Centre for
Mental Health

More than shelter

Supported accommodation and mental health

Dr Jed Boardman

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

MHPF
National Alliance of Voluntary
Sector Mental Health Providers

Contents

Acknowledgements

Executive Summary

Having somewhere to live in which we feel secure is essential to our physical and mental health. It is of great importance to children's healthy development. And for people who have experienced mental health problems, it is a key to their long-term independence, stability and recovery.

People with mental health problems are more likely than average to experience difficulties with their accommodation. They may become homeless, get into rent or mortgage difficulties, live in poor quality properties in need of repair, live in deprived neighbourhoods, experience crime and become isolated. They may need support to maintain their properties, pay their rent, manage their finances and apply for and receive appropriate social security benefits.

Some may lack the skills to manage their daily needs and live independently. These problems may fluctuate day to day or over a person's lifetime.

The provision of support for people with mental health problems to assist them to live an independent life is central to the delivery of comprehensive mental health support. This briefing paper presents a series of key themes for consideration in the future development of supported accommodation for adults with severe mental health problems, including those with multiple needs and substance misuse and those facing homelessness. The themes have been identified by speaking with people working in this field and from examining the literature on housing for people with mental health conditions.

1. Introduction

The state of the housing market in the UK has changed dramatically since 1945. The growth of social housing after 1945 improved the life chances for many people in the UK. The number of owner occupiers increased during the 1980s, as did house prices. Today we see unprecedented increases in house prices, particularly in London and the South East, a rise in private renters and a decline in social housing and truly affordable homes (Dorling, 2014; Family Mosaic, 2013; McDonald *et al.*, 2015; Citizens Advice and New Policy Institute, 2015). Recent welfare reform measures have had a significant negative impact on many people in social housing (Power *et al.*, 2014).

There are clear links between poverty and housing, and housing costs have a significant impact on poverty and material deprivation (Tunstall *et al.*, 2013). The positive associations between social housing and later advantageous outcomes for people born in the 1940s is no longer seen and has been replaced by outcomes indicating social disadvantage for those born in 1970 (Feinstein *et al.*, 2007). There has been a demise of council housing, a growing waiting list for social housing and an increase in poor quality social housing (Cabinet Office, 2010). Poor housing, poor mental health, worklessness and income poverty are all indicators of multiple disadvantage (Cabinet Office, 2010).

Housing, health and wellbeing

It is widely accepted that good housing is central to our health and wellbeing. Poor housing has significant ill-effects on people's physical health (Nicol *et al.*, 2015; Braubach *et al.*, 2011). Research studies on the association between mental health and housing are not extensive and are mainly cross-sectional surveys, which do not reveal the direction of causation between housing conditions and mental health. In addition, it is difficult to unravel the links between these two factors owing to the additional factors, such as deprivation and social position, which are also strongly linked to mental health and housing. Nevertheless it is possible to identify several key physical and environmental housing factors that are linked

with poor mental health (see Figure 1). Few studies have looked at diagnosed mental health conditions: most have used questionnaires to measure mental health and wellbeing (Weich *et al.*, 2002).

What is clear from these studies is that the built environment may have both direct and indirect effects on our mental health. Direct effects may be due to, for example, overcrowding, damp and noise (Parliamentary Office of Science and Technology, 2011). Indirect effects can be related to the influence of the built environment on psychosocial processes that have an impact on mental health, such as personal control, social support and relationships and social status (Bond *et al.*, 2012). Our homes are more than just physical structures: they provide a sense of security, comfort, pride, status and a place in the community. They can provide a stabilising force, a foundation on which to build our lives and raise our families.

The links between housing and mental health provide an important basis on which to build a picture of the type of supported accommodation and housing support that people with mental health problems should be offered.

Housing for people with mental health problems

The demise of asylums in the second half of the twentieth century and the improvements in welfare state provision after 1945 have provided the necessary conditions for people with severe mental health problems to live in mainstream housing or some form of supported accommodation.

Almost all people with common mental health problems (such as depression or anxiety) and four out of five people with severe mental problems live in mainstream housing. The remainder live in supported housing or other specialist accommodation, and half of those with their own home or tenancy live alone (Davis, 2003; Weich & Lewis, 1998a; 1998b). People with severe mental health problems are unlikely to own their own homes and most live

Figure 1: Factors associated with poor mental health

Poor Quality Housing

- State of housing (e.g. Presence of damp, cold, mould) associated with poor mental health (Guite *et al.*, 2006; Evans, 2003; Page, 2002)

- Insufficient daylight – associated with increased symptoms of depression (Evans, 2003)

Overcrowding and neighbourhood noise

- In adults – associated with depression, increase in psychological symptoms, accidental and violent death (including suicide) (Guite *et al.*, 2006; Evans, 2003; Page, 2002)

- In children – increases in irritability, tension, aggression, lower levels of interaction with other children, poor educational attainment and adjustment (Page, 2002)

Multiple occupancy and temporary accommodation

- In adults – increased depressive symptoms, domestic violence, alcoholism, family stress, relationship breakdown (Page, 2002)

- In children – delayed development, poor educational attainment, irritability, temper tantrums, disturbed sleep (Page, 2002)

- People living in temporary bed and breakfast accommodation are two and a half times more likely to experience poor mental health than people housed in permanent accommodation in the same area (National Housing Federation, 1999)

Tenure and control over housing

- Lack of control over the internal environment and choice of housing – associated with poor mental health (Page, 2002)

Housing type

- High rise housing – associated with poorer mental health in adults, behavioural problems in children and restricted play opportunities (Guite *et al.*, 2006; Evans, 2003; Evans *et al.*, 2003)

- People living in houses rather than flats tend to have better mental health (Bond *et al.*, 2012)

- Multi-dwelling housing is associated with poor mental health (Evans *et al.*, 2003)

- Deck access flats – associated with increased levels of diagnosed depression (Weich *et al.*, 2002)

- People in social housing are more likely to suffer from poor mental health than those who live in owner occupied accommodation (Meltzer *et al.,* 1995; Lewis *et al.* 1998)

Quality of neighbourhood

Poor mental health associated with

- Physical aspects of the environment (e.g. presence of derelict buildings, lack of green space)

- Dissatisfaction with access to green spaces and community facilities

- Fear of crime and feeling unsafe to go out in the day

- Limited opportunities for social participation

(Guite *et al.*, 2006; Weich *et al.*, 2002; Ellaway *et al.*, 2001; Evans, 2003; Araya *et al.*, 2006)

Higher levels of mental wellbeing associated with:

- Living in an area perceived to have attractive buildings

- Living in an attractive, quiet, peaceful environment

- Perceiving the area to have a good internal reputation

- Being satisfied with the house and landlord

- Feeling that both home and neighbourhood contribute to a sense of wellbeing

(Bond *et al.*, 2012)

in social housing owned by local authorities or registered social landlords (Foster *et al.*, 1996; Singleton *et al.*, 2001). They are more likely than the general population to have housing problems (see Figure 2).

Poor housing rarely exists in isolation; it is often located in areas of social deprivation with associated high levels of unemployment, poverty, crime, poor transport and other inadequate infrastructure. People with mental health problems often find themselves living in such areas in social housing or renting low quality accommodation (Boardman *et al.*, 2010). They are likely to share the problems associated with changes in social housing since the 1960s, including growing levels of poverty, debt, family and relationship breakdown, joblessness, stigma and discrimination (Feinstein *et al.*, 2007; Hills, 2007). These problems affect people in both urban and rural areas, but may be hidden in the latter (Nicholson, 2008).

Homelessness and mental health problems

Historically, significant numbers of people with mental health problems have faced homelessness. Obtaining accurate figures for the numbers of homeless people, or the proportion of homeless people who have mental health problems, is difficult. They may be street homeless or living in direct access hostels and in temporary housing or unstable accommodation. Refugees and asylum seekers are also at risk of homelessness and many have mental health problems (Palmer, 2006; Pernice and Brook, 1994). Studies in western countries show large variations in the proportion of homeless people who have mental health problems (Fazel *et al.*, 2008) but overall approximately 13% have psychoses (ten times the rate in the general population), 38% alcohol dependency and 25% drug dependency. Homeless people with severe and enduring mental health problems often have multiple problems including substance misuse, physical illness and disabilities, and they die prematurely. The services that they receive are variable and often poorly co-ordinated. In addition to mental and physical health services, they need social support, help with housing and increased economic security (Herman, 2008).

Figure 2: People with mental health problems and housing

People with mental health problems are (Meltzer et al., 2002):

- Less likely to be homeowners
- More likely to live in unstable environments
- Twice as likely to be unhappy with their housing
- Four times as likely to say it makes their health worse

In addition:

- 33% of people with housing problems are likely to suffer from poor mental health compared to 12% of those with no mental health problems (Payne, 2006)
- One in four tenants with mental health problems have rent arrears and are at risk of losing their homes (Neuberger, 2003)
- Almost half of the 24,429 people with disabilities accessing Supporting People housing related support in 2008/09 defined themselves as having a disability related to a mental health problem (Centre for Housing Research, 2010)
- Data from the English and Welsh Civil and Social Justice Survey of rights problems found that 26% of people with a mental health problem reported a housing rights problem, compared to 11% of other people surveyed. 30% of those with a mental health condition and a long-term illness or disability reported a housing rights problem (Pleasence & Balmer, 2007).

2. What is supported accommodation?

There is no clear definition of what constitutes supported accommodation for people with mental health problems. The term is usually used to cover services that combine accommodation and support to 'vulnerable' people to help them live more independently (Rethink Mental Illness, 2013). The term may cover hostels, sheltered housing, shared homes and support to people living in their own homes. In the UK the largest proportion of housing support is provided to older adults. Specialist supported housing for people with mental health problems has evolved over time and includes nursing and residential care homes, group homes, community-based rehabilitation units, step down units, blocks of individual or shared tenancies with staff on-site and independent tenancies with staff off-site or outreach ('floating') support (Killaspy *et al.*, 2015; Chapman, 2014; O'Malley and Croucher, 2005). Temporary accommodation such as Crisis Houses and short-stay hostels are sometimes added to this list. In England there is now a large range of different approaches to supported housing offered to a wide range of people with mental health problems (Chapman, 2014).

