MHPF

National Alliance of Voluntary Sector Mental Health Providers

Housing Models: Examples of Innovative Practice and Design

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Introduction

Through the decades an abundance of housing models for people with mental health issues have been developed, tried and tested. Many of these have been restricted in their full impact due to factors such as design, a lack of collaborative commissioning, or not fitting in with funding stream eligibility criteria. Other issues have been isolation from a defined housing pathway and problems where demand outweighs supply. Some models have evolved alongside the changing customer's need, diversifying provision to co-ordinate and support a range of complexities and chaotic lifestyles.

In particular the third sector (including housing associations) has a long history of providing housing models, housing services and housing pathways. Their proven track record in establishing integration, working in partnerships and collaboratively, enabling communities and providing capital and revenue investment is well documented.

Traditionally, the sector is recognised as being the closest to the communities they serve and therefore it has developed an expertise and extensive knowledge base in understanding community need, identifying gaps in provision and providing flexibility to work with multiple partners across all sectors. All of this has provided added benefits to people with mental health issues.

There are many familiar housing model definitions including: core and cluster; hub and spoke; dispersed supported housing; residential care; community based rehabilitation; community based step – down unit; group living schemes; hostels; extra care; outreach etc. However, beyond these definitions is a hidden plethora of modern, innovative and cutting edge provision that has responded to the changing complexities and aspirations of people.

The samples detailed in this report go some way in challenging the traditional view of housing's role, which is held by many but is no longer valid.

Today good quality housing remains one of the most important commodities that can contribute to having a fulfilled and healthy life.

Scope

The report provides a narrative on 15 examples of housing models that have been developed to offer housing options to people with mental health issues. There is a particular emphasis placed on the building and environmental design, the nature of the care and support, the levels of co-production and collaboration, innovation and outcomes. Additional consideration was given to their contribution to the reduction of spend or impact on the health and social care economy.

The data included in the report is largely drawn from information produced by each participating organisation and based on a predetermined baseline data set.

The narratives stem from the semi structured telephone and face to face interviews, which were conducted between August 18th and September 26th 2014 with each participating organisation's representatives and from information published/ presented as part of the process.

The report is divided in to four main sections:

1. The introduction, scope, methodology, participating organisations and acknowledgements

2. Housing model examples split into user groupings:

3. General Findings

4. Additional Commentary

Methodology

The fundamental purpose of this piece of work is to provide a narrative on existing housing models/ pathways that can demonstrate innovation, quality, cost effectiveness and positive user outcomes. The participant identification process used intelligence within the Mental Health Providers Forum and other key stakeholders. A formal introduction and invite was sent out to each potential organisation. This was followed by a selection process which was assessed using the criteria including uniqueness, diversity of the housing models and different mental health user groups.

All of the meaningful entries in the report have been developed using a systematic and structured approach developed through initial dialogue with tools designed to support the collation of both qualitative and quantitative data.

Phase one: a baseline data set form was produced and forwarded for completion to each participating organisation. This was returned prior to phase two.

Phase two: A semi-structured interview with each organisation was then carried out, based on a set of key starter questions.

The examples used in the report were developed from the data return and notes from the semi-structured interviews.

Participating organisations and acknowedgments

Andy Warren	Interim Director of Operations	Together
Raymond Sheehy	Chief Executive Officer	Bridge Mental Health
Helen Wadley	Chief Executive Officer	Birmingham Mind
Cheryl Yardley	Residential Care Manager	Birmingham Mind
Lydia Bailey	Head of Mental Health and Learning Disabilities	Midland Heart
Joe Redmond	Assistant Directior of Operations	Richmond Fellowship
William Lilley	New Ventures Manager	Bromford Housing
Mike Gallagher	Head of New Ventures	Bromford Housing
Lyndsey Lloyd	Assistant Director	Imagine
Alan Thompson	Service Manager	Mental Health Concern
Karen Russell-Haines	Operations Manager	Turning Point
Dindi Mphi	Team Leader	Turning Point
Paula Routledge	Service Manager	Turning Point
Lynne McNamara	Senior Practitioner	Turning Point
Carol Matthews	Chief Executive Officer	Riverside Group
Sheryl West	Team MOD	Riverside Group
Peter Cockersell	Director of Health and Recovery	St Mungo's Broadway
David Devoy	Regional Director	St Mungo's Broadway

Housing Model Examples

Forensic Mental Health

bridge Mental Health		Bridge Mental Health are a charity based in the South East providing a range of services for people with mental health problems with a particular specialism for forensic mental health. The aim of Bridge is simple. We want to help all our service users along a path that ultimately leads to them enjoying the same freedom, opportunities and everyday pleasures that most people take for granted. For more information visit www.bridgementalhealth.org			
Name of Model		**TILT Project**			
User Cohort	Forensic Mental Health	**Gender**	Male	**Age Range**	18-65 year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 40% White British, 20% Black and Minority Ethnic and 40% other groups.				
Number of Units	18 of which 4 are self-contained bedsits	**New Build or Redesign**		Redesign	
Cost of Redesign	£1.4 m	**Annual Running Costs (not including support or care)**		£170 k	
Type of Tenure	Assured short hold with care and support provision as a condition			**Average length of Stay**	14 months
Recovery Rates	95% of users of the service have not returned to prison			**Predominant Diagnosis** Schizophrenia Personality disorders Dual diagnosis Co and multiple morbidities Learning disability as a secondary diagnosis	

Brief Overview

This housing model provides a three tier step down residential facility for service users leaving medium and low secure mental health units.

The first tier of the model provides fully furnished accommodation and an intensive support function for service users in a core building of 14 bedrooms and communal spaces.

The second tier is provided within the same building as the first but comprises of 4 self-contained bedsits. This step down has been specifically designed to provide service users, who are in transition between tier one and moving out into independent accommodation, greater freedom and an opportunity to further enhance their living skills.

Tier three of the model supports the identification of move on accommodation and works with service users to develop community and social skills and supports the transition between leaving tier two and resettlement activities in their own accommodation. Tier three is provided by Support

Time and Recovery Workers who are employed by Oxleas Foundation Trust but are hosted and managed within Bridge Mental Health.

In addition to the three core tiers additional services have been developed to support the user post discharge. These include a housing management support scheme delivered in conjunction with a private organisation.

The original need and concept of the model dates back to 2003 and was developed with Oxleas Foundation NHS Trust as a response to the need to move people out of long term forensic mental health services. The trust still own the building but the service and housing pathway are run by Bridge Mental Health.

The building is on NHS property and is situated amongst other NHS residential facilities within a residential area.

The core service is not registered with the Care Quality Commission. This was a conscious decision to ensure support focuses on intensive rehabilitation. The partnership with Oxleas provides clinical or specialist provision that wraps around the support provided by Bridge staff. Another positive aspect to this model is this allows the service user to ensure that they are receiving their full and correct benefit entitlement.

The model in action

The model's referral process starts while the user is still residing in an inpatient facility, normally medium or low secure units; this is where the collaborative partnership ethos begins. The staff team operating the model are embedded in the clinical service pathway and attend twice weekly meetings during which the existing user group at TILT are discussed as well as new referrals identified. This approach allows for advance planning and joint management of the move on and move in approach. The staff team engage at the earliest stage with the identified service users and work on engagement, relationship and readiness activities to ensure a smooth transition from secure unit to the project. The user group includes men who are under "restrictions" and "non-restrictions".

Once a service user is living within the tier one service the model provides a holistic assessment and needs-led intervention function, including establishing community health service and interaction with social care where deemed appropriate. The staff team work in equal partnership with the user group to support them in a range of social and daily living skills. This compliments the collaborative work with the user group carried out by community forensic mental health services, social services, GPs, dentist, housing and employment specialists. The holistic ethos stretches across all aspects of delivery which offers opportunities from which service users can benefit.

Risk assessment and risk management are fundamental and critical tools to support service users functioning and facilitate the move on process; again this process within the model starts collaboratively at the earliest stages of referral and this is carried on throughout the user's stay and beyond.

One of the crucial factors in managing this very specialist user group is the use of the RiO system. The RiO system provides joint access and recording which supports effective multi-agency collaborative management.

The second tier is accessed once a service user is assessed as requiring further step down into the selfcontained, more independent part of the housing pathway. During their time there service users will further advance their skills and abilities to self-manage with a continuation of the multi-agency collaborative approach. It is during this stage that the Support, Time and Recovery Workers engage with the user on move on, property identification, resettlement activities and community engagement. This service follows as a natural extension into the tier three phase of the pathway.

The Bridge staff team provide social recovery working in tandem with other visiting professionals who provide a range of clinical and non-clinical interventions.

The project is staffed 24 hours a day, 365 days a year. The staff team are supported on a daily basis through line management and formal handover and meeting processes. The organisation also

operates to a supervision and appraisal model with mandatory and specialist training.

For compliance the organisation provides internal service review functions that include service user involvement and managerial input. Service users also have access to a range of opportunities to influence the model's continuous improvement processes including formal meetings and user surveys.

Once move on is agreed Bridge Mental Health has developed a range of options that can support service users to live independently in the community. These include access to housing through a partnership with a private property developer. Bridge has also established working relationships with a range of registered social landlords, private landlords and specialist housing providers to provide suitable, high quality and a choice of move on accommodation.

Tiers one and two are commissioned through the following routes: several block contract arrangements are in place which guarantee a quota of beds for forensic mental health services in the locality through clinical commissioning and Oxleas Foundation NHS Trust. However these arrangements do not cover all of the availability in the model and the remainder are on a spot purchase basis.

Tier three (Support Time and Recovery Workers element) are employed by Oxleas Foundation NHS Trust. Bridge Mental Health host and joint manage these posts.

The model operates on equal partnership with a high level of collaboration, all of which is focussed on ensuring service users can maximise the opportunities available to them. The delivery element is innovative and has emerged through continuous learning and improvements; it is generating a significant level of positive outcomes across a range of social, health, economic and resettlement activities.

The tiered model (step down) is extremely effective and there is a guarantee of consistency through each transitional phase for the service user. Together with the environmental factors, innovative positioning as a Care Quality Commission non-registered service allows service users to experience as close to independent living as is possible e.g. receiving the correct benefits, accessing community services, greater choice etc. while remaining safe and expediting recovery/ move on.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

	Together for mental wellbeing is a national charity that works with people with mental health issues on their journey to independent and fulfilling lives; the organisation provides a range of models including home based community support, criminal justice mental health, housing, community resource centres, advocacy, research. For more information visit www.together-uk.org				
Name of Model		**York Road**			
User Cohort	Forensic Mental Health	**Gender**	Male	**Age Range**	18-65+ year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 40% White British, 20% Black and Minority Ethnic and 40% other groups.				
Number of Units	14	**New Build or Redesign**		The service has two properties one was a new build the other a remodelled existing property	
Cost of Redesign	Data unavailable	**Annual Running Costs (not including support or care)**		£120 k	
Type of Tenure	License Agreement with care and support a legal component			**Average length of Stay**	Ranges from 24-36 months
Recovery Rates	Over a 36 month period 79% of all users move into more independent settings			**Predominant Diagnosis** Paranoid schizophrenia Schizoaffective disorder Personality Disorders Dual diagnosis	

Brief Overview

This housing model provides a two tier step down residential facility for service users leaving medium and low secure mental health units.

The first tier of the model provides the initial accommodation, intensive care and support functions in a core house, offering nine bed rooms and several communal spaces including a lounge, dining room, kitchen, and laundry room, on site main office, bathrooms, showers and toilets.

The building is a remodelled and renovated Edwardian property.

The second tier provides a further step down for service users ready to leave the core house but require further transitional support and care of a lesser nature in a more independent environment prior to moving on in the housing pathway to their own place.

This tier is provided in a newer purpose built detached property set in the large back garden and offers five bedrooms, a kitchen, bathroom, showers & toilets, there is a manager's office and a staff sleep-in room.

Both tiers are registered with and regulated by the Care Quality Commission and in addition to this the organisation operates to an internal auditing function to ensure compliance.

The properties are owned and run by Together.

The model in action

A typical referral profile includes people who have committed a serious index offence and have been restricted under the Mental Health Act (sections 37/41) due to their serious mental health

problems at the time. The majority have experienced step down within the NHS e.g. initial inpatient at the likes of Broadmoor Hospital before then been transferred to local medium secure units and then onto low secure hospitals prior to a referral made to York Road.

The housing model starts with involvement at the earliest stage of the referral process and it works collaboratively with statutory services on a range of pre-placement engagement activities including risk management, direct work with the service user while still in hospital, co-ordinating visits to the accommodation, supported overnight stays etc. In this model it is common for the pre-placement and referral process to take between 3 to 6 months but what can be seen as a protracted process is actually a positive as it allows for a detail assessment/planning phase and relationship building with the service user. The placement is normally their first non-hospitalised accommodation in the community for many years.

Once at the service their legal status is still as a "restricted patient" with conditionally discharged and still subject to close supervision (typically weekly visits) by specialist forensic community psychiatrist or members of their team with most service users requiring reports on their progress to the Ministry of Justice.

The model provides a holistic care and support package that is recovery-focussed with an emphasis on rehabilitation through person centred planning. An individually tailored pathway is developed that encompasses all of the complexities associated with the specialist user group including the significant multiple agencies working across a range of disciplines. One of the key elements of the care and support package focusses on improving daily living skills, personal care and socialisation needs. Initial functions include establishing community based health and social care services e.g. GPs, dentist. Health screenings are untaken and appropriate integrated care emerges.

