



Mental Health
Foundation



Mental Health and Housing

A project to identify which types of supported accommodation successfully meet the needs of people with mental health problems in order to recommend effective housing solutions



This paper was prepared by:

Jonny Savage, Policy Officer for the Mental Health Foundation for the Mental Health Providers Forum.

The Mental Health Providers Forum leads a strategic collaboration of “not for profit Mental Health organisations” including: The Centre for Mental Health, The Mental Health Foundation, National Mind, Rethink Mental Illness and NSUN.

Together with 21 other “not for profit partners”, they link strategically with the Department of Health, NHS England and Public Health England undertaking specific agreed work programmes aimed at benefiting the strategic development of the “not for profit mental health sector”.

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Executive summary



Having somewhere safe and warm (literally and figuratively) to live is fundamental to our mental health and wellbeing. Housing should provide not only shelter but also a secure and positive environment that supports people as their lives progress.

Research has shown that those who are homeless, or at risk of homelessness, are much more likely to experience mental distress. Further, Homeless Link reported in 2010¹ that 7 out of 10 of clients had mental health needs and a third of those currently lack the support they need to address their mental health.

The experience of mental ill health is different for each individual, and mental health problems can occur at any point in our lives. As a consequence of these diverse needs, housing solutions for people with mental health problems must be equally diverse. This requires taking account of the different type of support that people need, and how that changes over time.

Creating this diverse response requires the insights of people with lived experience of mental health problems and the contributions of all who contribute to good housing and good mental health. Only with a holistic approach to supported housing will we be able to provide adequate supported accommodation for people with mental health problems.

The term supported accommodation refers to a product that is comprised

of two elements: the physical building, and the service which is provided to the resident. Supported accommodation covers a wide range of different types of housing, and it will offer 'services to tenants with special needs that are not normally provided in the mainstream rented sector'.²

This study asks the question: "How do different types of supported accommodation meet the needs of people with mental health problems?"

It focusses on five approaches to providing supported accommodation.

- Care Support Plus – High Level
- Integrated Support
- Homelessness
- Complex Needs
- Low-Level Step Down
- Later Life

Through semi-structured interviews the Mental Health Foundation has drawn on the expertise of people living and working in these services across England, and presents their views of both building and service related issues. With regard to the building, residents were asked how the physical environment: addressed their physical access needs, supported their mental wellbeing, and facilitated their social interaction with other residents. The interviews explored how successfully the service's design and delivery met individual's needs and how they could be improved – from the perspectives of residents and managers.

Summary of Recommendations



Quality – investment in both Psychologically Informed Environments whose design (i) delivers (future proofed) physical access, (ii) promotes mental health and wellbeing, and (iii) facilitates social interaction; and also services delivering therapeutically innovative, responsive and dynamic care.

Co-production – adoption of co-production with residents, representative groups and other expert advisers in the design and development of buildings and services.

Staff recruitment and training – investment in the recruitment and continuous professional development of staff who want to do this work; share the ethos of the service; and are committed to create safe, positive homes for residents.

Policy Informed Practice – development of and support for staff to understand and implement the approaches articulated in policies. This requires ongoing training and supervision.

Resourced, Appropriate Accommodation – We recognise the pressures on the housing, health and care systems. In this context, it is essential that those who require supported accommodation are provided with appropriate accommodation. Services must be thoughtfully designed and resourced to meet their needs. Otherwise, people with mental health problems are being set up to fail.

Introduction



Evidence has developed through both research and practice to show that there is a wide range of supported accommodation schemes, which effectively work to meet the needs of people with mental health problems.

The variety of supported accommodation around the country also reflects the different types of support needs that people with mental health problems may have. This report focuses on how specific types of supported accommodation meet certain mental health needs. The types of supported accommodation which will be analysed are: high level integrated support; housing for complex needs; homelessness; low level step-down care; and housing in later life. In each of these areas housing plays a central role in providing the necessary mental health support to individuals.

The term supported accommodation refers to a product that is comprised of two elements: the physical building, and the service which is provided to the resident.

Supported accommodation covers a wide range of different types of housing, and it will offer 'services to tenants with special needs that are not normally provided in the mainstream rented sector'. This includes, for example, intensive 24 hour support, hostel accommodation, and accommodation with only occasional social support or assistance provided.

These types of housing schemes can be divided into three main areas: 'private accommodation with resident or non-resident carers; purpose built accommodation with full or part time staff provided by charities or voluntary groups; or hostel accommodation'.³

Mental health needs can be met across all of these different types of accommodation but crucially individuals need the right support in the right setting.

The service delivered by supported accommodation schemes cater for people from a wide range of backgrounds and support needs, including people with mental health problems. People with mental health problems necessarily require all different types of support - whether on a temporary or a more permanent basis, and for a higher or lower level of support. As such a whole range of supported accommodation services have developed, and continue to do so.

The drivers for service development include: commitment to better meet the needs of people with mental health problems, policy agendas, changing funding arrangements and levels of expenditure.

The schemes analysed below show how effective support can be provided both within specialist mental health supported housing, as well as general needs housing that support people with

all different needs beyond mental health. In the same way that the service delivered varies, there are also multiple housing models designed to deliver support specifically to individuals.

These models vary according to different needs, with certain models proving particularly common or wide-spread. They include, for example, care delivered in your own home; self-contained flats with accessible features; or housing with separate bedrooms but shared communal services such as kitchens and bathrooms. These different models will be discussed with reference to the different types of services which are provided.

What draws these supported housing schemes together is that housing support is an essential element of looking after someone's mental wellbeing. Investing in housing related support services can generate savings across health and social care, including avoiding acute admissions, as well as across criminal justice and care systems. This is on top of the core benefits that individuals get from being provided with choice, control, and independence in their lives.⁴

Methodology



The first phase of the study was a review of literature on policy and practice development related to supported accommodation for people with mental health problems. This provided a context for the study and identified the five supported accommodation approaches: high level integrated support; housing for complex needs; homelessness; low level step-down care; and housing in later life.

The selection of these five approaches was confirmed by conversations with key informants in the housing and mental health sectors.

The Central Research Question was developed through the literature review and these conversations.

“How do different types of supported accommodation meet the needs of people with mental health problems?”

A qualitative methodology using semi-structured interviews was chosen in order to access rich data from residents and managers in these services. A set of materials was developed: Participant Information Sheet, Consent Form and Interview Schedule.

The Interview Schedule was based on the literature review and informed by advisers’ guidance. It had four parts:

1. explaining the purpose and scope of the study and confirming that Informed Consent had been secured.

2. building design

3. service design

4. demographic data.

Ethical approval was secured in December 2014. The application included the Mental Health Foundation’s Safeguarding Policy. The researcher was advised throughout the study by the Mental Health Foundation’s expert on mental capacity and later life; and was supervised by the Head of Policy and Research.

The National Housing Federation assisted the Mental Health Foundation in identifying services across England that exemplified successful provision of supported accommodation for people with mental health problems using the five approaches.

Between January and March 2015 ten interviews were conducted in five different supported accommodation services across England:⁵ 5 interviews with managers and 5 with residents of those services.

Interviews were audio-recorded, transcribed by the researcher, and the transcripts were analysed thematically. The following limitations of the study are acknowledged. Due to the small scale of the study the findings are not generalizable. The study only provides evidence from services that are working well.

Policy Context



This overview of the current policy context analyses Government policies relevant to both mental health and housing, both of which influence the care and support that people with mental health problems receive.

Mental Health Policy

Responsibility for mental health care is guided by both national and local Government. National strategies provide guidelines for how mental health services should be delivered in the future and what outcomes providers should aim for, and local health services identify what specific needs there are linked to their population.

National Policy

The Coalition Government's 2011 Mental Health Strategy No Health without Mental Health outlined six broad objectives to secure better mental health of the population as a whole, and better outcomes for people with mental health problems. The objectives were:

- More people will have good mental health;
- More people with mental health problems will recover;
- More people with mental health problems will have good physical health;
- More people will have a positive experience of care and support;

- Fewer people will suffer avoidable harm;
- Fewer people will experience stigma and discrimination.⁶

All of these areas concern the kind of housing support that people with mental health problems should receive, however the strategy recognised that although "the quality of mental health care has improved significantly in recent years... only recently has attention been paid to the importance of employment and housing in the recovery process".⁷

Rhetoric takes time to pass through to reality and so acknowledging that thought has only recently turned to housing in a meaningful way, gives an indication of the scale of the barriers that need to be overcome to integrate these areas.