While there have been many attempts to provide a definition or system for classifying 'supported accommodation' (e.g. Clifford, 1993; Lelliot *et al.*, 1996; Tabol *et al.*, 2010) no single description has stood the test of time. Nevertheless, Pleace and Wallace (2011) have outlined three broad types of housing support services:

- **Staircase models**: the provision of a series of types of accommodation or stages that provide less support at each stage, with the aim of progression to independent living.

- **Accommodation-based services**: the provision of purpose built supported housing with on-site staffing. The purpose is often to provide a 'halfway' house between institutional care and ordinary housing.

- **Mobile support workers (often called 'Floating Support')**: usually provided in independent accommodation with the aim of preventing problems related to sustaining a tenancy or maintaining stable housing.

Rather than attempt a single definition, for the purposes of this paper it has been accepted that there is a considerable diversity in the approaches to 'supported accommodation' covering the range of facilities listed above which provide both accommodation and support to people with mental health problems. We focus on the spectrum of schemes that provide accommodation and support for people with mental health problems, ranging from Residential Care (where people receive 24 hour high intensity support in a community setting, but without tenancy) to Supported Housing (where people with an individual or shared tenancy receive building-based support, to variable levels of intensity) and to Floating or Housing Support (outreach to people living in independent accommodation).

How many people use supported accommodation?

In an area beset with problems of definition, it is not surprising that there is a paucity of data on the use of supported housing. There are some limited data available on several of the components of supported housing, but no comprehensive data. Killaspy and Meier (2010), using Freedom of Information requests, found that around 30,000 people with mental health problems were in nursing or residential care homes in England. In 2005, of the 160,000 people in England who were receiving floating outreach support, 24,000 were in receipt of a specialist mental health outreach scheme (Department of Communities and Local Government, 2006). Of 239,366 people receiving a Supporting People funded service between 1 April 2009 and 31 March 2010, people with mental health problems made up the third largest group, constituting 9% of all primary clients. In addition, 2% of the primary client groups had learning disabilities, 4% had alcohol problems, 4% had drug problems and 0.1% were offenders with mental health problems (Centre for Housing Research, 2010).

3. Why do we need supported housing?

It is well recognised that social policies that rely on 'community care' need to be backed by effective housing provision and support (O'Malley and Croucher, 2005). Underpinning this is the principle of providing the least restrictive setting for peoples' accommodation. Many people have argued that housing is one of the most important factors affecting people with severe mental health problems (Fakoury *et al.*, 2002). This is partly due to the relationship between health and housing outlined earlier and additional reasons are outlined in Figure 3. Support and housing are closely linked for people with severe mental health problems; having somewhere to live is a stabilising force for people allowing them to establish daily routines, to receive support and access services. Having a stable tenure allows them to develop a sense of security and control over their lives. Finding stable accommodation is not the end point for a person with mental health problems, but often the starting point for rehabilitation and recovery (Gonzalez and Andvig, 2015). People with severe mental health problems often cite income and housing as the most important factors in their recovery (O'Malley and Croucher, 2005; Kyle and Dunn, 2008). Of central importance is 'having one's own place': a secure tenure and a safe environment.

The effects of a lack of housing support are well recognised:

"Unsuitable housing, or a lack of suitable housing related support, can also lead to an escalation in care needs and can contribute to "trigger" events that could result in admission to hospital or reduce the individual's or their carer's confidence that they can live safely in the community. Naturally, this increases the pressure for residential or similar support". (Department of Health, 2009a, page 2).

The provision of supported housing can have a significant economic impact on services, reducing the costs of tenancy breakdown and homelessness, reducing hospital admissions, the number of people in institutional care and the costs of out-of-area placements (Appleton et al., 2011; Appleton and Molyneux, 2011; Crisp et al., 2016; Killaspy and Meier, 2010; Ryan et al., 2011). Housing support and stable accommodation can also lower the length of time spent in hospital by reducing the transfer delays from hospital to home. It has been estimated that, set against an annual investment of £1.61 billion, the Supporting People Programme generated net savings of £3.14 billion per year (Department of Communities and Local Government, 2009). Significant savings are related to the costs to health services, and costs of crime and homelessness.

Figure 3: Importance of supported housing for people with severe mental health problems.

Provision of a healthy environment (see Figure 1, page 5)

- Promotes wellbeing, mental and physical health
- Reduces physical risks e.g. accidents

Stability and security

- Own tenancy
- Long-term living environment
- Increased hope, control, sense of self and planning longer term goals
- Opportunity to establish financial security – welfare benefits, employment income
- Developing new skills
- Adaptations to physical environment to meet changing personal needs
- Use of assistive technologies
- Support to carers
- Respite

Access to services

- Social care and support
- Health services
- Rehabilitation and reablement

Social network and integration

- Contributing to local community
- Maintain/establish family and social networks
- Peer support
- Crisis support

Cost reduction

- Reduced acute admissions
- Reduced need for institutional care
- Reduced 'Out of Area Treatments'
- Reduced time spent in hospital (lowered 'delayed discharges')
- Reduced tenancy breakdowns and homelessness

4. Development of supported accommodation for people with mental health problems

The provision of appropriate accommodation and support has been central to the success of community provision of services for people with severe mental health problems. However, the coordination of services between housing, health and social care agencies has always proved difficult and the provision of housing support has been 'modest and patchy' (O'Malley and Croucher, 2005). Early schemes were provided by NHS monies related to the closure of the old asylums (Killaspy *et al.*, 2015). The UK has never had a national plan for supported housing, resulting in a diversity of types and quality of housing support across the country (Pleace and Wallace, 2011). There has been a range of revenue funding and grants to support the capital costs of developing purpose built accommodation.

Before 2003, supported housing was developed by housing providers and charities to meet local need and predominantly funded by Housing Benefit. There was very little local authority involvement or coordination. Capital costs were met through mainstream grant programmes from the Housing Corporation and a small amount of revenue funding was also available from the Housing Corporation in the form of Supported Housing Management Grant (SHMG). In 2002, about £1.4bn of the £1.8bn revenue pot was in the form of Housing Benefit.

One important problem for supported housing services was the distinction between 'housing support' and the support provided to people by health and social services. Monies for housing related support could not be used to fund clinical or personal care. This meant that certain facilities, such as rehabilitation units, could not be regarded as housing support. This blurred demarcation led to unintended consequences and hampered the development of a 'housing support continuum' (Pleace and Wallace, 2011; Killaspy *et al.*, 2015).

In 2003, the UK government launched the 'Supporting People' programme in England and Wales, which focused on 'low-intensity housing related support' to improve independence for 'vulnerable people', including people with mental health problems and those with substance misuse problems. Local authorities were given dedicated ('ring-fenced') revenue grants to commission local housing support services. The schemes were mainly provided by housing associations and voluntary sector groups. Local authorities were, and still are, direct providers of supported housing services, particularly for older people and those with learning disabilities. The guidance for Supporting People services was not specific about the types of services to be provided but was more prescriptive about the range of supports, which did not include personal and clinical care. Nevertheless, over time the line between housing support and personal care began to blur and schemes developed from shared funding between Supporting People, social and health services which allowed for a wider range of support services to be provided (Pleace and Wallace, 2011).

In 2010, the ring-fencing of the Supporting People budgets was removed, creating both opportunities and uncertainties for supported housing services. In particular, people with mental health problems have to compete with other vulnerable groups and other services that local authorities have to provide with increasingly limited funding (Killaspy *et al.*, 2015).

Current funding for supported housing remains at the local level. Recent reductions in local authority budgets, welfare reforms and increasing rents in urban areas have had negative consequences for these types of supported housing placements (Cooper, 2013). The continuing welfare reforms are likely to have further adverse consequences.

In England, more intensive forms of supported accommodation (hospital, nursing and residential care) are funded by a separate mechanism with NHS and local authority monies. When a person requires these specific placements, their case is put to a specialist placement funding panel (which

includes representatives of NHS and local authorities) who consider the person's needs and appropriate placement and decide who will provide the funding (NHS, local authority or both). Arrangements for these panels and budgets will vary across the country. These arrangements may be even more complicated for people who have both a mental health problem and a physical disability (Killaspy *et al.*, 2015).

The historical division of housing and non-housing support, complexity of funding arrangements, reduction of available resources and the external pressures from welfare reforms and national housing policies, all combine to reduce the likelihood of adequate supported accommodation services being offered to people with mental health problems and the development of effective partnerships between statutory agencies. This is compounded by the differing responsibilities, values and approaches of housing, social and health services, and the lack of a coherent view as to what are the most effective models of supported accommodation, what constitutes best practice in this area, and a lack of sound research and evaluation.

5. Providers and funders of housing support

Since the 1950s, there has been a radical shift in the provision of long-term residential care for people with mental health problems from the NHS to local authority and independent sector organisations. At present the main responsibility for the provision of supported accommodation remains with local authorities who mainly sub-contract the responsibility for providing to 'for profit' and 'not for profit' independent agencies. Since 2009, austerity in public spending and the removal of the ring-fencing for the Supporting People budget has meant that people with mental health problems have to compete for funding both with other vulnerable groups for housing support, and with the other services that local authorities are required to provide.

These changes are set against a background of increasing house and land prices and a lack of truly affordable housing in the UK, particularly in London and the South East. Historical variations and inequalities in the provision of supported accommodation are amplified by the current funding arrangements and housing crisis. In addition, over the past 20 years there has been a move from capital to revenue funding in social housing. Originally capital grants covered almost all of the housing cost, leading to cheap rents and less reliance on welfare benefits. The average capital subsidy is now about 5% of the cost and so rents are high and most tenants are reliant on benefits. This change in funding structure makes the delivery of revenue-intensive supported housing even more vulnerable.

Over recent years the policy trend has been to decentralise decision making and funding to local bodies. This is unlikely to resolve the present inequalities in the provision and funding of supported housing and it raises questions as to how funding can be made to match the local need for supported housing, how to prioritise the provision of supported housing for people with mental health problems and how local housing markets can be adapted to provide the buildings necessary for high quality accommodation.

There are many examples of supported housing schemes for people with severe mental health problems (Chapman, 2014), mostly provided by Housing Associations. Many housing associations provide the 'bricks and mortar' component of the supported housing with an independent organisation providing the support. Only a few large Housing Associations with specialist care and support divisions provide both. These approaches to the provision of support illustrate the different responses to risk made by Housing Associations. Some are moving away from care and support provision to a landlord-only function, suggesting an unwillingness to take on the financial risks of providing support services which yield lower profit margins than the building of new accommodation and the risks associated with the provision of services to a complex client group. Others have shown a different response, successfully managing risks by combining care and support with the landlord function.