Routine is a vital component of the model and through a structured programme of activities that supports and promotes service users taking responsibility for their own lives the model offers a unique two meeting approach, one sets the more practical requirements for the day, the second explores the recovery based initiatives. The Recovery Star is used as one of the service's measuring tools.

Because of the nature of the user group then the model applies numerous restrictions including the use of alcohol, movements, visitors, use of equipment etc. All staff members are trained to carry out breath tests for alcohol and urine tests for drugs, which will be completed at the request of the service user's consultant.

The model requires a minimum staffing level of two at any given time, this is often exceeded and during the week this can rise to four which allows for a more intensive level of intervention. It is staffed 24 hours each day throughout the year. The staff team are non-clinical with all additional interventions to the user group provided by visiting professionals or through community based access.

The staff team are supported through a range of processes starting at the recruitment phase, induction and probationary period. There is access to supervision and an appraisal system, specialist and mandatory training and on-going learning opportunities.

The success of each placement is heavily reliant upon a comprehensive, co-ordinated and multiple agency partnership across mental and physical health services, social care, Ministry of Justice, housing, employment etc. Critical to this are communications, timely interventions, planning and decision making. Greater emphasis on proactive and detailed continuous risk assessment and management is at the heart of the model.

Most service user's needs decrease as they make progress through the pathway, and will move from the service in a positive planned way, including following the internal step-down route. Their onward journey is in practice very much controlled by the community forensic team who will nominate to local specialist supported housing schemes or independent living models. However as part of the move on strategy the model can provide a time limited outreach function to support the transitional phase. Service users have moved on successfully to independent self-contained accommodation, including those provided by the local authority and registered social landlords.

The model functions on a spot purchase arrangement meaning and in theory service users can be accepted from anywhere in the country. There are no formal agreements with statutory agencies regarding nominating and referral rights, however the majority access from the five boroughs of south west London (Sutton, Merton, Kingston, Richmond and Wandsworth). The service are experiencing an ever increasing number of placements from out of area.

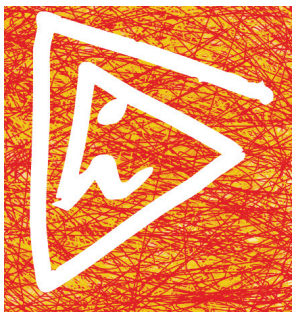
Spot purchases are normally commissioned by numerous Clinical Commissioning Groups with some via Local Authorities. Financial components of the spot purchase include forensic supervision requirements, care and support levels, contribution to the cost of the property during their stay etc.

This type of financial model has inevitable financial vulnerabilities including ensuring voids are well managed but it can also allow for greater freedom for innovation including diversification and additional provision created on enhancing the model and housing pathway.

This model has effectively managed to combine environmental factors, appropriate care and support levels, multi-agency collaboration while providing a home and a future to its users. The location of the properties plays a vital role in its success and the building design and layout allows for implementation of restrictive practices, holistic care and non-instructive observations. One of the particular features is the two tier step down which operates as a natural extension in a familiar environment which aids recovery and rehabilitation. The added value of this model is it has the capacity in its design to extend a transitional service to users moving on to independence and in real terms ensures consistency throughout the entire pathway e.g. from referral identification to independence. This approach generates significant positive outcomes for users, commissioners and the community.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	limited
Reduced costs in the health and social care economy	✓		

	Imagine is a charity with a positive approach to mental health and works to promote opportunities for people to live a full and independent life. They have spent the last four decades working with the mental health sector to improve the lives of its service users. The organisation provides a range of services including: specialist accommodation; outreach and floating support; peer support; drop ins and employment services; advocacy and mainstream services etc. The organisation has expanded in recent times and today more than 1000 people use its services in Liverpool, Knowsley, Sefton, Cumbria, London and Greater Manchester. For more information visit www.imaginementalhealth.org.uk				
Name of Model		**Fielder House**			
User Cohort	Forensic Mental Health	**Gender**	Female	**Age Range**	18-65 year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 75% White British, 12.5% Afro- Caribbean and 12.5% other groups.				
Number of Units	8	**New Build or Redesign**		New build	
Cost of New build	£1.2 m	**Annual Running Costs (not including support or care)**		Data unavailable	
Type of Tenure	License Agreement with Great Places (Registered Social Landlord)			**Average length of Stay**	24-36 months
Recovery Rates	Measured through successful move on and since opening 3 women have moved out to independent living. This represents 37%	**Predominant Diagnosis** Emotionally unstable personality disorder Narcissistic Personality disorder Schizophrenia Schizoaffective disorder (with additional Personality disorder diagnosis) Paranoid Personality disorder			

Brief Overview

The model is a specifically designed to support women returning to the community after inpatient stays in medium and low secure units.

It is delivered from a purpose built property that comprises of 8 self-contained fully furnished flats with additional communal areas including a living room, dining room and kitchen, a respite room, garden courtyard, lobby area and staff office facilities.

The property has been designed to a high specification that considered the needs of this particular user group including health and safety requirements minimising risks in relation to ligatures, self-harm and isolation

The initial concept was developed as part of a pilot scheme by the Department of Health in response to gaps identified for women with complex needs during the development of the national women's mental health strategy.

This model was designed through high level of co-production between Great Places Housing, Department of Health and Salford City Council. The outcomes from consultation within the secure units with patients and clinicians also supported the final

construction.

Initial capital investment came from the Department of Health.

The model is located in an urban area and is gated with additional security measures provided e.g. CCTV.

Initial consultation with the neighbourhood was undertaken in preparation for a smooth implementation and opening of the property.

The property is owned by Great Places Housing who provides the landlord tasks and tenancies to the users and Imagine provides all of the interventions and care/support services within the model.

The funding was initially provided in a block funding arrangement with NHS England but recent changes has seen the service working with four separate clinical commissioning groups and major changes to their financial model.

The service is registered and regulated by the Care Quality Commission. Commissioners also review the service for contract compliance.

The model in action

The model starts at the referral stage with identification by the forensic inpatient services of women requiring discharge or step down. It is at this stage that the service involvement starts with staff working on pre-placement engagement activities with the user that includes: establishing a therapeutic relationship, motivational activities etc. Prior to acceptance into the model a comprehensive multi-disciplinary assessment is undertaken; this draws on available historical information as well as current presentation and will inform the development of a shared individual formulation that attempts to understand and articulate the origins of a person's emotional, behavioural, interpersonal or mental health difficulties. The aim is to try to understand how bio/psycho/social influences may be manifested in the person's present situation in order to identify ways of intervening therapeutically.

Within each commissioning area there is a placement panel where each case is presented by Care Co-ordinators for funding agreement.

The model is gender-specific, dedicated to providing high intense support interventions to women with complex backgrounds returning to the community after a significant period of time as inpatients in secure services. The users have histories of mental illness such as schizophrenia, schizoaffective disorder and bipolar disorder or severe mood disorders, with an emphasis on providing therapeutic interventions to women with personality disorder(s).

A significant proportion of the women have had additional secondary traumatic experiences including, but not exclusive to, criminal justice, substance misuse and non-compliance with treatment, are restricted patients or on a community treatment orders.

The effective referral system and screening tools ensure that assessment, care and treatment for individual mental and physical health needs of service users are delivered via a multi-disciplinary team approach.

From the onset of the placement there is an intense level of support and care which includes resettlement activities and the development of holistic care and support plans with the underpinning philosophy of hope and recovery and individualised goal setting. The holistic model incorporates bio/psycho/social with the integration of clinical and therapeutic interventions aimed at having positive effects on overall health and wellbeing.

Some of the interventions in the model include developing social and daily living skills, supporting behavioural change, medication regimes, community integration, personal care, physical health assessments, attachment therapy, user empowerment, advocacy and self-advocacy, relationships and social skills, child protection and child welfare, establishing structure and routines, social inclusion, leisure and educational opportunities and alternative therapies.

From the referral stage and throughout the pathway there is a significant level of multi-disciplinary collaboration and working. This is driven by individual user needs. Common disciplines comprise of core health

professionals from nursing, medical, occupational therapy, psychology, social work and arts therapies backgrounds as well as by allied professionals from other areas e.g. psychotherapy, family therapy, substance misuse, employment, primary care, education, dietetics etc.

Other core and essential components of the model include relational security, risk identification, risk assessment and risk management, the latter is performed using structured clinical judgement tools as well as individual observation and clinical judgement.

The physical environment is both therapeutic and functional and plays a role in motivating users to shift away from institutionalised living promoting autonomy and independence.

Although the model provides self-contained flats there are communal areas which provide a safe and relaxing environment for socialisation, group meals, activities and role-modelling behaviour work.

There are regular service user reviews: internally these are in partnership with user and through service discussions at internal clinical meetings. There are all linked into external review under care programme approach. Supporting this process is the use of a range of tools that includes: the Recovery Star, My GRiST, stay well plans and horizon planning, all developed and reviewed in partnership with the users.

In addition to influencing their individual care and support, users are encouraged to influence the overall model through community meetings facilitated by the service user involvement worker.

As the users' recovery journey progresses, the intensity of input changes shape to incorporate more aspirational and social inclusion work. This forms part of the move on process and sees engagement with local housing providers; the overall service philosophy of collaboration continues to facilitate exit strategies to more independent living.

As a direct result of their move on experience the organisation currently provides transitional outreach work post discharge from the service, focussed on resettlement and community integration and establishing self-management plans to minimise the potential for relapse or recall. Note: this provision is not funded by the formal contractual arrangements.

The model provides 24/7 staffing with the ratios assessed on the basis of presenting risk, relational security and the overall duty of care but in general there is 2:1 users to staff. The night cover is through wake in provision. The current configuration is a senior manager and a team leader post; there is additional clinical provision through a contracted community psychiatric nurse from Greater Manchester West, senior support staff, support staff, and peer support workers and admin.

There are regular staff team meetings internally as well as ongoing supervisions both individually and in peer groups using reflective practice, annual appraisals and handovers. All staff members have a comprehensive induction and training. Team Leaders and the Service Manager have regular clinical supervision/reflective practice with a Consultant Clinical Psychologist.

The training programme includes mandatory expectations but also role and user specific courses e.g. de-escalation techniques, the impact of sexual abuse, self-harm, positive risk management (GRiST), managing challenging behaviours, mental health awareness, managing boundaries, medication training and as a minimum all staff will complete NCV Level 3.

This model provides a seamless rehabilitation pathway and the provision of treatment, care and support with the least restrictive environment possible. It has successfully combined a social recovery model with both internal and external clinical pathways through the co-ordination of a high level of collaborative multi-agency provision. It can demonstrate that new and innovative ways of providing both relational and operational security can create safe therapeutic environments for women who present with high risk behaviours.

This multifaceted holistic service is providing a real step down provision to one of the most vulnerable user groups providing hope and aspirations and encouraging them to develop their own potential and abilities to self-manage their own mental health and wellbeing and to continue their individual journey to recovery.

This model supports the decreased use of services such as A&E, crisis teams, police and other community support services. Major physical health problems are supported at the service through guidance and interventions from GPs, reducing the need for regular GP appointments or severe deterioration resulting in hospital admissions; it also contributes to the reduction in offending behaviours and addiction.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	
Reduced costs in the health and social care economy	✓		

Complex and Multiple Needs

midland heart housing, care and opportunity		Midland Heart is one of the top ten housing and care organisations based in the UK. Their work involves; supporting those who need help to live independently, assisting in regenerating communities and helping an individual to discover their own abilities just as much as it involves providing and maintaining homes for more than 70,000 people with maximum customer involvement. They own and manage more than 32,000 homes across 54 local authority areas and invest in excess of £100 million each year in neighbourhoods. For more information visit www.midlandheart.org.uk			
Name of Model		**Lancaster Street**			
User Cohort	Complex and Multiple Needs	**Gender**	Male	**Age Range**	18+ but average is 30-50 year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	15	**New Build or Redesign**		Redesign	
Cost of Redesign	Not known	**Annual Running Costs (not including support or care)**		Data unavailable	
Type of Tenure	Licence to reside			**Average length of Stay**	18-24 months
Recovery Rates	Recovery is determined by the rate of move on, the model average stay is 18-24 months with 2 to 3 people experiencing positive move on each 12 month period.			**Predominant Diagnosis** Schizophrenia Mental health issues Personality disorders Dual diagnosis Co and multiple morbidities Learning disability Note: often, people are referred due to their chaotic lives and exclusion from numerous services; this can be without a formal diagnosis but during the first part of their stay it is common for a mental health diagnosis to be made.	

Brief Overview

The housing model is based in a converted grade 2 building close to Birmingham city centre and has been designed to accommodate men who have multiple complexities, often excluded from a range of services, homeless and living chaotic lives.

The property comprises of 15 self-contained flats each fully furnished. There is also the provision of a shared kitchen, sitting/dining room and there is an onsite office.

The property has been remodelled and refurbished keeping its original exterior and internally a modern block of flats has been designed.

Its location makes it ideal for this customer group as it is close to the city centre and all amenities while maintaining a discreet position.

The original need and concept for this type of model stems from Midland Heart recognising that within their own housing/homeless services there was a pattern developing of males who were frequently presenting themselves with difficulties securing and maintaining a suitable and stable accommodation base.

The model is not registered with Care Quality Commission and operates as a supported housing model with its main funding source being the Local Authorities Supporting People programme.

The property is owned and managed by Midland Heart.