In terms of making the Strategy inclusive, the objectives are bolstered by the 2010 Equality Act which addresses those with certain protected characteristics such as age.⁸ This has implications for supported accommodation which is provided for people across the life course and means that housing, as a determinant of poor mental health, can also be addressed.⁹

The Department of Health published updated priorities for the mental health Strategy in 2014, three years on from its launch. This document identified 25 areas across mental health care, where improvements would be directed. Housing was addressed as a key concern under the section “more people with mental health problems will live in homes that support recovery”. This reinforced the interplay between housing and health by looking at how people with mental health problems can “live safely and more independently for longer”.¹⁰ However as a step beyond recognising the role of factors such as housing on mental health, it is then necessary to involve and engage the broader group of stakeholders.

A joint publication in October 2014 from both Department of Health and NHS England set out a five year vision to 2020 to improve access to mental health services.

The plan earmarked £120m to improve areas of mental health care including: implementing waiting times for psychological therapies and boosting early intervention services. An overarching theme of the publication was aiming for “people with mental health problems receiving the right treatment at the right time and the right place in the least restrictive setting and as close to home as possible”.¹¹

The implications for housing area are clear: for people in supported housing, their accommodation needs to respond to their mental health needs to ensure that they receive the support that they need. Equally supported accommodation was recognised as a place for effective treatment and management of mental health.

The NHS Five Year Forward View, published in October 2014, reported that it aims to work towards an “equal response to mental and physical health and towards the two being treated together”. This will be achieved in part by looking at ‘new models of care’: “Just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three”. As such the direction of care is more towards patient-centred rather than separate services delivering different parts of someone’s care.¹²

Supported housing, and housing more broadly is the final element to add in to show how these services can be provided in different settings to support people with mental health problems. This will be essential in ensuring that ‘patients get the right care,¹³ at the right time, in the right place’, taking into consideration both their physical and mental health.

Local Policy

Following the Health and Social Care Act 2012, much important decision-making around expenditure on health takes place at a local level.

A national vision for public health is defined by the Public Health Outcomes Framework,¹⁴ which is then used as a guide for upper tier and unitary authorities who have responsibility for public health of their populations. These activities are supported by a ring-fenced grant which is used to improve the wellbeing of the local population and reduce health inequalities.¹⁵

Local Government therefore has a vital role to play, however concerns were raised by Mind in 2014 on the low levels

of spending on public mental health relative to prevalence.¹⁶

Applying the 2011 mental health Strategy may require time still to become embedded in thinking, with practices like co-production of services, working alongside Clinical Commissioning Groups (CCGs), and assessing how commissioning decisions impact on mental health as ways of making it a reality.¹⁷

From April 2013 CCGs became responsible for around two thirds of the NHS budget in England. Comprised of General Practitioners, CCGs are responsible for commissioning 'secondary and community care services for their local populations'.¹⁸

Commissioning decisions are undertaken in collaboration with the local population via Health and Wellbeing boards. The boards involve both elected representatives and patient representatives, and alongside Clinical Commissioning Groups and Councils, the boards develop a Joint Strategic Needs Assessment (JSNA) to drive local commissioning of health care, social care and public health.¹⁹

With housing in mind, Health and Wellbeing Boards provide an important opportunity to properly assess mental health as a whole and build local partnerships.²⁰ However across certain areas of housing concern, stakeholders identified shortcomings in some assessments early on. A report from St Mungo's Broadway and Homeless Link found that 14% of JSNAs sampled made no reference to homelessness, and 61% of Joint Health and Wellbeing Strategies (JHWS) make no reference to homelessness at all.²¹

Housing Policy

Housing policy covers a broad range of legislation and a number of cross-Government strategies. This section only discusses the areas of housing policy which impact on supported accommodation.

In the Government's 2011 document, *Laying the Foundations: A Housing Strategy for England*, it stated that "A stable home provides a building block for everyone as they try to improve their lives and meet aspirations for a better future. More choice and extra support when we need it becomes even more important as we get older".

Recognising the importance of stable and secure housing for individuals, as evidenced in the strategy, is an essential starting point for improving wellbeing and recovery for people with mental health problems; equally it requires input from sectors outside of housing to be truly effective.

Chapter 6 of the strategy identifies how support will be delivered to vulnerable groups. This includes homelessness, with the establishment of the Ministerial Working Group on Homelessness and the creation of the 'No Second Night Out Programme'.²²

Concerning 'Troubled Families' the housing strategy identifies 'family support' (including for mental health needs) to improve services to troubled families. The strategy also outlines the investment available for the 'Supporting People' programme to 'help vulnerable people to live more independently and maintain their tenancies' in part through personal budgets.

Finally, regarding older people the strategy emphasised the need for 'good housing for older people' which would facilitate independence, and choice over the most appropriate type of housing in later life.²³

Support in the design of housing for older people is also evident in the Government's support for the Housing our Ageing Population: Panel for Innovation (HAPPI), which looked at specialised housing for older people.

The strategy was also supported by a range of wider provisions. The Disabled Facilities Grant (DFG) was set up to create funding for 'the provision of adaptations that enable disabled people to live as comfortably and independently as possible in their homes, including private and social rented housing'.²⁴ This fund is part of a broader picture of support which helps to facilitate independent living, particularly in later life; in the same vein the strategy committed to encouraging local authorities to provide a range of supported accommodation options for local populations, including extra care housing and sheltered accommodation.²⁵ Acknowledging this recognises the importance of different solutions for different people.

The Government's policies for providing 'housing and support for older and vulnerable people', were elaborated by the Department for Communities and Local Government in 2012, and demonstrates the range of support provided to this group, across older people, homelessness, and disability (including mental health).²⁶

Across the course of the Coalition Government there have been moves to create more 'personalised' care based on

individual needs. For older people, the Government has invested in FirstStop housing advice to help 'older people make informed decisions about their housing, care and support options'; Home Improvement Agencies, which include advice for older or disabled people, home repairs and arranging adaptations; Disabled Facilities Grant; lifetime neighbourhoods which are 'places that are designed to be lived in by all people regardless of their age or disability'.²⁷

Looking at arrangements for housing support in particular, top-tier local authorities provide 'supporting people services' (or housing related support services) which are defined by local need to help 'vulnerable people to live more independently and prevent crises in their lives'.²⁸ As such, housing related support services vary across each local authority.

The 'Supporting People' programme initially provided local authorities with a ring-fenced grant when it was introduced in 2003. However this ring fence was removed in 2009, opening up the funding to be used across other services.

The funding itself is provided so that 'people living in supported housing receive "housing related supported services" in order to enable them to live independently'.²⁹

Regarding people with mental health problems, the rationale underpinning the programme was that 'their quality of life can be immeasurably enhanced by being enabled to live in the community, perhaps in a shared house or other supported accommodation, and sometimes eventually in independent housing with support'.³⁰

The interviews below demonstrate the range of support that has been provided in practice and how it has been effective in supporting people with mental health problems.

The Lyons Commission report into the future of housing demand, published in 2014, outlined that there would be a 'continued need for specific forms of housing for people who cannot meet their needs without support in the housing market' and emphasised that it is essential for vulnerable groups to continue to have their needs met.³¹

Bolstering this work, the Elphicke Commission was announced following the 2013 Autumn Statement, looking into the role of local authorities in housing supply. The interim report indicated that 'housing activity should be increased across all housing tenures'. However initial findings also indicated that there are currently concerns over how assessment of need takes place and whether this is sufficiently linked to the local authority's 'strategic vision'.³²

Local housing supply and demand also interacts with policies explicitly around disability (including mental health).

In the cross-Government strategy Fulfilling Potential: Making It Happen, 'inclusive communities' is a key action point, to ensure that communities 'are inclusive to all people', including housing options. One of the indicators for this – crucial for how policy translates into practice within housing – is "the gap between the proportion of disabled and non-disabled people who are able to access all parts of their home without difficulty", which is essential to assessing what an inclusive community looks like.³³

At the strategic level, impetus and direction towards integrating services is evident. The examples below show how supported accommodation providers are translating this into practice but with barriers to integrated services still evident.

Adult Social Care

In 2010 the Coalition Government published A Vision for Adult Social Care: Capable Communities and Active Citizens. The document emphasised a convergence of health and social care funding to promote prevention, and extending personal budgets for care; the principle being to 'make services more personalised, more preventative and more focused on delivering the best outcomes for those who use them'.

