London and Quadrant, for example, with 390 bed spaces, managed either directly or by agencies, have been able to remodel only one scheme.

**Assertive outreach**

The most significant new developments in the last five years have been in home-based support for people with high levels of needs, including those on enhanced community programme approach plans. Opendoor has worked with Partnership in Peckham to develop an Assertive Outreach Team, targeting people who are disengaged with the statutory service.

This has been a most successful scheme. Of 36 clients who had been with the team for at least a year, the number of bed days used was 761 in the year after their first contact with the team, compared with 1245 in the previous year. For a summary of the project, see Good practice, p 62.

**Move-on**

The problem of lack of move-on accommodation has become much more serious in the past five years. Opendoor has an ex-offenders hostel in Kensington and Chelsea where re-housing takes two years, while London and Quadrant quoted a scheme where people had been waiting six years for re-housing. Housing associations are moving away from offering quotas to specialist providers, because common housing registers are seen as a more equitable way of rationing such a scarce resource. Some common housing registers do award extra points, for example, if someone has been in a secure hospital.

Look Ahead’s mental health projects are mainly of a long-term nature, so relatively few people move on. They do, however, have greater problems with finding appropriate move-on for people in their homeless hostels. Since mental health problems are common within the hostel population, one problem experienced is that if move-on accommodation is found, there is no support attached to it. The resettlement team is therefore investigating whether people need to move on from hostels into supported housing, rather than to independent living, since in this way they can continue to receive some support.

Hyde, being a large, general-needs housing association, is able to offer a quota of its own housing stock for move-on. However, even here, the pressure for housing is so acute (and the requirement of keep voids low) that supported housing staff are sometimes not able to take the offered accommodation because they do not have a person ready to move on within the timetable required by the allocations section. Support staff members have to argue for their clients to be treated as a special case if, for example, they want to live in a certain area to be near their psychiatrist or day centre.
Hyde felt that people leaving supported housing were considered as a homogeneous group, whereas their needs were in fact very different. A young single homeless person, for example, could be housed in a bedsit, because they would probably not stay there for very long, and might move on when they formed a relationship. An older person with mental health problems would probably live in that bedsit for years, and might go out infrequently, and would therefore be more likely to remain healthy if they had more space.

This illustrates that housing pressure means that even housing associations with a large stock are not always able to meet the move-on needs of their specialist projects.
Supported housing in 2002

The development of the Supporting People funding system has created, for the first time, a relatively comprehensive database for supported housing provision. In the past, the Housing Corporation held statistics on supported housing that it funded, and data on registered care schemes were held by the inspection units, and later by the National Care Standards Commission.

There was no comparable data on the private-sector landlords providing supported housing schemes in a number of areas and local arrangements, and these often failed to appear in social housing statistics. (One such scheme is the ‘private landlords and landladies’ service, developed by the London Borough of Merton, to support people with mental health needs prior to moving into independent accommodation.)

As all such schemes are now eligible for Supporting People funds (other than registered care homes), this should give us a more complete picture of local provision than was previously the case. The missing link remains the schemes funded by health agencies.

Action point

- We urge local authorities and health agencies to work together to create a single database of all provision for people with mental health problems, to assist with the co-ordination of Supporting People with health planning and commissioning.

The new Supporting People databases will significantly improve the quality of the data available. Unfortunately, at the time of publishing this working paper, the databases were not yet complete, and the authors had serious reservations about some of the figures produced by the SPINTLS system (the IT programme commissioned by the Office of the Deputy Prime Minister and distributed to all local authorities, to ensure that systems would be standardised). Errors should have been ironed out before April 2003, when all contracts have to be signed, but at the time of drafting this working paper, figures from the Supporting People databases should be treated with considerable caution. It is vital that Supporting People databases are accurate, because planners and commissioners will be basing decisions about service developments on figures produced from these databases.

Principal supported housing models

There are a large number of different models of supported housing, based on a combination of housing type and levels and models of support, in addition to registered homes.

There are three principal accommodation models:

- specialist housing with on-site staffing
- specialist housing with visiting staff
- non-specialist housing with floating support.
Generally, it is true to say that the more recent the scheme, the more likely it is that the housing will be self-contained. Much of today’s supported housing was developed from the 1980s through to the 1990s via social housing grant or health authority capital as part of re-provision programmes. Much of this provision is shared housing in hostels and houses.

There is also a significant number of older schemes developed by local authorities, by older charities and by specialist agencies and housing associations that have been active in their respective fields for many years – for example, Peter Bedford, Richmond Fellowship and others. Many of these schemes offer shared housing, although in recent years shared rooms have largely been phased out.

No list of models of housing for people with mental health problems can be comprehensive, but the principal models are described below.

**Group homes**

The most common form of supported housing for clients with mental health needs is shared housing within a group home. These were developed in large numbers during the 1980s and early 1990s by housing associations with capital funding from both mainstream social housing grant or from health funds, linked to closure of long-stay mental health hospitals. The accommodation usually consists of a number of individual bedrooms, with shared kitchens, lounges and bathrooms. In a minority of schemes, there may also be some shared bedrooms, although these have largely been phased out. The number of clients varies but schemes are usually designed for between four and seven people.

Some of these schemes will have been registered, dependent on the client group and revenue funding arrangements. The remaining ‘homes for life’ provision is usually within this type of scheme.

Group homes have been a relatively inexpensive means of providing accommodation, and some were developed with specific users in mind, often from pre-identified peer or friendship groups from within the hospital. As the specific clients have changed and as clients’ views of acceptable standards have increased, this form of provision has become less acceptable and less popular. In practice, this has meant that many schemes are now viewed as interim housing, rather than permanent provision. The actual length of stay of a client is closely linked both to their own care needs and to the availability of suitable self-contained permanent housing in the area.

In recent years, key changes within these schemes include:

- single occupancy only
- more use as medium-term housing
- older, poorer schemes closing
- change of use to provide for ethnic and/or gender-specific housing for shorter periods of occupancy
- de-registration to provide more flexible services – a process increasing under the new Supporting People funding arrangements.
Cluster flats

More recent developments have tended to provide either cluster-type accommodation (similar to student housing) or self-contained flats, often grouped together in a specific building or, less often, within a larger development. Rooms are en suite or bedsitter flats, sharing some communal facilities. This is an updated version of the group home and provides a more acceptable form of shared housing.

Grouped flats

Increasingly, providers have sought to balance the preference for self-contained accommodation with the need for revenue efficiencies and the potential for peer support, by developing a number of self-contained flats within a single building or adjacent buildings, and providing a unified management and support service for the units as a single entity. In the main, this type of housing is viewed as permanent, but this model is also used for shorter-term provision.

This type of accommodation may or may not have some form of communal space – for example, an office or shared space linked to training programmes as part of the support service. This provision has proved popular with clients, but in some areas has met resistance from local communities concerned with the growth of people with ‘problematic’ special needs being placed in their areas.

Dispersed schemes

A number of support agencies have entered into agreements with landlords (both housing associations and local authorities) to lease or manage a number of specific housing units to which social services will nominate clients with mental health needs. The agency will then provide a housing support service across these units.

These have often been relatively hard-to-let housing units, or are properties with a limited life. The limitation of these schemes is that the support is linked to the housing unit rather than the individual, but this form of support service has been invaluable in moving away from seeing mental health provision as needing to take the form of some kind of clustered arrangement, separate from mainstream communities, and this has been the basis of developing floating support schemes.

Floating support

Support to individuals in their own homes, rather than to residents of specified housing, is commonly referred to as ‘floating support’, and is one of the major areas of growth within supported housing. All local authority areas have increased their provision of floating support in recent years, and the advent of Supporting People will allow this form of support service to increase further. Support is tailored to the needs of the individual as far as possible, although contracts with purchasers tend to be for relatively set levels of support determined by the time allowed for client contact.

In some areas, housing support workers are now being included within community mental health teams and assertive outreach teams. Harrow is one example of home-based support through multi-disciplinary team working, incorporating housing workers.
This approach is likely to increase in the future as a logical method of providing a ‘whole systems’-based service to clients.

Crisis intervention

The development of crisis intervention housing models is limited, with a small number of schemes nationally and schemes in London within Islington and Hackney. Two of the London schemes were part of a recent assessment by the Sainsbury Centre for Mental Health and the Mental Health Foundation (SCMH/MHF 2002) and have been highly praised for the overall service they provide, the highly positive response of clients, their cost effectiveness and the decisions to focus on groups for which there are limited specific housing schemes.

Two examples are a women-only scheme in Islington that also offers accommodation for mothers and children, and an African-Caribbean scheme in Hackney.

The schemes are emphatic demonstrations of fast, effective, responsive services, based within the community, to periods of crisis that would otherwise necessitate hospitalisation. Robust and effective partnership working across a range of agencies is necessary and has been demonstrated to work well. Some schemes also provide 24-hour drop-in services to non-residents, again as part of the National Service Framework agenda, although the service in the Highbury scheme in Islington is now restricted to registered users.

The length of stay within these schemes varies from two to six weeks, although some schemes are now increasing this period to the upper end of this scale.

This model was highlighted within the NSF, and evidence would show that this option is highly thought of by clients. By locating the schemes in relatively central parts of the community, there are possibilities for economically developing this type of provision, linked to community mental health teams and assertive outreach teams, and incorporating 24-hour resource centres, as well as other primary care facilities within a single site.

At present, schemes are primarily provided by voluntary sector organisations, including housing associations. In Islington, one scheme is run by the Mental Health Trust and one by the voluntary sector. Private-sector organisations may find managing such schemes less attractive given the inter-agency working required on a continual basis, but the use of PFI or PPP development models is likely to be necessary to adequately fund development. Private sector providers with experience of mental health care should be included in local planning where this type of model may be appropriate.

Safe havens

The United States produced its first major government-funded initiatives to address homelessness in the 1980s, following the McKinsey Act. Subsequent developments and funding programmes via the Housing and Urban Development Agency (HUD) targeted the needs of homeless people with mental illness. To address the needs of those outside of the system, the concept of assertive outreach was established in the same period and, lesser known in the UK, the housing model referred to as ‘safe havens’. The physical form
of these safe havens varies considerably, but the service objectives are shared. These are:

- to provide easily accessible housing without time-limited stays, primarily to street homeless
- to focus on clients outside the system, including people with dual diagnosis
- to deploy multi-disciplinary, multi-skilled teams to address mental health drug/substance use, employment, and life skills.

Local models have developed across the United States, but the core focus has been maintained and the schemes are regarded as highly successful in working with a client group that often remained outside the care and support system.

**Meeting the needs of diverse communities**

We have only a partial picture of the range of diversity of communities served by housing support services. We are aware of a limited number of schemes for African-Caribbean people, for Somali men and specific schemes for Asian communities, but overall the level of provision is low and in many areas there is no ethnic-specific housing. And yet black people are disproportionately represented in the users of services. Examples of successful schemes exist in several boroughs, both accommodation-based schemes and floating support services.

The schemes run in Hackney and Waltham Forest by Kush Housing Association, a black-led housing association, are good examples of partnership arrangements that serve specific communities and provide high levels of added value over and above the housing itself.

The same supply issues apply to gender-specific schemes across all ethnic groups. From the partial data available, it appears that few areas within London have adequate provision for women, particularly for women whose cultural and religious beliefs would prevent them from sharing accommodation with men. However, some boroughs have successfully developed schemes of this type – for example, Tower Hamlets has specific provision for women of Asian origin.

From a more detailed assessment of schemes in a small number of boroughs, it is clear that physical accessibility to many of the schemes is limited and there is little provision for people with limited mobility and physical disability. This is in part an issue of the housing design and the use of converted properties rather than purpose-built housing. Although housing is not subject to the Disability Discrimination Act, it remains to be seen whether hostels and larger shared housing schemes at which a service is provided will continue to be excluded from the provisions of the Act. This could have a significant impact for support providers and, consequentially, for housing supply.
Asylum seekers and refugees

The mental health needs of asylum seekers and refugees were mentioned in interviews in case study boroughs. In October 2002, Havering had the highest number of asylum seekers in London (4,703) while Kingston had the fewest (291) (source: London Asylum Seekers Consortium website at: www.westminster.gov.uk/socialservices). The presence of large number of asylum seekers adds significantly to the demand for services. Many have suffered violence, imprisonment or other trauma, and have high levels of needs. However, this is not reflected in increased funding for mental health services.

Overall supply figures

Table 16, overleaf, shows the total provision within London boroughs of supported housing that will be funded via Supporting People contracts from April 2003. The total figure is 11,187, but this is thought to be an overestimate. The statistic is assembled from a standard table produced by the Office of the Deputy Prime Minister’s ‘standard information technology package’ (SPINTLS). The authors suspect some double counting has occurred, since some figures in this table are significantly higher than expected. This suspected overestimation may be partly offset by the fact that many floating support schemes have opened since these figures were produced in autumn 2002.

The figures only include registered care where a Housing Corporation Supported Housing Management Grant is currently received. Figures for registered care were available from the National Care Standards Commission, but it proved impossible to eliminate double counting between the Supporting People and the registered care lists. The Supporting People database is therefore presented here as the most complete statement of supply that was available, but with some reservations about the accuracy of the data. As many statistics as possible have been verified by cross-checking against published Supporting People plans, but at the time of publication many Supporting People lead officers were so fully employed with agreeing contracts with providers that they were (understandably) unable to assist with additional queries.

In addition to these figures, there are a further 390 clients, supported by probation funding, who are designated mentally disordered offenders and 699 clients who are older people, including those with dementia. To provide a sense of scale, the total figure for older people in need of support is over 125,000.