Regrettably, there is a lack of evidence as to who is best placed to provide the support component. However, there is less uncertainty that support needs to be supplied by specialist providers that are locally based, in stable organisations that can provide services of a high standard over a prolonged period using well trained and experienced staff.

6. Housing First

The predominant UK approach for re-housing street homeless people with "complex support needs" (people with severe mental health problems and/or active substance misuse) has been one of a 'continuum of care' or 'staircase' approach, whereby there is a progression from being street homeless through a series of residential settings (emergency shelters, transitional housing, supportive housing) to independent housing. This 'treatment first' approach involves support and treatment before people attain 'housing readiness' (Johnsen and Texeira, 2010). Recently this approach has been challenged by a different approach, 'Housing First', which bypasses the progressive stages and places homeless people into permanent and independent tenancies.

The first clear example of this type of service was established in New York in 1992 for street homeless people with severe mental health problems by the Pathways to Housing organisation (Tsemberis, 2010a).

Most Housing First services have been developed in the USA for homeless people with severe mental health problems and with alcohol or drug misuse (Tsemberis, 2010b). More recently this approach has been used in Canada (At Home/Chez Soi – Goering *et al.*, 2014) and in France (Un Chez Soi d'abord – Bretherton and Pleace, 2015), with other European examples seen in Amsterdam, Budapest, Copenhagen and Lisbon, and in Glasgow (Housing First Europe Project - Busch-Geertsema, 2014; Bretherton and Pleace, 2015). In England there have been several examples of small scale services based on the Housing First approach in Camden, London and in nine other centres (Bretherton and Pleace, 2015).

The key elements of the Housing First approach are shown in Figure 4. The underlying philosophy of Housing First regards housing as a basic right, and emphasises self-determination, choice and a recovery-orientated approach. The housing that is provided is permanent with a secure tenure. The offer of housing is not conditional on receiving treatment, thus separating these two elements. Support however is conditional and offered on a long-term basis. Mental health services are offered through the use of assertive outreach or intensive case management. Many schemes use accommodation based across several sites ('scattered site housing'), but some use accommodation based in clusters.

Figure 4 – Key elements of the Housing First approach

- Immediate provision of independent accommodation
- No requirement of 'housing readiness'
- Provision of permanent housing
- Open-ended access to support
- Respect for choice and self-determination ("Respect, warmth and compassion for all clients")
- Personalised approach targeting the most vulnerable people
- Provision of integrated and comprehensive community-based support by Assertive Outreach teams (ACT) or Intensive Case management (ICM)
- Harm-reduction approach to substance misuse

7. Research evidence and evaluations of supported hous-

It is widely accepted that there is a lack of good quality research on supported housing (Pleace and Wallace, 2011). This review has, at times, struggled to find the evidence on which to base its conclusions, but despite this we can see that the supported housing field is not evidence-free and what evidence there is can inform the development of better services.

In their review of research into housing support for people with mental health problems, Pleace and Wallace (2011) point out the need to clearly define the housing support that is being delivered and to delineate the extent to which the service reflects its original objectives and design ('programme fidelity'). The importance of including the views and input of service users is also emphasised. And evaluations need to be rigorous, using mixed methods, comparison groups, randomised controlled designs, longitudinal and cost-benefit approaches.

Many successful studies of supported housing, notably the evaluations of the Housing First approach, have used the sustainment of a tenancy as the main outcome factor and some have measured the knock-on effects on other services, usually health, social care and criminal justice. Good supported housing can also bring additional benefits to health and wellbeing, quality of life, a sense of security, and a means by which people can engage in their communities and in health and education. This range of outcomes should be included in the evaluative process.

We know much more about housing interventions for homeless people than, for example, people with severe mental health problems who are precariously or inappropriately housed (Kyle and Dunn, 2008). We still lack evidence as to what types of supported housing work best for whom.

Much of the better quality research into the outcomes of supported housing has been done in North America, almost exclusively the evaluation of Housing First. This has significantly contributed to Housing First approaches being incorporated into social policy initiatives to combat homelessness in the USA. This has not been the case in the UK, where funding for supported housing research remains largely insignificant.

Existing research from the UK

In the UK the reduction and closure of the large asylums and the resettlement of their residents is considered to have been successful, with no commensurate increase in homelessness or crime. The TAPS project, which evaluated the closure of Friern and Claybury hospitals in north London was one example of a well conducted evaluation of hospital closure which showed an improvement in health and social functioning of those who left the hospitals and their general satisfaction with their community homes (Leff, 1997). Nevertheless, concerns remained about the younger group with severe disabilities and those with repeated admissions (Lelliott *et al.*, 1994).

A review of the evidence for "low intensity support" services for people with mental health problems concluded that:

"Overall there is a range of evidence to support the development of low intensity support services for some people with mental health problems, although there are dangers in assuming that this level of support is adequate for all types of patients particularly in terms of the 'revolving door' pattern that can result from providing inappropriate levels of care to people. In general the literature suggests that people are satisfied with the support they receive and would support an extension of these kinds of services. Alongside evidence suggesting that community care is a positive option for many people with mental health problems, it appears that the housing and support needs for this group can be met outside institutional settings". (O'Malley and Croucher, 2005; page 837)

The same review examined "high support" accommodation and noted that this formed "...a crucial part of the spectrum of services available, often dealing with patients with particularly difficult and challenging problems..." but also noted that:

"...there is a clear tension present in all these facilities with regard to how far they should be considered permanent forms of accommodation and how far they are transitional residences that should prepare people for more independent lives" (O'Malley and Croucher, 2005; page 838).

Despite this general evidence to support the success of providing community based housing and support for people with severe mental health problems, it remains difficult to answer questions as to what are the elements of supported housing that work best and for whom. Several commentators have noted that the lack of clear models of supported housing and the inconsistent use of terminology has hampered the research into supported housing schemes (Fakhoury *et al.*, 2002; Siskind *et al.*, 2013; Tabol *et al.*, 2010).

The use of randomised controlled trials (RCTs) to evaluate the effectiveness of interventions is usually regarded as the 'gold standard' of evidence, but the use of RCTs is uncommon in supported housing studies (Waegemakers, Schiff and Rook, 2012). In her systematic examination of research on low intensity support services across several fields, Quilgars (2000) found no studies using RCTs. A systematic review of supported housing for people with severe mental health problems also found no such studies (Chilvers *et al.*, 2006).

Two recent small scale evaluations of supported housing projects in England showed encouraging results. An evaluation of the Midland Heart Complex Needs Services, which supplies supported housing services to homeless people with mental health problems and substance misuse (Miller and Appleton, 2014), suggested that the success of the service was related to the approach of staff, involving and engaging users of the service, linking successfully with other agencies and a positive risk management approach.

Tile House in North London, meanwhile, was set up to provide housing for people with severe mental health problems who had spent many years in registered care or forensic care homes. A small scale evaluation of 19 residents in Tile House provides some evidence for supported housing schemes that offer a service to bring people placed in out of area accommodation back to their area of origin (One Housing, 2015). 14 of the 19 residents had moved into Tile House from out of area schemes. Re-admissions to hospital for the residents in the scheme did not decrease after their move to Tile House but they spent less time in hospital when they were admitted (81 days over two years since their move to Tile House compared to 317 days before the move). They showed an improvement in their daily living skills, the number of goals they achieved and their satisfaction and engagement with services. In addition, a follow-up of people discharged from a rehabilitation unit in Islington, by Killaspy and Zis (2012), found that 40% of people moved successfully to less supported accommodation without relapse, readmission or placement breakdown over a five year period, and 26% remained in the same placement or one with the same level of support.

Despite the apparent lack of studies on the effectiveness of supported housing, there are two areas where helpful evidence to inform service development can be found: qualitative studies and evaluations of Housing First schemes.

Qualitative studies

These studies have mainly examined the characteristics of supported housing schemes from the point of view of the residents (see Figure 5, page 17). Many studies examine satisfaction with housing and report a moderate to high degree of satisfaction. However, some studies show that residents have low expectations of housing, possibly as a result of their previous experiences with mental health services, thus suggesting that they may tolerate lower standards than may be acceptable to others (Brolin *et al.*, 2015).

A recent international review of the experiences of housing support for people with severe mental health conditions examined 24 studies with 769 informants and identified key aspects of their support, neighbourhood and community experiences (Gonzalez & Andvig, 2015). They concluded:

"The findings underline the importance of continually available staff that offers emotional, therapeutic, educational, and practical support. Achieving autonomy and experiencing having respect and choices were highly valued and contributed positively to recovery and integrational processes for tenants with SMI [severe mental illness]. The positively experienced staff attitudes and values reported by tenants were generally in line with the core values and ideas of the Housing First program and the recovery tradition... The findings underline the importance of addressing both neighborhood and community issues in housing programs and strategies" (page 985).

In general, residents prefer independent living in ordinary housing and value flexible support rather than living with staff (MacPherson *et al.*, 2012). Qualitative studies suggest that successful approaches to supported housing involve a person-centred, personalised approach which is flexible and respectful of choice and autonomy, and which employs a range of supports and develops high quality relationships between staff and tenants. Residents also value stability and the permanence of their tenancies. The location of the housing is important, people preferring safer and more supportive communities. Residents are split in their opinions as to whether the accommodation should be integrated with mainstream housing or provided in clusters with others who have experience of mental health problems. This perhaps reflects their differing experiences of rigid living environments, stigma, prejudice, loneliness and support from peers.

Many of these aspects of supported housing are associated with the satisfaction of residents. Other aspects such as choice and control and the physical quality of housing are associated with a better subjective quality of life (Nelson *et al.*, 2005). Long-term support and case management are associated with retention of housing.

These studies also identify conditions which are unsatisfactory to residents, including:

- lack of companionship;
- lack of control;
- lack of support for physical or domestic activities, leisure, education, and work;
- lack of independence;
- limited leisure opportunities;
- conflicts with other residents;
- poor neighbourhoods.

Many residents dislike the instability they experience from moving across stepped-down accommodation (Browne, Hemsley *et al.*, 2008).