This was built on seven principles: prevention, personalisation, partnership, plurality, protection, productivity, and people. The report highlighted that take-up of personal budgets had been low among people with mental health problems. However the strategy emphasised that supported housing and extra care housing were preferable housing options for people who required supplementary help to remain independent, in relation to both cost and outcomes.³⁴

Effective preventative care was also an essential element of social care reform, as outlined in the document, and required the integration of related services such as the NHS and housing associations.³⁵

The 2010 strategy was supported by reports from the Law Commission and the Dilnot Commission. The Law commission report on adult social care showed it was integral for the complex

law surrounding care and support to be simplified so that individuals and carers had a clearer understanding of their rights. The report argued for a new 'unified adult social care statute'.³⁶

This was supplemented by the report of the Dilnot Commission which examined the future of funding for care services. One of the main findings was to cap the 'lifetime contribution to adult social care costs' that any individual would make. However in connection to this the report also highlighted the imperative to provide support around the individual person (including housing support) so that the services they received would no longer be disjointed.³⁷

These reports led to the publication of the Government White Paper, *Caring for our future: Shared ambitions for care and support in 2012* which looked at the future of adult care and support services.

The Care and Support Specialised Housing Fund was announced in 2012, alongside the *Caring for our future: reforming care and support White Paper*. The fund was established to 'support and accelerate the development of the specialised housing market', following the principle that 'housing plays a critical role in helping older people and adults with disabilities or mental health problems to live as independently as possible'. Overall the fund intended to provide a greater supply of appropriate specialised housing. The Department of Health announced that £160m capital funding would be available 'to support the development of specialist housing for older people and adults with disabilities outside London'. £40m was also announced for developments in London.³⁸

The Care and Support Act, passed in 2014, had implications across housing, mental health, and disability. Suitability of accommodation would be considered as central with regard to someone's wellbeing in the provision of social care.

Following this housing providers would now be 'potentially well placed to help improve the well-being of more people through their services'.

Prevention was also included as another strand of social care, with the 'clear intent in the Act that the care system should help people maintain their independence and improve their well-being'. This was complemented by a section on 'delaying needs' which targeted early intervention, including adaptations to people's homes. With regard to 'reducing needs', this strand emphasises the need for re-ablement services in 'helping people to improve their ability to live in their homes or return home from hospital to an environment which maximises their independence. Although the exact implications of this are unclear at the time of writing, it may play a significant role in how housing support is developed in the community'.³⁹

In order to support integration between health and care services, the Better Care Fund was established by the Government in June 2013. In practice, "it creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people".⁴⁰

In October 2014 the budget stood at £5.3 billion and aims to provide 'better care closer to home'.⁴¹ This was supported by a commitment from key health and care partners who argue that 'national and local organisations need to take urgent and sustained action to make integrated care and support happen'. Signatories included NHS England, the Local Government Association, and Public Health England among others.⁴²

The above review gives an indication of the pressures acting on the supported housing sector and the incentives to provide high quality care and support to individuals who experience mental health problems. With this in mind, the case studies below examine what providers of supported accommodation are doing in practice for individuals with mental health problems to create effective accommodation on the ground.

Care and Support Plus



Definition

Care Support Plus is a model of supported housing, launched in 2012, in response to the need to create supported housing which could accommodate people with a high level of mental health support needs who might otherwise be in hospital or residential care.

The scheme was developed through a tripartite agreement between the housing provider, the local NHS Foundation Trust, and the local authority to develop a new type of supported accommodation specifically geared towards people who had often been excluded from supported accommodation due to their complex mental health needs.

The approach has proven successful on several of levels, including recovery of customers and improved quality of life. There is also a clear economic case to using this model with an overall annual saving per customer estimated at around £450,000.

The scheme was able to tackle a local problem across several areas of concern: A high number of people being placed in expensive out of area care; care that was not particularly suitable for the client group; a system lacking rehabilitation work; as well as concerns over the quality of care being received.

From another angle, the Care Support Plus model also provided an appropriate level of support for people in hospital unable to find suitable supported accommodation which could meet their needs. Although the impetus to develop the scheme was created by local demand, in practice the core elements of building and service can be reproduced to see how they might apply to customer needs across the country.

Building

At present the Care Support Plus model is not widespread. However the principles behind the construction are indicative of what other schemes might look like. Evidence from interviews suggests that the building formed part of the success of the scheme, proving a core element of effective support and may well be for further housing aimed at customers with similar mental health and support needs.

The scheme is purpose built supported accommodation, but to same specifications as private sale housing by the same provider. According to a member of the team:

“The organisation has the philosophy that anyone with a mental health problem should get the same quality of accommodation as anyone else”.

However, there were specific technical considerations, given that the model is aimed at customers with a high level of support needs:

- The scheme provided fully self-contained flats with each customer holding their own tenancy.
- The flats contained essential items which might otherwise preclude someone from moving on from hospital, such as a bed, dining table, and cookware.
- Regarding physical access needs, the building itself is step-free and fully accessible. This included a lift to all three floors with the first floor containing all wheelchair accessible rooms, so as not to prevent someone with mobility problems needs from accessing the scheme.

The effectiveness of the accessibility measures was confirmed by the resident interviewed who felt the building met all their physical access needs.

The safety features of the building comprised an important part of the scheme. There were three elements of the building in particular which contributed: a 'front facing office, airlock doors, and sensitive use of CCTV'. In each of these areas, the safety appeared mindful of the specific concerns of people with high level mental health needs.

The position of the office functioned as a safeguarding feature as it enabled staff to be aware of who is entering and leaving the building and prevent unauthorised visitors from entering

the scheme. This was bolstered by the 'airlock' system, which is a two-stage glass entry door, which helps to manage visitors' access to the scheme.

According to staff this has resulted in fewer safeguarding incidents compared to other schemes.

The levels of staffing also mean that visitors can be closely monitored and customers supported in this area; however in lower level supported housing with nine to five staffing it may not be possible to support customers in the same way.

CCTV in the scheme provided a final security feature, however it was set up to avoid being 'too obtrusive' and therefore mindful of the fact that it can make the scheme feel too 'big brother'-like. The building clearly responded to the support needs of customers by installing an appropriate level of security.

The importance of creating the right 'feel' for the building was evident across other areas. The staff member interviewed believed that the physical environment supported the mental wellbeing of residents:

"I think having an environment which is non-institutionalised, homely, is quite important, it enables residents to feel part of the project".

Part of this was making sure that information was displayed but would not be too intrusive, drawing away from a supported housing stereotype.

This was reflected in the views of one of the residents, who thought that the physical environment supported their mental wellbeing, and was happy with the look of the flats on first seeing them:

"I thought the flats were very nice... I still do think they are very nice".

The building also has a shared lounge and kitchen for customers to use, alongside the self-contained flats. This is a space for residents to socialise if they want to use the lounge, as well as maintaining space for privacy in their own apartments, and the resident interviewed felt that the space made it easy to interact with other residents.

However there were some drawbacks to the current building as highlighted through the interview. There was no private space outside of the development such as a garden, although this was not an issue picked up by the resident interviewed.

Concerning inside space, another drawback of the building was the lack of a separate room that would staff space to meet with residents.

These characteristics demonstrate the significant role that the building has to play in the provision of excellent care in supported housing. Understanding the customer needs was evidently central to this building, although shortcomings of the building through experience demonstrate shortcomings to be learned from.

Service

The package of services put together for the Care Support Plus model was pioneering in the way it drew together three different stakeholders to provide high level wraparound support for a group previously excluded from supported accommodation.

The principal difference of the arrangement was that it enabled NHS staff to be embedded into the scheme itself, through sub-contracting agreements. Having clinical staff based in the scheme meant that customers can receive a higher level of support, and equally it enabled staff to work with different customers.

The two clear differences in staffing in the Care Support Plus scheme compared to more traditional models were the level of staffing, and the presence of NHS staff on site.

Concerning the level of staffing, this meant that the scheme could work with individuals who may previously have been too high risk for supported housing schemes to manage, for example those with forensic backgrounds. Provisions therefore included double staff cover twenty four hours per day. Staff were also required to have prior experience of working with people with mental health problems, and were also supported by risk management procedures embedded in the scheme.

On top of the higher level of staffing provided by the housing scheme, there was also a higher level of clinical input. This meant that more intensive work could be done with residents and issues could be addressed more quickly than if clinical staff were off site.

Among other clinical staff, the care coordinator, psychologist, and Occupational Therapist would be on site each week:

"We can sit down with the Deputy Manager and the psychologist and Care Coordinator and work out a plan. In a traditional model you fire off emails and meet in three weeks' time while people are struggling. We can deal with things very quickly and very effectively here."

The high level of support also enabled staff to work intensively on the skills that customers need to develop in order to move on to more independent accommodation.

Feedback from a staff member suggested that this service provided the independence and rehabilitation work needed to empower people towards more independent living. This included intensive work around areas such as boundaries and safeguarding, to provide customers with the skills to avoid incidents such as financial exploitation when they move to less intensive support. As above, the key difference which complements the intensity of the service provided is the speed with which support plans can be put in place when issues arise.