The model in action

Referrals are made to the service via a multi-agency panel co-ordinated by Midland Heart in partnership with the Supporting People Programme and other housing and support providers in the Birmingham area. Referrals come from a wide range of sources with the majority from the Assertive Outreach Teams, but others from criminal justice, mental health services and from the homelessness Single Point of Access (SPA). More often than not the names of people are known to the organisation or through their collaborative partners including police, mental health services, prisons, forensic services and homelessness.

At the start of access all individuals participate in a comprehensive holistic needs assessment that ascertains a range of health, social, activity and economic issues/needs. This particular customer group have led extremely chaotic lives and this model works intensively in the first few months to unravel and address a significant range of issues e.g. engagement, relationships, re-settlement, community integration, health issues, behavioural aspects and finances. Running in concurrence with this is the co-ordination of health screening and acquiring GP and other primary care services and arranging more specialist assessments as required.

The service develops a support plan that is in place for the duration of their stay, changing through reviews as needs/circumstances change.
One of the critical components for a successful placement is how risk is managed in partnership with the individual through on-going assessment and planning process, the scope of this is dependent upon the individuals own history and current situation but normally involves other agencies particularly where offending behaviour is prevalent.

One of the unique elements of the model is how the layout and design of the building supports the function of a managed environment. This approach plays a crucial role in creating a safe and secure place, governing appropriate access as well as allowing the individual their own private space where they can work on their own behavioural changes without impacting on others.

The communal space is used effectively, encouraging individuals to socialise and to become less isolated, it also provides the staff with the opportunity to develop a broader skill range with the customer group e.g. empathy, choice, negotiation and compromise.

Most individuals come with issues of substance misuse and have had experience of living on the streets, some have criminal convictions and all have led chaotic lives, however their situation has often been exacerbated by the lack of input from statutory/support services as their presenting issues have not met eligibility or they themselves have disengaged.

One of the functions within the model is to support people to take more control over their lives and working in partnership with them to enhance their daily living skills, social skills, address their behaviours and providing the start of a journey to having a more fulfilled life.

It is often the case that during this stable phase, individuals access primary and secondary care services and as result of this underlying, undiagnosed conditions/illnesses are ascertained and treatment/interventions follow. This ranges from mental health, learning disabilities and personality disorders.

The model provides quality accommodation often for the first time and input starts at an intense level; this then fluctuates remaining flexible and fluid for a period of time. Support normally tailors off as the placement progresses, as needs diminish and skill base and confidence grows and individuals prepare to move on from the service.

There is an emphasis placed on move on from the onset of the tenancy and as the individual progresses towards the end of their stay they are encouraged and supported to develop move on strategies including the identification of appropriate accommodation through a range of housing options and developing a resettlement plan. Built into the model is a transition service that works on an outreach basis (6 weeks) post move on to ensure a successful move.

Individuals have input into the continuous improvements processes through regular meetings, optional exit interviews and annual surveys.

The model is staffed 24 hours with two support staff on site at all times. All staff members receive on-going supervision and annual appraisals. There are also regular internal staff meetings and handover processes.

The model's success lies within the unique combination of environment, location and building design linked to the fluid and flexible support, establishment and co-ordination of a multi-agency plan/involvement and the method adopted regarding risk management. All provide crucial tools used to support the behavioural change aspects in this social recovery model. Therefore generating the provision of stability and security to one of the most disadvantaged customer groups, encouraging and motivating them to develop and adopt a more productive, healthy and meaningful life. Primarily, the model aims to break the cycle of exclusion and engendered access to opportunities that up until now have been denied to this customer group.

Successful recovery is measured through the move on to settled accommodation. Some customers never achieve this aim, but for those who do, although there is no formal longer-term monitoring in place, informal links suggest that a high number have managed to maintain their move on accommodation. With the model based on medium term stays of between 18 months and 2 years several people move out each year. However, there has never been an issue with void management as demand outweighs supply.

The productivity and effectiveness of this model and where is sits within the wider housing pathway has all been achieved through a contract with Supporting People. However, it is worth noting that impact of this type of provision goes further than just social, demonstrating positive outcomes on health and wellbeing, reduction in criminal justice interventions, reduction in homelessness numbers, creating greater access to services and ultimately provide its customers with opportunities and hope. The success of this model is being replicated in other localities.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

Bromford.		Bromford provide a range of services including developing and managing general needs housing and providing specialist support services that are designed to help unlock their potential. They also sell homes through a range of options (private sale, part buy/part rent or part exchange) and build well-designed, high-quality homes. For more information visit www.bromford.co.uk			
Name of Model		**The Willows**			
User Cohort	Complex and Multiple Needs	**Gender**	Male and Female	**Age Range**	18-65 + year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	7	**New Build or Redesign**		New build	
Cost of New build	£1.3 m	**Annual Running Costs (not including support or care)**		Data unavailable	
Type of Tenure	Assured Short Hold			**Average length of Stay**	Average of 2 years, but no set time limits
Recovery Rates	Average of 2 people moving on each 12 month period, averaging at 29%	**Predominant Diagnosis** Schizophrenia Dual Diagnosis Co and multiple morbidities Forensic mental health Personality disorders			

Brief Overview

The housing model is based in one property built by Bromford Housing Group following the purchase of land. It was designed and built to a high specification focussed on meeting the needs of people returning to the locality from out of area placements who have multiple needs.

It comprises of seven self-contained one bedroom flats with a staff office and sleep in facilities. Its location is accessible to the centre of the town as well as local amenities. Access to the service is relatively discreet and blends into the characteristics of the neighbourhood.

The model was developed initially in co-production with Shropshire PCT, Local Health Trust and Local Authority as a response to the repatriation of high cost out of area placement. Most of the user group have multiple needs including forensic mental health, personality disorders, dual diagnosis and multiple morbidities.

The initial building and model received opposition from the local community but through a joint well managed community engagement strategy the level of "not in my back yard" and fear diminished and now the model is well supported by neighbours.

The model is funded through two main resources, the users housing benefit entitlement pays for the rent and housing management provision and their placement costs are met through joint commission placement payment on a spot purchase arrangement.

The property is owned and ran by Bromford Housing Group.

The model is not registered with the Care Quality Commission but governed through a range of internal policies and procedures and subject to

the organisation auditing and compliance regime that involves management, peers and user groups.

The model in action

The referrals to the model are made through Shropshire's Single Referral Scheme. This is a collaborative partnership approach hosted by the Local Authority and is a multi-agency panel covering referrals to all of housing and housing related support services for adults in the county. Once a referral is identified then the staff team within the model initiate contact and start the process of joint needs assessment and risk management. They also engage with the user themselves, and their families and carers visit them in their current placement. Most referrals have existing multi-disciplinary input and information sharing forms a key part of formulating a moving in plan. The referral also has the opportunity to utilise a dedicated space within the property for overnight stays etc. to see how they feel about the service and moving back to their original locality.

The support provided in the model starts with pre-placement work often for up to six months as detailed planning across a range of agencies and with the user themselves needs to take place. Returning from an out of area placement can often be an anxious time for people and a timely approach has proven to be effective.

There is a tiered approach to the support offered once a referral moves in, there is a settling in period during which staff work intensively to establish a detailed needs assessment covering social skills, health needs, daily living skills, social inclusion, relationships with families and friends and integrating people into the wider community. There are also additional factors of relocation in this user group and work is undertaken jointly with other statutory services to ensure there is a smooth transition and that users get the additional input they require e.g. community mental health services, local forensic mental health services, primary involvement e.g. GPs, health screenings, dentists etc.

This period of intensity tails off as users become more confident in their enhanced skills and social abilities. The staff team undertake additional work to engage the user in training, educational opportunities and other work related activities.

This approach has seen users take up voluntary work placements, gain new and additional skills set, attend colleges and training courses. Not only is the model linked in collaboratively with multiple agencies, it has developed partnership across local third sector providers to offer a holistic meaningful package of support/opportunities outside of the core functions built into the property.

The model's emphasis is on recovery through timely planning and interventions, the complexities of each user are met through an extremely effective multi-agency collaborative all captured in individualised Wellness Recovery Action Plans.

With this user group the risk assessment and management forms a substantial element of each placement. Risks can often increase when the user moves in as additional recognition is given to the environmental changes, increased anxiety rates and behaviours associated with a significant level of change. Risk as with support and care is undertaken jointly (dependent upon the user) with a range of agencies but often includes forensic psychiatry, social services and community mental health.

The model does not operate to a set move on timescale but, since its inception, informal move on rates have emerged and now on average two users move on within a housing pathway each 12 to 14 months. The model recognises that each user is individual and works in partnership with them to identify readiness levels in preparing to exit the service. Once the user has established a level of housing management ability, has gained the necessary daily living skills, is linked into the community, is having their additional health and care needs met, and has maintained connections with statutory services, then exploration of housing options are assumed. Most users move on to independent living arrangements normally within the existing locality. The service has developed positive links with a range of accommodation providers including private sector landlords.

The move on process like the referral one is completed at a managed pace ensuring everything is in place and that the user's future on-going needs are all assigned. The model continues to offer resettlement work post move for up to 6 weeks and during this time more practical housing management arrangements are

undertaken including overseeing the setting up of utilities, maximising benefit entitlement and re-orientation to their new surroundings.

The model is staffed 24 hours a day, 365 days a year by non-clinical employees. All clinical and specialist input is through visiting professional or community access.

The staff team are provided with a comprehensive induction period, training package and on-going personal development plans, there are also staff meetings, daily handovers and formal supervisions.

This model has successfully returned a number of complex users back from out of area placements in an effective multi-partnership arrangement. The commitment level of the staff team and other professionals has seen the service flourish and the outcomes have included financial value for money, providing a real alternative to residential care and out of area placements. So far, none of the users have required hospital admissions (mental health) none have been recalled and demand is outweighing supply.

The property allows the user the opportunity to have their own front doors to modern apartment type flat and to take control over their environment. The support is proactive while remaining flexible and responsive. The combination of building design, high level of collaboration pre, through and post placement have all been fundamental in creating a secure and stable home from which users can begin to develop more fulfilled lives.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

		Birmingham Mind is a charitable organisation affiliated to National Mind and is one of the leading providers of mental health services in Birmingham and the West Midlands. Their high quality, recovery based services support mental wellbeing and promote good health and also challenge discrimination and stigma that surrounds mental illness. For more information visit www.birminghammind.org			
Name of Model		**Charles Davis House Three Stage Step Down**			
User Cohort	Complex and Multiple Needs	**Gender**	Male and Female	**Age Range**	18 - 65+ year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 47% White British, 18% Black and Minority Ethnic and 6% Eastern European, 39% other groups.				
Number of Units	13	**New Build or Redesign**		New build	
Cost of New build	Data unavailable	**Annual Running Costs (not including support or care)**		£45k	
Type of Tenure	Licence agreement			**Average length of Stay**	18 - 36 months
Recovery Rates	The model expected stay is up to 3 years with 17.5% moving out each year. This is slow stream rehabilitation in 3 stage step down.			**Predominant Diagnosis** Schizophrenia Dual Diagnosis Co and multiple morbidities Forensic mental health	

Brief Overview

The housing model provides a three stage step down facility within one location for people with multiple and complex needs including those leaving a hospital environment following long term stays (sectioned) and for those from forensic mental health services.

The design of the building cleverly delivers three distinct linked smaller units built around an enclosed open space. The three stage step down functions within the properties encompass a core house to which most new service users are housed. This is step one and comprises of shared facilities and five bedrooms with 24 hour staffing, stage two is provided in an adjoining part of the building and contains four self-contained studios with stage three provided in a linked property of four move on flats.

The buildings are all purpose built originally in conjunction with the NHS trust, in response to the need to move people on in a planned way from long term inpatient care. The original capital costs of the model were part funded by the NHS and a local Registered Social Landlord.

Currently Birmingham Mind manages the housing pathway in partnership with a superior landlord who is a housing association.

There is a small block contract arrangement with the Joint Commissioning Unit. It is not a nomination contract but aims to support the users referred from the Birmingham locality.

All placement costs are met through spot purchase normally through the Local Authority.

The entire housing model is registered and regulated by the Care Quality Commission. The organisation also has an internal quality assurance process which occurs using a variety of

methods, managerial and peer assessments, service user meetings (monthly) and through a range of policy and procedural applications including complaints, suggestions and compliments.

The model in action

There are multiple routes of referral to the model that cut across both health and social services. Predominantly service users have been an inpatient in longer term wards and/or from a forensic medium or low secure unit. This is normally their first community based living for a significant period of time. Dependent upon the nature of referral then the model responds accordingly, for those users from forensic services engagement and joint work/planning for discharge occurs a lot earlier than those from acute services. Common themes spanning both are needs assessment, risk assessment and management, baseline data, health information and background, the majority of this information is controlled through a multiagency collaboration including psychiatrist, social worker, staff from the service, inpatient provider, service user and carers.

The majority of users enter the model at stage one, this is entirely focussed on recovery and rehabilitation that includes further clinical stabilisation undertaken jointly between the model and community mental/forensic health services. As part of resettlement the model ensures a full physical health screening is undertaken and GP and other health provision is in place. This is then incorporated into an integrated physical health, mental health and generally wellbeing plan. As there are a small number of users in this phase, more intensive work in undertaken with the service users supporting their social and daily living skills, medication regimes, adherence to any restrictions and integration into the community. During this stage there are numerous agencies involved in a partnership with the user to ensure their individual aspirations and outcomes are met and supports /promote an effective recovery journey. Stays at stage one are around 12-18 months.