The percentage figures for the local authority programme show the level of mental health provision in each borough as a percentage of the total supported housing provision. The right-hand column shows the percentage for each borough of the London mental health provision. Westminster shows the highest levels of provision, with Hillingdon and Richmond having the lowest level of provision (the City of London has none, but is an exceptional case).
### Table 16: ‘Supporting People’ services for people with mental health problems

<table>
<thead>
<tr>
<th>London borough</th>
<th>Accommodation-based service</th>
<th>Accommodation-based with floating/resettlement/outreach support</th>
<th>Floating support service</th>
<th>Outreach service</th>
<th>Resettlement service</th>
<th>Total</th>
<th>Percentage of local authority programme</th>
<th>Percentage of total London Supporting People programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>48</td>
<td>0</td>
<td>63</td>
<td>0</td>
<td>111</td>
<td>2.2%</td>
<td>1.0%</td>
<td></td>
</tr>
<tr>
<td>Barnet</td>
<td>434</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>484</td>
<td>2.3%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Bexley</td>
<td>101</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>101</td>
<td>3.3%</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Brent</td>
<td>310</td>
<td>20</td>
<td>30</td>
<td>0</td>
<td>360</td>
<td>7.5%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>183</td>
<td>10</td>
<td>121</td>
<td>0</td>
<td>314</td>
<td>3.7%</td>
<td>2.9%</td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td>213</td>
<td>65</td>
<td>234</td>
<td>20</td>
<td>532</td>
<td>5.6%</td>
<td>4.9%</td>
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</tr>
<tr>
<td>Corporation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Croydon</td>
<td>194</td>
<td>99</td>
<td>28</td>
<td>0</td>
<td>321</td>
<td>3.0%</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>Ealing</td>
<td>288</td>
<td>30</td>
<td>55</td>
<td>170</td>
<td>543</td>
<td>5.3%</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Enfield</td>
<td>231</td>
<td>42</td>
<td>15</td>
<td>22</td>
<td>310</td>
<td>5.1%</td>
<td>2.9%</td>
<td></td>
</tr>
<tr>
<td>Greenwich</td>
<td>123</td>
<td>0</td>
<td>58</td>
<td>12</td>
<td>150</td>
<td>3.7%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Hackney</td>
<td>406</td>
<td>0</td>
<td>68</td>
<td>0</td>
<td>474</td>
<td>4.8%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>183</td>
<td>0</td>
<td>162</td>
<td>110</td>
<td>455</td>
<td>11.7%</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Haringey</td>
<td>292</td>
<td>84</td>
<td>37</td>
<td>0</td>
<td>413</td>
<td>9.6%</td>
<td>3.8%</td>
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</tr>
<tr>
<td>Harrow</td>
<td>134</td>
<td>0</td>
<td>95</td>
<td>0</td>
<td>229</td>
<td>3.7%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Havering</td>
<td>42</td>
<td>23</td>
<td>200</td>
<td>0</td>
<td>265</td>
<td>13.2%</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td>66</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>80</td>
<td>6.2%</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>Hounslow</td>
<td>71</td>
<td>0</td>
<td>98</td>
<td>0</td>
<td>169</td>
<td>4.9%</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td>320</td>
<td>13</td>
<td>25</td>
<td>0</td>
<td>382</td>
<td>7.6%</td>
<td>3.6%</td>
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</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>250</td>
<td>0</td>
<td>77</td>
<td>0</td>
<td>335</td>
<td>5.3%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Royal Borough of Kingston</td>
<td>129</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>138</td>
<td>5.3%</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Lambeth</td>
<td>283</td>
<td>44</td>
<td>181</td>
<td>0</td>
<td>508</td>
<td>6.5%</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Lewisham</td>
<td>399</td>
<td>66</td>
<td>42</td>
<td>0</td>
<td>507</td>
<td>12.9%</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Merton</td>
<td>133</td>
<td>83</td>
<td>6</td>
<td>0</td>
<td>222</td>
<td>5.9%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Newham</td>
<td>125</td>
<td>45</td>
<td>139</td>
<td>0</td>
<td>309</td>
<td>4.3%</td>
<td>2.9%</td>
<td></td>
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<tr>
<td>Redbridge</td>
<td>120</td>
<td>31</td>
<td>36</td>
<td>0</td>
<td>187</td>
<td>8.3%</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Richmond</td>
<td>30</td>
<td>6</td>
<td>20</td>
<td>0</td>
<td>56</td>
<td>6.3%</td>
<td>0.5%</td>
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</tr>
<tr>
<td>Southwark</td>
<td>327</td>
<td>0</td>
<td>152</td>
<td>0</td>
<td>479</td>
<td>6.6%</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>Sutton</td>
<td>145</td>
<td>0</td>
<td>174</td>
<td>0</td>
<td>319</td>
<td>3.7%</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>176</td>
<td>0</td>
<td>224</td>
<td>0</td>
<td>400</td>
<td>7.6%</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>145</td>
<td>33</td>
<td>40</td>
<td>0</td>
<td>218</td>
<td>7.1%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Wandsworth</td>
<td>339</td>
<td>0</td>
<td>81</td>
<td>12</td>
<td>432</td>
<td>9.4%</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Westminster</td>
<td>301</td>
<td>0</td>
<td>474</td>
<td>7</td>
<td>782</td>
<td>12.9%</td>
<td>7.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6,780</td>
<td>694</td>
<td>3,170</td>
<td>353</td>
<td>11,187</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Comparison with ODPM supply profiles

The Supporting People team of the Office of the Deputy Prime Minister (ODPM) provided a norm against which local Supporting People teams could compare their actual provision. They prepared different profiles for counties with districts, metropolitan areas, London boroughs and unitary authorities. Each profile was then customised to the particular authority to which it is being sent using population data.

Table 17: ‘Supporting People’ provision levels

<table>
<thead>
<tr>
<th>Level of support</th>
<th>Accommodation-based services</th>
<th>Floating support</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than twice the top of the ODPM range</td>
<td></td>
<td>Westminster</td>
</tr>
<tr>
<td>Above the top of the ODPM range</td>
<td>Hackney</td>
<td>Camden, Greenwich, Hammersmith and Fulham, Sutton, Tower Hamlets</td>
</tr>
<tr>
<td>Top quartile of the ODPM range</td>
<td>Islington, Lewisham</td>
<td>Ealing, Havering</td>
</tr>
<tr>
<td>Second quartile of the ODPM range</td>
<td>Camden, Ealing, Haringey, Kensington and Chelsea, Southwark</td>
<td>Lambeth, Newham, Southwark</td>
</tr>
<tr>
<td>Third quartile of the ODPM range</td>
<td>Barnet, Brent, Enfield, Hammersmith and Fulham, Lambeth, Merton, Wandsworth, Westminster, Barking and Dagenham</td>
<td>Bromley, Hackney, Harrow, Hounslow, Kensington and Chelsea, Wandsworth</td>
</tr>
<tr>
<td>Lowest quartile of the ODPM range</td>
<td>Bromley, Croydon, Kingston, Newham, Redbridge, Sutton, Tower Hamlets, Waltham Forest</td>
<td>Haringey, Islington, Lewisham, Redbridge, Waltham Forest</td>
</tr>
<tr>
<td>Below the bottom of the ODPM range</td>
<td>Bexley, Greenwich, Harrow, Hounslow</td>
<td>Barnet, Brent, Croydon, Enfield, Richmond</td>
</tr>
<tr>
<td>Less than half the bottom of the ODPM range</td>
<td>Barking and Dagenham, Ha...</td>
<td>Bexley, Hillingdon, Kingston, Merton</td>
</tr>
</tbody>
</table>

Source: King’s Fund (2003)

The construction of the profiles took no account of relative levels of need within boroughs (although this is not surprising, since data on needs is so difficult to come by). Since the profiles are constructed solely on a population basis, we would expect to see the inner boroughs towards the top end of the supply profile range, and this is the case. There are some suggestions of under-provision, with Lambeth, Wandsworth, Westminster.
and Tower Hamlets appearing below the mid-point of the range for accommodation-based services.

Eight boroughs fall below the bottom point on the ODPM range, with Barking and Dagenham, Havering, Hillingdon and Richmond recording less than half the amount of accommodation which the ODPM supply profile suggested as a minimum.

These extreme variations are not all statistical quirks. The impact of lack of supply is telling. In Hillingdon 50 per cent of outreach clients are occupying acute beds, unable to secure appropriate housing in the community.

Provision in terms of population needs

The lack of data on needs severely hampers the usefulness of the ODPM supply profiles as comparators. The following analysis attempts to refine the comparisons by incorporating an indicator of need. There exist many different variants to basic deprivation indicators that are used for specific purposes. One good example is the Mental Illness Needs Index (MINI), which uses census-based variables to estimate needs for acute mental health services.

Table 18, opposite, shows a marked variance in terms of the level of provision compared to the population, ranging from 50 Supporting People clients per 100,000 in Hillingdon to 444 per 100,000 in Kensington and Chelsea and Westminster. This is to be expected given the variation in levels of deprivation across a broad range of socio-economic factors. However, the level of variation is surprising, and it is clear that some areas have insufficient provision.

The addition of MINI scores attempts to build in needs factors. These scores are now quite old, and would change if recalculated, particularly in relation to the ethnic composition of some areas. However, it is reasonable to assume that, in relative terms from one area to another, the results would be similar (and they are the only consistently applied scores we have identified). They are calculated to assess the need for acute services, and are not strictly comparable with Supporting People supply figures. For example, these supply figures exclude a large proportion of registered provision and acute facilities, and include support for many people with lower needs than those requiring acute services.

A direct comparison between needs (calculated from MINI scores) and supply (calculated from Supporting People services) is therefore extremely tenuous, and figures are presented here as a means of relative comparison between authorities. The MINI score is calculated on the basis of need per 100,000 of the population, and we have therefore compared MINI score with the Supporting People provision per 100,000 of the population.

Bearing in mind the limitations of the approach, we have assumed that the MINI score is an indicator of need equivalent to one Supporting People unit of provision per 100,000 of the population. The final column of Table 18 expresses the Supporting provision as a percentage of MINI score. A result of 100 per cent would indicate that Supporting People provision exactly matched the MINI score.
### Table 18: Distribution of ‘Supporting People’ provision

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>MINI score</th>
<th>Total SP clients</th>
<th>SP clients, per 100,000</th>
<th>SP provision, per 100,000</th>
<th>% of MINI score</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>4,915,050</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking and Havering</td>
<td>246,653</td>
<td>231</td>
<td>376</td>
<td>152</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Barnet, Enfield and Haringey</td>
<td>543,767</td>
<td>231</td>
<td>1,207</td>
<td>222</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Bexley, Bromley and Greenwich</td>
<td>473,870</td>
<td>256</td>
<td>758</td>
<td>160</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Brent and Harrow</td>
<td>323,024</td>
<td>298</td>
<td>589</td>
<td>182</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Camden and Islington</td>
<td>272,775</td>
<td>455</td>
<td>914</td>
<td>335</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Croydon</td>
<td>219,813</td>
<td>257</td>
<td>221</td>
<td>101</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Ealing, Hammersmith and Hounslow</td>
<td>479,213</td>
<td>335</td>
<td>1,217</td>
<td>254</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>East London and The City</td>
<td>442,122</td>
<td>419</td>
<td>1,179</td>
<td>267</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td>160,143</td>
<td>201</td>
<td>80</td>
<td>50</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Kensington and Chelsea and Westminster</td>
<td>251,324</td>
<td>437</td>
<td>1,117</td>
<td>444</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Kingston and Richmond</td>
<td>219,196</td>
<td>238</td>
<td>194</td>
<td>89</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Lambeth, Southwark and Lewisham</td>
<td>537,711</td>
<td>408</td>
<td>1,494</td>
<td>278</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Merton, Sutton and Wandsworth</td>
<td>439,664</td>
<td>304</td>
<td>973</td>
<td>221</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Redbridge and Waltham Forest</td>
<td>305,775</td>
<td>285</td>
<td>405</td>
<td>132</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>4,915,050</td>
<td></td>
<td>10,724</td>
<td>218</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: King’s Fund (2003)

**Fig 3: Distribution of ‘Supporting People’ provision – visual aid**
Taking account of the MINI score, the highest level of provision (at 102) is in Westminster. This would in part reflect the level of resource investment in Westminster through the Homeless Mentally Ill Initiative in floating support services, such as tenancy sustainment teams. The lack of provision in a number of outer London boroughs is reflected in these calculations.

Extrapolating further from this approach, the average Supporting People provision per 100,000 of the population is some 64 per cent of the MINI figures for the 14 former health authority areas. If the provision was increased to 100 per cent of the MINI score, the overall provision would need to increase from 218 places per 100,000 to 311 places per 100,000. Across London as a whole, this would be equivalent to some 4,500 places or support packages.

This is a high figure compared to the more anecdotal view of the need for new provision derived from interviews and figures taken from Supporting People strategies of some 1,300 housing places. This is equivalent to an average of some 40 places per local authority. Support-only schemes would be additional to these.

If as little as 30 per cent of these 1,300 units were to be translated into a programme for additional housing, it would require capital funding of £25–30 million. This is in addition to any funds needed to ensure existing provision meets current standards.

Further research is needed to compare the total supply of acute, residential and community-based provision for those with higher levels of need, with needs data using updated MINI scores, based on the 2001 census. This would provide a first step to assessing overall need for new housing-based provision in relation to a health assessment of need for acute services.

Analysis of mental health services is particularly complex because of the great many individuals and agencies involved in health, support and housing. In attempting to gain an overall picture of services, the authors were frequently referred on to other people for information.

Table 19, opposite, lists some of the information that would be needed to inform a mental health and housing strategy. Even for such a small number of boroughs, the authors were unable to identify all the information in the time available.
### Table 19: Background data for compiling a strategy

<table>
<thead>
<tr>
<th></th>
<th>Hillingdon</th>
<th>Newham</th>
<th>Hackney</th>
<th>Islington</th>
<th>Southwark</th>
<th>Harrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (15–64)</td>
<td>160,143</td>
<td>162,147</td>
<td>138,875</td>
<td>127,229</td>
<td>172,487</td>
<td>138,655</td>
</tr>
<tr>
<td>MiNi score</td>
<td>201</td>
<td>419¹</td>
<td>419¹</td>
<td>455</td>
<td>408²</td>
<td>298¹</td>
</tr>
<tr>
<td>Floating support (places)</td>
<td>14</td>
<td>13</td>
<td>25</td>
<td>67</td>
<td>173</td>
<td>95</td>
</tr>
<tr>
<td>Supported hsg units</td>
<td>66</td>
<td>82</td>
<td>123</td>
<td>291</td>
<td>336</td>
<td>134</td>
</tr>
<tr>
<td>CPA enhanced</td>
<td>641</td>
<td>507</td>
<td>558</td>
<td>N/K</td>
<td>1400</td>
<td>300</td>
</tr>
<tr>
<td>CPA ordinary</td>
<td>450</td>
<td>345</td>
<td>338</td>
<td>N/K</td>
<td>N/K</td>
<td>800</td>
</tr>
<tr>
<td>Assertive outreach clients</td>
<td>67</td>
<td>29</td>
<td>96</td>
<td>N/K</td>
<td>N/K</td>
<td>73</td>
</tr>
<tr>
<td>Acute beds</td>
<td>64</td>
<td>66</td>
<td>107²</td>
<td>262</td>
<td>701</td>
<td>70</td>
</tr>
<tr>
<td>Identified need (units)</td>
<td>NQ³</td>
<td>NQ</td>
<td>30 + floating support</td>
<td>NQ</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Local strategy</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Identified capital funds for new hsg</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y – bid to be approved</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>No. of units</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Identified revenue funds for new hsg</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Ethnic-specific provision</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Women-only provision</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Crisis-resolution beds</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

¹ Based on East London and City as a whole
² Based on Lambeth, Lewisham and Southwark
³ based on Brent and Harrow
⁴ plus 35 rehab beds
⁵ not quantified

Source: King’s Fund (2003)
Key issues for providers

If housing for people with mental health problems is to be improved over the next five years, this will require a partnership between housing providers, commissioners and service users. The key issues to be addressed are outlined in this section.