From the customer perspective the most important element of the service from the interview was the activities:

"I just think it's brilliant we do an activity every day".

This reflected the work toward skills for independent living and the personal goals that had been achieved by the customer through the scheme. The activities available in the scheme were also compared to the customer's experience of residential care, where daily activities were not available to the same level. This was also reinforced by the customer as they said the availability of daily activities was the main thing for a future development to bear in mind. This reflected that beyond the essential provision of clinical support, there are a wide range of interventions surround that which support and enhance daily life.

Certain shortfalls were also identified in the services provided by the scheme. In particular this included the need renegotiate the exact level of clinical input at the scheme in order to provide customers with the right level of support.

This highlights the need for open dialogue between partners and the role that a joint commissioning can play in bringing about effective support for excluded groups. Overall the member of staff interviewed said that joint commissioning of the scheme addressed a problem which was both costly, and not serving a community which could benefit from a better level of care in supported accommodation.

Homelessness and mental health



Definition

Housing support for people who have experienced homelessness is both dependent upon individual need and reliant upon input from a wide range of stakeholders.

There are a number of complex factors which come together to constitute homelessness. Understanding of this includes both individuals sleeping rough without access to any accommodation, and those who are not sleeping rough but without any permanent accommodation.⁴³

Statistics suggest that people experiencing homelessness are more than four times as likely to experience mental ill health as those in stable accommodation. This is compounded by the fact that homeless people can often come up against significant barriers which can prevent them from accessing timely help and support with their mental health.⁴⁴

There are also strong correlations between homelessness and the severity of mental and physical health problems, as well as prevalence.⁴⁵

An emphasis on the importance of working across different teams was raised multiple times as a theme in recent studies. Data gathered by Homeless Link from its membership found that services which showed

'good practice' in their ability to work with homeless people with mental health problems had the following characteristics in common: "integrated working protocols; a multi-agency approach; a flexible patient-centred ethos"; accessible at each stage of the client journey".⁴⁶

For those with an established mental health problem and experience of homelessness who are in a position to take on an independent tenancy, tenancy support can be an effective solution to help them maintain that tenancy, and avoid a downward cycle to homelessness or crisis care.⁴⁷

Similar findings were prevalent in another study into 'multiple exclusion homelessness'. Themes emerged around a failure of services which support individuals to join up so that holistic support could be provided within housing: "Housing related support services have become the mainstay of support for people experiencing multiple exclusion homelessness. These services often work in parallel with health and social care services. As a result we found little evidence of integrated assessment and support planning".⁴⁸ This has been supported elsewhere, in findings which recommend that for highly excluded groups it is essential not to make distinctions in the different elements of their lives based on professional distinctions.⁴⁹

It is essential that staff in homeless or housing support agencies are provided with sufficient training. This is important for the individuals that they are helping – to ensure that they are receiving sufficient support – and also for employees, to ensure that they do not feel ‘isolated and out of their depth’.⁵⁰

This must therefore fit into the broader picture of how services are set up and what their primary function is: whether to address complex needs of individuals, or to focus on a specific area.⁵¹

The supported housing scheme used in this report supported individuals experiencing homelessness who also had specific mental health needs. The scheme itself is a licenced hostel and is funded by the Supporting People programme, with the referral process for individuals taking place through the local Council’s accommodation team. As the scheme is specifically targeted at people experiencing mental ill health, the services provided are tailored to that group, and the model suggests some solutions to what effective supported accommodation looks like for this excluded group.

The scheme itself forms part of a staircase pathway into independent accommodation, a model of housing support which is discussed below. The case study here is the first step on the ‘staircase’, and provides the most intensive level of support to individuals who present with mainly mental health needs. The scheme delivers housing related support and aims to provide residents with the skills they need to ‘reengage’ with the system of health and housing to provide more long term stability.

Building

The scheme interviewed for this study comprised of an adapted building, repurposed for the scheme, rather than a commissioned new build.

Rooms comprised of basic facilities with a shared kitchen and bathrooms.

As the scheme is based in an adapted building, this provoked a discussion regarding the importance of both the environment, as well as physical access to the building. These provide key pointers to what an effective model looks like, whether in a new or adapted building, as a key point raised by the staff member in interview was the importance of environment:

“in terms of those who present with mental health [needs], the less institutional it is, the better it is for their recovery”.

One of the main areas drawn out of the interview from the provider’s view point was the importance of a therapeutic environment for the recovery of customers. The member of staff felt that the building itself played a large role in the recovery process of the individual:

In practical terms this could mean creating a more ‘homely’ feel by having smaller apartments which felt like ‘home from home’. Other schemes within this provider’s staircase programme were formed of purpose built blocks which fostered a more therapeutic environment. In reference to the high-level need hostel itself the staff member interviewed felt that the scheme had too much of an ‘institutional’ feel which had been drawn out from residents and their own experience in the past.

“if it’s friendly and welcome and up-to-speed it will encourage the clients to take part in their treatment process”.

In terms of the building, schemes should ideally reflect their overall purpose: recovery of, and engagement with, customers. However this is in the context of restraints on the availability of funds, and land, to develop purpose-built blocks. From the perspective of the resident interviewed, the environment itself was not highlighted in particular as a concern although they did note that it was ‘quite comforting’ in some rooms but this varied across the building, suggesting the need for consistency in the design of the building for all residents. Beyond the scheme being based in an adapted building, both the staff member and resident interviewed said that the design of the scheme itself played an important social function. The resident felt that they were able to use the communal space such as the kitchen to meet with other residents as well as invite residents into their room.

From the perspective of the staff member, the benefits of a staircase approach to independent living and reengagement with services was that residents had access to a greater level of social interaction through buildings like this one:

“you need to be able to sit down and discuss things, not just four walls and no one to talk to, only staff coming in once every three days”.

This is evidently linked the individual needs of the customer but shows the level of staff input required in high need supported housing. Both of these perspectives on the building also interact clearly with the availability of services on site which can facilitate residents

participating in activities.

Looking at practical elements of the building itself, safety was raised as an important issue by both the staff and resident.

The building itself had secure entry and all residents had keys to come and go independently. There was also CCTV on the premises. The resident interviewed felt in particular that knowing that the staff could see who was coming and going, and being aware if there was an external guest in the building, eased the anxiety of residents.

A final concern for both customer and staff was mentioned in terms of the scheme being based in an adapted building as there was a lack of wheelchair access. There was an acknowledgement that it may exclude people from accessing the service who presented with mental health needs but were not able to navigate the building. This is a key consideration for future developments in order to ensure that clients are not excluded on the basis of physical health needs.

Service

The service provided at the scheme formed part of a ‘staircase’ model of care which aimed to move customers on toward more independent living.

Housing strategies for engaging people with complex needs, including homelessness, tend to follow a linear ‘treatment first’ approach. This means progression through different housing services with the aim of achieving independent living. However, this can

be problematic for people with complex needs as there may be a 'variable process of recovery'.⁵²

The emphasis on integrating multiple levels of support to match need is pivotal given that staff from any given agency must be able to provide support when needed.⁵³ It is essential therefore to consider housing as part of someone's care pathway, "by providing rapid home adaptation service, floating support and step-down service, housing organisations have played a key role in minimising delayed transfers of care".⁵⁴

In contrast to the treatment first model is the 'housing first' model. This places people into "permanent independent tenancies, with comprehensive non-compulsory support." This inverts the treatment first model by putting housing first, and there is evidence to show that it can 'significantly improve housing retention rates'.⁵⁵ In the context of complex needs and offending, these alternative models for housing are seeking to redress instability in housing, which 'appear to be linked to both poor mental health and offending, with one often compounding the other'.⁵⁶ However, there is still limited evidence in the application of the housing first model in the UK.

The pros and cons of the staircase model at the homeless scheme were raised by the staff member interviewed.

They highlighted that in the scheme they encouraged residents to access services and begin to look at issues such as, for example, antisocial behaviour. As such the scheme addressed underlying needs before moving clients on to more

independent services. The staff member also felt that in some cases housing first can be "setting people up to fail" when they have a particularly high level of need or are particularly vulnerable, and require staff to support them to engage with services.

However they also recognised that the treatment first approach does work for everyone and in effect it can be around 50 per cent in terms of success rate for customers. Some of the drawbacks of the treatment first approach include the fact that the environment can hold people back;

"when you're in an environment where people are still recovering the temptation to relapse is there".