In stage two users move into a more independent part of the building e.g. more personal space and privacy where they are supported to take more control over every day decisions, establish a more reality based daily structure, incorporate more activities away from the building and enhance daily living skills. Often at this stage joint reviews start to look at move on and a broader range of organisations link in to the multi-layered care and support plan e.g. educational and training establishments.

Although stage three is seen as step down it is in real terms stepping up towards total independent living. As the user accesses this phase then they have their own front door type accommodation, responsibility for their own space, cooking, cleaning, personal care etc. However, the caveat is this is still provided within the same location and the same staff team, therefore it is a safe way of managing move on through consistent and proactive interventions. Within this final stage discussions/decisions are reached regarding acquiring suitable move on accommodation. This is often linked to the model's relationships with numerous housing suppliers, including the more traditional Local Authority and housing associations but also through more prominent partnerships with private sector agencies.

As users move out of the model altogether there is an additional short term transitions service that supports the resettlement, ensuring all services are in place and devises an on-going self-management plan to support the sustaining of independence.

The service is staffed by a non-clinically focussed team with all users accessing a range of additional services through either visiting professionals or community based access.

All three tiers are staffed 24 hours a day, 365 days a year. The staff team are provided with a range of support functions including supervision (monthly), annual appraisals, weekly staff meetings, formal handovers and daily management input. Initial induction is underpinned by mandatory training and a probationary period. Then the organisation provides each staff member with on-going training and development opportunities.

Most users are from within the Birmingham region and there is a steady referral demand from within. However the financial arrangements (spot purchase) does mean the pathway is open to people from across England and because of the lack of nominating rights with the small block

arrangement the service technically could take out of area placements as void management in spot provision can often be the driver.

This model has emerged from its original intention to providing an individual innovative pathway for some of the most disengaged, dependent and complex service users within the mental health community. It has, through its slower stream rehab design, provided the opportunity for users to experience different housing arrangements while in one "placement", as opposed to the normal requirement that when a user's needs diminish they often have to move locations to access the next phase in their journey. One of the crucial factors in this type of delivery is that the potential for failed placements are mitigated as positive risk taking is governed through total collaborative approaches and within the same site.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

Early Intervention in Psychosis

<table>
<tr><td colspan="2">  </td><td colspan="5">Mental Health Concern is part of Concern: The mental health and wellbeing group. The organisation is based in the North East of England and provides a wide range of specialist mental health services. Nationally as Insight Healthcare they provide a range of primary care mental health services and employee wellbeing programmes. The services are predominantly commissioned by the NHS and Local Authorities. For more information visit www.mentalhealthconcern.org</td></tr>
<tr><td colspan="2">Name of Model</td><td colspan="5">Early Intervention in Psychosis</td></tr>
<tr><td>User Cohort</td><td>Early Intervention Psychosis</td><td>Gender</td><td>Male (75%) and Female (25%)</td><td>Age Range</td><td colspan="2">18-35 year olds</td></tr>
<tr><td>Ethnicity</td><td colspan="6">Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 97% White British, 3% other groups</td></tr>
<tr><td>Number of Units</td><td>4</td><td colspan="2">New Build or Redesign</td><td colspan="3">Existing social housing stock</td></tr>
<tr><td>Cost of New build</td><td>Not applicable</td><td colspan="2">Annual Running Costs (not including support or care)</td><td colspan="3">Utility bills are paid by each user and vary according to usage</td></tr>
<tr><td>Type of Tenure</td><td colspan="3">Licence agreements</td><td>Average length of Stay</td><td colspan="2">14 months</td></tr>
<tr><td>Recovery Rates</td><td colspan="3">An average of 2 people move on successfully from EIP Supported Housing in each 12 month period</td><td colspan="3">Predominant Diagnosis

Psychosis
Dual Diagnosis</td></tr>
</table>

Brief Overview

The housing model is based on four dispersed flats all within one locality and accessible to a staff base just outside of the centre of Newcastle. Each flat is fully furnished and modern in design and layout.

The model has been designed to accommodate users who are experiencing their first episode of psychosis and who fall within 18-35 year old age range.

Its location is important to its success with the organisation managing to implement a "core" facility and culture into a "dispersed" design similar to a hub and spoke.

The original need and concept for this type of model stems from discussions held at the Voluntary Sector`s Mental Health and Housing Meetings which was an established group of providers who look at the accommodation needs of people with mental health issues and the gaps in community provision across Newcastle. The Early Intervention in Psychosis user group had limited housing options open to them and appeared to be excluding from existing provision because of eligibility criteria.

Following discussion with the then PCT commissioners and Northumberland, Tyne and Wear NHS Foundation Trust, a co-production approach was adopted and oversaw the initial design and service specification.

The model is not registered and is regulated

through the Local Authority commissioners of the services, and self-regulation that includes user and stakeholder input.

The properties are leased by Mental Health Concern from Your Homes Newcastle (Local Authority Arms-length Management Organisation) with Mental Health Concern managing the properties and services within the model.

Funding comes from three main sources: health, adult social care and housing benefit.

The model in action

All referrals to supported housing in Newcastle come through a Local Authority led Gateway System which co-ordinates referrals, access and vacancies across the city and although the early intervention model falls within this system's remit, nominating rights remain with the NHS statutory Early Intervention in Psychosis (EIP) Team.

Running in parallel with this is a bi-monthly clinical meeting to which the clinical lead from Mental Health Concern attends. One of the functions of this is to identify potential referrals and to work in partnership prior to accessing the Gateway System on preparatory work with the user themselves. This work includes engagement, joint work on clinical pathways and determining social recovery needs and risk management.

Demand for the model outweighs supply and on average they receive over thirty referrals annually. This is believed to be a very conservative figure in relation to service demand as Care Coordinators will generally only make referrals when a vacancy is imminent. The service offers limited places and although they attempt to maintain a "waiting list" this is often futile as referral need is often immediate.

One of the essential elements of the model is the provision of integrated clinical and social pathways with the organisation providing each user with a RMN keyworker who oversees the development of holistic care and support plans and risk management using GRiST.

The keyworker also works jointly with the statutory EIP team to ensure seamless provision is maintained and that positive outcomes are achieve for the user. The organisation has developed their own holistic planning tool 'Recovery Focussed Outcomes` which focusses on supporting service users aspirations in six key areas :

- To develop a sense of meaning and purpose in their life
- To improve personal relationships and social networks
- To build on hope and self esteem
- To develop independent choice and control
- To be in touch and active in the local community
- To enhance stability and consistency in the individual`s life.

It covers clinical needs, medication regimes, social and daily living skills, physical health screening and interventions, collaborative approaches with multiple agencies, community engagement and activities.

There is a strong emphasis placed on individuality and links have been made with a broad range of community and mainstream provision. As the user group tends to be younger than your average accommodation service for people with mental health issues the model offers additional age appropriate interventions including gym membership, sports and leisure functions alongside the skills development and clinical stabilisation programmes.

Although the holistic planning process was developed and co-ordinated by the RMN lead internal in the organisation, it would involve community support workers providing input into the social recovery element, daily living skills development and supporting community integration.

Other agencies involved include statutory EIP team, GPs, social services, housing and substance misuse services.

The intensity of the support and care tails off during the users stay and for the majority of cases this is limited eventually to monitoring and signposting activities. It is at this stage that work is undertaken with the user to plan and access move on accommodation.

Some people move on into the lesser supported environments, some back to families and others access mainstream housing options. In a small

number of cases however, this may lead to further inpatient care or community rehabilitation as this is often the users first episode of mental illness and engagement with services, and their symptoms may need more clinical interventions.

The model also incorporates an out of hours nurse led on call service for the user group offering support, advice and interventions when other traditional and statutory provision is unavailable.

Risk Management forms a significant part of each placement and this process starts at the referral stage. The relationship between the model and the statutory services is one of partnership and relies upon effective communications and joint working; this can be demonstrated throughout the intervention. The organisation uses GRiST as a risk management tool and is developed through from the statutory face risk profiles.

The model is staffed by a range of roles, including a RMN nurse manager and an RMN clinical lead plus community support workers. The organisation provides all staff with on-going supervision and appraisal processes; dependent upon profession this can include clinical supervision and CPD. There are regular staff meetings and handover systems and daily input from clinical leads to help, train and educate the support staff in a range of behavioural management techniques, management of psychosis and understanding the multiple interventions.

Mental Health Concern also provide a range of models that can offer support to the user in the recovery journey, they lead on a consortium of housing providers who offer a range of supporting accommodation for different levels and categories of need that can be accessed as part of the move on strategy for this group of people. They provide "moving forward models" which are a range of innovative community and individual interventions which replaced traditional day services and rehabilitation and recovery housing models that can be utilised for respite, more intensive input and as alternative to inpatient care.

This EIP housing pathway is unique in many ways, in its design and use of dispersed self-contained flats that are local to the staffing hub. This provides the user with their own front door maintaining discreet community integration. The inclusion of clinical led interventions supported equally by social recovery and holistic approaches mindful of age appropriateness, ensures the support offered is flexible and responsive to need. Additional out of hours nurse led on call function and the high level of collaboration across multiple agencies is generating positive outcomes and recovery rates for this specific user group.

Note: The Gateway System is multi-functional and supports not only the referrals into supported accommodation but provides agencies with access to services that are not within the collaborative pathway e.g. outreach and floating support. This can be useful in the support of transitions between the EIP service and independent living.

Areas where the model can demonstrate outcomes

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

Adolescent Mental Health

TURNING POINT inspired by possibility		Turning Point was founded on the principle of reaching out to support people to find a new direction on their journey throughout, and this has always remained the case. Today, they provide specialist and integrated services which focus on improving lives and communities across mental health, learning disability, substance misuse, primary care and employment. Their tailored personalised care helps achieve positive outcomes by offering choice, creating independence and helping people build a better life. For more information visit www.turning-point.co.uk			
Name of Model		**The Mill**			
User Cohort	Adolescent Mental Health	**Gender**	Male and Female	**Age Range**	16-25 year olds in adolescent service and 18+ in complex needs
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	12	**New Build or Redesign**		Data unavailable	
Cost of New build	Data unavailable	**Annual Running Costs (not including support or care)**		The users pay their own bills	
Type of Tenure	Assured shirt-hold tenure			**Average length of Stay**	9 months
Recovery Rates	On average 14 users move on in each 12 month period at present	**Predominant Diagnosis** Severe and enduring mental ill health Dual Diagnosis Emerging mental illness Personality disorder Personality disorders including emerging disorder ADHD			

Brief Overview

The housing model is based in two adjacent properties, the first is six self-contained flats for 16-25 year olds and the second, although independently commissioned from the first, also provides six flats for people with complex and multiple needs. In practice, this provides the opportunity for them to support one another's outcomes in the overall pathway with the second property offering some element of move on from the adolescent service and/or can provide alternative residence where behaviour mix may have presented issues.

The properties are owned by two different landlords however their locations make them ideal for creating a "joint" service. They are only separated by a car park and are in an urban area with good access to surrounding facilities and amenities.

The adolescent service is for individuals aged 16-25 years who are homeless, at risk of being homeless and have a range of complex needs including mental health, substance misuse and offending behaviour.

The complex needs element is for individuals aged 18 years plus who have a range of complex

mental health needs that may also include substance misuse, offending behaviour etc.

The service is commissioned by Lancashire County Council Supporting People Team and has been run by Turning Point since 2003.

Turning Point acquired the original model from another organisation who was failing to deliver an effective service and since that time they have reinvested, redesigned and implemented a unique innovative approach to supporting these two distinct user cohorts.

The original concept was derived from the recognised need to provide younger people with mental health and multiple needs housing options.

Additional expenditure costs are met through housing benefit e.g. rent and housing management activities.

The model is registered and regulated by the Care Quality Commission and also the commissioning body. The organisation has its own internally auditing process known as IQAT and includes user and managerial input.

The model in action

Referrals come from a range of sources that includes: youth offending teams, probation, prison, community mental health teams and self-referrals. All routes are subject to an application and assessment process with all discussed at a multi-agency panel that includes the provider. Once priority cases are agreed the staff team will work on pre-placement activities.

On average the model receives over seventy referrals annually, however some of these are not appropriate and people are signposted to other providers/services. As demand clearly outweighs supply a waiting list is not an effective way of meeting need but the service retained a data base on all referrals either signposted and or "accepted" and will revisit these when vacancies are becoming available.

The pre-placement work includes engaging the user, developing a relationship, further need and risk assessments, educating the user on the model and support functions, boundaries and rules, developing goals and aspirations through the use of a self-assessment tool and staff interventions.

Once someone moves in then the level of input is intense, covering a range of priority needs and resettlement activities. In some cases users come with limited additional care and support in place so one of the core functions is to establish a multi-agency package to meet broader health, social, educational and therapeutic requirements. Internally the focus is on recovery with the aim of developing livings skills, confidence and self-management abilities.

A strong emphasis is placed on the promotion of positive relationships and encouraging personal responsibilities through increasing self-esteem. The philosophy is one grounded in holistic assessment and person centred approach that enable all of the support to be structured around individual need and goals. Placing the user at the heart of every aspect of their life ensures they acquire and/or enhance the skills needed to maintain independent living.

As most of the users have multiple and complex needs and require a collaborative approach to ensure all needs are addressed, the model has perfected relationships and partnership working across a wide range of professions and organisations e.g. GPs and primary care functions, specialist interventions to address substance misuse and behavioural issues, links with educational establishments, on-going joint working with the youth offending teams, community mental health teams, secondary care services and the interventions from the community based voluntary sector.