Quality

Supported housing providers face significant problems in ensuring they meet clients’ aspirations for independent housing. The most severe impediment is the lack of access to ‘ordinary’ housing as a result of the reducing supply, which has choked the supply of move-on accommodation. This in turn silts up schemes that would otherwise provide accommodation for people seeking discharge from acute beds. The lower the overall level of provision, the greater the problem faced by practitioners and clients alike.

Surveys in the UK and in the United States emphasise people’s desire to have independent housing – that is, a home of their own. Where poor quality shared housing is the only option available within the social sector, people choose not to stay, and try to find their own housing solutions. This is often not possible, and people become trapped within the revolving door of short-term housing, lack of support, homelessness and, often, readmission to acute beds following a crisis.

The statistics collected and interviews undertaken for this working paper have painted a picture of specialist housing available for Londoners who have mental health needs that:

- is shared rather than self contained
- is often based in older conversions of Victorian properties that do not meet current expectations
- is medium-to-long-term rather than short-to-medium-term
- offers only limited access to independent housing, as move-on accommodation becomes less available
- offers clients limited choice.

The information presented here is not comprehensive. It is to be hoped that the service reviews required under Supporting People will analyse the current provision in detail, resulting in plans for remodelling and re-provisioning where necessary. This will depend on the Supporting People funding keeping pace with changing needs.

In addition, statistics for the total housing supply are not a sufficient indicator of the provision of appropriate, adequate and satisfactory housing from both the clients’ perspective and that of local practitioners within the mental health services. As time passes, using numbers to equate with adequate supply is increasingly erroneous.

There are also serious question marks as to the appropriateness of some of the current specialist, supported housing available. This relates primarily to the shared housing schemes, but covers a number of factors:

- the undesirability of shared or communal living
- the lack of gender-specific housing
- limited specific provision for minority ethnic groups
- the quality of some of the older housing schemes, particularly older hostel schemes.
Distribution

Distribution tends to follow patterns of historical development activity by housing associations, as well as hospital closure programmes. The expected gap between provision in outer London boroughs as compared to inner London boroughs reflects both needs levels and social housing core activity areas. There is a need for outer boroughs to redress the balance where it is clear they have insufficient provision.

For all boroughs, the distribution of provision within their areas needs to be considered, as certain areas have had much greater levels of supported housing development than others. This not only creates an imbalance in services, but is a source of resentment where local people can, to a certain extent justifiably, claim that people with special needs are over-represented in their locality.

A great deal of regeneration activity is improving the living conditions of Londoners. Often these programmes have a strong social inclusion agenda, but local community involvement has led to resistance to the planning of supported housing. This is especially true of supported housing for people with mental health problems, where community nervousness is often fuelled by local and national press. These challenges should be acknowledged and tackled by regeneration staff and mental health specialists working in partnership.

Choice

Choice of housing provision is limited in all areas of the social sector in London, but nowhere more so than in supported housing. Few clients feel they have any choice as to where they are referred, let alone the form of housing. However limited, it is essential that clients are given full information on the housing options open to them, and that these are discussed and agreed with them wherever possible before referrals are made.

Planning of new services and housing should take account of the views of local clients, and the planning process should try to ensure that the long-term objectives include the provision of a range of housing options that affords future clients a degree of choice in the type of home available to them and the location of their home.

Skills base of staff

The authors found no consistent evidence of improvements in the skills base of the staff members, who are now working with people with much more complex needs. Current funding contracts are seldom generous in terms of funding training. The recruitment and retention difficulties of frontline staff have worsened as housing costs have spiralled upwards. It is well documented that it is often impossible for nurses to be able to afford to live in London; the position for support workers is equally, if not more, severe.

The new Supporting People contracts require that staff should have sufficient skills, training and experience, and the new Quality Assessment Framework also emphasises the need for well-trained staff. The costs of training staff must be included within the Supporting People contract price.
Given that the increasing complexity of need and the increasing incidence of dual diagnosis is widespread, a London-wide co-ordinated training programme should be established as a cost-effective means of addressing skills shortages.

**Unmet needs**

This section describes the key stakeholders' views of greatest areas of unmet needs. Information was collected from strategies and interviews and the level of agreement between commissioners and providers across London is remarkable.

**‘Supporting People’ strategies**

When preparing Supporting People strategies, local authorities were asked to list priorities for developments, should additional funding be made available. This gave some of the strategies an air of 'wish-lists', with a great many urgent priorities identified.

There is a tremendous variation between local authority Supporting People strategies in respect of the level of detail for the mental health client group. Some, such as Islington and Kensington and Chelsea, are very detailed, and reflect the planning work carried out elsewhere in assessing the housing and support issues for mental health. The authors requested strategies from all authorities, and where these were not received, downloaded the documents from the Office of the Deputy Prime Minister’s Supporting People website (www.spkweb.org.uk). Even by the end of December 2002 not all strategies were publicly available.

From those strategies that were available, Table 20 highlights the indicated priorities (in abbreviated form) identified within each strategy.

**Table 20: Indicated priorities in strategies of boroughs**

<table>
<thead>
<tr>
<th>Borough</th>
<th>Mental health priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>Strategy not available</td>
</tr>
<tr>
<td>Barnet</td>
<td>• High support clustered, self-contained units</td>
</tr>
<tr>
<td>Bexley</td>
<td>Strategy not available</td>
</tr>
<tr>
<td>Brent</td>
<td>• Floating support</td>
</tr>
<tr>
<td></td>
<td>• Complex mental health needs</td>
</tr>
<tr>
<td></td>
<td>• Remodelling of poorer existing provision</td>
</tr>
<tr>
<td></td>
<td>• Shift to housing-based care and support from residential and acute provision</td>
</tr>
<tr>
<td></td>
<td>• Dual diagnosis worker</td>
</tr>
<tr>
<td></td>
<td>• Crisis intervention housing</td>
</tr>
<tr>
<td></td>
<td>• Women suffering violence and mental health needs</td>
</tr>
<tr>
<td>Bromley</td>
<td>• Bringing in a number of patients placed out of borough</td>
</tr>
<tr>
<td></td>
<td>• Higher level support units</td>
</tr>
<tr>
<td></td>
<td>• Dual diagnosis (mental health and substance misuse)</td>
</tr>
<tr>
<td>Borough continued</td>
<td>Mental health priorities</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Camden            | • 24-hour and crisis support  
|                   | • Intensive floating support  
|                   | • Extended resettlement support  |
| Corporation of London | • Counselling services  |
| Croydon           | • Schemes to reduce the use of out-of-borough residential and nursing homes  
|                   | • Temporary accommodation  
|                   | • Tenancy sustainment for people living independently  
|                   | • Dual diagnosis (mental health and deaf)  |
| Ealing            | • Core and cluster high- and medium-support needs (in development)  |
| Enfield           | Strategy not available  |
| Greenwich         | • High-intensity support for people with complex needs (for example, young people who have been in custody)  
|                   | • Dual diagnosis (mental health, substance misuse and offending, and mental health and learning disability)  
|                   | • Schemes for single-sex and minority ethnic clients  
|                   | • Tenancy sustainment  |
| Hackney           | • Accommodation-based, long-term support service for older Orthodox Jewish men with functional mental health issues  
|                   | • Accommodation-based, long-term support for African-Caribbean elders with functional mental health issues  
|                   | • Accommodation-based, short-term support for people with mental health and intensive tenancy support needs and for nuisance offenders with mental health problems  
|                   | • Generic, flexible, floating support with capacity for specialisation  |
| Hammersmith and Fulham | • High-care hostel  
|                   | • Remodel existing schemes  
|                   | • Floating support  
|                   | • Declassification of care homes  |
| Haringey          | • Borough-wide floating support  
|                   | • Tenancy support workers (16) as part of community mental health team/assertive outreach service  
|                   | • High-support rehabilitation housing for high-care/high-support clients at risk of re-offending  
|                   | • High and medium support for clients being discharged from hospital  
|                   | • Self-contained grouped flats  |
| Harrow            | • Crisis-intervention housing  
|                   | • Self-contained high support  
|                   | • Floating support  |
| Havering          | Strategy not available  |
| Hillingdon        | • Floating support  
|                   | • Additional provision and reconfiguration to meet higher needs or dual diagnosis  |
| Hounslow          | • Extension to 24-hour cover via existing floating support services  
|                   | • High-care provision for people with complex needs or dual diagnosis  
|                   | • Crisis-resolution housing as alternative hospital admission  
|                   | • Development of culturally aware or diverse services  
|                   | • Homelessness preventative measures  
<p>|                   | • Provision for homeless people with mental health needs  |</p>
<table>
<thead>
<tr>
<th>Borough continued</th>
<th>Mental health priorities</th>
</tr>
</thead>
</table>
| **Islington**     | • Increasing the range of supported housing available  
|                   | • Developing more accommodation for people with high-level needs (either high-level floating support or schemes with staffing and communal facilities on site)  
|                   | • Providing accommodation for those with multiple needs  
|                   | • Developing improved access to supported housing for people from black and ethnic minority groups  
|                   | • Identifying mechanisms to increase access to accommodation in the south of the borough  
|                   | • Reducing the number of people on mental health acute in-patient wards waiting for supported accommodation |
| **Kensington and Chelsea** | • Categories 3 and 4 accommodation (medium and high care)*  
|                   | • Provision for people with a dual diagnosis of mental illness and substance use (including rough sleepers)  
|                   | • Provision for people who are unwilling and/or unable to engage in rehabilitation and require long-term support and monitoring  
|                   | • Provision for people with mental health problems not categorised as severe and enduring, who nevertheless require a high level of support and supervision as a result of chaotic and/or anti-social behaviour, substance use and offending  
|                   | • Provision for wheelchair users with mental health problems, (and/or those with limited mobility)  
|                   | • Services providing an alternative to bed and breakfast accommodation for homeless people waiting to be rehoused through the common housing register  
|                   | • Targeted services for people from black and minority ethnic groups  
|                   | • Crisis house (or access to crisis beds)  
|                   | • Targeted service for young people with mental health problems  
|                   | *Kensington and Chelsea has identified five levels of support and has graded provision and needs on this basis. |
| **Kingston**      | Strategy not available |
| **Lambeth**       | Strategy not available |
| **Lewisham**      | • Services for people with higher support needs, including those with challenging behaviour  
|                   | • Dispersed services for younger people  
|                   | • Schemes for women with children  
|                   | • Schemes for black and minority ethnic groups  
|                   | • 24-hour services for older people |
| **Merton**        | • Expanding the housing support team (floating support)  
|                   | • Self-contained accommodation, including remodelling a 20-bed registered care scheme  
|                   | • Small group homes |
| **Newham**        | • In-borough supported housing  
|                   | • Floating support  
|                   | • Promotion of provision for black and minority ethnic groups |
| **Redbridge**     | Strategy not available |
| **Richmond**      | • Permanent housing |
| **Southwark**     | • Re-provisioning of shared hostels into purpose-built self-contained clusters, especially for dual diagnosis  
|                   | • Floating support  
|                   | • Short-term crisis-intervention team |
| **Sutton**        | • Services for people with complex needs  
|                   | • Floating support |
| **Tower Hamlets** | • Early-intervention supported housing scheme for six young people recovering from psychotic illness  
|                   | • Dual diagnosis (mental health and substance misuse) |
| Waltham Forest continued | • High-support accommodation  
• Floating support services |
|--------------------------|-----------------------------------------------------------------|
| Wandsworth               | • Moving people with lower support needs out of hostels into independent living  
• Remodelling of hostels to house people with complex needs, including dual diagnosis (mental health and drug or alcohol misuse) |
| Westminster             | • High-support accommodation for dual diagnosis (mental health and substance misuse), forensic and personality disorder  
• Move-on accommodation  
• Renovation of shared housing  
• Community-based support for crisis, hospital discharge and rehabilitation |

Source: King’s Fund (2003)

Commonly identified priorities included:

- housing and services for people with high support needs, particularly dual diagnosis
- floating support or tenancy sustainment for people living independently
- crisis-intervention housing
- black and ethnic minority-specific provision
- re-modelling of existing housing
- re-modelling and refocusing of existing support services.

Mental health trusts

The most common need identified by mental health trusts is for greater numbers of units for clients with severe and enduring mental illness – in particular, accommodation able to provide high levels of support.

This would include housing with 24-hour staffing. Although this form of staffing has primarily been associated with registered homes, the challenge is to develop housing-based models that can offer similar levels of care. The view of the trusts is that existing accommodation is meeting the needs of clients with less complex, less severe needs and the use of floating support is enabling them to develop home-based care services along with housing support for clients living independently.

This requirement would appear to be particularly acute among outer London boroughs with less history of housing association activity for high-needs groups. Redbridge, for example, identifies a shortfall of some 30 to 40 places of 24-hour staffed accommodation. However, the investment projection shows a proposed capital expenditure of some £100,000 per annum over a three-year period. At most, this would meet less than half of their identified numbers.

