

## **Getting a move on**

Addressing the housing and support issues facing Londoners with mental health needs



July 2003



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**Cover image**

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*'I was admitted to The Maudsley Hospital in March 2002 after suffering a breakdown. It was from here that I began using art as a form of mental therapy. This picture was drawn while attending occupational therapy, since then I have been attending Network Arts Lewisham. I have also completed a pre-foundation Art course, a 20th Century Art History course and I have been offered a University place which starts in October 2003.'*

Veli Bekir July 2003

Veli has been attending Network Arts Lewisham, an arts project for people with mental health support needs. For further information visit the website [www.networkartslewisham.com](http://www.networkartslewisham.com) or write to Network Arts Lewisham, 2nd Floor @ Olbys, 307-313 Lewisham High Street, London SE13 6NW

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## Foreword by Ken Livingstone, Mayor of London

*Getting a Move on* is an important report about the housing and support issues that face people with mental health needs trying to return to life in the community after a period of treatment. It describes the experiences and views of people with mental health needs and service providers about trying to get the right housing and support.

One in four people will face some form of mental health issue during their life and London has a high proportion of people more vulnerable to mental health problems, including young people and people living alone. That's why I have identified mental health as an important policy priority.

Stable and appropriate housing for people with mental health needs is essential for rehabilitation, security and social inclusion. As this report shows, there are still many barriers to adequate provision and access to the right accommodation and support services. The research identifies good practice that has been useful in overcoming local problems and could be used by others to improve services.

I believe the report's recommendations can make a real impact on providing better access to the right housing and support and helping people who have suffered mental health problems to live more independent lives. I will be exploring with partner organisations how best to implement them.

A handwritten signature in black ink that reads "Ken Livingstone". The signature is written in a cursive style with a large, stylized 'K' and 'L'.

**Ken Livingstone**  
Mayor of London



## Summary

### Introduction

- This project was conducted by staff from the Greater London Authority (GLA), Association of London Government (ALG), Sainsbury Centre for Mental Health (SCMH) and Advocacy Really Works (ARW), supported by funding from the GLA.
- The purpose was to examine the problems associated with people moving on from acute mental health provision to supported housing and on towards greater levels of independence, and to suggest ways of addressing these issues.
- Move-on is a term that a number of commentators use solely in relation to a move into independent accommodation from a more supportive environment. In this study however, we have used the term to describe the broad range of moves, including moving from inpatient settings, which can be faced by someone when they are accessing the mental health services and accommodation appropriate to meet their needs.
- Social exclusion of people with mental health needs is a key issue, compounded by many factors including the shortage of suitable good quality, affordable accommodation. Factors that can lead to a high level of mental health needs are more prevalent in London than other parts of the country including poverty and more overcrowding.

### The research methodology

- Eighteen housing projects in one Outer and two Inner London boroughs, encompassing high, medium and low levels of support, were selected.
- Staff from the housing projects selected, and from the local authority Social Services and Housing Departments and the NHS in each borough, were interviewed along with people with mental health needs with experience of the move-on process. Staff from Social Services, Housing and Health are referred to as statutory sector staff throughout the report. The people with mental health needs interviewed are referred to as residents.

### Summary of the main findings

#### The residents

- Most of the residents interviewed had come into supported housing from hospital; a third of them had waited up to six months for allocation to their present housing, while over half had waited more than a year.
- Most of the residents had found their present accommodation via their Social Worker, Community Psychiatric Nurse (CPN) or Key Worker. In general, the residents spoke positively about these staff, but were concerned about a lack of continuity of staff and a lack of communication between agencies.
- Delays in moving on to independent unsupported housing were mainly due to a shortage of such accommodation and the way in which the benefits system works.
- The residents who were most content with their present housing situation were in supported accommodation with some degree of independence.
- Some residents reported feelings of isolation, being subjected to noise from other residents and felt that the local area was unsafe.
- Most of the residents who were happy with their housing had previously lived in hospital, on the streets or in bed and breakfast accommodation. They felt that living in supported housing or their own flat was a great improvement.

### The housing project staff

- Interviewees valued having up to date and accurate information about the housing available for people with mental health needs, seeing it as essential to a successful move-on process.
- Most of the project staff regarded trial periods in new accommodation as an important step in making a successful placement. There was however considerable financial pressure on those funding a placement to keep these to a minimum.
- A number of housing projects reported that the dependency levels of people being referred to them were increasing; in some cases, they planned to modify their service to meet these new demands.
- Some interviewees suggested that there was a tendency towards maintaining the status quo in the system, with statutory sector workers overly cautious about placing their clients in new situations, residents being reluctant to move into less supportive settings, and project managers employing restrictive acceptance criteria to prevent the introduction of residents with complex needs. This reluctance to change by all involved may hinder the move-on process.
- The Care Standards Act was said to impose staff qualification requirements that some projects viewed as compounding existing recruitment and retention problems.