Studies comparing the views of staff and service users often show them differing in their rating of needs and goals (Slade *et al.*, 1996). In one UK study the commonly reported goals of people in supported housing who had mental health problems included wishing to get independent housing, to improve their living skills and to stay healthy. These differed from the views of staff (Fakhoury *et al.*, 2005). In Canada, staff valued safety and support, whereas residents valued independence and privacy (Piat *et al.*, 2008).

Housing First schemes

Most of the evidence for Housing First comes from the USA. Housing First is targeting 'chronically' homeless people, so the evaluations inevitably focus on achieving housing stability for this group. It is generally accepted that Housing First is successful in getting people off the streets and out of shelters into more permanent and independent housing (Raitakari and Juhila, 2015). The randomised controlled trial (RCT) of the New York Pathways to Housing Programme (Tsemberis, 2010a, 2010b; Tsemberis *et al.* 2003a; 2003b; Stefanic and Tsemberis, 2007) showed 80% of the people in Housing First schemes were stably housed over a two year period, compared to 30% of those in the treatment first schemes. Over a four year period, 78% of the Housing First clients remained continuously housed (Stefanic and Tsemberis, 2007).

Most of the US studies of Housing First have focused on homeless people with mental health problems and/or substance misuse (Waegemakers Schiff and Rook, 2012) and there have been randomised controlled trials of the schemes in New York and Chicago (Tsemberis, 2010b; Basu *et al.*, 2012). Many of the US studies are based on evaluations of

Figure 5 – Qualitative studies: Characteristics of successful supported housing

Choice and Flexibility

- Active participation in decisions about housing (Kirsh *et al.*, 2009)

- Provided with choice, autonomy and control over living environment (Kirsh *et al.*, 2009, Bowpitt & Jepson, 2007; Andvig & Hummelvoll, 2015)

- Having goals and choices in everyday life (Petersen *et al.*, 2012)

- Increased competence and better self-confidence (Pejlert *et al.*, 1999)

- Increased independence, improved sense of wellbeing (Nelson *et al.*, 2005)

- Coherence, stability, security and flexibility (Carpenter-Song *et al.*, 2012)

Quality of relationships between residents and staff

- Dignity, trust, respect and choice (Kirsh *et al.*, 2009)

- Person-centered, individualised approach (Kirsh *et al.*, 2009)

- Supportive atmosphere and good relationship with staff (Goering *et al..*, 1992)

- Community spirit, having someone to attach to (Bengtsson-Tops *et al..*, 2014)

- Good quality supportive relations (Browne and Courtney, 2005)

- Good case worker, having someone who understands (Browne *et al..* 2008; Andvig & Hummelvoll, 2015)

- Continued access to a support worker and long term case management (Kirsh *et al.*, 2009)

Provision of a range of support

- Support with:
    - independent living
    - preventing and managing a crisis
    - pursuing work and education
    - creating and maintaining social connections
    - physical and mental health

(Kirsh *et al.*, 2009)

- Structured programming (Goering *et al.*, 1992) (if too rigid, this proved unsatisfactory for residents)

- Engaging in an activity (Lindstrom *et al..*, 2013)

Tenancy and environment

- Maintaining tenure over time (Browne & Courtney, 2005)

- Place of rest (Bengtsson-Tops *et al..*, 2014)

- Security and privacy (Brolin *et al.*, 2015)

- Choice of residential area and accommodation (Brolin *et al.*, 2015)

- Neighbourhood fit (Kirsh *et al.*, 2009): matching needs and goals of residents to the environment best suited to them e.g. close to community resources and social connections, stable neighbourhoods with lower crime rates.

- A more diverse neighbourhood may be more accepting (Kirsh *et al.*, 2009)

- Integrated with mainstream housing – thus 'anonymous' and neighbours unaware of their mental health problems (Kirsh *et al.*, 2009)

Or

- Clustered housing - benefit from the support of peers (Kirsh *et al.*, 2009; Bowpitt & Jepson, 2007)**.**

See: Kirsch et al. (2009) and Gonzalez & Andvig (2015) for reviews

the New York Pathways to Housing Programme (Tsemberis *et al.* 2003a; 2003b; Gulcur *et al.*, 2003; Stefanic and Tsemberis, 2007). Multisite studies have also been conducted (Tsai *et al.*, 2010) and separate studies have been carried out in San Diego (Gilmer *et al.*, 2009; 2010) and Chicago (Basu *et al.*, 2012).

More recently, a large RCT evaluation of Housing First, the At Home/Chez Soi project has been undertaken in five Canadian cities (Goering *et al.*, 2014). It was carried out between 2009 and 2013 and involved 2,148 people with mental health problems who were randomly placed in one of three groups: two Housing First groups who received either Assertive Community Treatment (ACT) or Intensive Case Management (ICM) and a control group who had access to existing housing and support services in their local area. The three groups of people were followed up over a two year period. As with the US studies, housing stability was high, with 62% of the Housing First groups remaining housed over the two-year period, compared to 31% of the control group. Housing stability was almost identical in those offered ACT or ICM.

The evidence for health and social outcomes across all the Housing First studies is mixed, but overall there is little evidence for deterioration in mental health or substance use, with some studies showing an improvement (Pleace and Quilgars, 2013). Engagement with health and support services generally improves, as do quality of life and satisfaction measures (Pleace and Quilgars, 2013). It is possible that many health and social outcomes take longer to achieve and may be seen more clearly in long-term studies.

The principles of Housing First do seem to be important in helping to achieve the desired outcomes. Services which more closely adopt the Housing First principles have better housing outcomes (Gilmer *et al.*, 2014). And people placed in Housing First schemes value the privacy, safety and security provided (Pleace and Quilgars, 2013; Waegemakers, Schiff and Rook, 2012).

No large scale evaluations of Housing First have been reported outside North America. The Housing First Europe Project found high housing retention rates in four out of the five projects evaluated (Busch-Geertsema, 2014). A small scale evaluation of a scheme in Camden, North London, reported success in re-housing with some increase in engagement with medical and mental health services and a reduction in alcohol and drug misuse and anti-social behaviour (Pleace and Bretherton, 2013). The researchers attributed the success to good levels of resources, experienced staff who were familiar with the local housing market, adherence to the Housing First model, flexible case management and a good working relationship between the staff and clients. Interviews with 60 service users of nine Housing First schemes across England produced similar findings (Bretherton and Pleace, 2015).

The evidence for the effectiveness of Housing First has been criticised and only a few rigorous studies have been undertaken in the UK (Pleace and Bretherton, 2013). Nevertheless, these studies are generally consistent and represent an oasis in an otherwise arid area of research and evaluation. Reviews of the Housing First studies have noted:

"We can safely conclude that HF [Housing First] has been shown to be effective in housing and maintaining housing for single adults with mental illness and substance use issues in urban locations where there is ample rental housing stock... There are... reports of substantial reductions in homelessness and associated costs for those who employ an HF approach... The evidence of best practice in housing is retention of domicile, as reported by program outcome data, and, despite lack of rigorous multiple clinical trials, Housing First overwhelmingly meets that requirement for a majority of the homeless population" (Waegemakers, Schiff and Rook, 2012, pages 17-18).

"...there is now simply too much evidence that Housing First services, with shared operating principles, are effective in a range of contexts across different countries for this critique to really be taken seriously. The evidence base is not however perfect" (Pleace and Bretherton, 2013, page 35).

8. Cost-effectiveness and value for money

One important test of supported housing is the extent to which its costs can be offset by savings in other areas, such as the NHS (e.g. reduced admissions and A&E attendances, fewer delayed discharges), criminal justice services (e.g. crime, time in prison), and homeless services (e.g. shelters, Bed & Breakfast placements).

Most studies that have provided data on costs and savings come from supported housing schemes in the United States for people with severe mental health problems. One study in New York looked at administrative data about over 3,000 people with severe mental health problems between 1989 and 1997, before and after they were placed in supportive housing and compared them to a matched group of homeless people who had not been so placed (Culhane *et al.*, 2002). Considerable reductions in costs were seen for the people in supported housing compared both to the period before placement and to the control group. This was due to their reduced use of homeless shelters, fewer hospital admissions, shorter lengths of stay in hospital, and less time spent in prison.

Several studies show an increase in outpatient or community health service costs as a consequence of the improved engagement of clients with health services.

While the studies are generally consistent in finding savings in other services, not all report whether these savings offset the costs of housing. The San Diego Housing First study found that cost savings resulting from the move to supported housing offset 82% of the costs of the housing programme (Gilmer *et al.*, 2010). The At Home/Chez Soi study found cost savings for people with the highest needs to be greater than those with moderate needs. The costs of providing the Housing First schemes were higher than the savings to health and criminal justice services and provision of homeless shelters, with a greater offset in costs seen in the high needs group. The study report estimated that "…every $10 invested in HF [Housing First] services resulted in an average reduction in costs of other services of $9.60 for HN [High Need] participants and $3.42 for MN [Moderate Need] participants" (Goering *et al.*, 2014, page 23).

The Tile House evaluation provided some estimated costs for the residents before and after their move (One Housing, 2015). Tile House was less costly than previous placements (an average of £58,218 per person per year before compared to £36,920 after). Hospital admissions costs were reduced from an average of £355,845 to £71,649 per person per year. The overall annual saving on accommodation and admission costs was £443,964.

9. What support do people want?

We often associate giving support to people as giving assistance, implying that this keeps them going and bolsters them. In considering housing support the aim is generally accepted to be to help people remain independent in their homes. Support can vary in nature, range and duration.

A review of "low intensity support services" which examined housing and tenancy support, direct practical support and emotional and social support concluded that the body of research evidence was poorly developed (Quilgars, 2000). The existing evidence suggested a high demand for tenancy support and that this support reduces the likelihood of tenancy breakdown. People who received the support saw it as adding something to their lives and felt that it helped them approach life in a more positive way. Consistent with the research findings detailed in Figure 5 (page 17), the quality of relationship with the support workers was crucial.

The experience from the Supporting People programme indicates that support for people with mental health problems needs to be broader than just tenancy support. The possible range of support will ultimately depend on an individual's needs and cover the range of supports shown in Figure 6. The provision of these supports will inevitably involve a range of agencies, implying the need for partnership across local services and coordination at the individual and agency levels. Evidence from the Housing First studies supports the implementation of some form of case management. There is also growing evidence for the value of Peer Support (Repper, 2013).