Crisis-intervention housing is also identified as a capital funding and service development priority. However, identifying accurate numbers of places needed is difficult for the mental health teams, and consequently overall, there remains a problem for establishing the level of needs and therefore the required supply. Dissatisfaction with the MINI index, variation in practice between authorities as to who is identified as requiring enhanced care programme approach plans (and therefore, the significance or otherwise of enhanced caseloads) lack of knowledge as to needs being addressed within the primary care sector, and lack of knowledge as to who was currently occupying supported housing were common issues across authorities. It was common, therefore, to be given ranges of figures for required provision, for example, 30 to 40 places are needed in this borough. Taken across the 32 boroughs, that is a significant variation.
Providers

Opendoor Housing Trust

Opendoor Housing Trust identified the key gaps in provision as:

- move-on
- housing for older people with mental health problems other than dementia.

The second of these is particularly interesting. Opendoor continues to house tenants well beyond the age of 65 because there is nowhere else for them to go. With increasing life expectancy, the ‘robust elderly with mental health problems’ is a growing client group, which receives far less attention than the ‘frail elderly’.

Look Ahead

For Look Ahead, the biggest gaps were:

- high-care outreach services
- alternatives to hospital.

Look Ahead saw a real need for a more flexible range of services. At the moment they described hospital care, schemes, and home-based support as being too compartmentalised, whereas a more flexible approach was needed to support people as their needs fluctuated.

London and Quadrant

London and Quadrant identified one priority:

- high-care services, especially forensic.

The providers interviewed saw future developments polarising around high-support schemes for people with very serious mental health problems who would previously have been cared for in hospital, and intensive home-based support.

The problem of move-on

The identification of unmet needs, and the development of new provision will provide only a temporary improvement to services if there is insufficient ordinary housing for people to move on to once they no longer need specialist projects. It was traditionally assumed that move-on accommodation for people leaving mental health projects would be provided by the social housing sector, but as we have seen in this section, this is a shrinking sector.

The very high costs of owner occupation and private rented housing in London means that there are very few alternatives open to people leaving specialist projects. No recent work has been done on assessing the size of the move-on problem, but in the early
1990s it was estimated that the cost to the public purse of people overstaying in specialist housing was around £16 million (Homes 1991).

Single Homeless in London produced two reports, that estimated the annual shortfall in the supply of move-on accommodation in London to be 9,000 in 1992 (SHiL 1992) and 18,000 three years later (SHiL 1995). (The difference was due partly to the definitions of temporary accommodation and move-on used in the two reports.)

A group of housing associations has been working with the London Borough of Camden to develop more flexible solutions to the move-on problem through the Move-on Alternatives Project (MAP). MAP's proposal for a major co-ordinated project is included in Appendix 6. This work has been prompted by the associations' grave concerns about the decreasing supply of accommodation.

Feedback from frontline agencies suggests that stays of five years or more in temporary supported housing are now common. The HOMES move-on scheme has seen its supply of move-on fall from around 500 units in 1995/96 to just 92 units in 2001/02.

The MAP proposal illustrates the seriousness of the move-on shortage through three facts about Camden:

- Single Homeless Project provides 247 units of temporary accommodation in 11 London boroughs but received only 33 units of move-on from housing associations (including Circle 33) and 41 units from the London boroughs.
- The London Borough of Camden provides a quota of 75 units of move-on for 66 providers, as well as 30 specifically for rough sleepers and a proportion of the 31 HOMES nominations.
- Circle 33 (one of four main housing associations in Camden) provides 55 move-on units for 30 managing agents across Camden, Hackney, Haringey, Islington, Tower Hamlets, Waltham Forest, Luton and Cambridge.

The Office of the Deputy Prime Minister has agreed in principle to fund the MAP across five London boroughs, and this may make a positive contribution.

### Homelessness

In 1996, the Mental Health Foundation (Mental Health Foundation 1996) reported on levels of homelessness and mental illness, and set out measures to address the issue. These remain valid today and, in terms of the numbers of homeless people with mental illness, regrettably accurate. Successive studies, both in the UK and in the United States, provide evidence of high numbers of homeless people with mental health needs and of the high percentage of homeless people with drug or alcohol use problems.

While street homelessness has been reduced by the Rough Sleepers Initiative, the overall level of homelessness is increasing to that last seen in the early 1990s when the recession and property market collapse had a significant impact. Fig 4, below, shows the quarterly level of homelessness acceptances (cases accepted by local authorities as homeless) in England and London over the past 20 years. Almost 25 per cent of all homeless people are in London.
Government concern over these figures is reflected in the changes in homelessness policy as set out in the ODPM report published in March 2002. This has required all local authorities to produce a ‘homeless strategy’, and the reorganisation of the Rough Sleepers Unit, the Bed and Breakfast Unit and cross-government working on homelessness into a single government department called the Homelessness Directorate. This directorate is intended to address issues of homelessness with further emphasis on health (through primary care trusts in particular) to resolve the issues of access to health services, including mental health services, for homeless people.

Dual diagnosis is increasingly exerting pressure on mainstream mental health services and the impact of increasing numbers of homeless people will inevitably add to that pressure. At the same time, many people with mental health needs will remain outside the care system and certainly outside the specialist support available through mental health supported housing services.

Recognition of the scale of this problem remains inadequate. Little change has occurred in the period from 1996 to 2002, although the housing programme for mentally ill clients, the Homeless Mentally Ill Initiative (HMII) programme initiated through the Rough Sleepers programme that has run throughout this period was valuable if limited in terms of supply of new provision. (See Rough sleepers and the Homeless Mentally Ill Initiative, p 59.)

Tower Hamlets council and the East London and City Health Authority published a report on their housing and mental health strategy (Jenkins and Maud 2000). Within this report, homeless hostels in the borough were surveyed to assess the numbers of clients with mental health needs living in supported housing outside of the specialist provision.
The report reviewed schemes housing over 500 single homeless people and commented:

They [the schemes] are, in fact, often dealing with clients with multiple problems, including many who would be regarded as Dual Diagnosis cases. A number of the designated projects will not accept the clients housed by direct access hostels, even where there is a medically diagnosed illness.

There is therefore a huge resource providing mental health related services outside of the purchasing and commissioning system. Some 24% of current residents within the surveyed projects are regarded as having some form of mental illness. In the past 12 months, 38% of all residents housed were regarded as having mental health problems.

When looking at the level of needs, it was estimated that as many as 10 percent of clients had medium to high needs levels.

Jenkins and Maud (2000), p 36

These figures are shown in Figs 5 and 6, below and overleaf, and are largely in line with the findings of the Mental Health Foundation four years earlier.

**Fig 5: Total residents and residents with mental health needs**

![Bar Chart](image)

Source: Jenkins and Maud (2000), p 36
In 2002, Homeless Link produced a national study of homeless people with multiple needs, many of whom would be regarded as dual diagnosis clients or as having complex needs (Homeless Link 2002). Homeless Link provided the definition adopted by the ODPM in its Homelessness Strategies: A good practice handbook, which defined a homeless person with multiple needs as:

*a homeless or formerly homeless person who has two or more of the following problems and usually lacks effective contact with services:*

- mental health
- multiple substance misuse
- personality disorders
- offending behaviour
- learning difficulties
- physical health problems
- challenging behaviour
- vulnerability because of age.


The figures in the Homeless Link briefing paper: *Supporting People with Multiple Needs* show little change from surveys over the past decade regarding homeless people and mental health needs, except that there are many more cases of multiple needs than ten years ago:

*Agencies reported 4458 service users having multiple needs, almost half (47.8%) of the total. Although there is no historical data with which to compare, this confirms the feeling of professionals that the levels of homeless people with multiple needs are increasing and look likely to become the majority of service users for many organisations. There is no significant difference for male or female service users.*

*Until this survey, the only available evidence detailing the proportion of homeless people with multiple needs was from St Mungo’s in London. Working predominantly with rough sleepers, analysis of their own records in 2001 showed that 62% of service*
users presented with multiple needs. Our own survey found that 42.7% of service users in London had multiple needs. However, when looking specifically at rough sleepers, 57.0% overall were reported to be multiple needs clients, with men at 56.0% and women at 64.4%. This finding supports the assertion that among rough sleepers in London, the majority have multiple needs.

Homeless Link website: Supporting People with Multiple Needs

As a comparison, the 1996 OPCS Psychiatric Morbidity Survey for the Department of Health compiled four reports during 1993 and 1994 on 1,100 people living in hostels for the homeless. These reports estimated the incidence of mental health problems among hostel residents at four times higher than that of the general population. The London Health Strategy Report Rapid Review of Health and Homelessness (Croft-White and Raynor 1999) repeated earlier estimates of between 30 and 50 per cent of those living in hostels and temporary accommodation having a severe mental illness.

Homeless Link’s survey showed only 2.9 per cent of those with multiple needs in London were housed within accommodation solely dedicated to those with multiple needs. It also indicated significantly longer stays in accommodation in London (19 months for non-specialist and 21 months for specialist housing, compared to England as a whole, with 11 and 13 months respectively), seen as evidence of a lack of available accommodation.

This lack of housing availability reflects our own views as to the current social housing provision within London and the emphasis on floating support as the increasingly most used form of resettlement. Homeless Link suggest that only 15 per cent of people with multiple needs are housed in high-care, 24 hour-staffed provision, compared to 48 per cent outside London. However, the use of high-support housing with limited ongoing support and floating support and tenancy sustainment outside of London appears to result in a very high tenancy failure rate: over 34 per cent compared to just 5.4 per cent of those resettled from homeless provision in London.

Rough sleepers and the Homeless Mentally Ill Initiative

The Homeless Mentally Ill Initiative (HMII) dates from 1990, funded via the Department of Health and, although envisaged as a time-limited programme, HMII funding continues today. The focus of the HMII very quickly became sharpest in relation to rough sleepers and in ensuring that those homeless people with mental health needs outside the system were able to access mental health care.

The initial focus was funding for five area-based outreach teams in key areas of London where rough sleeping was particularly high, with follow-up funding for hostel bed spaces and revenue to support individuals in move-on accommodation. The latter received capital funding via the Housing Corporation in programmes eventually managed by the Rough Sleepers Unit.

Further funding supported additional hostel beds, move-on and, because of concern over tenancy failures, tenancy sustainment teams. These were effectively the first floating-support schemes for people with mental illness living in their own homes. The review of the initiative in 1995 emphasised the need for more permanent housing complemented by flexible support services.
Increasingly resources were targeted at rough sleepers in particular, and supplemented by the Rough Sleepers Initiative. The joint effect of these two initiatives was a major contributor in cutting these numbers to something close to the Government’s target of a two-thirds reduction in numbers by 2001. However, critics of the HMII point out that its narrow focus leads to a lack of options for younger people and women in relative terms, although this has changed in the recent past as the profile of rough sleepers themselves has changed.

Other concerns in respect of the initiative have centred on the ‘ring fenced’ nature of the housing, and a concern that those with severe mental illness were losing out to less dependent homeless people able to access the HMII scheme. Similarly there has been concern over lack of investment in schemes to assist in avoiding hospital admissions or speed up discharge. However, this is a consequence of inadequate overall funding rather than the fault of this particular initiative.

Even with strong support – both political and financial – mental health workers have continued to find difficulty in securing enough permanent housing for resettlement and insufficient provision for higher need clients. The 1995 Department of Health evaluation report *The Homeless Mentally Ill Initiative* (Craig *et al* 1995) highlighted these issues, which were partly addressed by subsequent funding, but despite this, the same housing supply issues face mental health teams today.

### Action points

The issues for the whole system to address are:

- to what extent homeless hostels are used as a place of last resort by clients with complex needs, and why
- how floating support and outreach teams can be funded to work with hostel staff to provide the levels of support required, in particular the use of Supporting People funds
- how continuity of care and support can be provided as people move on to other housing
- to quantify the numbers of people with a severe and enduring illness within non-specialist supported housing that are outside the mental health system
- which measures local agencies can employ to reduce homelessness as a consequence of mental illness.

### People with mental health problems leaving prison

The Revolving Doors Agency studied 101 people with mental health problems serving prison sentences of less than 12 months in Wormwood Scrubs, Pentonville and Woodhill prisons between October 2000 and October 2001. People who entered prison from a secure tenancy had a 40 per cent chance of having lost it by the time they left. The major hurdle in maintaining a tenancy is the loss of housing benefit if the sentence is more than 13 weeks. Being in prison does not count as being homeless, so on discharge, people need to apply for housing through the normal routes. Many are judged to not
have sufficient priority to be housed quickly. Virtually half the sample – 49 per cent – were discharged with no fixed abode. (Revolving Doors Agency 2002)
Good practice

This section describes a range of innovative work, including examples of good practice in joint planning, commissioning and provision of housing and support.

‘Supporting People’ strategies

The Supporting People strategies studied for this working paper varied in their approach and detail. A number clearly had limited specific data other than for supply, and assessment of the quality and appropriateness of provision was lacking.

Others, where detailed work had been carried out prior to, or in tandem with, the development of the Supporting People strategy, were far more comprehensive. Among the strong strategy documents were those produced by Islington, Kensington and Chelsea, and Greenwich. The Greenwich strategy provided a good example of a concise analysis of supply, needs, and priorities, and is reproduced in this working paper as Appendix 5.

Assertive outreach and user engagement

The Opendoor Housing Trust provides a range of housing and support, including provision for people with very complex mental health problems. In recent years, it has expanded its service in partnership with the statutory authorities. It has successfully developed an assertive outreach project called Partnership in Peckham (PiP), which has shown very good results in reducing the need for inpatient care.

The following unedited extract is a summary of a detailed study undertaken by the South London and Maudsley NHS Trust to analyse the outcome of the project.

The Peckham sector:

- Is formed from the northern part of Southwark;
- Has an estimated population of 43,639 (40%+ from minority ethnic groups);
- Is located in the sixth most socio-economically deprived area in England and Wales;
- Is composed mainly of densely populated high rise council estates, with few green spaces; and
- Has a high level of psychiatric and physical morbidity.

Service Description

The PiP Community Outreach Team complements existing services with intensive community support. A staff group of five whole-time equivalents provides support for a maximum of 50 people suffering with psychosis in the Peckham Locality. The team targets particularly those individuals who have not benefited from statutory services.
Many of such individuals are caught in a cycle of mental distress resulting in a variety of negative outcomes including repeated admissions, contact with the criminal justice system, social isolation and homelessness. It is the aim of this service to interrupt this cycle by the provision of more flexible and assertive service focusing on social care needs.

**Demographics**

Since PiP began, to the end of this research period, they have received a total of 86 referrals of which they have accepted 55 on to their caseload. All patients are on the enhanced care programme approach plan.