### The statutory sector staff

- Staff in each of the three boroughs had developed procedures for moving clients out of acute mental health care, through the range of supported housing and finally into independent housing.
- Panels had been established in all three boroughs comprising representatives from Social Services, Health services, Housing Departments and housing providers, meeting regularly to consider the placement of people with specific issues, including mental health needs. In one borough, a jointly funded post had been set up to assist the panels.
- Two boroughs reported significant numbers of people in hospital waiting for accommodation. The third described regular meetings to discuss reviews and the discharge of clients from hospital, suggesting this helped them to reduce their numbers of delayed discharges.
- Because of the shortage of suitable housing locally, staff reported reluctantly having to place some clients in housing out of the borough, recognising this was not ideal as it impeded continuity of care. Similarly, they reported difficulties in providing support to clients placed locally from other boroughs.
- Staff identified the ideal range of accommodation needed, including different levels of support, access to local authority or housing association flats with funding for furniture and 24-hour floating support.
- All three boroughs regularly used local needs assessments to inform their planning of future housing developments, and one mentioned involving people with mental health needs in the planning process.
- Staff in all three boroughs identified improvements they wanted to make to existing services, and new types of work they wanted to initiate, to contribute to the effectiveness of the move-on process. They were also exploring how to reorganise provision to enable more efficient spending, as well as new ways of getting funds.

## Common Findings

- Housing providers and statutory sector staff attributed delays in the move-on process to gaps in existing provision, especially for people with specific needs such as those with a brain injury, dual diagnosis or a forensic history and for people from minority ethnic or religious groups and men and women who needed single sex accommodation.
- Other obstacles in the move-on process included delays in funding for placements, shortages of staff and other resources, administrative delays and the discrepancies of the benefits system.
- The inadequate supply of affordable independent accommodation in London was also a key concern to interviewees from all groups.
- Most staff from all sectors described good working relationships with others, although there were some examples of poor communication and delays in the exchange of key information due to staff leave or sickness, or incomplete paperwork.
- Most of the housing projects had encountered problems both with recruiting qualified staff and with providing adequate training for existing staff. This was also an issue for the statutory sector.
- Most of the housing projects and statutory staff were positive about Supporting People. However, some were uncertain about how it would affect them. Some people felt it would be useful in terms of funding, care provision and the review and reporting process.
- It is currently unclear what impact the development of Choice Based Housing Letting Schemes will have on the ability of people with mental health issues to access appropriate housing, but it is important they are not disadvantaged either by complex processes or by discrimination.

## Conclusions and recommendations

### Views on the movement of people with mental health needs through the system

Although the impression given by the majority of the interviewees in this study was largely positive about the processes involved in providing people with the services they need at the times when they are required, there were also clear examples of delays in the system and services not entirely matching the needs of clients.

#### Recommendation 1:

The GLA, the ALG and the London Development Centre for Mental Health should work together on mental health and housing issues and support the implementation of relevant recommendations.

### The lack of accommodation, support and other resources

Those interviewed in the study attributed delays in the system primarily to gaps in existing provision. The groups that were particularly mentioned as not being well catered for were those with complex needs, brain injury, a dual diagnosis or a forensic history. There was also said to be insufficient resources for people from minority ethnic or religious groups and those requiring single sex accommodation. The project staff, the statutory sector staff and residents all highlighted the inadequate supply of affordable independent accommodation in London as a key concern.

**Recommendation 2:**

Accurate needs mapping, incorporating unmet needs, must take place at a local, sub-regional and regional level in order to plan services for all client groups effectively. The *National Service Framework Mapping Database* (see: <http://www.dur.ac.uk/service.mapping/amh/index.php>) and information collected as a result of the implementation of Supporting People has led to the bringing together of some valuable information about existing supply. However, it is still unclear how well the existing supply matches the needs of Londoners with mental health needs. The Government should work closely with all those involved with people with mental health needs to make sure that the shortfalls between supply and demand in the full range of services (everything from high care residential to day centres) are accurately assessed. Regular reviews of the match between provision and needs should be undertaken.