Evidence from the studies outlined in Figure 5 (page 17) and the Housing First evaluations suggests that the way in which the support is delivered is of central importance: crucially, a person-centred, individualised approach which provides choice, autonomy and control, aiming to increase self-reliance and independence. Further evidence for the value of proving support in this way comes from several sources, including the literature on shared decision making and self-management support (Ahmad *et al.*, 2014), rehabilitation practice (Holloway *et al.*, 2015), co-production (Slay & Stephens, 2013), supported employment (Drake *et al.*, 2012) and recovery (Repper & Perkins, 2003; Slade, 2009; Tondora *et al.*, 2014). The 2014 Schizphrenia Commission highlighted the evidence for several approaches to supporting recovery, including employment support, physical health interventions, peer support, self-management, Personal Budgets and welfare advice (Knapp *et al.*, 2014). Gonzalez and Andvig (2015) noted that educational support was integrated in several programmes and was appreciated by residents. The use of Recovery Colleges may be of value in providing this support (Perkins *et al.*, 2012).

The literature on Housing First suggests that support should be provided either long-term or indefinitely. It may be more helpful to view the support as being provided 'when people need it'. For people with long-term conditions, needs and wishes for support will change over time. People need to be able to access support easily when required.

Figure 6 – Range of supports for independent living

- Tenancy support
- Housing rights advice
- Welfare benefit support
- Advocacy
- Life skills support – budgeting, cooking, cleaning, shopping, self-care
- Employment support
- Medications management

- Education/training
- Support to access services
- Support to access local activities
- Emotional support
- Crisis support
- Health services support – primary and secondary care

10. Support for people with complex mental health problems

There are several common routes through which people with long-term mental health problems access housing support. Some may be through homeless services, others through community mental health teams or an acute mental health service. However there are a small but significant number who will enter supported housing, mainly high support, via rehabilitation services. This group have 'complex problems', often a mix of challenging behaviours, poor response to treatments, cognitive impairments, co-existing substance misuse, learning disabilities or Asperger's syndrome. They represent about 14% of all people with a new diagnosis of schizophrenia or about 1% of all people with severe and enduring mental health problems (Craig *et al.*, 2004; Killaspy, 2014). Many experience long-stays in acute inpatient units and high support accommodation (Killaspy *et al.*, 2013; Killaspy, 2014). As a consequence of the closure of many local rehabilitation services, this group of people end up dispersed in mental health units away from their local area; so called 'Out of Area Treatments' (OATs), the cost of which is around £690 million per year (Ryan *et al.*, 2004; 2011; Appleton *et al.*, 2011). This process is both costly and ineffective, and compounds the marginalisation of those who have the greatest need, who remain in a 'virtual asylum' (Poole *et al.*, 2002; Priebe *et al.*, 2005; Ryan *et al.*, 2004; Killaspy and Meier, 2010; Crisp *et al.*, 2016).

The existence of this group of people has been recognised for many years, and is characterised in many ways ('revolving door', 'new long-stay' 'challenging behaviour'), but has been largely ignored by national policy (O'Malley and Crouch, 2005). At present, there is no national policy for rehabilitation services in England, although there are good practice guidelines for rehabilitation services (Wolfson *et al.*, 2009) and guidelines for their commissioning (Joint Commissioning Panel for Mental Health, 2012). In addition, there is increasing evidence for the effectiveness of rehabilitation services in producing desirable outcomes, such as increased independence and autonomy (Killaspy and Zis, 2012; Lavelle, 2011; Killaspy, 2014). It is unlikely that this group of people can be placed immediately into independent accommodation with support and they may be better served by a step-down approach. Some good examples of the types of intermediate units that can offer a cost-effective approach to supported housing to this group do exist (Killaspy and Zis, 2012; One Housing, 2015). Greater investment into high quality, local units offering a patient-centred approach is required.

11. 'Move-on' or a 'home for life'?

Should supported housing be regarded as transitional or permanent? This question represents a crucial tension in the residential field and there are arguments for both. Most people tend to prefer stable housing solutions and if they have to move, they wish that it is at a time of their choosing, not because of the application of some arbitrary rule (or the termination of funding).

Transitional facilities are based on an assumption of gradual and linear progression in terms of improved functioning, each improvement then 'triggering' the next move. For a proportion of people with long-term conditions, this is neither realistic nor desirable. A review of floating outreach commissioned by the Department of Communities and Local Government (2006) commented that *"Success cannot be measured in terms of the number of clients who no longer require support.*

Factors such as sustained tenancies, rates of hospital readmission, attendance at day centres, voluntary work, training courses and employment should be taken into account" (page 39).

For a relatively small but significant group of people with particularly complex and enduring problems, long-term support may be necessary. It is questionable whether we need housing models that contain a built-in assumption that it is desirable for the person to move on in a fixed period of time. However, in some situations, such as inpatient rehabilitation units, an expected maximum length of stay may be desirable to prevent the units from becoming blocked and to provide a focus for treatment and support. And for some people moving to accommodation with lower levels of support, a trade-off between quality of life and individual autonomy may have to be considered.

12. Partnership working

The problem of coordination across health, social services and housing has long been recognised and provides a significant barrier to the provision of supported housing (O'Malley and Croucher, 2005). This reflects the absence of any mechanisms for bringing these groups together, including the absence of integrated budgets, joint commissioning and strategic approaches. The different priorities and cultures of health, social care and housing agencies have hampered the development of integrated care and, owing to its prescriptive nature, the previous funding arrangements of the Supporting People schemes impeded the delivery of the range of supports that were needed.

The current prevailing consensus is that partnership working across the key agencies, which includes people who use the services, placed alongside a strategic approach to commissioning, are necessary ingredients in the planning and creation of good local supported

housing (Appleton and Molyneux, 2011; Appleton *et al.*, 2011; Department of Health, 2009b).

Some commentators have identified the local authority Health and Wellbeing Boards as one structure to provide the link between housing and social care, and the opportunity for joining up commissioning at the local level (Appleton and Molyneux, 2011; Appleton *et al.*, 2011). Few, however, include representation from housing services. Joint commissioning between clinical commissioning groups and local authorities may provide a means of making better use of joint resources and a greater appreciation of cost savings to be made from the provision of supported housing. The Joint Strategic Needs Assessment may also assist in developing a detailed understanding of the housing and support needs of the population (Appleton *et al.*, 2011; Department of Health, 2009b).

13. Inspection and standards

Public concern for the quality and standards of residential services for people with mental health problems have been with us since the 18th century (Shepherd, 1984). The establishment of the asylums in the 19th century was primarily the result of concerns about abuse and neglect in private 'madhouses' (Jones, 1972). Many organisations have been set up to detect and remedy abuse and monitor quality, but they have been only partially successful.

Abuse and neglect are an intrinsic risk in closed institutions in which human beings are placed in positions of power and authority over others who are weak and vulnerable. Violence, sexual exploitation, financial malpractice, neglect, and oppression, while uncommon, can happen and the danger is always present.

These are complex matters and most of our attempts to solve them have met with only partial success. There is only a weak association between the amount of resources devoted to the problem and the effectiveness of the systems to address it.

It is important to distinguish between two different aspects of what we consider to be poor quality of care: 'flagrant abuse' and 'low standards'. They are both failures of systems, but they differ in their severity and frequency (low standards are common, flagrant abuse is rare). Their remedies are also different.

Large, centralised, bureaucratic organisations may sometimes help detect flagrant abuse, but only if they have good channels of communication with the field. In addition, individual units need to have good leadership, to be reasonably well-resourced and subject to the 'checks-and-balances' that are part of proper management and supervision. They should also not be allowed to become physically or organisationally isolated (Martin, 1984). However, centralised organisations are unlikely to be effective in improving standards across the field. This requires a very different approach where ownership of the problems and collaboration of all the key stakeholders in setting targets and reviewing progress are the key ingredients (Iles & Sutherland, 2001; Shepherd *et al.*, 2010).

We need to develop a consensus about the standards required across the entire spectrum of supported accommodation, and in doing so we must consider the expertise of the people who run services, those who use them and their relatives. Quality is not solely a matter for external regulatory bodies, it is everyone's business and the responsibility for improving quality lies within the services themselves.

Figure 7: The QuEST programme

A programme of research, funded by the National Institute for Health Research in England and commenced in 2012, will attempt to address some of the evidence gaps in this field. The five-year programme (Quality and Effectiveness of Supported Tenancies for people with mental health problems – QuEST) includes investigation of the provision, quality, clinical and cost-effectiveness of different forms of mental health supported accommodation services and a feasibility trial comparing supported housing and floating outreach services (see www.ucl.ac.uk/quest) for more details.

The project includes the development of a free, web-based, standardised quality assessment tool that managers of supported accommodation services can use to audit their performance. This tool has been used to describe and assess the quality of care provided in a representative sample of the three main types of service (residential care, building based supported housing, and floating outreach) from across England.

A 30-month cohort study involving over 600 service users will help to identify the aspects of care that are most beneficial in terms of helping individuals to successfully progress to more independent housing or to manage with less support. Given the economic climate, it is crucial that decisions about investment in different models are made on the basis of their effectiveness and cost, and the accompanying health economic analysis will therefore be of particular interest.

14. The future of supported housing

In this report we have set out the arguments for the value and importance of supported housing for people with long-term and severe mental health problems. We need a national plan for the provision of supported housing for people with mental health problems which takes into consideration the principles and values underpinning the approach, improved provision, improved commissioning and support from research and development.

1. Underpinning principles and values

The Housing First approach integrates a set of principles into existing services and, while it is not a total solution, it does offer an evidence-based approach to the problems of people who are long-term homeless (Pleace and Bretherton, 2013; Pleace and Quilgars, 2013). It is consistent with a rights-based approach and the provision of independent tenancies for vulnerable groups. Importantly, it provides housing which is not dependent on an individual's treatment compliance or sobriety which may free people to voluntarily seek treatment (Kyle and Dunn, 2008).

The values and principles on which supported housing services should be based should be consistent with the key characteristics highlighted by service users (see Figure 5, page 17). These are consistent with the principles of Housing First. They include the provision of permanent housing, open-ended access to support, respect for choice and self-determination and a personalised approach. They emphasise the importance of choice in the type of housing provided and in the levels and nature of support (Kirsh *et al.*, 2009). And they are consistent with the principles of a recovery-oriented approach in mental health services and a person-centred approach (Department of Health, 2010).