The ability to move on is also dependent on the availability of other housing which is not always there at the right time. Overall there was the view that supported accommodation for people who have experienced homelessness should be:

"each according to his level of need... one thing's clear though, without housing there's no stability".

In terms of progression through the scheme, staff drew up action plans with the client based on an initial diagnostic of their needs. This is supported by outcome measurement tools to assess the client's progress.

Alongside supporting clients to access services such as the GP and other appointments, which are designed for people who have been out of the 'system' for a long time, the scheme places strong emphasis on activities, which was highlighted by both the

staff member and resident interviewed as one of the areas which makes the scheme stand out. Activities such as a breakfast group provided daily structure outside of support in taking clients to appointments.

The scheme also looked to the community for resources if clients wished to take part in activities which could not be supported internally or through the organisation's training and recovery programme. Activities can be used as an entry point for clients to start engaging in the recovery process. From the resident's perspective they mentioned that staff were supporting them to organise a trip abroad:

"We're trying to organise going to France or Germany but they're going to help us with the passports".

Support can therefore extend beyond immediate requirements to look at the wider concerns affecting reengagement with services. Underpinning these activities is the principle of coproduction which was reinforced again by both staff and resident. Within the scheme there was the ethos that activities and goals should be developed with, rather than for, the client. Previously clients were not so much part of designing their own care. The staff member felt strongly in interview that:

"if you're doing a service for them you're not going to get as much as it you're doing a service with".

They felt that the 'with approach improved the recovery process. From the perspective of the resident, the dynamic between clients and staff was of high importance in relation to their experience of the service. This meant

raising issues of how they are talked to by project, or other support workers. Politeness from staff was a key concern to ensure that people in supported accommodation enjoyed living there. In order to reinforce this, there was considerable emphasis on the attitude of staff toward clients at the scheme. The member of staff interviewed advised that for similar housing in the future, one of the primary concerns should be to "get in the right staff first"; this included how they communicated with and listened to clients:

"I ask, can you sit down and have a meaningful conversation without passing judgement".

The staff member also suggested that the housing sector could benefit from mental health professionals in the same way the mental health services have specific staff to provide expert support. However it was also reinforced that the approach of the staff needs to be underpinned by a properly resourced scheme, including the right staff to support client needs.

This concern was also picked up by resident who was keen for staff members to return who had previously undertaken a range of activities with the scheme, *"we were able to do cooking and have political discussions".*

Staffing levels, alongside the quality of the staff taken on, evidently have a significant impact on how high quality support delivered.

Complex needs and housing



Definition

There are different definitions of what constitutes complex needs. This report uses the term to mean 'someone with two or more needs affecting their physical, mental, social or financial wellbeing'.

These are needs which typically 'interact' resulting in multiple problems at the same time. This means that individuals can often require care from more than one service to address these needs.

Looking at how many people live with a multiplicity of needs, it is estimated that there are 60,000 people across England experiencing two or more of the following: homelessness, reoffending, problematic substance misuse and mental ill health. It is also estimated that at least 4 million people in England who are living with a long-term physical health problem also experience mental ill health.⁵⁷

Evidence suggests that people with complex needs consider tailored support and person-centred approaches to social care to be highly valuable. At a service level, this might mean providing a key worker to 'facilitate access to disparate services and coordinate services across sectors and boundaries'.

Even though person-centred support is advocated across different publications,

there is still limited evidence for which specific model to follow – particularly around the outcomes and costs of 'good practice'. Four areas with the most evidence on how to tailor social care were: a multidisciplinary specialist team; intensive case management; specialist social work; and inter-professional training.⁵⁸ However the emphasis on integration of needs across boundaries appears to be reinforced from both a health and social care perspective.⁵⁹ This suggests that further investment in a design for complex needs in housing needs to be accompanied by a rigorous evaluation process.

The scheme used in this report provided support specifically for customers with complex and multiple needs.

The supported housing scheme was developed in 2002 by a provider, as the local Council overhauled homeless provision in the city with a view to reform and improve services. The scheme is licenced as a homeless hostel and funded through the Supporting People programme. However it was developed specifically to provide support for people with complex needs.

As such there is high demand for the approach that the scheme provides and the referral process for clients is managed through a multiagency panel.

The accommodation provided by the scheme is targeted at men over 18 who have been excluded from all direct

access accommodation locally. The majority of customers are aged 30-50 and 15 units of accommodation are available with a move on period currently set for 12 months, with move on averaging in the scheme at 18-24 months when the service first opened. The main goal of the scheme is to provide accommodation, coordinate appropriate support, and to provide support around resettlement. The scheme set a standard for the kind of housing support service that can be provided for individuals with complex needs. Its success in providing this is a culmination of factors to do with both the services provided and the building in which it operates.

Building

Working with customers in supported accommodation, that have experienced very high levels of exclusion, poses a number challenges. However these challenges can be met by the service that is provided but also can be very much supported by the environment:

"I think our success has been very much due to the building".

The complex needs scheme run by the provider is situated in a refurbished Victorian building which was remodelled to provide 15 self-contained flats. Each flat was developed with a bathroom, kitchen, and is fully furnished - including a television and double bed. According to the staff member interviewed the quality of the furnishings sends an important message to the customer:

"if you give people rubbish often they'll act like rubbish. Whereas here we're saying to people, look we think you're important enough to have this lovely one bedroom flat".

From the resident and staff perspective they both noted that the building was bright after having been recently redecorated and that it had an airy feel to it.

There has also been particular consideration made to how the room was put together: The doors are very robust making them hard to break – a cause for people to be evicted – and there are no doors on the wardrobe, for example.

There are also wet rooms rather than baths as flooding can also be a reason for people to be excluded. By making these adjustments the scheme is reducing the risk factors which might trigger someone being evicted. There is also a communal lounge and training kitchen for residents to support activities with customers. The physical environment is therefore a direct response to the client group – recognising where people need support and what the most appropriate environment for their support needs is, considering a background of very high level of multiple-exclusion.

Safety measures were a very important consideration of the building, particularly for this client group. All of the communal areas are covered by CCTV – something which the resident noted on first arriving at the scheme:

"I feel secure because they've got the cameras and there's someone here twenty four-seven".

The cameras are used as an active deterrent to anyone who might be trying to approach vulnerable clients. The reception area has also been designed so that the communal lounge is fully visible from any point, without it being too intrusive. The building design and

safety features are backed up by the extensive risk assessments and protocols that are expected. Residents are also provided with a buzzer in their room. This enables them to contact reception staff (who are available around the clock) to inform them if they need help, or if there is someone outside their door that they don't want to speak to. Both the staff member and resident mentioned how useful this feature was to provide support when needed.

Regarding drawbacks in the physical environment, the lack of a garden was mentioned in the interview, a *"nice green open space would've been good"*.

The residents have access to an allotment however this is located a distance from the building which can put off some customers from using it. The lack of private outdoor space was also mentioned in the Care Support Plus scheme as a drawback. There is evidence to suggest that ecotherapy, an intervention to support people being active outdoors, can improve the physical and mental health and wellbeing of individuals – including those recovering from mental ill health.⁶⁰ The outdoor as well as indoor environment therefore seems to be an important consideration for both new developments and renovations.

Service

Customers who come into the scheme present with 'a multiplicity of unmet needs' as a consequence of exclusion. The scheme aims to provide platform for customers to begin reintegration into society:

"I believe that the customer really is at the centre of everything we do".

This means identifying and supporting the customers to access services:

"What we're offering is a safe and stable base from which external agents can access their customers".

Housing is an important factor in enabling people to both access and retain connections with care and support services, which due to the nature of multiple and complex needs, are dispersed across different agencies.

This stability is also being provided for a group whose housing needs are notoriously difficult to assess.⁶¹ In practice this can mean maintaining a stable base as people move in and out of prison or psychiatric care. What was emphasised in the interview was the particular recovery focus of the scheme. The staff member highlighted that it was on the customer that the recovery was ultimately focussed. This was supported by the customer mentioning the range of ways in which they were supported to engage through their personal barriers such as reading and writing, which may have prevented them in another from registering from services such as the GP.

The customer focus of the complex needs scheme is reflected by the way in which they deliver services. The underlying principle is "looking for creative ways to deliver traditional support". For example, customers are invited for 'tea and toast' in the morning as a social event to manage risk, rather than knocking on people's doors. If people do not make it down, then staff can follow up to see how individuals are.

A laundry service is also offered on site. Initially there was a separate charge which meant that uptake of the

service was very low, however this was developed to incorporate it into the general service charge. This has now become much more popular and is a way of encouraging people into changing their habits; regarding its approach, staff are asked to think how they would feel in the other person's shoes.