**Staff Demographics**

The staff team consists of 4 community workers, 1 welfare rights worker, 1 manager, and 1 administration support. All are between 30 and 40 years old. 2 workers are female, and 4 are male. 3 are White British, 1 is Black African, and 2 are Black Caribbean.

**Results**

**Hospital Bed Days Data**

The 36 clients included in this analysis have been with the PiP team for at least a year.

<table>
<thead>
<tr>
<th>Number of clients</th>
<th>Bed days one year prior to start with PiP</th>
<th>Bed days one year after start with PiP</th>
<th>No of admissions one year prior to start with PiP</th>
<th>No of admissions one year after start with PiP</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>1245</td>
<td>761</td>
<td>26</td>
<td>17</td>
</tr>
</tbody>
</table>

As can be seen by the table there has been approximately a 40% reduction in bed days and a 35% reduction in admissions for this client group.

**Conclusion**

Overall, the results show a positive picture of the PiP Team. There are several reasons as to why this team is successful. The overall philosophy of the team allows for positive flexible interaction on the service users’ terms. The engagement process is not capped and clients are constantly contacted with information that will be beneficial to their well-being. Service Users will have the opportunity to benefit from contact, in many cases via help with welfare benefits. This usually opens a window for engagement and trust, which can be built upon. This pilot study has indicated that a locally adapted version of the ACT model can work in an inner-city area. It also suggests that there is not a “cure all” answer to the problem of engaging hard to engage service users. The team attempting to engage
such a client group should be adapted to that client group based on research in the local area. Ideas from other research are there to be utilised but not taken as the final word on how a mental health service should be set up. This research has shown that the PiP team in collaboration with the CMHTs does work well and may provide some clues as to the future of community care for this client group.

Hammond N (2002), pp 1–4

**Hospital liaison service**

The hospital liaison service was established in 1997 to meet the housing needs of people with mental health problems at Charing Cross and Ealing Hospitals. In November 2002, the Housing Special Needs Unit of the London Borough of Hammersmith and Fulham produced a report entitled Review of the Hospital Liaison Service (Adolphe 2002) that analysed the assistance provided to inpatients in the period February to September 2002.

In this eight-month period, 131 cases were dealt with. Sixty-two per cent were described as having a mental health problem, 19 per cent a dual diagnosis and 19 per cent a drug or alcohol problem. They were referred because of homelessness, unsuitable housing, benefits problems and a range of other issues. In a significant proportion of cases (38 per cent) their discharge was being delayed by their accommodation problem. The hospital liaison service assisted all but three people to find accommodation, as follows:

- 35 people were accepted by the emergency housing section
- 40 were placed in temporary accommodation
- 28 were approved for supported housing
- 23 returned to their tenancy
- 2 were secured permanent accommodation from the housing register.

The highest degree of success was achieved with people returning to their own tenancy, with 70 per cent of these being successfully resettled and 13 per cent awaiting an outcome. Placements in supported housing were successful in 64 per cent of cases, with a further 18 per cent awaiting an outcome. Placement in temporary accommodation was less sure of success, as would be expected, with 50 per cent being judged successful and 20 per cent awaiting an outcome.

**Partnership with housing management**

Homelessness prevention and access to housing are two key issues for Londoners with mental health needs. Mental health trusts and local authorities in some areas are addressing these in a number of ways. In Hillingdon, the local authority housing department and the mental health service have developed a joint protocol to address a series of issues in securing housing and in supporting existing tenants by improving communication, understanding and joint working.
The protocol covers:

- referrals to the emergency housing service
- continuity of support following re-housing
- referrals to the mental health service by housing.

Programmes of joint training for housing and mental health team members are being developed to focus on the issues faced by clients and officers in dealing with individual cases. The intended outcome is for officers from both fields to develop their understanding, how to take appropriate action and use improved channels of communication for the benefit of clients.

This is simple and effective good practice at minimal initial cost.

**Re-evaluating existing accommodation**

Tower Hamlets has been shifting supported housing provision away from shared schemes to self-contained accommodation. In common with most local authority areas, capital funding is in short supply. Therefore utilising older schemes in a different but appropriate way, and addressing local priority needs in the process, is seen as a win-win outcome.

A need was identified within the borough for a women-only scheme for Asian women with mental health needs. Although concern was expressed at providing this within a scheme that had been viewed as undesirable (because it was shared), discussions within the community led to an agreement that for short-to-medium occupancy, shared housing on a small, group-home basis was desirable in order to minimise isolation and develop joint support among the clients. Although new provision might be specified somewhat differently, this change has met an outstanding and urgent need quickly and effectively.

**Ethnic-specific support**

The Kush Housing Association is a black-led housing association operating in north and east London, working predominantly with the African-Caribbean and black British communities in Hackney, Islington, Newham and Waltham Forest.

Kush developed the Nile Centre in Hackney to provide crisis intervention housing for black people who would otherwise have needed acute provision. However, the Nile Centre offers considerably more – in particular, a resource centre service for black people living in the community who are referred to the centre for non-residential services and support.

An important outcome has been the opening up of the agenda around mental health services for black people, a reduction in the sense of isolation felt by black clients in the community and a stripping away of both felt stigma and a reduction in stereotyping of black people with mental illness in the wider local community.

The Nile Centre is providing a black-led solution to a problem that is not race-specific, but one that disproportionately impacts on black people living in the inner city.
Kush is expanding its role in support for people with mental health needs. The work of the Nile Centre and other Crisis Intervention housing projects is reported in the Sainsbury Centre for Mental Health report *Being There in a Crisis* (SCMH 2002).

**Integrated working**

Harrow has a multi-disciplinary intensive-support team of ten workers. Although planned developments of this type do exist in other boroughs, this is one of the few teams that includes housing support workers as an integral part of the outreach team.

Two experienced housing workers are employed within the team, providing specific expertise and assistance to other team members as well as taking on a direct caseload on a floating-support basis.

Clients have the benefit of a single point of access to care, support and housing advice. This form of joint team is a strong model for delivery of locality-based services that can respond quickly to crises and also deliver a continuum of care.
Conclusions

The study has drawn on statistics and case studies to form a view about the extent to which housing is currently meeting the needs of people with mental health problems. The lack of comprehensive, consistent data is a major limiting factor. However, the views expressed by commissioners in interviews and within Supporting People strategies and other planning documents have clarified the picture of the sector built up in this working paper. The following conclusions are offered to assist with the planning and providing of the next generation of housing and support services.

The government agenda

Supported housing for people with mental health problems is touched by many government policies and initiatives, the key ones being:

- Housing and Community Care
- the National Service Framework
- Supporting People
- the wider housing agenda.

Housing and Community Care in 1997 set out clearly and concisely a strong approach for developing joint strategies in relation to housing, care and support. Nevertheless, six years on, housing seems to remain outside the planning loop. The National Service Framework contains relatively few references to housing, but does emphasise the need for partnership approaches and the involvement of housing agencies. At the time of publication, the required relationship between care and housing did not yet appear to be in evidence. (See The National Service Framework and housing, p 7.)

Supporting People entails fundamental change for the sector, and has enormous potential to improve the planning, funding, and monitoring of housing with support. It brings with it risks for providers because funding will be less secure. If implemented in an over-bureaucratic way it will increase costs, and may lead to smaller providers leaving the sector, thereby reducing the diversity and innovation currently in evidence. If funding is insufficient to keep pace with needs, then newly emerging priorities will only be supported at the expense of existing services.

The policy also brings uncertainty for commissioners, especially where they are placing people in projects outside their own geographical boundaries, since the funding for those projects will be in the hands of the borough where the project is located. (See The ‘Supporting People’ funding programme, p 9.)

Supporting People will make short-term housing much more affordable, and will allow people to work. However, people in long-term or permanent housing will be means tested, so it is not yet clear whether this group will see any financial benefit from working. The fact that people previously sectioned under the Mental Health Act cannot be charged for support means there are great disparities between the wealth of tenants, and this can cause tension. (See Appendix 3, p 82.)

The new comprehensive performance assessment flexibilities have removed the protected ‘ring fence’ from the Supporting People budget, and also removed the requirement to produce a Supporting People strategy in eight London boroughs. This
presents a major challenge to the success of Supporting People. If these authorities choose not to work within the Supporting People framework, this would remove any possibility of tracking whether the programme benefits any individual groups. It also undermines the partnership elements of the programme, and could potentially make cross-London planning impossible to manage.

There is a whole raft of wider housing and other policies designed to improve people’s living condition and environment. These include:

- choice-based lettings
- anti-social behaviour policies
- tenant incentive schemes.

In each of these, the needs of the wider community must be balanced against the needs of individuals and judgements reached as to whether difficult behaviour is as a result of inadequate support. (See The broader housing agenda, p 14.)

### Action points

- There should be a clarification and strengthening of cross-borough arrangements for mental health. One option would be to insist on consultation with any authority that has more than 10 per cent of the places in a given scheme.
- Research should be commissioned to monitor the effect of Supporting People on mental health provision in the capital.
- The Government should consider amending the Section 117 rules so that all those in specialist schemes are subject to the same charging regime.
- The eight boroughs given new freedoms under the Comprehensive Performance Assessment should remain within the nationally-agreed policies and procedures for Supporting People for at least the first three years of the programme, to allow the programme to become established and stabilised.
- Research should be commissioned to study the effect of the changes in housing and homeless legislation and government priorities on the ability of people with mental health problems to get ordinary housing.

### The supply of housing in London

In the decade 1991–2001 100,000 units of social housing have been lost (mainly through the right to buy). Only half this number of new social houses have been built, leaving a net loss of 50,000 units. The priority for new building was family housing, with the proportion of new one-bed units falling from 43 per cent in 1991/92 to just 20 per cent in 2000/01. (See Reductions in overall provision of social housing, p 15.)

The number of new lettings of social housing reduced by 31 per cent between 1996/97 and 2000/01. This gives a picture of a social housing market where demand outstrips supply, people have very few choices and housing mobility is increasingly restricted. (See Reductions in overall provision of social housing, as above.)
As housing support increases through home-based or floating support services, access to independent housing is increasingly important. The housing supply issues are the biggest threat to developing more client-focused services.

The supported housing sector 1997–2002

The Supported CORE database shows that the sector has been disappointing static in the last five years, with an increase of only 61 units (0.1 per cent). There are 10 per cent more projects, but of a smaller size. Some shared projects have closed, and most of the new developments have been in self-contained one-bed units. Progress has been slow, with the proportion of shared housing reducing from 64.6 to 60.8 per cent. The number of places that become available within specialist housing has fallen sharply (by 26 per cent), because the length of occupancy has risen.

There has been a significant change in the mix of people housed. A far higher proportion of people have complex problems, including drug use and forensic issues. This is apparent from the CORE database, and supported by interviews with commissioners and providers.

From this evidence, it may be concluded that to a significant extent the same housing schemes are now housing people with more complex and demanding needs, who are staying within schemes longer than before. The pressures for ordinary housing has grown, making move-on much harder.

There has been a big increase in intensive community-based support. We need new language to describe this. For example, ‘floating support’ now refers to the very intensive support for people who would otherwise have been in long-stay hospital, as well as much less intensive support for people with mild difficulties.

Action points

- Health authorities and local authorities need to work to develop strategic assessments of local needs, taking into account shortfalls in provision and shortcomings of existing accommodation and service models.
- Requirements for capital funding should be made on the basis of a recognition that private finance will be required in some if not all areas.
- The private sector must be involved as a partner both in planning new provision and in its development.
- The full economic and social cost of unnecessary acute and secure provision should be assessed and potential savings from housing based solutions identified. Savings achieved should be ‘ring fenced’ for revenue support to community services that reduce the use of, and periods spent in, secure and acute beds. This should be achieved to a level determined by clinical needs rather than supply issues.
Supported housing in 2002

Supporting People gives us the first opportunity to compare the provision by boroughs, and to look at London as a whole. (See Principal supported housing models, p 36.) There are enormous differences in provision between boroughs, which bear no relationship to population or needs. Current databases cannot identify how many of the people housed in any borough ‘belong’ to that borough. High levels of service may, therefore, reflect large numbers of referrals from other boroughs, or higher than expected needs within the home borough, or simply a higher quantity of provision. Such uncertainty makes it impossible to justify any statements about whether provision is adequate. A more sophisticated analysis will be needed before the full five-year Supporting People strategies are compiled. (See Overall supply figures, p 41.)

A comparison of Supporting People supply databases with Mental Illness Needs Indices shows widespread variation in supply relative to need. (See Provision in terms of population need, p 44.)

Supporting People presents threats as well as opportunities. As boroughs seek to exert more control over the provision geographically within their boundaries (now that they are aware of it), those depending on out of borough placements may find themselves with serious shortfalls in provision.

The greatest areas of unmet need identified in Supporting People strategies are:

- housing and services for people with high support needs, particularly dual diagnosis
- floating support or tenancy sustainment for people living independently
- crisis-intervention housing
- black and ethnic minority-specific provision
- re-modelling of existing housing
- re-modelling and refocusing of existing support services.

Highly difficult clients with dual diagnosis and extreme behavioural problems remain difficult to place within community settings – including crisis-intervention models of housing. Purchasers and providers need to address this group, who are most likely to suffer homelessness and be outside of the support of community mental health services, in line with recent government best practice advice in the treatment of dual diagnosis (Department of Health 2002b). (See Unmet needs, above.)

There is, as yet, insufficient breadth of provision to provide for the cultural, religious and ethnic diversity of communities within London. Models of good practice in meeting the needs of black and minority ethnic groups exist, for example, in Tower Hamlets and Hackney, but these models need to be adapted to meet local needs in many London boroughs. (See Meeting the needs of diverse communities, p 40.)

Gender-specific schemes are limited, and few schemes are able to offer support for women with children. Drayton Park in Islington is the one of only two schemes of which the authors are aware that can support clients with their children, and this example is very short-term housing for crisis intervention.

New forms of housing are required, in particular, to support crisis resolution and intervention. Such schemes would ensure that support is available in the community and that unnecessary hospitalisation is avoided. These could be joint centres for health, services and housing resources.
Given the potential savings to health in the use of acute beds, such schemes may be sensible candidates for PFI or PPP funding arrangements. Limited models already exist in London, and the Mental Health Foundation and others are urging further development to meet local needs. Schemes linked to assertive outreach work are limited, and there are no equivalents to the safe haven schemes found in the United States. (See Crisis intervention and Safe havens, p 39.)