One key relationship for housing as move on is earlier engagement with localised choice based letting processes and using links with housing providers to look at suitable move on properties, as part of the pathway/model.

One of the issues working with younger people who have chaotic lives is the reluctance on behalf of psychiatry to diagnose mental illness. This can be both a positive in the sense of stigma and discrimination but a negative when the service is supporting the user to acquire move on accommodation e.g. when there is a points system or where accessing mental health services without

a formal diagnosis meeting eligibility criteria is difficult.

Shared risk management is another key function of the model, with the service developing a range of individual risk assessments and linking in with other agencies involved to manage risks collectively. This process places the user at the centre of the risk identification and solution based resolutions/mitigation. This collaborative equal partnership approach is effective in users taking responsibility, in growth in maturity and in preparation for moving on in order for them to live safe and secure lives.

Another unique element built into the housing pathway is a "tenancy workshop" model. This is centred on each user attending five modules delivered through formal educational workshops covering budgeting and money management, keeping safe, legalities of a tenancy etc. This intervention not only equips and underpins the skills developed during their stay but supports applications for housing post discharge to landlord etc. who are often reluctant to take on younger tenants.

The level of input starts off at the intense level and as confidence and skills bases develop this tails off. However it remains flexible and fluid to meet changing need especially towards the end of placements where a more concentrated approach is required to allay increasing anxieties and support the transitional phase. The model provides a brief move on outreach function although this is not a contractual requirement or funded, it is an essential element to a successful resettlement into independent living.

The model uses a range of tools to support the work it does with users. These include the Outcome Star framework and homelessness as well as their internal risk management processes, support planning and moving on plans.

As an organisation Turning Point is committed to active user participation in the decision making processes and invites participation in decisions about meeting individual needs, service planning, performance and development and improvement of the services they provide including recruitment. This particular model's weekly sessions include workshops, service user meetings, "be involved" workshops and skills share sessions which all provide opportunities for regular feedback on service provision and outcomes.

The model functions 24/7 with the main staff presence till 9pm with a service user on-call system in operation late evenings and throughout the night time. The staff team comprise of Team Leader, Project Workers and Support Workers. This structure is linked to the organisation's own line management functions.

Each staff member is subject to a competent worker process, including a six month probationary period during which mandatory and service specific training and induction takes place. Turning Point has a strong culture of staff development that includes on-going supervisions, peer learning opportunities, on-going personal reviews, role specific training and career development. Also in the model are regular staff meetings, handovers, multi-agency reviews and joint working.

The success of this model is in its ability to use the environment, the support functions, their unique interventions, its nurturing and therapeutic milieu and collaborative approach to the ultimate benefit of its users. It has generated significant levels of successful move on and recovery rates which stands at an average of fourteen users per annum with additional core outcome represented as 77.78% of all users now managing their own mental health and wellbeing. Overall the model contributes to a reduction in hospital admissions, the use of accident and emergencies, a reduction in anti-social behaviour, a reduced criminal and re-offending rate in its user group.

This true holistic, multi-layered and individualised pathway is creating positive and healthy life styles enabling this often marginalised user group to live resilient and productive lives.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	
Reduced costs in the health and social care economy	✓		

Severe and Enduring Mental Illness

<table>
<tr><td colspan="2">  </td><td colspan="4">Richmond Fellowship are a specialist provider of mental health services, with a focus on providing high quality services to the 9,000 people we support each year. They have pioneered and practiced their belief in social inclusion and recovery for more than 50 years, and are now one of the biggest voutary sector providers of mental health care in England. They offer a wide range of housing, care, employment and community support across more than 120 services. They are a registered charity, a company limited by guarantee and a registered provider of social housing (RP). For more information visit www.richmondfellowship.org.uk</td></tr>
<tr><td colspan="2">Name of Model</td><td colspan="4">Derwent Square</td></tr>
<tr><td>User Cohort</td><td>Severe and enduring mental illness</td><td>Gender</td><td>Male and Female</td><td>Age Range</td><td>Average is 45-64 year olds</td></tr>
<tr><td>Ethnicity</td><td colspan="5">Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 80% White British, 20% Chinese.</td></tr>
<tr><td>Number of Units</td><td>5</td><td colspan="2">New Build or Redesign</td><td colspan="2">Redesign</td></tr>
<tr><td>Cost of Redesign</td><td>£640 k</td><td colspan="2">Annual Running Costs (not including support or care)</td><td colspan="2">£16 k</td></tr>
<tr><td>Type of Tenure</td><td colspan="3">Assured Short-hold Tenancy</td><td>Average length of Stay</td><td>The model is settle permanent accommodation</td></tr>
<tr><td>Recovery Rates</td><td colspan="3">The model has not experienced move on yet as the design is a home for life for people who have been in long-term patient care</td><td colspan="2">Predominant Diagnosis

Paranoid schizophrenia
Treatment resistent schizo-affective disorder</td></tr>
</table>

Brief overview

The model is provided in a core facility that compromises of two self-contained units, three en-suite rooms and numerous shared environments including lounge, dining room, kitchen and laundry.

The building has been designed to a high specification to reflect both the mental and physical health needs of the user group and is defined as a home for life with the building itself equipped to deal with the ageing process.

The original concept was developed in co-production with a local NHS Trust (Mersey Care) who had identified a number of inpatients that no longer required on-going clinical interventions in the Rathbone Hospital. There was a desire to provide a more independent lifestyle and a focus on social recovery for this group of patients.

From the Trust and Richmond Fellowship, there was upfront investment of time, resources and finances.

The co-production process encouraged potential users, their families and carers to become involved in the design, location and layout of the premises. This detailed process resulted in the acquisition of a large old building and the creation of a bespoke model that fitted the needs of a niche user group.

From concept/idea to opening, the time frame was

approximately 2 years. The property is both owned and managed by Richmond Fellowship.

The service is not registered with the Care Quality Commission but procured through Liverpool's integrated commissioning model with revenue streams stemming from that contract and housing benefit.

The model in action

The model is based on the notion of providing stable, secure and long-term community based accommodation to a specific user cohort. The targeted user group for this provision are those people residing in long stay inpatient units that no longer require on-going clinical interventions or move to residential care facilities is deemed inappropriate.

Referrals are identified through a multi-agency panel led by psychiatrists linked to staff working in the model and undertaking pre placement engagement work with all potential referrals. This includes developing a collaborative risk and needs assessment, developing a discharge plan and looking at re-ablement requirements. This pre work can often be up to 12 month pre discharge/move.

Once the referral moves into the property then the model develops a tiered support and care planning process. Starting at an intensive level, placing a significant emphasis on community integration and resettlement, this includes establishing GP and health practitioners, community mental health teams, engagement and re-orientations, familiarising people with their new environment and local amenities.

Often on entry this user group can display increased anxiety and distress as the environment is not a familiar one to them. The staff team provide support to ensure this is minimised and the introduction of greater choice and control is done in a timely manner.

The model is designed to manage this challenging user group who inevitably display institutionalised behaviours, have limited social and daily living skills. Their complexity can be further compounded by additional issues e.g. elective mutism and the group dynamics. As this is often their first out of hospital placement for a significant period of time and there are numerous health issues including smoking, physical exercise and mobility to consider.

The support hours are individualised and personal to each user, they can be fluid and flexible to meet the ever changing need and demand with additional input coming from a range of sources including community pharmacy, community mental health teams, health practitioners, other voluntary agencies, domiciliary care and district nursing.

There is an on-going joint planning and detailed collaborative approach incorporating all of the multiagency interventions; this is subject to on-going regular reviews.

Another element of the care/support plan is designed addressing the ageing needs of the user groups. As one of the models key aims is to provide a "home for life", the incorporation of the use of assistive technology and introduce of health services is included especially where co and multiple morbidities exist.

Risk assessment and management processes are imbedded into the model's delivery and developed in collaboration and partnership with the user and all relevant agencies. There is a recognition that risks in this model fluctuate and shift emphasis regularly and therefore a proactive and prevention process has emerged.

The model also recognises the limited move on within a given housing pathway and tends to measure its success on providing stable and secure "lifetime" services measuring health improvements and the less tangible outcomes and complexities/unique issues of the user group.

The model is staffed by non-clinical support workers with a management structure; all staff receive comprehensive on-going internal organisational support through regular supervision, staff meetings, handover processes and daily contact with their managers and at the onset of employment a comprehensive induction period and mandatory training programme is accessed. On-going training and development needs are identified for individuals and the staff group; these are both provided by internal and external sources.

The staff team and user groups are well supported by their collaborative approach with other agencies this allows for reflective learning to take place and to gain greater insight into other professions and how these link in with this user group.

From the designing end it can be demonstrated that the organisation has a culture of user, carer and family involvement. This extends throughout the delivery element of the model, whereby user input is encouraged individually and as a group through meetings, continuous improvement processes and seeking opinions through annual appraisals.

The organisation also has an internal quality assurance systems that includes managerial input, peer led assessments etc.

This model provides a real alternative to hospital for an often forgotten population and combines quality accommodation, maintaining a therapeutic and safe environment and providing a flexible care and support regime. Part of its success can be attributed to the way it is linked into communities and breaks the cycle of exclusion providing a positive future for this user group. The coupling of the aforementioned with an effective collaborative approach has stopped the 'having to move to receive' mentality often associated with housing options for people with mental illness. Added value within the design is the consideration on how ageing will affect the users looking at how assistive technology can continue to offer real choice and control.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	
Reduced costs in the health and social care economy	✓		

Bromford.		Bromford provide a range of services including developing and managing general needs housing and providing specialist support services that are designed to help unlock their potential. They also sell homes through a range of options (private sale, part buy/part rent or part exchange) and build well-designed, high-quality homes. For more information visit www.bromford.co.uk			
Name of Model		**My Place Model**			
User Cohort	Severe and enduring mental illness/ learning disabilities	**Gender**	Male and Female	**Age Range**	18-65+ year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	The plan is to provide 100 units each year	**New Build or Redesign**		New build	
Cost of New Build	Data unavailable	**Annual Running Costs (not including support or care)**		Tenants will pay their own bills	
Type of Tenure	Assured Short-hold Tenancy			**Average length of Stay**	Permanent Homes
Recovery Rates	This type of model will maintain the level of independence and recovery achieved through a housing pathway	**Predominant Diagnosis** Mental health Learning Disabilities			

Brief overview

The My Place housing model is a unique concept of supported housing from Bromford specially designed for people with long term conditions.

The idea has been developed in response to the demand for low level supported accommodation that primarily sits at the end of a housing pathway and designed to provide a "permanent" property to people with mental health conditions and learning disabilities.

The concept is thought to be the first of its kind in England and is both ambitious and innovative in its quest to answer the housing needs of potential users and commissioner alike.

The My Place schemes will comprise of well-appointed, self-contained, one bedroom apartments in decent and desirable locations.

The schemes will all be built by Bromford's internal design and construction teams to HCA standards.

The initial capital and investment requirements will be met internally. The schemes can operate without additional revenue funding from Local Authorities or through commissioning regimes.

The model in action

The My Place model offers long-term accommodation and can be defined as a home for life. Access to the accommodation will be through normal housing application routes however the vision is that strategic links will be developed with specialist housing partners to provide safe and secure move on properties from more intense supported/care environments and to relieve the pressure that can often occur in beds being blocked due to lack of quality move on accommodation within existing housing pathways.

The model will have a number of apartments in blocks built around a community hub which will have a lounge, meeting rooms and a kitchen. This facility will be available to encourage social and community interaction but also to provide training,

employment advice and activities to the scheme's tenants and wider community.

Each tenant will have a Bromford tenancy and will receive additional housing management support and a reliable/responsive repairs service. There will also be an onsite specialist housing and community champion at point during each week who will assist tenants with tenancy issues, benefit and general support issues, help manage visitors and organise repairs as well as co-ordinate multiple care and support provider interventions.

One of the many unique elements of each scheme will be the revenue sources likely to be generated through the eligibility criteria of housing services and rent from housing benefit plus the personalisation agenda.

This concept is to take users closer to fulfilling their dreams and aspirations of having somewhere permanent to live that is of a high standard and in desirable locations. This option provides users real control over their life, reduces dependency on other services and total independence.

Strategically these schemes could represent a much cheaper option to sustaining unneeded places in residential care or other high cost provision and an ultimate saving to the Local Authority.

For users/tenants they could represent the chance to achieve greater outcomes for themselves, improve provision currently open to them, be inspiring and motivational and meet their longer-term needs.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	✓
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

		Mental Health Concern is part of Concern: The mental health and wellbeing group. The organisation is based in the North East of England and provides a wide range of specialist mental health services. Nationally as Insight Healthcare they provide a range of primary care mental health services and employee wellbeing programmes. The services are predominantly commissioned by the NHS and Local Authorities. For more information visit www.mentalhealthconcern.org			
Name of Model		**Collaborative Housing Pathway**			
User Cohort	Severe and enduring mental illness	**Gender**	Male and Female	**Age Range**	18-65+ year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	68	**New Build or Redesign**		There are four organisations in the housing collaborative and the properties consist of both purpose built, redesigned properties and use of existing social ousing and private landlord stock.	
Cost of New Build	Data unavailable	**Annual Running Costs (not including support or care)**		Most users pay their own bills within the model	
Type of Tenure	Short-hold tenure in collaborative housing pathway			**Average length of Stay**	Individual need drives the length of stay and this is longer-term settlement
Recovery Rates	Across the collaborative housing pathway positive move on is a measurement of recovery and rates vary across the proivder patch. Each recorded a minimum 2 to 3 users moving in each 12 month period			**Predominant Diagnosis** Schizophrenia Bipolar disorder Schizo-affective disorder Dual Diagnosis Personality disorder Complex Needs	

Brief overview

The Collaborative Housing model brings together four key third sector agencies in the Newcastle area providing accommodation services to people with mental health issues into a consortium led by Mental Health Concern.