Housing as a right

Article 19 of the United Nations Declaration on the Rights of Persons with Disabilities states:

"Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs".

One important implication of this is to ensure that people in supported accommodation have secure tenancies. People who live in hostel accommodation, particularly homelessness provision, often have licence agreements, but tenancies are more common in supported housing. These tenancies are often more secure than in the private rented sector.

Supported housing as a 'health intervention'

As with employment support, housing support should be recognised as an important intervention by mental health services. There is sound evidence for the importance of stable housing in promoting mental health and recovery as well as the cost benefits of supported housing schemes. Housing considerations should be part of the acute and recovery care pathways. Ensuring a person is adequately housed upon discharge should be a treatment priority, as should the review and support of people who are in precarious or inappropriate housing. This may require a re-balancing of the priorities of many mental health services, which emphasise acute care

and short-term treatment approaches. A greater emphasis needs to be placed on the management of long-term conditions, with a central role for rehabilitation, and a recovery orientation.

2. Improving provision

Most people with long-term mental health problems live in social housing. It is recognised that the number of social housing units has dwindled, although still in better condition than much of the private rented stock (Murtha, 2015; Family Mosaic 2013). Many people in social housing have been hit by recent welfare reforms, for example the introduction of the 'bedroom tax', and there has been increasing pressures on social landlords to provide housing support to poorer tenants (Power *et al.*, 2014). Most privately rented schemes are beyond the reach of people with long-term problems and some are being squeezed out of their homes by increases in rent. Many of these matters are the concern of national housing policy which needs to pay attention to people on low incomes who are vulnerable to the rapid changes in housing provision and who have become increasingly marginalised and compromised. To improve the provision of supported housing for people with long-term mental health problems we need to ensure that there is a sufficient supply of good quality, sustainable housing stock which is affordable for people on low incomes and that the financial support to allow people to sustain their tenancies is not compromised by changes in rent-setting policies and welfare provision.

The development of new schemes to provide housing support is hampered by the lack of affordable and adequate housing (Bretherton and Pleace 2015) as is the development of good quality provision of high support housing schemes. The NHS may wish to consider better use of their assets and estate to provide for the building of supported housing (Appleton and Molyneux, 2011).

Located in safe, local neighbourhoods

Much low-quality social housing is located in deprived neighbourhoods. People value the security of safe environments with access to public transport and amenities and to a range of

health and social services. People should not be expected to move away from their known local environments, their family and other support networks.

A range of supported accommodation

It is clear that supported accommodation for people with mental health problems is not a single entity and has developed as a spectrum of provision from independent housing with floating support to high support provision and nursing homes. This includes provision for people who are homeless, precariously housed, in acute inpatient units or out-of-area placements, in crisis, or who present with long-term and complex problems which require longer-term input and rehabilitation. Defining who needs what type of supported housing, and who may benefit from what, is essential. An unresolved question is whether to use clustered or scattered housing. There may be no clear answer to this and we may need to consider the trade-offs between isolation and peer support, and between solidarity and risk of stigma, to allow people to live in their environments of choice (Kirsh *et al.* 2009).

Providing long-term and permanent solutions

The provision of long-term and permanent accommodation is the choice of most people with long-term mental health problems. These conditions are enduring and fluctuating; and the stability provided by long-term solutions to housing provide an environment in which health can be maintained, recovery facilitated and greater degrees of independence achieved (Kyle and Dunn, 2008).

Providing a wide range of support

There is a need to move away from the narrow provision of housing-related support to the provision of a wide range of supports which are based on the needs and wishes of residents and delivered in a way that is consistent with a recovery-based approach. The range of supports are listed in Figure 6 (page 20) and include: connecting residents to social networks, providing access to community resources, support during crises, and support for residents who want and need to learn independent living

skills. It may be useful to apply an educational model as in the development of Recovery Colleges (Perkins *et al.*, 2012). Many supported housing organisations have been creative in piloting more personalised and person-centred approaches, within a block contracting environment. These approaches to providing a wider range of support need to be better specified and evaluated.

Creating a skilled and motivated workforce

The available evidence shows that the relationship between residents and service providers is key, and is instrumental in achieving success in supported housing. This points to the need for well-motivated and appropriately trained staff. Pay scales need to reflect the scope of the job and the necessary experience, along with opportunities for career progression. Training needs to reflect the importance of a person centered approach. It should be continuous, with opportunities for reflective practice and team discussion. And it should be reinforced by regular supervision and a working environment that supports good practice. The workforce would also be enhanced by the employment of Peer Support Workers (Repper, 2013).

3. Improving commissioning

Supported housing represents the overlap of health, social care and housing services. This needs to be reflected in the way services are delivered as a partnership between statutory services, housing associations and private providers. This is not standard practice across England (Priebe *et al.*, 2009), but there are examples of good practice which have yielded promising results (One Housing, 2015). Support and education for landlords is also required.

Developing joint commissioning strategies

The development of Health and Wellbeing Boards in local councils provides an opportunity to develop joint commissioning between local authority housing, social services and health services. A strategic approach to the commissioning of supported housing would argue for the wider use of Housing First as an approach for reducing homelessness (Bretherton and Pleace, 2015; Pleace and Bretherton, 2013) and the adoption of a values-based approach to supported housing practice at strategic level. Joint funding could offer cost savings to statutory services and sustained funding would be required to maintain quality and effectiveness. It will be necessary to develop clear standards (e.g. eligibility criteria, content of care and support, permanent or move-on schemes) and an effective assessment process for the delivery and quality of supported housing services.

4. Research and development

A national programme of research should be developed to evaluate supported housing schemes and build up the meagre evidence base. This should not only examine the effectiveness of new developments but should monitor the spread and diversity of existing schemes and the quality of their work. Early findings from the QuEST project (Figure 7, page 23) suggest that, at present, large scale randomised trials may not be feasible owing to the variety of schemes across the UK and the lack of standardisation across schemes. Nevertheless, further comprehensive and coordinated surveys, cohort studies and smaller scale evaluations of well-defined approaches are possible.

References

Ahmad, N., Ellins, J., Krelle, H., Lawrie, M. (2013) *Person-centred care: from ideas to action. Bringing together the evidence on shared decision making and self-management support.* London: The Health Foundation.

Andvig, E. & Hummelvoll, J.K. (2015) From struggling to survive to a life based on values and choices: first-person experiences of participating in a Norwegian Housing First project. *Nordic Journal of Social Research, 6,* 167-183.

Appleton, S. & Molyneux, P. (2011) *Housing and mental health. NHS Confederation Briefing 233.* London: NHS Confederation

Appleton, S., van Doorn, A. Molyneux, P. (2011) *Mental Health and Housing. Housing on the Pathway to Recovery.* London: National Mental Health Development Unit.

Araya, R., Dunstan, F., Playle, R., Thomas, H., Palmer, S., Lewis, G. (2006) Perceptions of social capital and the built environment and mental health. *Social Science and Medicine, 62* (12), 3072-3083.

Basu, A., Kee, R., Buchanan, D., Sadowski, L.S. (2012) Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care. *Health Services Research*, **47** (1), 523-543.

Bengtsson-Tops, A., Ericsson, U., Ehliasson, K. (2014). Living in supportive housing for people with serious mental illness: A paradoxical everyday life. *International Journal of Mental Health Nursing, 23* (5), 409-418.

Boardman, J., Currie, A., Killaspy, H., Mezey, G. (2010) *Social Inclusion and Mental Health.* London: RCPsych publications.

Bond, L., Kearns, A., Mason, P., Tannahill, C., Egan, E., Whitely, E. (2012) Exploring the relationships between housing, neighbourhoods and mental wellbeing for residents of deprived areas. *BMC Public Health*, 12:48.

Bonnett, D. (1996) *Incorporating Lifetime Homes standards into modernisation programmes. Housing Research 174.* York: Joseph Rowntree Foundation.

Bowpitt, G., & Jepson, M. (2007) Stability versus Progress: Finding an Effective Model of Supported Housing for Formerly Homeless People with Mental Health Needs. *Social and Public Policy Review* 2 (1).

Braubach, M, Jacobs, D.E. Ormandy, D. (2011) *Environmental burden of disease associated with inadequate housing. Summary report.* Copenhagen: WHO Regional Office for Europe.

Bretherton, J. & Pleace, N. (2015) *Housing First in England. An Evaluation of Nine Services.* York: Centre for Housing Policy.

Brolin, R., Rask, M., Syren, S., Baigi, A., Brunt, D.A. (2015) Satisfaction with Housing and Housing Support for People with Psychiatric Disabilities. *Issues in Mental Health Nursing, 36,* 21–28.

Browne, G. & M. Courtney (2005). Housing, social support and people with schizophrenia: a grounded theory study. *Issues in Mental Health Nursing, 26* (3), 311-326.

Browne, G., Hemsley, M., StJohn, W. (2008). Consumer perspectives on recovery: A focus on housing following discharge from hospital. *International Journal of Mental Health Nursing, 17* (6), 402-409.

Busch-Geertsema, V. (2014) Housing First Europe – Results of a European Social Experimentation Project. *European Journal of Homelessness, 8* (1), 13-18.

Cabinet Office (2010) *State of the nation report: poverty, worklessness and welfare dependency in the UK.* London: HM Government.

Carpenter-Song, E., M., Hipolito, M.S., Whitley, R. (2012). "Right here is an oasis": how "recovery communities" contribute to recovery for people with serious mental illnesses. *Psychiatric Rehabilitation Journal, 35* (6): 435-440.

Centre for Housing Research (2010) *Supporting People Client Records & Outcomes. Annual Report 2009-2010.* University of St Andrews: Centre for Housing Research.

Chapman, I. (2014) *Housing Models: Examples of Innovative Practice and Design.* London: Mental Health Provider Forum.

Chilvers, R., Macdonald, G., Hayes, A. (2006). *Supported housing for people with severe mental disorders.* The Cochrane Library, Issue 4.

Citizens Advice and New Policy Institute (2015) *A nation of renters. How England moved from secure family homes towards rundown rentals.* London: Citizens Advice.

Clifford, P. (1993) *FACE Profile.* London: Research Unit Royal College of Psychiatrists.