Action points

• Local authorities and health agencies are urged to work together to create a single database of all provision for people with mental health problems, to assist with the co-ordination of Supporting People with health planning and commissioning.

• Mental Illness Needs Index scores should be updated using 2001 Census data, to assist analysis of how supply compares with needs.

• The increasingly complex needs of people with mental health problems needs to be explicitly recognised, and housing provision re-evaluated to see to what extent existing provision and models remain appropriate to the changed client mix.

• Given that the increasing complexity of need, and the increasing incidence of dual diagnosis, is widespread, a London-wide co-ordinated training programme should be established, as a cost-effective means of addressing skills shortages.

• Models of good practice in meeting the needs of black and minority ethnic groups need to be adapted to meet local needs in many London boroughs.

• New forms of housing should be developed to support crisis resolution and intervention. Given the potential savings to health in the use of acute beds, such schemes may be sensible candidates for PFI or PPP funding arrangements.

The issues for the whole system to address are:

• to what extent homeless hostels are used as a place of last resort by clients with complex needs, and why

• how floating support and outreach teams can be funded to work with hostel staff to provide the levels of support required, in particular the use of Supporting People funds

• how continuity of care and support can be provided as people move on to other housing

• to quantify the numbers of people with a severe and enduring illness within non-specialist supported housing that are outside the mental health system

• the continuation and use of HMII revenue funds to support those in need who have been successful prevented from being forced to sleep rough

• which measures local agencies can employ to reduce homelessness as a consequence of mental illness.
Appendices

Appendix 1: Uncharted implications of Supporting People

The Government’s Supporting People policy will entail much change to the planning, funding and monitoring of support for people with mental health problems. The background to the policy and its main implications are outlined on p 9 of this Working Paper. The policy is enormously complex, and there remain a number of critical unresolved issues. This Appendix discusses four areas in which there is a lack of clarity about how the policy will operate, and raises potentially unintended negative consequences that need to be addressed.

Funding out-of-borough placements

Before 2003, a mental health project might have the funding sources for its support service as shown in Table 21, below.

Table 21: Typical pre-2003 funding sources

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Housing benefit</th>
<th>Supported housing management grant</th>
<th>Topping up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid by</td>
<td>Housing benefit office</td>
<td>Housing Corporation</td>
<td>Nominating social services or health agency</td>
</tr>
<tr>
<td>Paid to</td>
<td>Tenant (or direct to landlord)</td>
<td>Support provider (via landlord)</td>
<td>Support provider</td>
</tr>
</tbody>
</table>

Source: King’s Fund (2003)

Before April 2003, the local authority in which a project was located played no part in the first two sources of funding (housing benefit and supported housing management grants). Projects requiring only these funding streams could operate relatively independently of the local authority, accepting nominations from surrounding boroughs.

For projects offering a higher level of support and receiving local authority top-up funding, there would have been a closer relationship, and a firmer nominations agreement. However, it would have been common to also have spot contracts from other local authorities to fill remaining places. In some cases, these spot contracts were subsidising the insufficient level of block funding available from the home local authority. Top-up funding from health was also sometimes available.

In many cases, this top-up funding has, with the agreement of the support provider, been withdrawn over the last year, and tenants’ charges have been increased to make up the shortfall. Since in the vast majority of cases these increased charges have been met by transitional housing benefit (the portion of housing benefit that paid for support prior to April 2003), tenants have not been disadvantaged.

The huge advantage for the local authority is that it can spend the saved funding elsewhere, and it will then receive the total amount of transitional housing benefit as...
part of the Supporting People grant in 2003. This additional money was available for a very short time only, and many local authorities have taken full advantage of it. Such major cost shunting has implications for the future.

After April 2003, funding will come from only two sources, as shown in Table 22.

**Table 22: Post-2003 funding sources**

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Supporting People contract</th>
<th>Topping up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid by</td>
<td>Local authority</td>
<td>Nominating social services or health agency</td>
</tr>
<tr>
<td>Paid to</td>
<td>Support provider</td>
<td>Support provider</td>
</tr>
</tbody>
</table>

Source: King’s Fund (2003)

In April 2003, the whole of the support funding previously paid through housing benefit and supported housing management grants will be transferred to the borough in which the scheme is based, which may well regard the funding as ‘theirs’, to be spent on ‘their’ population. Schemes serving a number of local authorities will be faced with persuading their home borough to fund places for people from other boroughs and rootless people.

Local authorities as well as providers face challenges from the new system. Out-of-borough placements may become unavailable, or much more expensive, if the home borough decides to use all the places for its own ‘home’ tenants. Rather than just having to pay the top-up amount, they may be required to pay the full support charge from their own Supporting People pot. Boroughs currently relying on large numbers of out-of-borough placements will be particularly hard hit.

**Cross-authority procedures**

The Supporting People policy recognises the inter-dependency of the provision of the boroughs through its cross-authority procedures. This designates schemes as ‘cross-authority’ and gives them additional safeguards. For example, the host borough cannot simply close a single homeless hostel in central London, as the people living there are not originally from that borough. The Association of London Government will co-ordinate a cross-authority group, and major changes to a cross-authority project will have to be agreed by this group.

Unfortunately, these arrangements only extend to a small number of schemes, primarily for single homeless people and those escaping domestic violence, where cross-authority planning is vital. The vast majority of mental health projects will not be covered by the cross-authority arrangements, and will be funded and reviewed by the host borough only. It will therefore be possible for one borough to impose changes without the consent of neighbouring boroughs. This problem is particularly serious in London, where boroughs are geographically very small, and it is far more likely that schemes will be serving a number of boroughs.

The inclusion of all mental health schemes within the cross-authority arrangements would make the system impossibly cumbersome. Sub-regional groups of boroughs are emerging, and it seems likely that any co-ordination will have to depend on voluntary arrangements worked out within these groups.
This working paper calls for clarification and strengthening of these arrangements. One option would be for boroughs that have more than 10 per cent of the places in a scheme having to be consulted before the host borough makes major changes to, or closes, a scheme. In addition, further research should be commissioned to monitor the effect of Supporting People on mental health provision in the capital. The factors described above mean that there are greater uncertainties for local authorities and for mental health projects in London than for other client groups (see p 14).

**Comprehensive performance assessment**

A further major challenge to the success of Supporting People is the very recently announced flexibilities awarded to those local authorities that received three stars under the Audit Commission’s comprehensive performance assessment. In London, eight of the 33 boroughs achieved this: Camden, Westminster, Hammersmith and Fulham, Kensington and Chelsea, Wandsworth, Bexley, Corporation of London and Kingston. These boroughs account for 25 per cent of mental health Supporting People services, and 37 per cent of provision for single homeless people in London.

When applied to Supporting People, these flexibilities mean the loss of the ‘ring fencing’ of the Supporting People grant. The ‘ring fence’ was fought for hard as it provided a safeguard that funding currently available for supported housing would not be diverted to other local authority priorities. Furthermore, these boroughs now do not need to prepare or submit Supporting People Strategies, consult with stakeholders, or co-operate over cross-authority planning and co-ordination. It is noticeable that Supporting People shadow strategies were publicly unavailable for Bexley and Kingston.

Being ‘excellent boroughs’, there is the full expectation that they will continue to demonstrate best practice, but the difficulty is that there is now no requirement for them to act in a co-ordinated way within the Supporting People programme. It also seriously undermines the partnership working on which Supporting People is based.

Probation and health will become very much weaker as a result of the local authority being given so much more flexibility over how they spend the Supporting People funding, and whether, indeed, they spend it on support rather than street cleaning.

This working paper urges the eight London boroughs, given the new flexibilities to remain within the nationally agreed policies and procedures for Supporting People for at least the first three years of the programme, to allow the programme to become established and stabilised.

**Impact on future developments**

Half of the current housing association provision for people with mental health problems is owned by just 10 housing associations, nine of which are large general-needs providers. For specialist providers, building and running supported housing is their reason for existing. Supporting People may increase the risks they face, but is unlikely to make them look for a less risky area in which to work.

However, general needs associations are involved in many different housing (and sometimes non-housing) activities, and their boards are concerned with managing risk across their organisations as a whole. If supported housing becomes more risky, boards may well seek to reduce their exposure by cutting back or stopping...
developments in the supported field. If general needs housing associations were to take a risk-averse view of Supporting People, the consequences could be serious.

Housing associations will have to estimate how much greater the risks have become under Supporting People than under previous regimes. Revenue funding from a Supporting People contract is less certain than from a combination of housing benefit and supported housing management grants. As noted above, where two or more authorities are involved, the risks increase. This also bodes ill for specialist, more intensive, projects since they may well rely on nominations from more than one borough.

The future role of the Housing Corporation

Under Supporting People, the Housing Corporation will continue to allocate Social Housing Grant to housing associations toward the capital costs of new supported housing. It is assumed that application for capital will be dependent on having secured firm revenue commitments from one or more Supporting People Authorities. It is not yet clear how the timetables for applying for capital and revenue will fit together. This represents a complication over the previous system, under which capital and revenue were awarded as a single package by the Housing Corporation.

It is also far from clear how the Corporation’s prioritisation of capital bids will mesh with the boroughs’ prioritisation of revenue bids. For example, the Corporation’s London Investment Strategy for 2003/04 lists the following criteria for bids:

- **Schemes, which meet a clearly identified need as, outlined in the relevant borough(s) Supporting People strategy.**
- **Where a scheme is proposed to meet the needs of vulnerable people from more than one local authority area, we will wish to see evidence of cross- borough support from the other local authority/ies involved.**
- **Schemes which have a clear and identified source of revenue funding under the Supporting People regime and that there is commitment from the local authority/ies involved to make revenue funding available on an on-going basis.**
- **Schemes should be able to demonstrate that there is an alternative use for the property if demand from the identified client group dries up or revenue funding is withdrawn in future. We will seek information about any proposed alternative use and client group and whether any change can be achieved without recourse to further ADP funding.**

Housing Corporation (2002), p 27

The first three link firmly to Supporting People, but the fourth raises issues about the future development of very specialist high-support units that might have no alternative uses.
Appendix 2: Broader housing issues

The broader housing issues that impact on supported housing are listed on p 14. This Appendix analyses each issue in greater detail.

New homeless legislation

The new Homelessness Act 2002 was broadly welcomed by the social housing sector, because it increased duties on local authorities to assist homeless people. However, it also contained new flexibilities in the way in which social housing may be allocated, and there is the potential within these new policies for intentional or unintentional discrimination against people with mental health problems and other vulnerable groups.

The new Act requires local authorities to produce a homelessness strategy and update this every five years. It also strengthens their duties to homeless households in a number of respects. Where an applicant is unintentionally homeless, eligible for assistance and in priority need, the local authority owes a duty to house that person. The previous two-year limit on this duty is repealed, and the exemption removed in cases where other suitable accommodation was available for occupation in the district.

The 1996 Housing Act recognised the particular needs of people with mental health problems. This category of priority need is maintained in the 2002 Act:

\[\text{a person who is vulnerable as a result of old age, mental illness, or handicap or physical disability or other special reason...}\]

The Housing Act (1996), Section 189(1)

A number of new categories are added to the list of priorities, including people escaping domestic violence and people leaving care or prison. It is to be welcomed that these people are to be given the priority they deserve, but without increasing the supply of housing, it is hard to see that this will result in anything other than people being housed in temporary housing, or placed out of the borough, with a slight shuffling in the order of the waiting list for everyone else.

New ways of allocating social housing

The Homelessness Act removed the requirement for local authorities to maintain a housing register. Instead, local authorities are to give ‘reasonable preference’ to various groups, including those who are homeless and those who need to move on medical or welfare grounds. When determining priorities, they may take into account any behaviour that affects a person’s suitability to be a tenant, and whether they have a local connection.

The authority is not required to give any priority to a person if they are satisfied that they or a member of their household has been guilty of unacceptable behaviour serious enough to make them unsuitable to be a tenant. The type of behaviour that could warrant a person being refused any priority includes nuisance, or deterioration of the home, common parts or furniture. This policy, coupled with the difficulty of proving a local connection, could have an adverse impact on the ability of people with mental health problems to access ordinary housing.
Local lettings policies

Under the new flexibilities, local authorities may operate local lettings polices, offering accommodation to people who fall outside the categories of reasonable preference. For example, they may seek to maintain an appropriate child density in an estate by balancing allocations of people with children against single people. Depending on the criteria chosen, this could either benefit, or exclude, people with additional support needs.

Choice-based lettings

The term ‘choice-based lettings’ is used to describe a range of methods for allocating social housing. The best-known model of choice-based lettings is the Delft model from Holland, in which vacant properties are advertised in the newspaper and elsewhere, and anyone who has the requisite banding of need may apply for them.

As part of the Government’s Spending Review 2000, £13 million was made available to support and evaluate pilot schemes that tested choice-based lettings policies and involved local authorities and housing associations (DETR 2000). The pilots began in April 2001, although several faced delays in implementation for a variety of reasons, including IT problems.

The 27 English pilots vary, but all involve the concept of advertising properties and allowing people to choose whether or not to apply to live there. This raises two issues for the mental health field:

- allocation of specialist housing
- allocation of ordinary housing.

Specialist housing for people with mental health problems cannot be advertised in the newspaper in the way that family housing can, because people’s needs have to be comprehensively assessed to ensure that their housing is suitable for them. In order to protect the interests of other residents, some mental health schemes, especially those housing ex-offenders, would not wish to advertise the nature of their housing. However, some pilots are advertising sheltered housing in this way, and it is not inconceivable that some lower-support projects could be similarly advertised.

It is far from clear how this would fit with the Supporting People regime, but perhaps accommodation could be advertised as ‘only people with a current Supporting People needs assessment may apply’. This may seem fanciful, but the pilots could have lessons for the specialist sector in terms of empowering people by asking them to apply for housing rather than simply being allocated whatever comes up next.

A more serious question is whether choice-based lettings schemes will unwittingly discriminate against people with mental health problems, if they do not or cannot read newspapers or newsletters, do not visit supermarkets and libraries, do not have access to the internet, or do not have the skills or confidence to apply for vacant housing. This issue was strongly flagged as a concern by the Newham team within City and East London Mental Health Trust.
The original bidding guidance stated that one of the factors to be used in choosing pilots would be 'practical and concrete ideas for housing advice services that support vulnerable, difficult and excluded groups'. Several of the pilots stated this as an explicit aim, but to date there has been no evaluation of whether this has been achieved.