The collaborative pathway comprises of over sixty properties in a range of designs with the majority offering own front doors types: this includes dispersed housing; small blocks of flats; core and cluster. There are some group living schemes in the pathway but these are specific to a level of need and user cohort.

Most of the properties are self-contained with only four providing users with shared facilities and en-suite provision, again this is specific to a level of need and user cohort.

All of the properties are fully furnished and provide

longer-term stable accommodation to people with severe and enduring mental health issues.

Their locations are throughout the city, some city centre based with others across the more suburban areas.

Most of the provision was already in existence and it was through Local Authority Commissioning intentions that the need for a more joined up pathway was established.

As a response to this and through existing relationships a consortium was established. The collaboration ensured there was maximum coverage geographically in the city, that there was a diverse range of housing options and different categories of supported housing available.

Some of the properties are owned by the four key agencies with others managed by them but owned by a broader range of housing providers including the Local Authority and housing associations.

The pathway is commissioned by the Local Authority Adult Social Care Department and provides funds for the support element with additional rental and housing management income generated through the user's entitlement to housing benefit or personal contributions.

There is no direct health funding in this pathway but there are established links with other housing provision not within the commissioned service e.g. residential and nursing care, floating and outreach services.

The model in action

All referrals to supported housing in Newcastle come through a Local Authority led Gateway System which co-ordinates referrals, access and vacancies across the city.

The consortium members also hold a monthly meeting during which all referrals are discussed and assigned a category of support which would best meet their need.

There are over sixty properties that fall within the consortium and each have been categorised into levels of support, remits and tiers both contractually and in practice.

1. ISOS Housing and Richmond Fellowship provide low level supported accommodation that offers between 3-6 hours of support per user each week (38 Units)

2. Mental Health Matters provide medium to intensive level accommodation that offers between 6–9 hours per week support (17 Units)

3. Mental Health Concern provide high level need (clinical led) that offers over 9 hours support per week and an RMN keyworker per tenant (13 Units)

The collaborative approach ensures that the referral's need is matched with the correct level of input and allocated to the appropriate organisation. All referrals complete an application form and additional needs and risk assessments are carried as per each organisational/models requirements.

Built into the consortium pathway is inter-agency support and user step up and step down e.g. where there are difficulties in managing a user in a particular accommodation tier, cross consortium intervention can often resolve the issues. More clinical awareness or intervention could come from Mental Health Concern or Mental Health Matters into ISOS or Richmond Fellowship for short periods to help resolve the issue. Where placements are potentially breaking down due to increased risk or behaviours then a move across the pathway can be facilitated to medium or higher support services and vice versa where need diminishes step down negotiations often take place.

Commonality across the model is the individualised person centred approaches and planning that takes place. This includes holistic assessment processes which identify support needs and plans across a range of needs, most of which can be met by the pathway providers e.g. the core housing management skills, daily living skills, resettlement activities and community integration. The provider will also facilitate and co-ordinate the additional multi-agency working arrangements. These are individual and at a minimum involve GPs and primary health care professions e.g. dentists etc. The pathway also manages people who have multiple morbidities and complexities leading to a more comprehensive care package being provided by visiting professionals e.g. district nursing services and

domiciliary care workers or through accessing a broad range of health and social care functions.

Aside from the inter consortium move through, there are links established with other housing agencies to support the move on from the consortium providers. These include the Local Authority who provide a "pathway team" who prioritise and work with people leaving supported accommodation to identify appropriate housing options. The staff configuration within the pathway comprises the higher need end of nursing and clinical staff working with community support workers through to support staff at the low end.

The lead contractor are Mental Health Concern and subcontracting arrangements ensure a level of quality and standardised provision is in place across the consortium. These include policies and procedures, contract compliance, data collation, staff support and training mechanisms, on-going development of the pathway and ensure that open effective communications and reporting are in place.

The consortium approach and inclusive housing pathway demonstrates what can be achieved when agencies work together under one contract to provide a range of housing options. In addition to the positive outcomes for users and commissioners there are benefits to the wider social and health economies. The single point of referral system hosted by Newcastle City Council which interacts with the consortium process ensures users do not fall through the gaps in provision. The interagency working allows for reflective practice, data sharing, learning and development opportunities, effective co-ordination of support and care and breaking down of organisational barriers and silo working arrangements.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	✓
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

Veterans/ Mental Health

<table>
<tr><td colspan="2">  </td><td colspan="4">Riverside is proud to be one of the leading registered providers of social housing in the UK, providing affordable housing, care and specialist support services to people of all ages and circumstances throughout England.

Riverside provides value for money services to a wide range of customers, agencies, local authorities.

Their work stretches across a wide variety of communities, enabling them to take a flexible approach in delivering the most appropriate scheme or service to address local needs. They have extensive experience of working in partnership on projects such as stock transfers, private finance initiatives and regeneration schemes.

They also provide specialist support to residents in their own homes - not just Riverside tenants - through 'Helpline', a telephone support service.

Overall Riverside takes an innovative approach to its work, from procurement and design through to a flexible method of working. This gives greater choice to our customers and partners. Main business is Care and Support, Home Ownership, Regeneration, Private Finance Initiatives and Property Management. For more information visit www.riverside.org.uk</td></tr>
<tr><td colspan="2">Name of Model</td><td colspan="4">The Beacon - Veterans Housing Pathways and Models</td></tr>
<tr><td>User Cohort</td><td>Single Veterans</td><td>Gender</td><td>Male and Female</td><td>Age Range</td><td>18-65 year olds</td></tr>
<tr><td>Ethnicity</td><td colspan="5">Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required. Current ethnicity split 93% White British, 7% Black and Minority Ethnic.</td></tr>
<tr><td>Number of Units</td><td>31</td><td colspan="2">New Build or Redesign</td><td colspan="2">New Build</td></tr>
<tr><td>Cost of New Build</td><td>£4.3 m</td><td colspan="2">Annual Running Costs (not including support or care)</td><td colspan="2">Data unavailable</td></tr>
<tr><td>Type of Tenure</td><td colspan="2">Self-contained Licence Agreement to allow an effective welfare management</td><td>Average length of Stay</td><td colspan="2">7 months</td></tr>
<tr><td>Recovery Rates</td><td colspan="2">41 move ins since opening with 94% recovery rates recorded</td><td colspan="3">Predominant Diagnosis

PTSD
Depression
Anxiety
Bipolar Disorder
Borderline personality disorder
Anger Management
Schizophrenia
Addictions</td></tr>
</table>

Brief overview

The housing model is based in a purpose built contemporary building comprising thirty-one one bedroom, fully furnished self-contained flats, with access to a health and resource centre with two consultant rooms and one treatment room, a training, education and employment centre including an IT suite, a gym, audio visual room, a music studio, a multi-purpose room and a therapeutic training bakery. There are also outdoor spaces including a garden and allotment areas.

The model is supported housing for single veterans aged 18 + and is made up of three main provision tiers: accommodation and support, health and wellbeing and training, education and employment.

The initial concept for the service was derived from co-production ideas from the Ministry of Defence, Riverside and the Local Authority.

Capital and revenue investment came from Home and Community Agency, Royal British Legion, the Department of Communities and Local Government and Riverside themselves.

The model offers residency through a licence agreement and on-going revenue funding is through a Supporting People contract and income from veterans and the benefit system.

All service users have a formal support agreement in place as a condition of tenure.

Riverside both owns and runs the service on a day to day basis and is supported through a collaborative approach across a range of multiple agencies.

Commissioners regulate the service through monitoring arrangements and there is a high level of user input into auditing and the continuous improvement of services.

The model in action

Riverside runs a range of services for veterans that support and compliment this particular housing model. Within Catterick Garrison in North Yorkshire, within The Beacon there is a service known as SPACES (Single Persons Accommodation Centre for the Ex Services). SPACES provide a national helpline and works in partnership with the Ministry of Defence to assist single service leavers from all three services by providing advice and support to find suitable housing prior to and post discharge. The type of accommodation that veterans use can range from supported housing to permanent homes.

This innovative service helps to reduce the likelihood of ex-service personnel/veterans from becoming homeless or sleeping rough. After discharge, SPACES provides clients with a 'future contact card' which holds details of an 0800 number that makes it easy to contact the project if they require advice on housing, or if they become homeless in the future and require their file re-opened.

Following on from SPACES completing their assessments and interviews with veterans it is evident that some require more specialist supported housing either because they have additional physical or mental health issues and/ or require a level of support to readjust to civilian life. The service will refer people into one of several housing models of which some are provided by Riverside specifically designed to meet the needs of the particular user group. One such service is The Beacon.

The Beacon takes all of its referrals from the process described above and since 2011 it has accommodated over 160 move ins with an average of 88 new referrals annually. Demand outweighs supply significantly.

Once a user moves in to the service then the care and support tiers vary dependent upon the individual needs and where they are along their recovery and resettlement journeys. However, all participate in a comprehensive needs assessment which then links into a tailor made support, risk management and resettlement plan: in most cases this forms part of the pre-acceptance and engagement work of the model. Most clients referred to this model have multiple needs and complexities of having served significant periods of time in the military.

The plans covers the 3 main tiers of the delivery: Tier one accommodation and support includes daily living skills, practical skills and community

engagement work; tier two health and wellbeing ensures specialist interventions are established including GPs, other health professionals, therapeutic interventions and where needed primary and secondary care services; tier three training, education and employment includes new skills development, educational opportunities and training all geared toward employability post leaving The Beacon. The level of intensity of the provision is responsive and fluid throughout the user's stay.

Support needs are reacted to internally and the model works with other specialist organisations to provide additional tailor made support and care packages. There are excellent working relationships formed with external agencies that offer specialist on site and off site support to the user group. Specialist support workers have been recruited to manage the health and wellbeing interventions and the training, education and employment activities.

The model provides staffing 24 hrs a day all year round with the team consisting of local management, specialist support staff and housing staff. As with most organisations all staff members are subjected to probationary periods that include mandatory and personnel development training, on-going supervision and appraisals. There are also supported learning opportunities through peer groups, staff meetings and handover processes.

The staff team and users work in a collaborative way with multi-disciplinary teams holding joint meetings and reviews as well as on an individual user level. Staff co-ordinate a range of communications and interventions with a high number of other agencies.

There is a high engagement level with the user group from pre entry stage: users are encouraged to feedback suggestions and improvements through both formal and informal routes.

This fully integrated, holistic model supports the users to grow in confidence and readjust to living in the community, ensuring their physical and mental health needs are addressed and preparatory work for move into independence includes heightening their economic wellbeing and employability. Once a user has completed a resettlement package at The Beacon then agreements have been reached with the Local Authority to provide the user group with priority banding on the Local Authority Choice Based Letting scheme for fair access to decent housing options. The services recent statistics demonstrate where people have moved to. For the period April 2013 – March 2014:

- 9.3% Supported Housing
- 30.23% Registered Social Landlord and Local Authorities
- 6.98% Private
- 44.19% Family and Friends
- 9.30% Other = 1 to a mobile home, 2 to custody, 1 unknown

This model has encompassed high specification accommodation with purposeful communal areas including therapeutic and creative spaces with the needs of a very specialist user group.

The balance struck between the provision of accommodation, priority needs and longer term planning for each individual has made this model unique and effective. Its culture of being a strength /asset based model that focuses on what the user can achieve and their aspirations as opposed to risks and negativity. The approach of being an entirely psychologically informed environment generates positive input to the way interactions occur with all users.

The incorporation of therapies, health and wellbeing workers who operate in partnership with NHS bodies, employment and training officers working closely with a variety of funding bodies to access vocational and educational providers and access to a number of Riverside offers such as GROW trainee placements (paid traineeships) and their peer mentoring scheme all working for the betterment of the user group.

Other outcomes the model is generating include: NHS savings due to the internal response and proactive nature of the model e.g. early interventions for mental and physical health. Savings to benefit system as many of the users receive employment training/employability skills and enter the labour market therefore stop claiming benefits. Savings to criminal justice system as the model provides interventions around substance misuse (including alcohol) which lead to anti-social behaviours, violent offences and other

offending to fund addictions. The model also addresses offending types through its interventions.

For the user groups outcomes include: reduced worklessness, full integration into civilian life and the community, reduced social exclusion and homelessness, addressed complex health problems, a holistic approach to resettlement and greater access to services.

Riverside has developed a range of housing options for veterans that are operated in a linked and integrated way. As previously mentioned the organisation's SPACES service provides the initial gateway and assessment and a national helpline, with access to specialist housing provision e.g. The Beacon (detailed above) and a similar model at Mike Jackson House. There are additional move on accommodation and plans to build family housing in the West Midlands. For more information visit www.spaces.org.uk.