There was also flexibility around the rules for each customer. It was noted that traditional hostel services can have identical rules for all customers with a principle of "three strikes and you're out". However by providing flexibility around individual need they can avoid excluding customers. For example, if consuming alcohol results in violent behaviour for one customer, that does not mean that all customers would be prevented from consuming alcohol. As such:

'we would have people living next door to each other with completely different support and risk mechanisms.'

In order to carry out these services and look at different approaches and attitudes this needs to be reinforced through the approach of staff.

Within complex needs evidence suggests that for mental health, awareness training for staff and the ability to direct people to appropriate services when necessary is essential to effective support. Staff are therefore trained in reflective practice. This is effective at avoiding situations in which the customer might be considered for exclusion from the service for behaviour which breaks the rules.

Reflective practice forms part of the system of Psychologically Informed Environments (PIEs). The principle behind PIEs is to enable staff to work 'more creatively and constructively with people with so-called challenging behaviours' in order to support customers who have experienced homelessness and other complex needs to a sustained recovery. For example, in the instance where a rule has been broken this would entail asking why the rule was there, what the circumstance was, could we have acted flexibly to avoid a conflict. Through using this methodology the scheme has been effective in engaging both with staff and customers when problems arise.

This forms part of a broader framework of ideas and actions to introduce the programme, and was initially developed from the Enabling Environments work from the Royal College of Psychiatrists.

The scheme took other practical steps to enhance understanding of customer needs among staff. There is an extensive handover in place between shifts which enable any member of staff coming on to understand what has gone on in the previous day. The purpose of the more extensive than usual handover has the aim on being sensitive to the customer's experiences if something stressful or traumatic has happened. For example, this might shape when, and how, a conversation about rent arrears would take place. Secondly this means that the customer should be able to approach reception at any time and the staff will be up-to-speed on what their concerns are, avoiding any delay in support.

Staff are also trained up to spot signs of distress so if a customer becomes unwell they are able to hand over to the teams working with that customer. This was picked up by the customer interviewed when asked whether they felt the staff understand their needs:

"If I've got a problem I just speak to them".

Regarding the progression of customers through the scheme, the organisation provides a 'tenancy ready' programme.

This is tailored to different individuals across the housing services that the organisation provides. Within complex needs, there is greater emphasis on areas such as acquaintances that individuals make in the community, and looking after money in a sustainable way, as well as safeguarding training for both staff and customers.

One of the areas of difficulty related to move on was the time frame the scheme has around this. The interview highlighted that although it is essential that local authorities understand how money is spent and that they get value for money with the service, the rate of move on depends on the individual, and in some cases this might mean providing more intensive support for a longer period of time. The rate of move on was also something picked up by the customer who felt they needed more time to have everything in place to move on, but noted the skills that they had learnt since being there:

"I've learnt to mix with people... because I never socialised before because I was on my own but ever since I've been here I'm starting to come out of my shell more."

Complex needs housing is perhaps the service which cuts across the greatest number of associated services by nature of the customer group. The evidence from interviews as well as research suggests that integration and communication across services is essential to providing the right kind of support to customers.

Regarding practical steps to facilitate effective integration of services, research has suggested that there are two key factors needed for integrated care for people with mental health problems:

- "having the right people in the organisations to drive integration, and;
- cross-boundary inter-professional training and education for health and social care professionals."

Having integrated services also relies on accepting the principle that physical and mental health are not different, but part of the whole picture of an individual's wellbeing. Specifically in relation to mental health, "the provision of fully integrated services to people with mental health needs goes further, into many other aspects of people's lives such as education, work, housing and leisure, and individual lifestyles."

In addition to the need to evaluate services effectively, it is essential that before this happens, a strategy for integrated care is fully translated into practice.

Low level step down accommodation



Definition

Supported accommodation can provide an effective living environment for people with all levels of mental health needs, and pathways of care enable people to move through a system of high intensity to low level care according to their need. Housing pathways are determined on a local level for mental health and as such the availability and type of housing varies. The provision of high quality, appropriate housing (and associated support) goes hand-in-hand with health and social care in order to produce a recovery focussed pathway for individuals. Housing-based care therefore has the opportunity to reduce acute admissions, the number of people living in institutional care, and reducing out of area treatment. However this is contingent upon having the choice to match demand.⁶⁸

For these pathways to be effective in mental health, a number of elements need to be in place. This includes adequate amounts of supported accommodation which match local need. This is something which can be effectively addressed through Joint Strategic Needs Assessments. Beyond matching supply and demand however, creating a meaningful pathway for individuals requires integrated working between health, care, and housing partners:

“mental health services can only be successful if housing and social care services, in particular, are working well”⁶⁹

This is a well-worn phrase, but case studies in this report show how this is already being done around the country, and work by organisations such as the National Housing Federation have further examples of integration in practice.⁷⁰ This joined up working applies from more long-term planning work, looking at provision of specialist housing, to the daily interaction between teams which helps to identify what support is most appropriate for any one person.

One type of supported accommodation at the lowest level of need is floating support; this service provides housing related support to individuals in their homes. However in comparison to higher levels of support, staff are not permanently based on site with the resident or customer. In simple terms this can be seen as:

“support that is provided usually on a temporary basis to service users by a visiting support worker to enable the service user to sustain their tenancy and remain in their home”⁷¹

The organisation interviewed for this report provides 23 units of accommodation for individuals with mental health problems, to whom they provide floating support. As such both the building and the service provided are equally important for the customer as in other supported accommodation services where staff are based on site full- (or part-) time. The service is long-term and so the rate of move on for

customers tends to be between three to five years although this is not fixed.

Building

The organisation provides self-contained one bedroom flats in the community. The flats themselves are presented as high quality accommodation for customers coming through the service, and this is part of the recovery model that is promoted by the organisation:

“if people are proud of their surroundings and their living spaces they are likely to treat them a lot better... [which has] an impact on their mental wellbeing compared to somewhere that’s a poor standard”.

The high quality of the accommodation was also acknowledged by the customer interviewed as well, saying it was “A gorgeous flat, I’m really happy there”. Both the customer and staff member mentioned that there was a disparity between the quality of the properties provided by the scheme the accommodation being offered by the Council which may not “match” up.

From the resident’s perspective they were also very happy with the cleanliness in communal areas in the building and the work of the cleaning staff. The reciprocal relationship between the individual and their environment was reflected across the other services interviewed, and demonstrates the importance of housing (as well as service) design for any scheme.

Regarding the physical access needs of customers, the interview highlighted that the layout of the flat all on one floor made it easy to clean and manage. Lift access to the flat also made it viable for the customer, “if they didn’t have the

lift I don’t think I’d have been able to take it”; demonstrating the importance accessibility to avoid exclude customers. Where appropriate the staff member noted that an assessment from an occupational therapist would be requested to ensure that there were no other physical barriers preventing someone from moving into more appropriate accommodation which fitted their mental health needs. However physical health can present as a barrier preventing individuals from moving through the mental health pathway. As such the staff member interviewed highlighted that it is essential to work with the physical health teams in order to ensure that customers are not held back when their mental health suggests they are ready to move on.

The relationship between different teams is central to the ability for customers to effectively move through the pathway when they are ready. This includes referral to self-contained units. The interview highlighted that from the perspective of the supported accommodation provider, they would only take appropriate referrals:

“If we’ve got someone for example coming from a shared unit they wouldn’t come [here] they’d go to one of our accommodation based services. That’s too much of a leap”.

The customer interviewed was very active in community activities, and was also very positive about having had the opportunity to take a self-contained flat.

Within this scheme the relationship between the different professionals contributing to the customer’s journey sits at the heart of this process. Having a good relationship would enable any concerns about the suitability of the

accommodation to be addressed before any move is made:

“We’ll sit and we’ll talk and we’ll see what we can do... because I don’t want to set people up to fail”.

As highlighted in the interview, self-contained accommodation will be appropriate for some people but not everyone and ensuring that the conversations happen will avoid inappropriate placements.

Looking at practical aspects of the buildings, the organisation ensured that they have suitable external security features (such as good main door security). The customer felt “very secure” in their environment, however said that the addition of a video entry phone (compared to an entry phone) would be a benefit to see who it at the door.

The organisation also undertakes safeguarding work with individuals. This covers issues such as cold calling, letting people into your home, and personal safety on the street. In providing that training for customers, it has meant that when issues arise they “have been able to act on it” to support customers. At each of these stages, the support provided by the service to the customers evidently has a close relationship with the built accommodation.