Anti-social behaviour

The Government’s campaign against anti-social behaviour has reached far into the world of social housing. The ‘right to buy’ has greatly marginalised the social housing sector, with the more attractive properties being purchased, and social lettings increasingly concentrated in large estates and unpopular areas. Social housing tenants are increasingly stigmatised.

Local authorities and the police may make an application to the magistrates’ court for an anti-social behaviour order against any person over 10 years of age. Orders may be granted where a person has acted in a way (whether or not criminal) that has caused or is likely to cause harassment, alarm or distress to someone outside their own household. The magistrates court may make an anti-social behaviour order prohibiting the defendant from doing anything specified in the order. Breach of the order is a criminal offence.

Provisions in the Police Reform Act 2002 give housing associations the power to apply for anti-social behaviour orders against persons living in (or who are on, or likely to be on) premises owned or managed by housing association or in the vicinity of such premises.

Detailed research is not available, but one London borough, Tower Hamlets, has identified that a significant number of tenants subject to action for anti-social behaviour are suffering from mental illness and are consequently at risk. The housing department and social services have begun to develop improved joint working to identify such instances as early as possible in the process, and to shift those with mental health needs from being viewed as perpetrators to being seen as clients in need of support.

Housing associations are divided over whether they should have the right to use of anti-social behaviour orders. Some do not want to stray from a landlord role to one of a law-enforcement, while others see the anti-social behaviour order as a useful tool to be used when appropriate. Housing associations are piloting a range of ‘acceptable behaviour contracts’ as an alternative approach to using judicial remedies.

Reform of housing law

In 2002, the Law Commission presented a series of proposals for reforming housing law (Law Commission 2002). It proposed two new types of tenancy:

- Type I would have similar rights to secure tenants.
- Type II would resemble assured short-hold tenancies, giving the landlord the right to send the tenancy without giving any reasons.

‘Nuisance’ would remain a discretionary ground for ending a Type I tenancy, but the courts would have additional powers to move anti-social tenants to other properties, or to demote their tenancy to Type II. The landlord could then summarily end the tenancy.
Alongside the Law Commission’s review, the Office of the Deputy Prime Minister issued a consultation paper in Spring 2002, entitled Tackling Antisocial Tenants (ODPM 2002d). This proposed a total of 15 remedies for anti-social behaviour, including the Law Commission proposal outlined above. Other options included simply making anti-social behaviour a mandatory ground for seeking possession, or keeping people permanently on an introductory-type tenancy.

The National Housing Federation’s response to this consultation sounded a cautionary note:

A balance needs to be struck between safeguarding communities and providing homes with support for vulnerable people whose behaviour causes problems. Successful resettlement and ongoing support is essential to the safety of the wider community. Therefore partnerships need to cover enforcement, prevention and rehabilitation.

Williams (2002), p 2

Federation members were divided on whether ‘demoting’ tenants to less secure tenancies was appropriate, with many stressing the importance of preventative work.

Information sharing

Housing associations report ongoing problems due to not receiving adequate information about people nominated to their housing, resulting in their unknowingly housing people with support needs. If important information is withheld, this can result in inappropriate housing being offered, and a great deal of housing management time being invested in trying to ascertain the reason for any subsequent difficulties that arise.

The National Housing Federation has called for a new information-sharing protocol to be included in guidance to accompany the Office of the Deputy Prime Minister’s new code of guidance for housing authorities, entitled The Allocation of Accommodation (ODPM 2002e). The federation suggests that social landlords should be given the following information routinely about people nominated to them for housing:

- age and gender
- details of any long-term illness, health problems or disabilities that require specific or specialist provision of housing, care or support
- details of other support or care needs, for example, due to learning disabilities
- details of existing or previous packages of care provision provided by statutory or other bodies, where known
- relevant and reasonable evidence of a history of anti-social behaviour that might impact on the safety of the local community.

Williams (2002), p 19

Tenant incentive schemes

These have caused some controversy within the social housing sector. The most famous is the Irwell Valley Gold Service, under which good tenants receive bonus bonds, and a higher quality housing management and maintenance service. Membership requires keeping the rent account up to date, or paying a regular amount off arrears.
The fear is that such schemes discriminate against the very types of people that housing associations have traditionally housed. However, associations such as Irwell Valley argue strongly that this is a patronising attitude to social tenants, who should be expected to take their responsibilities as seriously as any other members of society.

In Irwell Valley, tenants in supported housing schemes are eligible to be Gold Service tenants. Tenants can join one of two schemes – ‘Community Gold’, in which tenants join together to form a group, and receive double bonus points to be put to the good of the group (for example, people on an estate can join together, or all tenants in a specialist scheme can join). In ‘individual Gold Service’, people receive the bonus individually. Specialist schemes have tended to join Community Gold, and money has been spent on computers, individual fridges, and other improvements to the schemes.

Regeneration

Regeneration is a powerful factor in many London boroughs. The disruption it causes in neighbourhoods is generally regarded as a price worth paying for the great long-term improvements that can follow. People interviewed in case study boroughs, and a review of the literature, have suggested two areas of concern for people with mental health problems:

- First, major regeneration schemes often require large-scale decanting of the local population into other, temporary accommodation while their houses are being renovated. This can seriously affect anyone else’s chance of being allocated housing. If every available unit is needed for re-housing someone from a regeneration area, others have little chance of housing.

- Second, if people with mental health problems are decanted, some will find this a very stressful event, and will need additional support throughout the process.

When an area has been regenerated, there is a feeling that people move back with a renewed sense of pride and determination to keep ‘undesirable elements’ out so that the area does not slip back into its previous state.

If the area had a poor reputation, then it is likely that people with mental health problems would have been housed there, and the local authority itself might well seek to introduce a local lettings policy to ensure that the community becomes more balanced. This might seek to limit the number of people with support needs housed in one area, with the result that housing options for people with mental health problems are further reduced.
Key workers

Key workers are the new housing priority in London. People in jobs such as such as teaching and nursing cannot afford to buy property in London, and the government has committed substantial resources to schemes such as low cost shared ownership, where the person buys a share in the house, and pays rent on the remainder.

Again, this is a much-needed policy, and for people with mental health problems an important one, since nurses must be able to afford to live and work in London. However, the policy does not extend to support workers in specialist mental health schemes, outreach workers or to people with mental health problems themselves.

Conclusion

Housing, and social housing in particular, is under a great many spotlights at the present. The Government is aware of the intense housing pressure in London, but in the past has been wary of being seen to divert yet more resources away from the north towards London. There are no easy answers. The Mayor's London Plan (Mayor of London 2002, p 6) proposes new building at far higher density, while the Government has proposed major new developments of housing in Milton Keynes, the Thames Gateway and Kent. Neither plan has been greeted with enthusiasm.

The paradox of social housing in London is that although it is in such high demand, there are areas of extreme unpopularity. The ‘right to buy’ has concentrated social housing into smaller pockets of less popular housing, and has resulted in a higher concentration of people with support needs being housed in these areas.

The poor reputation of some social housing areas has resulted in an increasing focus on tackling anti-social behaviour, incentivising good behaviour, and changing lettings policies to increase choice and create communities that are more balanced. The challenge throughout is to ensure that people with mental health problems and other support needs are not labelled as ‘the problem that needs to be targeted’.

This working paper calls for research to be carried out to study the effect of the changes in housing and homeless legislation and government priorities has had on the ability of people with mental health problems to access ordinary housing (see p 15).
Appendix 3: Financial support

The brief for this study included an analysis of ‘how far financial support provided to assist with the costs of housing and related support in London is enhancing or hindering the ability of people with mental health problems to secure and maintain ownership or tenancy of a home’. This appendix describes the main sources of finance available to individuals to pay for their housing and support.

Housing benefit

Housing benefit has been (and will be until April 2003) the backbone of financial support for people with mental health problems. It pays for rent, plus eligible service charges.

Before ‘Supporting People’

Until the mid-1990s, ‘eligible service charges’ had a very wide meaning, and extended to covering the support provided by staff. This support was defined as ‘related to the provision of adequate accommodation’, but in reality the housing benefit regulations were so complex in this area that few understood them.

The Department of Social Security (DSS) – now the Department for Work and Pensions (DWP) – began in the mid-1990s to try and restrict the amount of housing benefit payable by issuing ‘clarifying’ circulars, and then establishing an inter-departmental review to investigate alternative ways of funding support. The minds of the inter-departmental reviewers were concentrated by the judicial review finding that housing benefit should only pay for a very small amount of support. Emergency interim regulations were put in place to avoid homelessness or bankruptcy, and it is from this problem that Supporting People has emerged as the solution.

The late 1990s

This was a difficult period for developing new supported housing due to the uncertainty hanging over the sector, as Supporting People slowly emerged. However, the transitional housing benefit regulations (which replaced the emergency interim housing benefit regulations) were drawn very generously in order to safeguard the sector through this uncertain period. This presented a ‘window of opportunity’ where high levels of housing benefit were available. Once these had been awarded, it was guaranteed that they would be transferred into the Supporting People ‘pot’ in April 2003.

Since ‘Supporting People’

After April 2003, housing benefit will continue to be available for people in supported and unsupported accommodation. It will pay only towards the rent, and a limited range of housing-related service charges (such as cleaning of communal areas).
Problems

Housing benefit suffers from a number of problems, and it is the government's long-term aim to substantially change the system. The most critical problems – complexity and inefficiency – are interlinked. The regulations are enormously complex, and are changed with alarming regularity.

The verification framework

- This requires people to produce original documents to prove their identity in order to claim. Some people with mental health problems have lived less settled lives than average, perhaps including times of homelessness. This is more likely to result in loss of original documents such as birth certificates.

The verification framework has been relaxed for homeless people, but not for all people with mental health problems. A pilot is currently underway in which housing associations are undertaking the verification of identity for claims. This might ease some of the difficulties, but does not solve the issue of people not having original documents at all.

The under-25s rule

- People under 25 living in private rented accommodation are assumed to be sharing a house, and the rent officer will only approve rents generally charged for this type of accommodation. (Tenants of housing associations, charities and local authorities are exempt.) Some people with mental health problems benefit from company, while others need to have sufficient space to maintain their mental health, and it is inappropriate (or even dangerous) to expect them to share a house. The housing benefit regulations take no notice of this, or of any other type of disability or difficulty.

The future

In the long term, the Government intends to reshape housing benefit. One option being discussed is the introduction of shopping incentives, where the benefit paid is not linked exactly to the rent on a specific property, but includes a fixed amount regardless of the rent. This gives the tenant the incentive to ‘shop around’ and find cheaper accommodation elsewhere, and to keep the rest of the benefit to spend on other things.

It is questionable whether this would provide a better safety net for people with mental health problems. In some cases, the location of housing may be more important to a person with mental health problems than to others, since they may need to be near support networks, friends, day care or other services. This might reduce their options and therefore restrict the advantages of shopping around.

Income support towards mortgage costs

Homeowners can claim income support towards their housing costs if they are a lone parent, sick or disabled, or of pension age. Income support is a means-tested benefit, and income and savings are taken into account when calculating benefit entitlement.
People with recognised mental health problems would therefore qualify for income support.

Home owners receiving income support who took out a mortgage before October 1995 are eligible to receive 50 per cent of housing costs after eight weeks, increasing to 100 per cent after 26 weeks. Those taking out a mortgage after October 1995 receive no mortgage help for the first 39 weeks, then full support after this. Help is provided towards mortgage interest payments including help with repairs and improvements to make the property fit for human habitation. No help can be provided for arrears payments, capital repayments, endowment policies, premiums or tax-free saving schemes such as ISAs or PEPs. Mortgage interest payments are calculated on a Standard Interest Rate, and loans can only be met to a maximum of £100,000.

The Social Fund

The Social Fund, administered by the Benefits Agency, can provide a grant or loan towards housing costs. The fund is cash-limited, and it is not guaranteed that claimants will receive a grant or loan. Claims can include furniture, repairs and adaptations. Within the Social Fund there is a special category of ‘community care grant’ for people who:

- plan to leave residential or institutional accommodation
- need help to stay in their own home rather than going into residential or institutional accommodation
- need help because they have had an unsettled way of life and are being resettled by an organisation such as a local council or housing charity
- need help because they and their family face exceptional pressure, such as family breakdown or someone in the family having a long-term illness
- look after someone who is ill or disabled, or has been released from custody on temporary licence
- need help with expenses for visiting someone who is ill, or attending a funeral
- need help because they or their family are in a similar situation to any of the above.

Benefits Agency (2000), p 13

The payments are discretionary, and savings of over £500 affect the amount awarded. Older or disabled people, people with mental health problems and young people who have left local authority care are considered a high priority. People who misused drugs or alcohol, ex-offenders, and homeless people tend to be medium-to-low priority.

In October 2002 the National Association of Citizens Advice Bureaux published a report entitled Unfair and Underfunded (NACAB 2002). This noted that the refusal rates were high, with 60 per cent of community care grant applications turned down.

The current Community Care Grant system is a failure. Clients get a very poor deal, whilst huge amounts of administrative resource are spent on refusing applications or on making awards that fall far short of clients’ needs. The standard of decision-making is poor. The 2001/02 Annual Report on the Social Fund shows that 50% of initial decisions that are referred for an initial, internal review are revised at this stage. When the Independent Review Service reviews reviewing officer decisions,
60% are modified in favour of the applicant. A system that results in so many bad initial decisions cries out for reform.

NACAB (2002), p 22

Section 117

Section 117 of the Mental Health Act governs the aftercare of people who have been compulsorily detained in a mental health hospital. If, as part of the care programme approach arrangements, a person is required to be placed in a residential setting, then they cannot be charged for that service. If placed in a residential care home, or a supported housing project, they are entitled to Department for Work and Pensions benefits, but cannot be asked to use these to pay for their housing or support.

This can leave clients with in excess of £100 a week, leading to danger of intimidation by other residents who are very much poorer, or of spending the money in ways that are unhelpful to their aftercare (for example, on drugs and alcohol), or putting them at risk of theft. (One resident of a care home was found to have £5,000 under his mattress.)