**Recommendation 3:**

London has its own unique requirements for mental health services. It is important that these requirements are reflected in the allocation of Central Government funds. The London local authorities' Social Services and Housing formulae should be reviewed to make sure that they are fair and they enable adequate services to be developed within the capital. It is also important that the Supporting People programme receives adequate long-term funding to allow appropriate improvements to be made and sustained. By providing a better assessment of needs and available provision, Supporting People is likely to highlight important areas of previous under-funding.

**Recommendation 4:**

Where a gap in provision has been identified, local authorities, health agencies, the Housing Corporation and voluntary and private sector providers should work closely together to identify how best to develop and fund these new services. If a highly specialist service is required that is beyond the means of an individual borough to develop, it is important that appropriate regional and sub-regional groupings are working together to develop such services. Opportunities for the development of such arrangements should be maximised by all concerned as part of the move towards the full implementation of Supporting People.

**Recommendation 5:**

Expansion of the supply of affordable long-term independent housing for people with mental health needs must be prioritised to ensure appropriate housing opportunities for clients at the final stage in the move-on process, in both the social rented and private housing sectors. It is important that the Mayor's plans for 23,000 new homes to be built in London each year are achieved and 50 per cent of these must be affordable housing. The requirements of people with mental health needs should be considered in the planning of these homes.

**Information about existing provision**

Up to date and accurate information about the available provision for people with mental health needs and good procedures for sharing this information were highly valued by those we interviewed. Information about the availability of provision and the knowledge to match the needs of clients to this provision is essential to a successful move-on process.

**Recommendation 6:**

The leads of Local Implementation Teams (LIT) should ensure that they meet their responsibility to make sure that the *National Service Mapping Database* is accurate and kept up to date to ensure that information about the full range of provision for people with mental health needs is available.

**Recommendation 7:**

Robust procedures should be in place in all boroughs for allocating accommodation, using full data on people with mental health needs and up to date information on provision. A useful model being used in the study areas was the establishment of regular panels where key personnel are brought together in order to match the needs of clients with well organised information on current vacancies collated by a key person with a specific responsibility for this work.

**Recommendation 8:**

The viability of providing an online database of mental health provision containing up to date information about vacancies and waiting lists should be explored. The Hostels Online website which includes information about hostel vacancies for homeless people could provide a useful model for this.<sup>1</sup>

**Trial periods**

Trial periods in new accommodation were widely regarded by interviewees as an important step in making a successful placement. However, there was considerable financial pressure on those funding placements to keep trial periods to a minimum because the cost of such placements needs to be met whilst at the same time maintaining an original placement in case the new placement breaks down.

**Recommendation 9:**

The value of trial periods in avoiding placement breakdowns in supported housing may need further investigation, but if, as seems likely, they do lead to more successful placements, then further ways of funding them should be explored. For trial periods not to cause delays in the system a small permanent surplus of places in all types of accommodation may need to be maintained. The sub-regional groups established as part of the Supporting People process could explore ways in which such a surplus might be maintained if appropriate.

**Working relationships**

Although most interviewees described good working relationships with others in the mental health sector, there were a few examples of poor communication and delays in the exchange of key information. In the case of inappropriate referrals, the cause was often a lack of information about the potential resident. This could be addressed through an improvement in the information available (see 'Information about existing provision' above). There were some delays in holding key meetings because people were on leave or off sick, or because of incomplete paperwork.

**Recommendation 10:**

A shared and agreed approach to defining needs would reduce the level of confusion around

the needs of individual clients and make it easier for them to access appropriate accommodation and support. Where they do not currently exist, protocols should be developed on how information is to be shared between statutory agencies and with the voluntary and private sector. These should include appropriate arrangements to cover for staff absences and delays in completing relevant paperwork. A London-wide approach to these issues is recommended.

### **Changes in service provision**

A number of projects felt that the dependency levels of those being referred to them were higher than previously, and in some cases, they planned to modify their service to meet these demands.

#### **Recommendation 11:**

Commissioning approaches should encourage the market to offer a wider range of provision as closely matched to the needs of the community as possible. Those planning services on a regional/sub-regional/local level should closely monitor shifts in the market and make sure that important types of provision are not lost because of such shifts.

### **Staff in the projects**

Most of the projects had encountered problems both with recruiting qualified staff and with funding adequate training for existing staff. The value of a skilled workforce in relation to facilitating the move-on process should not be underestimated. Staff working in projects have a key role to play in helping people with mental health needs move towards independence.

#### **Recommendation 12:**

Both recruitment and training issues in the sector need to be explored at a regional/sub regional level. Creative ways need to be developed to attract staff and provide them with the incentives to remain in the capital. Addressing the affordable housing shortage discussed above is clearly a key part of this. Special attention should be paid to the needs of smaller providers to assist them in the adoption of a more professional approach to staff development issues.