Service

The floating support service differs from the accommodation-based support in that it is much lower intensity and the frequency of visits by housing support staff will vary depending on individual needs. Alongside visits in their own homes, there are also sessions put on in central offices for customers to attend. Customers receive support

from different members of staff, but each customer has a support assistant to provide most of the activity-based support, and it is part of the customer’s agreement with the provider that they will engage with the service.

One of the main areas of work for the support assistants is in “customer involvement”. This means supporting them to attend events which might be organised internally by the organisation such as fire safety, health and wellbeing, or sexual health. It would also include day-trips out, and provide a culturally competent environment by marking events in the calendar which are inclusive to clients from different backgrounds, including Eid, Chinese New Year, or Black History Month, for example.

However another side to this is getting people involved in local activities so they can: “tap people into what is going on outside” to create a strong emphasis on social engagement. The other aspect to this is supporting customers with daily living activities, which in low support accommodation still varies depending on the individual:

“some people will come here and they’ve got more life skills than others”.

This therefore requires an approach from staff which can support the various needs, with an emphasis on support in paying bills, to help getting to a GP appointment.

The ability to provide clients with a service geared to recovery therefore needs to be able to provide comprehensive support in whichever areas of peoples’ lives that it is most needed. This practical delivery of

support to customers is reflected in the ethos of the service:

"we do try to empower people as much as possible because really it's all about preparing people to live independently".

Although the service does not operate within the same strict time-frames to "move on" clients as some other services, it is key that a dialogue is kept open between the staff and customers to know that the service is the most appropriate place for them to be:

"if they don't need the support we need to look to move people on".

Movement through the services therefore operates as a dialogue between the customer, housing provider, and local authority. However the availability of alternative housing locally means that there isn't the same pressure to move people on from the service that might operate elsewhere, allowing a greater customer focus than may otherwise be possible.

An element that made the service particularly adapted meet the needs of people with mental health problems was the staff working at the organisation. When employing new staff to work in specialist mental health supported accommodation, the organisation specifies that they need to have knowledge of, and to have worked with, people with mental health needs. From the staff member's point of view, having this background means that the staff are: "A lot more understanding, a lot more empathetic" towards customers. This was reflected in the experience of the customer who said:

"I think the service they provide it's of a high calibre... any help or support you might need".

This included having a good "rapport" with staff meaning that the customer would not be hesitant to ask anything of staff.

The staff member interviewed also highlighted that working in mental health is different to working in general needs housing, and as such staff:

"all have a commitment... a commitment to working with people with mental health problems".

This is reflected in the training provided to staff internally as well. All staff have mental health training, including understanding psychosis, dual diagnosis and medication among other issues. This is also alongside proper training for support planning and risk assessments. As such the organisation is, "very clear about their expectations" of staff; at the same time the ability to support and listen to staff was seen as essential, ensuring that:

"you're providing them with the training and the support that they need because it can be quite tough this job".

This was also recognised from the customer's perspective who felt that staff were "very good at spotting the signs" if someone became unwell and to help them in the "best way". In this case, the scheme appear to have been successful in communicating that mental health knowledge to customers.

The service is evaluated internally by the organisation, as well as externally

by the local authority. Alongside this achievements of the service were customer focussed:

“it’s all customer led and it is very much about how they see themselves and what support they feel they need”.

However one area of concern within the service was the referrals coming through with higher support needs, which would have previously been referred to other services.

This can result in clients with complex needs who are harder to work with being recommended for a lower level service than might otherwise be appropriate. Avoiding inappropriate referrals which can lead to tenancy failure have been averted by maintaining an open dialogue with the local authority; however it is essential that financial pressures on services do not lead to inappropriate referrals.

Mental health and housing in later life



Mental health affects us across the life course. The most common mental health concern associated with later life is dementia. There are currently around 11 million people aged 65 and over in the UK.⁷² In 2010 there were over 800,000 people living with late onset dementia,⁷³ which is expected to rise to one million by 2021.⁷⁴

Excluding dementia, other types of mental health problems are just as prevalent in the older population as people of working age. Each year around 22% of men and 28% of women over 65 are affected by depression.⁷⁵ Considering severe and enduring mental health conditions, Schizophrenia affects about 1 in 100 people and normally starts during early adulthood. Around half of people diagnosed with the condition will have a long-term illness.⁷⁶

Effective supported accommodation for people living with dementia or enduring mental health conditions is therefore essential and extra-care housing is a scheme offering a range of solutions.

Definition

Extra-care housing is a broad term for care and support services which are provided in someone's own home. This section used the following definition: "The term 'extra care' housing is used to describe developments that comprise self-contained homes with design features and support services available to enable self-care and independent

living. Extra care housing is popular with people whose disabilities, frailty or health needs make ordinary housing unsuitable but who do not need or want to move to long term care (residential or nursing homes)".⁷⁷ As a housing solution for people living with mental health problems it can provide a long-term means of support.

The focus of this housing model is support for people in later life. As a form of accommodation it enables people to live independently for longer. It is also increasingly popular for people with a disability of any age group.

Extra-care housing is often developed with design features in the building which enable independent living, alongside the service which is provided to residents. This means that the buildings can be very diverse in both their design and the services provided.⁷⁸ However whether new builds or remodelled homes, residences are created with the users in mind. By adapting buildings, this makes facilities more accessible and better equipped for the needs of residents. There are currently around 49 000 units of extra care housing in the UK.⁷⁹

As extra-care housing provides such a diverse range of services and buildings, it is better to consider it as a concept rather than a housing type. This is reflected in ownership models, as extra-care housing can either be rented at market rate or for 'social' tenants; equally

there are developments to purchase either outright or through shared ownership (rent and leasehold).

The core principle of extra-care housing is that care and support services are delivered at home, rather than in residential care.⁸⁰ As such it can be a vehicle for effectively integrating a range of health and social care services around individual need.

The scheme used for this research shows the steps that have been taken to create an extra-care scheme that is able to meet the needs of people with mental health problems. As a means of accommodation to support people with mental health needs in later life, two are two distinct areas: those living with dementia in extra-care housing and those with ongoing mental health needs in later life. The scheme discussed below refers to the less-investigated area of mental health in later life.

Dementia

To look at dementia initially, thinking is divided over how extra-care housing should be provided for people living with dementia. Older people living with dementia can face discrimination from those who do not have a diagnosis. As such some believe that there should be distinct units of housing within projects for people living with dementia, whereas others believe that the two should not be separated out; there is also the possibility of distinct dementia-only projects. The principle behind all of these approaches is how to deliver the most effective care.⁸¹

Regarding the design of extra-care housing for people living with dementia there are a number of principles which have been developed by research into this area. These include principles of

design, which incorporate ideas that the space should 'compensate for disability; maximise independence; be and be orientating and understandable', among other key areas.

Regarding the features of the design, key points include that the building should include: 'age appropriate furniture and fittings; good signage and multiple cues where possible; familiar, domestic, and homely in style'. These features combined with the specialised service are able to create all-round support for individuals living with dementia.⁸²

Literature in this field indicates that attention needs to be given to both the service and design of the buildings, as well as the commissioning of such buildings to assess local need. However there is evidently consideration given to the physical design of the building in order to support wellbeing and independence.

Mental health in later life

For those living with a diagnosis of dementia, it may be the first time that they have lived in supported accommodation. However, there is a cohort of older people living with long-term mental health conditions such as depression or schizophrenia who may have previously lived in supported accommodation. This group may also include adults who developed a long term mental health problem later in life.

Mental health needs in later life will be as diverse as needs at any other point, with the added likelihood of increased physical frailty. Moreover supported accommodation will only be appropriate where someone is deemed to be able to have their needs sufficiently met in supported accommodation, and not

at a higher level of care. The scheme discussed below has developed the integration mental health support into extra-care housing.

The supported housing scheme interviewed for the report is an extra-care scheme operating in South East England. It was developed to provide modern, independent living for older people. The scheme has been operating for six years and is a purpose built block, which replaced out-of-date sheltered bedsit accommodation that was no longer meeting demand of the local community. The scheme comprises 40 flats, of either one or two bedrooms. The scheme's housing service is delivered by a non-profit housing provider, with care services delivered to residents separately by a care organisation. For referral to the scheme individuals must have a care lead and be registered on the housing register.

The scheme provides an alternative to residential care for older people, aged over 55, with an approach which takes independence of residents as its starting point. However over time the scheme has also had an increasing number of referrals from working age people with either a learning disability or mental health problem, who have care support needs who may be 'isolated, anxious or vulnerable adults'. The wide range of residents in the scheme shows the relevance of a model which supports independence in later life, for people living in the community with a range of care and support needs. As a new build scheme, the building itself has had careful consideration for the customer group, and the service provided is also mindful of those needs.