Areas where the model can demonstrate outcomes:

Lower offending rates	✓	Greater levels of inclusion	✓
Lower admission to low and secure units	✓	Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Increased employability and economic wellbeing	✓
Reduced costs in the health and social care economy	✓		

Rough Sleepers

St Mungo's Opening doors for homeless people	St Mungo's Broadway helps people recover from the issues that create homelessness and to rebuild their lives. They provide a bed and support to more than 2,500 people a night who are either homeless or at risk of becoming homeless and also work to prevent homelessness. The organisation helps around 25,000 people a year. They support men and women through more than 250 projects including: • Emergency, hostel and supportive housing projects • Advice services • Specialist physical and mental health services • Skills and work services They currently work across London and the south of England including in Bristol, Reading, Milton Keynes, Oxfordshire and Sussex, as well as managing major homelessness sector projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN). The organisation also campaigns and influences nationally to help people to rebuild their lives. For more information visit www.mungosbroadway.org.uk

Name of Model		**The Lodge**			
User Cohort	Older, entrenched, long-term rough sleepers	**Gender**	Male and Female	**Age Range**	40+ year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	40	**New Build or Redesign**		Redesign	
Cost of Redesign	Data unavailable	**Annual Running Costs (not including support or care)**		Data unavailable	
Type of Tenure	Data unavailable			**Average length of Stay**	2 years maximum
Recovery Rates	Average stay is 261 days with an average of 3/4 moving into more permanent housing options	**Predominant Diagnosis** Multiple morbidities Mental health issues Physical health issues			

Brief Overview

The lodge model is an award winning, innovative and pioneering project designed to help the long term rough sleepers move off the streets.

It opened in March 2010 and operates in partnership between St Mungo's Broadway and the City of London Corporation.

Initial funding and financial support came from a collaboration of Fresh Hope Trust, Taylor Wessing

and the Santander Foundation and unusually for a residential homelessness project, the model has never received any Supporting People funding.

The building is a renovated property with funding from the Department for Communities and Local Government's Places of Change programme and is located in the London Borough of Camden, whose willingness to host and active ongoing support for the scheme is also commended.

The building comprises of forty well maintained, fully furnished bed spaces, a number are en-suite but all have high quality furnishings and surroundings.

The building is leased from Origin Housing Association

The model in action

People referred into the Lodge have spent a minimum of two years sleeping rough with some having slept rough for over 20 years. The project is designed exclusively for older, long term rough sleepers who do not have high support needs and are often reluctant to stay in projects that are shared with younger homeless people, who may have different support needs.

Referrals are made through applications by the street outreach teams and then assessed by the Lodge's established panel. Referrals of couples, people with dogs etc. are also considered.

Users are referred to as guests, the model operates to a "hotel style ethos" and is reflective of the preference of its users who have often rejected 'hostel style' accommodation in the past and or have previously entered more conventional short term accommodation but then returned to rough sleeping.

The model centres on its strong customer care ethos and guests staying at the Lodge, many of whom are used to the extreme independence of life on the streets, do not have to engage with 'high intensity' support levels. They are also not expected to attend regular key working sessions although key working is a vital part of the recovery process for many vulnerable adults. Several guests at the Lodge have indicated that this "forced" model of support has pushed them away from hostels in the past. In place of "hostel type keyworkers systems", guests continue to be supported to move into permanent accommodation by the street outreach workers who initially befriended and referred them into the Lodge.

Outreach workers and staff at the Lodge have successfully developed joint working arrangements that give guests the freedom to access support when they feel they are ready. Priority needs including health and wellbeing form a critical part of the service. The joint working and multi-agency input is managed through an organisational process known as 'case conference protocol'.

The unique atmosphere of the Lodge is maintained through ensuring that all guests meet the referral criteria, the approach adopted in this model has ensured that there is a sense of community and this is evident through the voluntary contributions to the local area and the day-to-day running of the project made by guests, for example, shopping and cooking for one another. There is a great emphasis placed on community engagement and this has resulted in significant levels of integration including guests providing pet-sittings for some of the other projects, playing the organ in a local church and helping to maintain nearby community gardens. There is a guests contribution reward scheme including issuing cinema and theatre tickets.

There is also a Time-banking initiative introduced as part of the resettlement activities in the model.

Staff and guests have been successful in maintaining a strong relationship with local businesses and residents and there are regular constructive and friendly meetings with local stakeholders.

Risk management at the Lodge is based on guests taking considerable responsibility for their own behaviour and are treated with respect by other guests and staff. Any cases of disruptive behaviour are isolated and are dealt with quickly.

The staff team's interventions are rooted in wellbeing and recovery ethos and to underpin this approach they receive training and on-going development opportunities. The team comprises of a manager, five fulltime staff and security staff outside of the working hours which are normally

8am–11pm. The street outreach team provide the on-going support and reviewing processes.

The Lodge model has succeeded in helping men and women make a sustainable move off the streets. This success can be attributed to the unique philosophy; the project prioritises maintaining a safe, comfortable 'hotel-style' environment in which the demands placed on guests are minimised. Instead of expecting guests to adhere to what might be perceived as an onerous support plan, the model focuses on enabling some of the most excluded members of society to begin to feel valued and respected.

Some of the significant outcomes generated through this model include:

- Guests at the Lodge spend an average of 261 days in the project before leaving, most often in a planned move to other accommodation: this is in comparison to the 96 day average stay in the capital.
- Three quarters of these who have remained at the project have made a planned move into other accommodation.
- Almost a third of the first 40 guests to enter the project since it opened in March 2010 have moved into independent or supported accommodation.
- Guests pay their rent promptly and there is a minimum arrears level.
- Of a sample of 27 guests of working age at the Lodge in February 2012, seven are engaging with Job Centre Plus, nine are engaging with employment or skills courses and one is working.
- Guests are on a variety of courses including painting and decorating, IT, catering, first aid and gardening, as well as courses provided by other organisations.
- 90% of guests interviewed say that they have benefited 'a lot' by moving into the Lodge; in particular they report improvements in their mental and physical health.
- A third report that they have reduced the amount of alcohol they drink since moving in, several also say that they have stopped smoking.

They cite being able to sleep properly, eat regularly and no longer being subject to the continuous stress of living on the street as important factors in their improved health.

Throughout their stay guests are encouraged to contribute to the running and improvements to the service through formal and informal mechanisms including bi-monthly user meetings.

Move through is a significant function of the model and links to housing providers have been established. However,as a direct result of their experience in the field and in particular with this model, St Mungo's Broadway and the City of London Corporation secured funding for a new mini-Lodge project that now offers permanent supported accommodation for some of the guests to move into.

The model collates a series of statistical information on the user group and this now extends to outcomes and information on those guests who have moved into permanent accommodation.

The Lodge has established a positive reputation amongst London's entrenched rough sleeper population, and the agencies that support them, as a positive alternative to life on the streets or in conventional hostels. It is now over-subscribed and runs a carefully managed waiting list.

This model continues to be a pioneering model of supported housing and is a brilliant example of what can be achieved by joint partnership arrangements coupled together with the correct environment and intervention levels for this unique user group. It is a towering achievement that has exceeded even its own intent and ambition; it has raised the bar for how partners can work dynamically to create a homely environment where entrenched rough sleepers become guests. There is recognition of the many who have contributed to the model becoming a reality, especially the Lodge's neighbours and the support of the building's leaseholder, Origin Housing Association.

The model has received wide recognition, most notably in 2011 the project won Partnership of the Year at the National Housing Excellence Awards and the Meeting the Needs of Older People award in the Chartered Institute Housing – Inside Housing UK Housing Awards (as well as being a finalist for their overall merit award). It was also a runner-up for the Andy Ludlow Innovation in Social Housing award.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Reduced homelessness	✓
Reduced costs in the health and social care economy	✓		

Substance Misuse/ Mental Health

TURNING POINT inspired by possibility		Turning Point was founded on the principle of reaching out to support people to find a new direction on their journey throughout, and this has always remained the case. Today, they provide specialist and integrated services which focus on improving lives and communities across mental health, learning disability, substance misuse, primary care and employment. Their tailored personalised care helps achieve positive outcomes by offering choice, creating independence and helping people build a better life. For more information visit www.turning-point.co.uk			
Name of Model		**Marine Avenue**			
User Cohort	Substance Misuse	**Gender**	Male and Female	**Age Range**	18-65 year olds
Ethnicity	Although this is not an ethnicity specific service, the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.				
Number of Units	9	**New Build or Redesign**		Redesign	
Cost of Redesign	Data unavailable	**Annual Running Costs (not including support or care)**		£16.2 k	
Type of Tenure	Licence Agreement			**Average length of Stay**	12-18 months
Recovery Rates	60% annual move on rates to lesser supportive or independent housing options	**Predominant Diagnosis** Dual Diagnosis Mental health issues Personality disorder Bipolar disorder Depression			

Brief Overview

Marine Avenue provides supported housing for residents aged 18 + who are recovering from alcohol and or drug misuse.

It is a low level supported service funded by North Tyneside Adult Social Care Department. The project is based in Whitley Bay and provides a shared living environment.

There are nine bedrooms and on each floor there are shared bathrooms. Other communal spaces include: a living room; kitchen and utility room. All are fully furnished. There is also an onsite gym room.

The model works with users aged 18 + and are supported through a multi-disciplinary approach to ensure continuity and consistency to the support they receive during their stay.

The formal contract with adult social care provides revenue for the support activities and the rental income generated from the user's benefit entitlement supports the property rental and maintenance services.

The property is owned by ISOS Housing Group but leased to Turning Point who retains all of the housing management services as part of the lease agreement.

The initial need for the service was identified by Supporting People as part of the strategic plan in the early 2000s, however since then Turning Point

have re-modelled the delivery from its original intention to become a more inclusive, responsive and dynamic service.

The model in action

This model of supported accommodation offers semi-independent living for users with substance misuse issues who often have co or multiple morbidities including mental health. The main ethos is grounded in a social recovery methodology linked closely to clinical and therapeutic pathways that all support the user's journey towards a move to independent living.

All referrals come through the North Tyneside Gateway Service, this is a Local Authority run process where vulnerable people are identified from across a range of user groups. One of the main functions of this service is to complete the application for supporting housing services, residential care and specialist housing provision. Once the initial application process is completed and funding is agreed, the most suitable provider is identified and then they engage in an assessment process.

For this model this entails carrying out a joint holistic assessment with the referral and in partnership with their lead agency, normally probation, mental health teams and/or substance misuse teams. As a collaborative they develop a needs plan and risk management process.

Once in the model the level of collaboration continues. The service itself will support the user through a series of support tiers addressing in the first instance priority needs often including establishing GP/GP relationships, creating access to other health professionals and practical daily living skills. During this initial phase it is common for users to increase their level of engagement with the staff team and a positive "can do" culture emerges; this relationship ensures that the user is assessed and accessing appropriate therapeutic intervention including drug programmes and counselling.

There is a significant emphasis placed upon taking responsibility and the staff team ensures that the user is placed at the centre of every decision about themselves, their behaviour, risks, aspirations and goals.

All users have an appointed key-worker who work on a one to one basis and, as confidence and recovery grows, support to encourage users to access educational, social and vocational opportunities is given. The model has a series of community integration programmes and has liaised with local businesses that support the "giving back" approach as part of the user's recovery journey.

Another critical factor is support with relapse prevention and plans. This forms a part of the high level of multi-agency working and often involves the police and safeguarding. The amount of contribution from the collaborative approach is driven by the individual but it is not uncommon for the user to have involvement from the substance misuse team, probation, criminal justice, mental health teams, psychology and psychiatry. One of the areas the model excels at is its ability to co-ordinate and link individual plans into statutory services and intervention planning processes, which are engendered through shared information.

As part of the aforementioned, risk assessment and management is governed and reviewed.

The average length of stay is around 14 months and, as part of the housing pathway the model sits in, they have developed a range of move on options jointly with the local authority. They have also addressed some of the barriers often faced by this user group in securing suitable accommodation through determination and educating housing providers. This has included establishing links with virtual bond agencies, exemption of the user group from housing benefit and their own provision of 4-6 months of transitional outreach work.

For all users during their placement the organisation runs a mandatory course to educate on housing, tenancy, independent living and money management.

Additional collaboration with NHS dieticians who provide nutrition and cooking advice, Shelter who provide legal and housing advice and support, the family and carer service who mediate on broken family relationships and employment services including a Job Centre Plus agreement for people currently in treatment.

The staff team comprises of an operations manager, senior practitioner, project worker and support worker functions that are all subject to a probationary period and mandatory training. Turning Point operates to a competent worker programme that encompasses all on-going training requirements including for this staff group more service specific training including drug and alcohol, CBT and Mindfulness.

The user group are encouraged through various routes to contribute to the model's continuous improvement through the mechanisms of budding support, tenant meetings and via a raft of organisational processes including complaints and suggestions. There is also an ideas board where users and staff alike can post ideas and solutions.

This model has successful incorporated a significant range of interventions on a small core budget; it has brought together statutory, voluntary and private agencies into its service delivery and provides a comprehensive forward thinking approach. At the centre is the user themselves who drive forward their own recovery journey. The combination of core and complimentary services ensures that there are positive outcomes across a range of determinates including:

- Reduction in social inclusion
- Increased giving back to the community
- Enhanced independence
- Reduction in homelessness and rough sleeping figures
- Increased recovery from substance misuse
- Increased joined up working with drug and alcohol treatment
- Increased joint working with the police and probation
- Support with employment options
- Increased economic wellbeing
- Better physical health outcomes
- Increase volunteering
- Reduction in debt

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Reduced homelessness/ rough sleeping	✓
Reduced costs in the health and social care economy	✓		

Psychologically informed environments (PIE)/ Mental Health

<table>
<tr><td colspan="2"> 
</td><td colspan="4">St Mungo's Broadway helps people recover from the issues that create homelessness and to rebuild their lives. They provide a bed and support to more than 2,500 people a night who are either homeless or at risk of becoming homeless and also work to prevent homelessness.