This also creates a financial disincentive to end the Section 117 order, and therefore impedes progress towards recovering a greater degree of autonomy. A person in long-stay accommodation on a Section 117 order would receive free support, but if the order ended, they would be means tested and charged. Any savings accumulated whilst on the Order would quickly be used up.
Appendix 4: Southwark case study

The authors of this working paper undertook detailed study of six London boroughs in order to supplement the statistical data collected. The following is an example of the information they were able to collect through interviews.

Profile of the borough and its housing stock

The population of Southwark consists of 245,000 people, of whom 32 per cent are from black and minority ethnic groups. More than 100 languages are spoken in the borough’s schools. The population has grown by nearly 8 per cent since 1991. This is nearly double the London growth rate and well above the inner London rise (5.3 per cent). Southwark is the second most deprived borough in London and the eighth in England and Wales. (LSLHA 2002). In November 2001, the local unemployment rate was 5 per cent, as opposed to a London average of 3.3 per cent.

In April 2002, Southwark Council owned more than 47,000 dwellings (41 per cent) of the total stock, with housing association and ‘other public sector’ housing accounting for 12 per cent, private renting for 13 per cent and owner occupation at only 34 per cent. Of the council stock, over 80 per cent is in medium- or high-rise flats.

The increased pressure for housing is shown by the fall in the number of lettings in recent years. Between 1998/99 and 2001/02, the total number of people moving into council accommodation fell from 3,511 to 2,394 a fall of 32 per cent. Within this, the lettings to homeless households in priority need rose from 819 to 1,408.

Planning

Southwark’s housing strategy covers the period 1998–2005, and was updated for 2002–03. Supporting People is named as one of the key national agendas (along with reducing bed and breakfast usage, developing new homelessness priorities, developing key worker accommodation, and developing a strategy for travellers’ sites). The borough’s Supporting People priorities are listed within its housing strategy. It also has a mental health strategy, which has a section on accommodation.

Regeneration dominates the housing scene in Southwark. Within the strategy are listed 16 area-based programmes, involving demolition and re-provisioning of over 2,500 homes.

Incidence of mental illness

Southwark has extremely high rates of mental illness across all measures. Lewisham, Southwark and Lambeth Health Authority is estimated to have an incidence of psychosis that is six times greater than the national average.

Here, as elsewhere, there is over-representation of people from black and minority ethnic communities, with black people making up 21 per cent of Southwark’s population but accounting for 43 per cent of assessments in 1998/99 (LSLHA 2002).
Lewisham, Southwark and Lambeth Health Authority has more mentally disordered offenders in special hospitals than any other area of the country. Of those from Southwark, 48 per cent are from an African or African-Caribbean background. This very high incidence of offenders has an impact throughout the system. Of the last 25 people placed by the joint placements panel, 10 had been in a special hospital.

There are an estimated 2,500 refugees and asylum seekers in the borough, many of whom have experienced torture, imprisonment, war, and loss of their home and family. Their mental health needs are often characterised as post-traumatic stress disorder.

In 1998, the health authority undertook a balance of care review, which concluded that actual service use in all services was higher than that predicted by the national norms and resource allocation formulae. This finding was developed in the 2002 mental health strategy, which reported that current levels of provision were ‘mostly inadequate to meet demand, despite offering services at, or beyond, accepted good practice levels’ (LSLHA 2002). It was calculated that spending on mental health was approximately 25 per cent above the expenditure predicted by its weighted capitation allocation.

There are 1,400 people on enhanced care programme approach plans.

Substance misuse is increasingly an issue for mental health services. It is estimated that over 30 per cent of service users on community mental health team caseloads have additional substance misuse problems. This figure rises significantly in forensic services.

Budget considerations

There is severe budgetary pressure within the borough. The placements panel, which allocates a range of supported housing, operates on a strictly ‘one-in, one-out’ policy.

Budgetary pressure is hitting supported housing from all angles. The mental health trust has stopped all out-of-area transfers, increasing the pressure on inpatient beds. This has fed through to increased pressure to unblock any beds, by placing people in residential care.

Out-of-borough placements

Southwark purchases a remarkably high 150 places of supported housing (all in registered care homes) on a spot-contract basis outside the borough. These out-of-borough placements are very expensive, partly because of the council’s legal advice, which states that out-of-borough placements should be in registered care homes.

One commissioner suggested that councillors had tended to believe that because the Bethlem Royal and Maudsley Hospital (a large mental health hospital) was ‘on the doorstep’, there should be no need for other services – in other words, the Maudsley should be big enough to cope with everyone who needed help.

The supported housing that was developed often grew from voluntary groups, started by staff from the Maudsley who identified the gaps and undertook this work in their own time.
Priorities for supported housing

Southwark’s mental health strategy identifies the following priorities:

- a community-based rehabilitation team to provide a time-limited assessment and to commission a care package for service users with low-to-medium support needs
- a new inpatient rehabilitation service and a 24-hour staffed accommodation unit
- a 12-bed forensic hostel in the community
- 24-hour staffed accommodation
- supported living in ordinary housing
- long- and short-term assessment of accommodation and support needs.

Their rehabilitation team is now managing over half of the clients in residential care and managing all the move on accommodation and is involved in the development of increased 24 nursed residential provision in borough. Good progress has therefore been made in developing practices to keep clients moving forward within the system.

All the commissioners interviewed identified the top priorities as high care crisis intervention or emergency housing. For the most complex cases, the placement panel often has to look for places a long way from Southwark.

The demand for forensic services is enormous. Recently, there has also been more emphasis given to developing floating support, and two new floating support schemes have been set up for council tenants. In general, commissioners think there is a glut of medium support and a shortage of higher care units. Women-only schemes are also a priority.

The gaps in the services were clearly identified as being financial, due to lack of revenue funding, and not due to lack of bricks and mortar.

There is a significant amount of lower-level supported accommodation run by housing associations and voluntary organisations. Most of these do not have adequate staffing levels to support such a significant increase in the complexity of the needs presented.

Black and minority ethnic services

A black and minority ethnic group has been established as part of the Supporting People planning processes in partnership with Lewisham and Lambeth councils to provide a wide-ranging, cross-boundary approach, and to give these groups more visibility, especially those who are transient or small in numbers.

The council contracts with Ujima Housing Association, to provide 10 places for young black men. Other local projects that are open to all have a very high proportion of tenants from minority ethnic groups – up to 90 per cent in some schemes.

Women-only services

There is one women-only unit of five places, within a larger scheme.
Cross-borough services

Southwark shares an assessment unit with Lambeth because it cannot afford to purchase all the places in it. Longer term, it aims to bring the whole resource back into Southwark.

Access to ordinary housing

Commissioners were willing to admit that 10 years ago, more people with mental health problems were ‘dumped’ in tower blocks than would happen now.

The amount of stock demolition being undertaken in regeneration areas means that access to ordinary housing has become much more difficult. Many properties that become vacant are needed as replacement homes for people who have been moved out of renewal areas.

The current emphasis on reducing the use of bed and breakfast accommodation has severely restricted the amount of housing becoming available.

Supporting People

Commissioners viewed Supporting People relatively positively. They saw it as a means of developing independent living, and understood the potential for using transitional housing benefit to improve and reconfigure services. Focus groups involving providers have resulted in new ideas for services. The providers have all raised the issue that people being referred have increasingly complex needs.

Southwark Council has saved nearly £500,000 by transferring eligible services into transitional housing benefit. Unfortunately for people with mental health problems, instead of using this money to improve and extend other services, the authority has used it to offset pressures elsewhere. Mental health provision has seen no benefit from the considerable amount of effort involved.

The views and experiences of commissioners and providers in the case study boroughs have been used to inform much of this study. The example given above is presented to illustrate the level of investigation that the authors were able to undertake. Although it describes the issues that the London Borough of Southwark is facing, it remains very much a thumbnail sketch of an area of enormous complexity.
Appendix 5: Extract from Greenwich strategy

The authors found several examples of high quality Supporting People strategies. This Appendix contains a series of unedited extracts from the Greenwich Supporting People Strategy, as an example of good practice, chosen because it concisely draws together relevant information from a number of local sources.

**People with mental health problems**

**Supply**

There are currently just over 90 units of accommodation for people with mental health and 75 units of floating support. The current supply of accommodation is below the ODPM supply profile range but an additional 30 units are currently in the pipeline. The floating support provision lies within the ODPM profile.

Over 3,000 people are currently receiving mental health rehabilitation services in the community.

Currently there are a total of 90 people placed in residential or specialist facilities outside the Oxleas NHS Trust and Greenwich Social Service provision. Out of borough placements represent a significant financial pressure across the local health and social care economy.

**Need**

The most recent assessment of mental health needs was conducted as part of the Local Modernisation Review in July 2001. This study found Greenwich has over 50% higher levels of need for services for people with severe mental illness per head of population than its borough neighbours.

The supplementary housing needs survey indicates that the overwhelming majority of people with learning disability or mental health problem would prefer to remain in their present housing.

National research suggests there is an over representation of BME groups in residential care. An increasing number of referrals are of African, African Caribbean and Asian origin. There is no comprehensive local data available on the proportion of people from BME communities using mental health services but the profile is estimated to be consistent with the borough profile. Research for the local modernisation review (2001) found 25 per cent of admissions to acute services were from clients from Black and Asian populations. Local evidence also suggests the mental health needs in particular of Chinese and Vietnamese communities are poorly met.

**Other issues:**

- Persistent drug users who have a good level of functioning but whose needs increase as soon as drugs are used.
- Increasing level of needs for newly admitted people.
Increasing number of frail elderly whose needs are unsuitable to be met by generalist provision

High level of hidden need amongst young people, although this is difficult to quantify.

Further in depth needs mapping is currently underway and will be used to supplement information set out in this Supporting People strategy.

Unmet need: The greatest areas of unmet need for this group are: health care, rehabilitation following drug and alcohol misuse, leisure activities, rehabilitation following illness, personal care, supervising medication, budgeting, social skills, finding training and employment and advice and advocacy.

Analysis/action

The Best Value review of mental health services carried out in 2001 outlined that mental health services need to change to meet the growing and changing needs of the service users. Existing clients in homes are growing older leading to higher physical and health needs. Increased floating support services within peoples own homes would significantly contribute to the mental well being of individuals and could assist in preventing tenancy breakdown and hospital admissions.

Planned discharges are often delayed due to lack of suitable supported housing accommodation in the borough. The issues preventing discharge are complex and are being jointly explored by Health, Social Services and Housing. Through improved use of local services and better management of move on through services, Supporting People services could assist in relieving the demand for acute services. It is roughly estimated that 30 per cent of delayed discharges are due to a lack of appropriately supported accommodation. The numbers of new presentations from people who could live independently on discharge with appropriate support and monitoring is increasing. Of this group there is a higher number of women than men in this position and it has proved more difficult to find appropriate placements for women. An audit in 1999 found a high correlation between women’s mental health and experience of domestic violence.

Key priorities therefore include:

- At present there are relatively few services specifically for young people on the cusp of adulthood and who fall between children and adult services.
- There is a continued need for both an increase in the number of units available and an increase in the choice in the type of provision. This needs to be balanced with improvements in the coordination of existing services ensuring maximum use is made of available supply.
- Development of schemes or services appropriate for single sex and minority ethnic clients.
- The development of additional housing related support through tenancy sustainment type services will play a significant role in supporting independence and preventing tenancy breakdown in this group. This service will be established by March 2003 and will complement services including the Crisis Resolution Service.
- Increase support in some schemes to accommodate more challenging clients. Develop more consistent low-level support, monitoring and intervention for people with mental health problems that are triggered by substance use.

Appendix 6: The Move-on Alternatives project

The Move-on Alternatives Project (MAP1) is a partnership between housing associations, voluntary agencies and the London Borough of Camden. It is a groundbreaking project that recognises that social housing cannot meet the move-on needs of all those who live in temporary supported housing, and that other move-on housing options have to be pursued. The following is a brief summary of the aims of the project, drawn from a series of unedited extracts of an application for funding submitted to the Office of the Deputy Prime Minister.

The outputs from the MAP1 will include:

- An informative and accessible Toolkit that will enable service users and frontline staff to explore and pursue a range of housing options including private renting and moving to areas of low demand.
- Good practice guidance and tools for practitioners covering initiatives to increase access to the private rented sector, how to develop and manage flat-sharing arrangements, and techniques for managing service user expectations.
- A conference for frontline staff to disseminate the guidance and to improve their ability to access a range of housing options for their service users.
- A strategic conference aimed at support and move-on providers, local councils, and Supporting People Commissioning Bodies.
- A dedicated website to disseminate the outputs.

Stage 2 of this project (MAP2) aims to build on this, and the following outputs have been identified:

Creating the platform for change

- Commitment from all 33 London boroughs to work with the Project to develop a London-wide strategy.
- Engagement with all major housing association providers of social housing move-on in London.
- Quarterly newsletter for Supporting People Teams, housing associations, providers and housing authorities.
- Circulation list for newsletter of at least 200 organisations.
- Periodic newsletter for service users.
- Maintenance and updating of dedicated website.

Strategic development

- Dialogue and collaboration with key strategic bodies, including ALG, Homelessness Directorate, the Housing Corporation and the Government Office for London.
- Agreement from at least six Supporting People Commissioning Bodies to work closely with the Project to develop a move-on strategy that establishes good practice.
- Development of a more accurate picture of the imbalance between the need for and supply of move-on accommodation across London from detailed work with a sample of Supporting People Commissioning Bodies.
Building consensus and partnerships

- At least six authorities implement a common policy for allocating social housing to move-on that is shared across different providers.
- At least five authorities implement a pooling arrangement for social housing move-on e.g. as part of a choice-based lettings scheme.
- All London boroughs to have access to common policies for allocation, methodologies for pooling arrangements and support from the MAP2 Team to develop these approaches.
- All ‘SHIP’ housing associations agree to adopt a common approach to allocating social housing to move-on.

Supporting implementation and change

- Securing capital funding from the Housing Corporation for remodelling schemes and new investment in move-on accommodation.
- Development of supply mapping methodology.
- Contribution to development of needs assessment methodology by ODPM (to ensure move-on needs can be covered).
- Development of ‘model’ framework for allocating social housing to move-on applicants.

Sustaining change

- Evaluation report on the nature and impact of the strategies.
- Good practice guidance for development, implementation and evaluation of move-on strategies.

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