Cooper, K. (2013) Supporting People funding boost is a mirage for cash-strapped councils. *The Guardian*, 23 January [online]. Available from: http://www.theguardian.com/ local-government-network/2013/jan/23/ supporting-people-funding-mirage-local-authorities [Accessed 1 June 2016]

Craig, T., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornella-Ambrojo, M., Dunn, G. (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. *British Medical Journal,* **329**, 1067-1071.

Crisp, N., Smith, G., Nicholson, K. (2016) *Old Problems, New Solutions – Improving Acute Psychiatric Care for Adults in England.* London: The Commission on Acute Adult Psychiatric Care.

Culhane, D.P., Metraux, S., Hadley, T. (2002) Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing. *Housing Policy Debate*, **13** (1),107-163.

Davis, A. (2003) Mental Health and Personal Finances – A Literature Review. Prepared for the Social Exclusion Unit, quoted in *Mental Health and Social Exclusion* (p. 143), Social Exclusion Unit (2004), Office of the Deputy Prime Minister.

Department of Community and Local Government (2006) *Research into the effectiveness of floating support services for the Supporting People programme. Final Report.* London: Communities and Local Government.

Department of Community and Local Government (2009) Research into the financial benefits of the Supporting People programme. (Tom Ashton, Claire Hempenstall – Capgemini). London: Communities and Local Government.

Department of Health (2009a) *Support Related Housing. Summary. Care Service Efficiency Delivery: supporting sustainable transformation.* London: Department of Health.

Department of Health (2009b) *Use of Resources in Adult Social Care – A guide for local authorities.* London: Department of Health.

Department of Health (2010) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* London: Department of Health

Dorling, D. (2014) *All that is Solid: The great housing disaster.* London: Allen Lane.

Drake, R.E, Bond, G.R., Becker, D.R. (2012) *Individual Placement and Support. An Evidence-Based Approach to Supported Employment.* Oxford: Oxford University Press.

Ellaway, A., Macintyre, S., Kearns, A. (2001) Perceptions of place and health in socially contrasting neighbourhoods. *Urban Studies,* **38** (12), 2299-2316.

Evans, G.W. (2003) The built environment and mental health. *Journal of Urban Health - Bulletin of the New York Academy of Medicine,* **80** (4), 536-555.

Evans, G.W., Wells, N.M., Moch, A. (2003) Housing and mental health: a review of the evidence and a methodological and conceptual critique. *Journal of Social Issues,* **59** (3), 475-500.

Fakhoury, W.K.H., Murray, A., Shepherd, G. and Priebe, S. (2002). Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology*, **37**, 301-15.

Family Mosaic (2013) *London's Housing. A Crisis in Need of a Strategy*. London: Family Mosaic.

Fazel, S. Khosla, V., Doll, H., Geddes, J. (2008) The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis. *PLoS Med* **5** (12): e225. doi:10.1371/journal.pmed.0050225.

Feinstein, L., Lupton, R., Hammond, C., Mujtaba,T., Salter, E., Sorhaindo, A. (2007) *The Public Value of Social Housing: A Longitudinal Analysis of the Relationship of Housing and Life Chances.* London: The Smith Institute.

Foster, K., Meltzer, H., Gill, B., Hinds, K. (1996) *Adults with a psychotic disorder living in the community. OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 8.* London: HMSO.

Gilmer, T. P., Manning, W. G., & Ettner, S. L. (2009) A cost analysis of San Diego County's REACH program for homeless persons. *Psychiatric Services*, **60** (4), 445-450. doi: 10.1176/appi.ps.60.4.445

Gilmer, T., Stefanic, A., Ettner, S., Manning, W., & Tsemberis, S. (2010) Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Archives of General Psychiatry*, **67** (6), 645-652. doi: http://dx.doi.org/10.1001/archgenpsychiatry.2010.56

Gilmer, T.P., Stefancic, A., Katz, M.L., Sklar, M., Tsemberis, S. and Palinkas, L.A. (2014) Fidelity to the Housing First Model and Effectiveness of Supported Housing in California, *Psychiatric Services,* **65** (11), 1311-1317.

Goering, P., Sylph, J., Foster, R., Boyles, S., Babiak, T. (1992). Supportive housing: A consumer evaluation study. *International Journal of Social Psychiatry* **38** (2): 107-119.

Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., Aubry, T. (2014). *National At Home/Chez Soi Final Report.* Calgary, AB: Mental Health Commission of Canada.

Gonzalez, M. T. & Andvig, E. (2015) Experiences of Tenants with Serious Mental Illness Regarding Housing Support and Contextual Issues: A Meta-Synthesis. *Issues in Mental Health Nursing* **36** (12), 971-988, DOI: 10.3109/01612840.2015.1067262.

Guite, H.F., Clark, C., Ackrill, G. (2006) *The impact of the physical and urban environment on mental well-being. Public Health,* **120** (12), 1117-26.

Gulcur,L. Stefancic, A., Shinn, M., Tsemberis, S., Fischer, S.N. (2003) Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes. *Journal of Community & Applied Social Psychology,* **13**, 171–186.

Herrman, H. (2008) Mental disorders among homeless people in Western countries. PLoS Med **5** (12): e237. doi:10.1371/journal.pmed.0050237.

Hills, J. (2007) *Ends and Means: The Future Roles of Social Housing in England (CASE Report 34).* Economic and Social Research Council Research Centre for the Analysis of Social Exclusion.

Holloway, F., Kalidindi, S., Killaspy, H., Roberts, G. (2015) *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry.* London: RCPsych Publications

Iles, V. & Sutherland, K. (2001) *Organisational Change – A Review for Health Care Managers, Professionals and Researchers.* National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO), London School of Hygiene and Tropical Medicine.

Johnsen, S. & Teixeira, L. (2010) *Staircases, Elevators and Cycles of Change 'Housing First' and Other Housing Models for Homeless People with Complex Support Needs.* London: Crisis.

Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of rehabilitation services for people with complex mental health needs. Volume Two: Practical mental health commissioning.* London: Joint Commissioning Panel for Mental Health.

Jones, K. (1972) *A history of mental health services*. London: Routledge, Kegan & Paul.

Killaspy, H. (2014) The ongoing need for local services for people with complex mental health problems. *Psychiatric Bulletin* **38**, 257-259.

Killaspy, H., Marston, L., Omar, R., Green, N., Harrison, I., Lean, M., Holloway, F., Craig, T., Leavey, G., King, M. (2013) Quality and clinical outcomes: an example from mental health rehabilitation services in England. *British Journal of Psychiatry*, **202,** 28-34.

Killaspy, H. & Meier, R. (2010) A Fair Deal for mental health includes local rehabilitation services. *The Psychiatrist,* **34**, 265-267, doi: 10.1192/pb.bp.109.028530.

Killaspy, H., Priebe, S., Shepherd, G. (2015) Housing: A Place to Live. (Chapter 19 in F. Holloway, S. Kalidindi, H. Killaspy, G. Roberts: *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry.* London: RCPsych Publications).

Killaspy, H. & Zis, P. (2012) Predictors of outcomes of mental health rehabilitation services: a 5-year retrospective cohort study in inner London, UK. *Social Psychiatry and Psychiatric Epidemiology*, **48,** 1005-12.

Kirsh, B., Gewurtz, R., Bakewell, R., Singer, B., Badsha, M., Giles, N. (2009) *Critical Characteristics of Supported Housing: Findings from the Literature, Residents and Service Providers.* Toronto: Wellesley Institute.

Knapp, M., Andrew, A., McDaid, D., Iemmi, V., McCrone, P., Park, A-La., Parsonage, M., Boardman, J., Shepherd, G. (2014) *Investing in recovery.* London: Rethink Mental Illness.

Kyle, T. & Dunn, J.R. (2008) Effects of housing circumstances on health, quality of life and healthcare use for people with severe mental illness: a review. *Health and Social Care in the Community,* **16** (1), 1–15.

Lavelle, E., Ijaz, A., Killaspy, H., Holloway, P., King, M., Keogh, F., McDonough, C., Spelman, L., Goggins, R., Daly, I., Murphy, K., McCrone,P., Drake, R. (2011) *Mental Health Rehabilitation and Recovery Services in Ireland: A Multicentre Study of Current Service provision, Characteristics of Service Users and Outcomes for those With and Without Access to These Services.* Mental Health Commission of Ireland.

Leff, J. (1997) *Care in the Community. Illusion or Reality?* Chichester: Wiley.

Lelliott, P., Audini, B., Knapp, M. & Chisholm, D. (1996) The mental health residential care study: classification of facilities and description of residents. *British Journal of Psychiatry*, 169, 139–147.

Lelliott, P., Wing, J., Clifford, P. (1994) A national audit of new long-stay psychiatric patients I: Methods and description of cohort. *British Journal of Psychiatry*, **165**, 160-169.

Lewis, G., Bebbington, P., Brugha, T., Farrell, M., Gill, B., Jenkins, R., Meltzer, H. (1998) Socioeconomic status, standard of living, and neurotic disorder. *The Lancet*, **352**, 605–609.

Lindstrom, M., Sjostrom, S., Margareta Lindberg, M. (2013). Stories of Rediscovering Agency: Home-Based Occupational Therapy for People with Severe Psychiatric Disability. *Qualitative Health Research* **23** (6): 728-740.

Macpherson, R., Shepherd, G. Thyarappa, P. (2012) Supported accommodation for people with severe mental illness: an update. *Advances in Psychiatric Treatment* **18**, 381–391.

Martin, J. P. *Hospitals in Trouble.* Oxford: Blackwells

McDonald, N., Whitehead, C., Williams, P. (2015) *The Future Housing Needs of London.* London: Family Mosaic.

Meltzer, H., Gill, B., Petticrew, M., Hinds, K. (1995) *Economic Activity and Social Functioning of Adults with Psychiatric Disorders OPCS Surveys of Psychiatric Morbidity in Great Britain. Report No. 3.* London: HMSO.

Meltzer, H., Singleton, N., Lee, A., Bebbington, P., Brugha, T., Jenkins, R. (2002) *The Social and Economic Consequences of Adults with Mental Disorders.* London: TSO (The Stationery Office).

Miller, R. & Appleton, S. (2014) *Evaluation of Multiple Complex Needs Service.* Birmingham: Midland Heart.

Murtha, T. (2015) We are witnessing the slow death of social housing. *The Guardian,* 1 April [online]. Available from: http://www.theguardian.com/ housing-network/2015/apr/01/slow-death-social-housing-affordable [Accessed 1 June 2016]

National Housing Federation (1999) *Housing and Mental Health.* London: NHF.