The organisation helps around 25,000 people a year. They support men and women through more than 250 projects including:
• Emergency, hostel and supportive housing projects
• Advice services
• Specialist physical and mental health services
• Skills and work services

They currently work across London and the south of England including in Bristol, Reading, Milton Keynes, Oxfordshire and Sussex, as well as managing major homelessness sector projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN).

The organisation also campaigns and influences nationally to help people to rebuild their lives. For more information visit www.mungosbroadway.org.uk</td></tr>
<tr><td colspan="2">Name of Model</td><td colspan="4">Psychologically informed Environments and Housing</td></tr>
<tr><td>User Cohort</td><td>Substance Misuse</td><td>Gender</td><td>Male and Female</td><td>Age Range</td><td>18+ year olds</td></tr>
<tr><td>Ethnicity</td><td colspan="5">Although this is not an ethnicity specific service , the service seeks to be inclusive and would not exclude anyone on the basis of ethnicity, and would seek to make appropriate adjustments to address access issues where required.</td></tr>
<tr><td>Recovery Rates</td><td colspan="3">90% positive move on in PIE provision</td><td colspan="2">Predominant Diagnosis

Complex Trauma
Personality disorder
PTSD
Opposition disorder
Persistent, pervasive problems
Co-morbidity
Attachment disorder
Emotion regulation</td></tr>
</table>

Brief Overview

St Mungo's are one of the pioneering organisations regarding the development and implementation of Psychologically Informed Environments (PIEs). Their involvement pre dates the PIEs concept which saw them introducing a similar approach into a housing model for homeless people with dual diagnosis in 2006.

The main aims were to provide a motivational environment from which behavioural change is generated through addressing the psychological and emotional wellbeing of the user group.

From the success of this pilot the concept was rolled out to other service types including their psychotherapy services and other housing models.

Although the organisation funds most of its PIEs activity through its charitable income; two particular commissioning bodies, Brent Clinical Commissioning Group and Camden Borough Council have purchased services based on PIEs principles.

The organisation then engaged with the work of Robin Johnson, Dr. Nick Maguire and Panos Vostanis which produced a plethora of research and a good practice guidance document on the PIEs concept:

Psychologically informed services for homeless people[1]

St Mungo's Broadway continues to lead the way in managing complex trauma in homeless people through creativity and innovations linked to the PIEs methodology.

The model in action

Psychologically informed environments focus on the psychological and emotional wellbeing of the user(s) and support the work St Mungo's Broadway do with homeless people with complex trauma.

At heart, the approach is enabling for the users as it recognises and employs the potential for change in all of us, helping the contemplation that change is possible and applying the support to try to help bring about such change.

The concept provides emotional safety, the development of trust, a greater understanding of behaviour and relationships with others in a genuine way, alongside a sense of community and inter-dependency.

For the staff teams and services it affords the inclination, capacity and opportunity to reflect and develop awareness and skills that are psychologically informed. It builds resilience in coping with the emotional impact of demanding work, enhances understanding of that work and informs the team's practice.

Although not all of St Mungo's Broadway services operate to the model, this is mainly due to funding restriction as opposed to intent but strategically the organisation has a desire to implement the notion of PIEs and are looking at investment in order to fulfill this.

Where their housing models implement PIEs (seven in total) the outcomes have been phenomenal and in a recent cross organisational data analysis exercise based on like for like user groups it highlighted:

Outcome Measure	**PIE**	**Non-PIE**
Rates of eviction	10%	26%
Positive move on	90%	70%
Reduction in serious untoward incidents	20%	5%

Most notably in the PIEs models then hospitalisation rates dropped dramatically to near non-existence.

PIEs can operate effectively across all tiers of care and support but primarily it is most beneficial where there is access to psychological therapies in the housing model for users and where staff teams operate within a clinical based ethos.

In St Mungo's Broadway one element of their PIEs model sees investment in the staffing structure of clinical psychologists/psychotherapists normally 0.4 FT equivalent per service working alongside team members. The organisation has developed a hybrid staff support system that includes reflective and dynamic 'team' approaches, training to develop and maintain psychologically minded staff, mindfulness, supervision by clinically trained psychotherapists and innovative client co-production.

In the model, clients access formal psychotherapy and personalisation input and live within a positive and informed environment with staff working with them on their aspirations and goals as opposed to addressing the negatives. Risk assessment and management focusses on individual dynamics and adopts a thoughtful response to situations and factors.

There is additional consideration given to the environment in PIEs models and where afforded then co-production between users and staff have generated the most beneficial outcome, whereby control over the physical space is seen as one of

1All references can be found on p. 55.

the fundamental contributor to successful recovery. The users that have experienced this new approach have expressed that they are more interactive not only with the accommodation model but with other agencies involved in their care and support. They are engaged and remain so for longer than ever before and initial outcomes suggest they feel valued and understood. More outcomes have shown a significant five times reduction in the use of health and medical services and user recovery and move on to sustained independent living.

The model also builds on the strengths of its collaborative relationships and partnerships with a range of bodies including GPs, health professionals, psychiatrists and mental health teams who have all expressed their appreciation for this additional input and ethos and have seen the difference made to this particular user cohort.

The organisation recognises that there is more work to be done if PIEs are to play a more recognised role and can demonstrate the major impact on people lives. Within this there is a need to develop other strands of the health and social care system e.g.to have psychologically informed:

- discharge from hospitals and long-term placements
- transitions between services or levels of care/ support
- housing options teams
- co-production/multi-agency input

Although it is still early days in gathering effective data, developing screening tools and outcomes measurements for PIEs, the initial evidence suggests for the user groups St Mungo's Broadway work with the outcomes are clear. They have enabled some of the most disengaged people to change and go on to lead fulfilled and active lives. PIEs not only address the priority and immediate needs, it can contribute to lifetime changes.

Areas where the model can demonstrate outcomes

Lower offending rates		Greater levels of inclusion	
Lower admission to low and secure units		Greater access to services	✓
Reduced cost to commissioners	✓	Heightened independence	✓
Improved mental health	✓	Reduction in the use of secondary care services	✓
Improved physical health	✓	Reduction in the use of primary care services	✓
Improved wellbeing	✓	Better self-management	✓
Reduction in mental health symptoms	✓	Reduced costs in the health and social care economy	✓
Reduced costs in the health and social care economy	✓		

General Findings

a. The housing models sampled in this report exude a high level of quality and represent some of the most innovative environments and pathways for people with mental health issues.

b. The scope of the sample included models that have been specifically designed to meet the needs of specialist user groups and general mental health, however cross cutting themes include the increasing complexity of referrals, introduction of holistic assessments processes, integrated and collaborative support and planned interventions, multi-agency co-production and on-going inter-agency support.

c. The complexities of service users as mentioned in b. include increased levels of dual diagnosis, people living with co and multiple morbidities, history of offending behaviour, people referred with forensic histories, with learning disability and personality disorders.

d. The productivity levels in the models sampled can partly be attributed to their design and ability to operate at a preventative and reactive level when meeting the needs and outcomes for the user groups.

e. There are three main types of property designs that have emerged from the sample: high specification purpose built core buildings, remodelled existing properties and the use of existing dispersed housing stock. All have been specifically designed to fit their intended customer's needs. This can be demonstrated in the use of communal space, location and increased use of "own front door" models.

f. Each sample offers variances on their internal layouts and are archetypal of their cohort of users e.g. step down models from low and secure accommodation and longer term hospital stay offer more communal and shared spaces as opposed to those provided for more general mental health illness.

g. Again it has been noted that a contributing factor to f. is the definition of the level of care and support offered in each model and this ranges from high and intense levels to low level housing management functions. However, all of the samples have balanced the importance of the physical environment remaining homely and practical, intertwining this with therapeutic and psychologically informed environments.

h. Recognition that good building design can facilitate community interactions, positive non-intrusive observations, enhanced engagement and reduced isolation.

i. All recognise that good mental health requires more than just health and social care services and must involve a broader range of community resources including housing, education, employment and service/activities provided by community and voluntary organisations.

j. A need for housing to be more aligned to the health agenda than purely seen as a social care commodity as these samples demonstrate the long established links between good housing, better health and positive outcomes.

k. All of the models have generated positive outcomes for users across a range of social, health and economic measures and although it can be argued that they have contributed to savings within government spending, organisations have mixed abilities to determine the precise level of savings made across the health and social care economy. However, all collate a data set that incorporates hard outcomes and those less tangible e.g. wellbeing.

l. In all of the models there is a determination to provide people with mental health issues the skills and abilities to live the best lives possible. This can be seen with the introduction of holistic person centred planning which aims to address wider social determinates of poor health and contributing to a reduction of inequalities, improving health and wellbeing, enhancing economic standing and offering housing options.

m. The majority of the models are delivered by non-clinical staff teams and are focussed on

various types of social recovery models and behavioural change methodologies. These have all integrated clinical pathways and interventions delivered through multi-agency input, striking an appropriate balance based on individual user need, aiding the recovery journey.

n. The models that employ clinical staff members are those managing specialist user cohorts e.g. forensic and early interventions in psychosis. Clinical roles include registered mental health nurses and psychologists.

o. Most of the examples in this report are offering "bolt on services" free of any commissioning or funding arrangements. These are normally within the transitional functions of moving in or moving out and take the form of time limited resettlement or pre placement engagement.

p. The sample represents a range of commissioning and contractual types from full or partial block contracts with health and local government, mainly in services where nominating rights are required or where they are linked to a specific user cohort e.g. forensic step down. More common though is the use of supporting people funding, spot purchase arrangements and personalised budgets.

q. The level of collaborative working is phenomenal and includes co-production partnerships at the design stage, shared values and interest in the model's application and working jointly for the betterment of the user.

r. New and emerging approaches such as psychologically informed environments (PIEs) should be explored further and commissioning of these should be at the forefront of new thinking for housing models for particular patient and user cohorts. More investment into the research and development of outcome measurement tools and how to establish PIEs successfully should form a part of the future agenda. This can be aiding through contacting and or reading the existing body of work in this area:

The Psychologically Informed Environment or PIE

Psychologically informed environments and the "Enabling Environments"initiative

Psychologically informed services for homeless people

Additional Commentary

As the NHS seeks alternatives to caring for people with mental health issues, the third sector (including housing associations) are in the best position to respond to changing needs. The assets of and contribution from the sector cannot be underestimated and throughout the samples there is evidence that aside from delivering effective housing pathways and housing options it can:

- Capital and asset manage
- Provide affordable rents
- Provide decent quality accommodation
- Be innovative and creative responding to fluctuating and ever changing support and care needs
- Operate and navigate through the plethora of conflict policies
- Problem solve and be resilient when faced with fragmented commissioning and funding streams
- Provide available housing that is sustainable
- Create accommodation options
- Facilitate early discharge
- Lessen the future demand for primary and secondary mental health services
- Provide greater geographical locations locally
- Facilitate and work within multiple agency provision
- Provide added value to increase economic wellbeing, employment and healthy lifestyles
- Oversee the integration of housing into discharge and statutory care planning
- Be at the centre of health partnerships with other NHS bodies enabling housing to play a significant function in providing greater independence and choice.
- Localism and community ownership
- Tackle homelessness

Housing for people with mental health issues should be at the centre of community psychiatry and be influencing the direction of travel. Although housing is often defined as a social commodity it is a fundamental health driver from where safe and stable environments are provided. It can contribute to the co-ordination of care and the management of risk and be proactive in supporting the recovery and rehabilitation of service users.

More thought needs to go into commissioning of housing models, in particular to widen the options and choices and tackle a range of issues including "the having to move to receive" approach and the inclusion of "wrap around services" from the onset of design.

There needs to be a move away from fragmented commissioning that has, in the past, procured isolated services that have not considered the ripple effect where commissioned services may increase the use of resources and interventions required from elsewhere.

As Local Authority commissioning is limited to core services and austerity remains the driving force, integrated commissioning is one key factor in addressing the need to diversify funding streams for housing models that generate a broad range of health, social and economic outcomes.

Consideration should be given to how self-directive care, individual health budgets and the personalisation agenda can interact with housing pathways.

There is a desire to see more needs-led design as opposed to fitting the needs into the property or pathway. This should include the notion of "homes for life" where individual dwellings have the ability to adapt to meet changing care needs e.g. ageing.

The opportunity should be created to look at the incoherent regulation of the supported housing and residential care sectors.

The importance of the physical environment cannot be emphasised enough. The properties in all models have the ability to generate positive outcomes for users, contribute to risk management and safeguarding of people. They provide hope and opportunities and a real choice.

In commissioning regimes there needs to be a sensible balance drawn between quality, outcomes and the contract value. A real and cautionary approach should be encouraged to cease the recent decline in hourly rates, particularly in low level interventions such as domiciliary care

and the increased use of zero hour contracts most common in social care contracting.

Consideration of how to create a greater choice of housing options for people with mental health issues similar to those experienced by other user groups e.g. learning disabilities and older people including tenancy diversity.

The right balance and use of tenure mix is important to ensure move on and allocation of appropriate housing/choice is maintained.

There are few examples out there of people with mental health issues who have any permanent stake in their homes; therefore further exploration of "shared ownership" models should be encouraged.

There needs to be consideration about how housing models can fully integrate social care, personal care, health care with choice and control.

Housing models should remain affordable, be efficient and of a decent standard. There needs to be more cohesion across the sectors to address the adult social care eligibility criteria and people who continually fall between the gaps in provision. We need to ensure that the availability of the best housing options for vulnerable people becomes the norm.

References

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