Building

The individual flats provided by residents are built to a high quality, with a one or two bedrooms, and open-plan living and kitchen area, and bathroom. The resident noted that:

"I enjoy living in the flat, the bedroom, the living room... and I can watch the birds".

The individual tenancies and self-contained flats provide a clear distinction with residential care. The staff member defined the living in the extra-care scheme as "a street with a roof over the top" and that the independence provided by the combination of the service and the building meant that it did empower older people as well as those of working age who may have previously lived in residential care. The building can, in this case, provide the framework for the care provided.

Alongside the self-contained flats the site has a range of facilities for residents including: a restaurant, activities room, shop, hairdressing salon, and a bar, among others. The benefits of these facilities were remarked on by the resident who was very active in using the spaces available on site. In particular they saw the restaurant as an area:

"where you sit down and eat with your friends; you make friends and eat".

For residents with restricted mobility, meals are available in their rooms. Concerning residents with more restricted mobility, the availability of activity rooms on site means that external organisations such as Age UK

are able to use the site to run activity groups. This can improve inclusivity of less mobile residents and reduce the risk of social isolation. There are lounges available for residents on each floor which means communal space close by as well.

One major benefit of the communal scheme was the availability of gardens on site. This was a notable drawback of two of the other schemes interviewed for this report, which noted that access to green space could have provided an improvement for customers. In this scheme the importance of the garden was mentioned by both the staff member and resident. From the resident's perspective, they said:

"I like the communal garden outside. That's nice to walk on a sunny day".

From the provider perspective the garden was one of the benefits of the scheme and had been used to enable one resident who was more isolated to undertake meaningful activity,⁸³ alongside the other structured activities available in the scheme. The scheme is also well situated in terms of local amenities which is also essential more older people with reduced mobility. The resident interviewed felt that:

"it seems an ideal place to live, close to the shops, close the bus routes, close to the Church".

In looking at building design and its ability to support the mental wellbeing of residents, connectedness and the construction of community can be an important factor in avoiding loneliness,⁸⁴ and the emphasis on the role of neighbourhood to combat loneliness in later life has been defined by Age UK as a 'structural enabler'.⁸⁵

Regarding security at the Court, there is a system whereby there is public access to some facilities, including the hairdresser and the shop. However, there is no access to the private living area of the residents. This double security means that residents must 'buzz' through any visitors. Staff reinforce security procedures with residents at the Court, as they are able to view CCTV on the television sets in their rooms to see who is visiting them. The resident felt that:

"it's very secure, not just anyone can come in".

The building was designed to be fully accessible throughout. Doors to individual apartments can fit wheelchairs and the lifts to each floor can also fit motorised wheelchairs. However the staff member noted that due to the higher number of motorised wheelchair users now compared to when the building first opened, the lifts could now benefit from bigger. On the same theme the storage space for motorised buggies no longer quite matches the number of residents using these. Another final drawback was small step to access the garden. Although this did not restrict any residents from accessing the garden it makes it more difficult for wheelchair users. These minor points emphasise change in use of the space over time, as well as the involvement of service users in both the design of the building as well as the delivery of the service.

Service

The care that residents receive is determined by the package agreed when they first move in to the scheme and will vary depending on the individual.

Care services are delivered by an organisation specifically contracted in, which operates separately from the organisation managing the building and housing services itself. The decision to refer individuals to the scheme is taken by a joint panel, with the housing staff inputting whether they feel the individual would be a suitable match for the scheme considering the existing community. Cohesiveness and acceptance in the community is a concern for all referrals and is of concern also for individuals with mental health problems.

Stigma around mental ill health is evident across adult life, with older people seeing it as a barrier to accessing services⁸⁶ as well as a barrier preventing working age adults from accessing mental health services when they need them.⁸⁷ Addressing attitudes, as well as issues around disclosure of mental health, are essential in mainstream supported housing provision if they are to ensure that older people with mental health problems do not become ostracised by a new community.

One way in which this might be addressed is ensuring that people's care needs are the right match for the service being offered. For example, for an individual who has wandering problems outside the home this service would not be appropriate as staff would only be able to advise residents, but they cannot stop them from coming and going. However, where need can be matched at an appropriate level there was a strong feeling that:

"if you come in here at the right time it's

a very good place to be because it does empower you".

For older people living with mental health problems this means retaining independence, alongside receiving care and support. However this relies on an effective referral service with communication between health, social care, and housing provider to create an inclusive service in later life, incorporating those living with mental health problems.

A major part of delivering a high quality service to residents was the working relationship between the staff on both the care and housing side. By working closely together between the teams, a more seamless service can be provided for clients. For example, if a customer's light had blown and no one was in the housing office, a carer could write a note so that it would be dealt with as soon as possible. These small gestures provide a more 'cohesive' service, and also 'gives a better atmosphere' for customers. From the resident's perspective they also felt a continuity of care in that both sides of the team were present and that they would help if needed:

"The court manager's there at any time if you have a question... and if I need anything about my health there's the care manager... and they would sort out anything for me".

The dialogue between care and housing also opens more avenues for residents to air views if they are unhappy with the service. Regular resident meetings allow issues to be raised via another means if they have not already been dealt with. In

this scheme, as in others, the ethos and attitude of staff was of central concern from an organisational perspective and the need to ensure that:

“people who work here... have it in them to put themselves in the position of people that are going to live here”.

That attitude should shape how the service is delivered. Having an upbeat approach to delivering the service was also important and this was reflected in the resident’s view who said:

“I always get a big smile which is great”.

For both staff and service users, integrated working needs to take place from the strategy and design level, through to referral, and day-to-day functioning of housing projects. This has the opportunity to benefit delivery from ethos through to functionality.

The building was constructed with space for activities for residents which take place in a number of capacities. Age UK deliver activities twice weekly, and there are other events such as ‘knit and natter’ and IT classes to engage residents in learning. There was also engagement with the local community providing an opportunity for residents to share their experiences with a younger generation.

There are other less formal opportunities to mix with other residents, including a bar, open from five – eight in the evening. However the dining room and shared

meals evidently played a large social function in the scheme, which provided a daily opportunity to sit and meet with friends to catch up.

Supplementary services were also put on by the catering company such as nutrition and hydration weeks to inform residents. One drawback in managing events for residents is the wide age range of residents in the service, from working age, to ‘younger older’ people, and ‘older older’ people. This made experiences and interests extremely diverse and is reflected in how interested some residents are in participating or not.

Underpinning extra care housing is the principle of independent living. Creating an inclusive later life service provides an opportunity to empower individuals to live independently in a community. Testament to how this can work well is the resident’s view that:

“I feel very secure about my health because if I have any problems they will sort it out”.

However this relies on appropriate referrals, inclusive support, and a consideration of community dynamics to avoid stigmatising anyone living with a mental health problem. This “Street with a roof over the top” also means that there is an opportunity to overcome some of the existing barriers faced by all older people in accessing mental health services. This could mean providing more access routes to talking therapies, where uptake is currently lower among older people,⁸⁸ and older people can directly benefit from more integrated services addressing both their physical and mental health, including treatment at home.⁸⁹

Conclusions



In this report, the Mental Health Foundation has identified five key approaches to supported accommodation for people with mental health problems.

Care Support Plus – High Level Integrated Support:

- Homelessness
- Complex Needs
- Low-Level Step Down
- Later Life

In order to identify the characteristics of effective service provision, we selected five services across England that a leading housing body, the National Housing Federation, identified as successfully delivering for people with mental health problems. The scale of this qualitative study means that its findings are not generalizable. However, it has generated rich material that draws on the expertise of those living and working in supported accommodation; sufficient for the Mental Health Foundation make the recommendations around investment in: quality; co-production; staff recruitment and training; policy informed practice; and resourced, appropriate accommodation.

We look forward to working with our partners to progress this agenda.

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Our vision is for a world with good mental health for all.

Our mission is to help people understand, protect and sustain their mental health.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place. We inform and influence the development of evidence-based mental health policy at the national and local government level. In tandem we help people to access information about the steps they can take to reduce their mental health risks and increase their resilience. We want to empower people to take action when problems are at an early stage. This work is informed by our long history of working directly with people living with or at risk of developing mental health problems.

The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.

London Office:
Mental Health Foundation
Colechurch House
1 London Bridge Walk
London SE1 2SX

Edinburgh Office:
Mental Health Foundation
18 Walker Street
Edinburgh
EH3 7LP

Glasgow Office:
Mental Health Foundation
Merchants House
30 George Square
Glasgow G2 1EG

Cardiff Office:
Mental Health Foundation
Castle Court
6 Cathedral Road
Cardiff, CF11 9LJ