Nicol, S., Roys, M., Garrett, H. (2015) *The cost of poor housing to the NHS. Briefing Paper.* Watford: BRE Trust.

Nicholson, L. A. (2008) Rural mental health. *Advances in Psychiatric Treatment.* **14**, 302–311.

Nelson, G., Clarke, J., Febbraro, A., Hatzipantelis, M. (2005). A narrative approach to the evaluation of supportive housing: Stories of homeless people who have experienced serious mental illness. *Psychiatric Rehabilitation Journal* **29** (2): 98-104.

Neuberger, J. (2003) *Housekeeping: Preventing Homelessness through Tackling Rent Arrears in Social Housing.* London: Shelter.

One Housing (2015) *Integration that Works. An evaluation of Tile House.* London: One Housing.

O'Malley, L. & Croucher, K. (2005) Supported Housing Services for People with Mental Health Problems: A Scoping Study. *Housing Studies* **20** (5), 831-845, DOI: 10.1080/02673030500214126.

Page, A. (2002) Poor housing and mental health in the United Kingdom: changing the focus for intervention. *Journal of Environmental Health Research* **1** (1), 31-40.

Palmer, D. (2006) Imperfect prescription: mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them. *Primary Care Mental Health*, **4**, 45–56.

Parliamentary Office of Science and Technology (2011) *Housing and Health. Postnote 371.* London: Parliamentary Office of Science and Technology.

Payne, S. (2006) Mental Health, Poverty and Social Exclusion. (In P. Pantzalis, D. Gordon & R. Levitas, eds. *Poverty and Social Exclusion in Britain.* Bristol: Policy Press).

Pejlert, A., Asplund, K., Norberg, A. (1999). Towards recovery: living in a home-like setting after the move from a hospital ward. *Journal of Clinical Nursing,* **8** (6), 663-673.

Perkins, R., Repper, J., Rinaldi, M., Brown, H. (2012) *Recovery Colleges. ImROC Briefing 1.* London: Centre for Mental Health.

Pleasence, P. & Balmer, N. (2007) Mental health and the experience of housing problems involving rights. *People, Place & Policy Online* 2/1, 4-16. DOI: 10.3351/ppp.0002.0001.0002

Pernice, R. & Brook, J. (1994) Relationship of migrant status (refugee or immigrant) to mental health. *International Journal of Social Psychiatry*, **40**, 177–188.

Petersen, K., L. Hounsgaard, Borg, T., Nielsen, C.V. (2012). User involvement in mental health rehabilitation: a struggle for self-determination and recognition. *Scandinavian Journal of Occupational Therapy* **19** (1), 59-67.

Pleace, N. & Bretherton, J. (2013) The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness. *European Journal of Homelessness,* **7** (2), 21-41.

Pleace, N. & Wallace, A. (2011) *Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review.* York: Centre for Housing Policy.

Pleace, N. & Quilgars, D. (2013) *Improving Health and Social Integration through Housing First. A Review.* York: Centre for Housing Policy.

Piat M, Lesage A, Boyer R, Dorvil, H., Couture, A., Bloom, D. (2008) Housing for persons with serious mental illness: consumer and service provider preferences. *Psychiatric Services,* **59**, 1011–7.

Poole R, Ryan T, Pearsall A. (2002) The NHS, the private sector, and the virtual asylum. *British Medical Journal*, **325**, 349-50.

Power, A., Provan, B., Herden, E., Serle, N. (2014) *The impact of welfare reform on social landlords and tenants*. York: Joseph Rowntree Foundation.

Priebe S, Badesconyi A, Fioritti A, Hansson L, Killian R, Torres-Gonzales F, *et al.*. (2005) Reinstitutionalisation in mental health care. Comparison of data on service provision from six European countries. *British Medical Journal*, **330**, 123-6.

Priebe S, Saidi M, Want A, Mangalore R, *et al.* (2009) Housing services for people with mental disorders in England: patient characteristics, care provision and costs. *Social Psychiatry and Psychiatric Epidemiology*, **44** (10), 805-14.

Quilgars, D. (2000) *Low intensity support services: a systematic literature review*. York: Joseph Rowntree Foundation.

Raitakari, S. & Juhila, K. (2015) Housing First Literature: Different Orientations and Political-Practical Arguments. *European Journal of Homelessness,* **9** (1), 145-189.

Repper, J. (2013) *Peer Support Workers: Theory and Practice*. London: Centre for Mental Heath.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery*. London: Balliere Tindall.

Rethink Mental Illness (2013) *Supported Housing. Factsheet*. London: Rethink Mental Illness.

Ryan, T., Davies, G., Bennett, A., Meier, R., Killaspy, H. (2011) *In Sight and in Mind. A toolkit to reduce the use of out of area mental health services*. London: National Mental Health Development Unit [online]. Available from: http://www.rcpsych.ac.uk/

pdf/insightandinmind.pdf [Accessed 1 June 2016]

Ryan T, Pearsall A, Hatfield, B. (2004) Long term care for serious mental illness outside the NHS: a study of out of area placements. *Journal of Mental Health* **13**, 425-9.

Shepherd, G. W. (1984) *Institutional care and rehabilitation*. London: Longmans.

Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing recovery: A methodology for organisational change.* London: Centre for Mental Health.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., Meltzer, H. (2001) *Psychiatric Morbidity among adults living in private households, 2000.* London: TSO.

Siskind, D., Harris, M., Pirkis, J., Whiteford, H. (2013) A domains-based taxonomy of supported accommodation for people with severe and persistent mental illness. *Social Psychiatry and Psychiatric Epidemiology*, **48** (6), 875-894.

Slade, M. (2009) *Personal Recovery and Mental Illness*. Cambridge: Cambridge University Press.

Slade, M., Phelan, M., Thornicroft, G., Parkman, S. (1996) The Camberwell Assessment of Need (CAN): comparison of assessments by staff and patients of the needs of the severely mentally ill. *Social Psychiatry and Psychiatric Epidemiology* **31**, 109–13.

Slay, J. & Stephens, L. (2013) *Co-production in mental health. A literature review.* London: Mind.

Stefancic, A. & Tsemberis, S. (2007) Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Outcome Study of Housing Access and Retention. *Journal of Primary Prevention,* **28**, 265-79.

Tabol, C., Drebing, C., Rosenheck, R. (2010) Studies of "supported" and "supportive" housing: A comprehensive review of model descriptions and measurement. *Evaluation and Program Planning*, **33**, 466-456.

Tondora, J., Miller, R., Slade, M., Davidson, L. (2014) *Partnering for Recovery in Mental Health. A practical Guide to Person-Centered Planning.* Chichester: Wiley Blackwell.

Tsai, J., Mares, A. S., Rosenheck, R. A. (2010). A multisite comparison of supported housing for chronically homeless adults: "housing first" versus "residential treatment first". *Psychological Services*, **7** (4), 219-232. doi: 10.1037/a0020460

Tsemberis, S. (2010a) Housing First: Ending Homelessness, Promoting Recovery and Reducing Costs (Chapter 3 in I. Gould Ellen and B. O'Flaherty (eds) *How to House the Homeless*) Russell Sage Foundation: New York.

Tsemberis, S. (2010b) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction*. Minnesota: Hazelden.

Tsemberis, S., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003a). Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program. American Journal of Community *Psychology*, **32** (3/4), 305.

Tsemberis, S., Rogers, E., Rodis, E., Dushuttle, P., & Skryha, V. (2003b). Housing Satisfaction for Persons with Psychiatric Disabilities. *Journal of Community Psychology*, **31**(6), 581-590. doi: http://dx.doi.org/10.1002/jcop.10067

Tunstall, R., Bevan, M., Bradshaw, J., Croucher, K., Duffy, S., Hunter, C., Jones, A., Rugg, J., Wallace, A., Wilcox, S. (2013) *The Links Between Housing and Poverty: An Evidence Review*. York: Joseph Rowntree Foundation

United Nations General Assembly (2006) *Convention on the Rights of Persons with Disabilities* [online]. Available from: http://www.un.org/
disabilities/convention/conventionfull.shtml [Accessed 1 June 2016]

Waegemakers Schiff, J & Rook, J (2012) *Housing First – Where is the Evidence?* Toronto: Homeless Hub.

Weich, S., Blanchard, M., Prince, M., Burton, E., Erens, B., Sproston, K. (2002) Mental Health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *British Journal of Psychiatry*, **180**, 428-433.

Weich, S. & Lewis, G. (1998a) Poverty, unemployment and common mental disorders: population based cohort study. *British Medical Journal*, **317**, 115–119.

Weich, S. & Lewis, G. (1998b) Material standard of living, social class and the prevalence of the common mental disorders in Great Britain. *Journal of Epidemiology and Community Health*, **52**, 8–14.

Wolfson P, Holloway F, Killaspy, H. (2009). *Enabling Recovery for People with Complex Mental Health Needs: A Template for Rehabilitation Services*. London: Royal College of Psychiatrists.

More than shelter

Published June 2016

Photograph: istockphoto.com/lolostock

£10 where sold

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here: www.centreformentalhealth.org.uk/why-support-us

© Centre for Mental Health, 2016

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.

Register for our emails at www.centreformentalhealth.org.uk
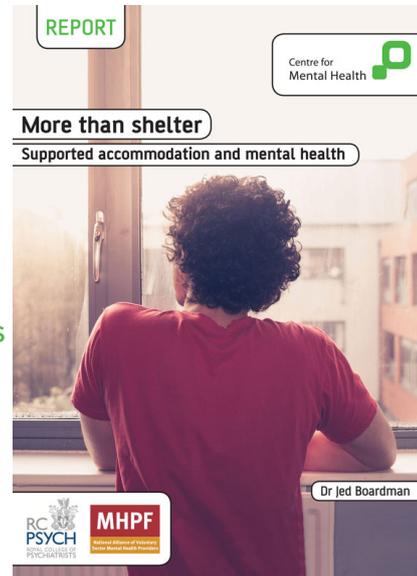
Centre for
Mental Health

Realising a better future

Centre for Mental Health

134-138 Borough High Street, London SE1 1LB

Tel 020 7827 8300

Fax 020 7827 8369

www.centreformentalhealth.org.uk

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.