### **Approaches to rehabilitation and the impact on move-on**

Some interviewees suggested there was an overly cautious attitude in the system, with statutory sector workers on occasion reluctant to place people in new situations, residents sometimes reluctant to move into less supportive settings, and project managers from time to time employing restrictive acceptance criteria to prevent the introduction of residents with complex needs. This tendency towards the status quo from all those involved may have a negative impact on the move-on process.

#### **Recommendation 13:**

Clients' long-term goals should remain of paramount importance. More checks may need to be built into the system in order to regularly review progress towards greater independence.

#### **Recommendation 14:**

When move-on is planned, there should be appropriate consideration of a resident's needs with

particular attention paid to figuring out what might help to make each stage of their move less daunting and how best to provide this help.

### **Input from people with mental health needs**

A significant number of the residents interviewed identified things they were unhappy about in relation to their existing accommodation such as noise levels and problems in relation to maintaining their privacy.

#### **Recommendation 15:**

People with mental health needs should be regularly consulted about the services that they receive and wherever possible their views should be taken into account when making improvements in existing services or developing new ones.

### **Supporting People and other policy and legislative changes**

Some concern was expressed that the new Supporting People contracts arranged with providers may limit the referral routes into projects, thus making it more difficult for out of borough placements to take place. Whilst an emphasis on local placements is welcomed it is important that people with mental health needs in boroughs with an inadequate supply of local provision are not penalised. There should not be a situation where projects have vacancies because they cannot accept referrals from those whom they would otherwise wish to accommodate.

The Care Standards Act was reported to impose staff qualification requirements that some projects viewed as compounding existing recruitment and retention problems.

#### **Recommendation 16:**

Local authorities and the ALG should carefully monitor the effect of new Supporting People contracts on provision in London. This is particularly important over the next three years of protected funding and service reviews when there are unlikely to be major shifts in the supply of different types of accommodation in each area, but any changes in arrangements for accessing it could restrict new placements.

### **Allocations procedures**

It is currently unclear what impact the development of Choice Based Housing Letting Schemes will have on the ability of people with mental health needs to access appropriate housing, but it is important they are not disadvantaged either by complex processes or by discrimination.

#### **Recommendation 17:**

Those who establish Choice Based Housing Letting Schemes should pay close attention to the findings from the 27 Office of the Deputy Prime Minister (ODPM) funded pilot schemes and their impact on people with mental health needs and other vulnerable groups.<sup>2</sup> They should also consult, and preferably involve, people with mental health needs and the agencies working with them when developing and implementing such schemes.

**Recommendation 18:**

People with mental health needs must be provided with the necessary support in relation to these schemes; both in terms of making applications and also in maintaining tenancies once they are in their new homes.

**Recommendation 19:**

Where Choice Based Letting is not seen as a viable option, individuals should be able to opt out and have alternative arrangements made on their behalf.

**Recommendation 20:**

Mechanisms should be established to monitor the effects of all schemes. These should include regular consultation with disadvantaged groups to make sure that they understand the schemes and close scrutiny of their bidding activity.

## 1 Introduction

### The organisations involved in the research

This project was conducted by staff from the Greater London Authority (GLA), Association of London Government (ALG), Sainsbury Centre for Mental Health (SCMH) and Advocacy Really Works (ARW), supported by funding from the GLA.

Under the GLA Act (1999) the Mayor and the GLA have a responsibility to promote the health of Londoners in exercising their powers and mental health is one of the priority areas identified by the Mayor for improving the health of Londoners. This priority is being reflected both in the work of the London Health Commission launched by the Mayor in October 2000 and in the work of the GLA itself.

The GLA has its own Health Policy Team, established in order to take forward Mayoral objectives in relation to health. In their initial work programme the team identified the improvement of mental health services as one of their main objectives. This project was developed following extensive discussions with key London stakeholders, many of whom identified problems in relation to move-on as a key concern.

The Sainsbury Centre for Mental Health is a national charity established to improve the quality of life for people with severe mental health issues by enabling the development of excellent mental health services, which are valued by users, carers and professionals. SCMH staff have considerable experience of the mental health sector having been involved in a broad range of work from policy development and research, to service development and training.

The ALG speaks up for Londoners, and their local councils. The ALG's work falls into four main areas:

- Making the case for London, fighting for adequate resources and powers so that member councils can do the best job they can.
- Leading the debate on key issues, developing policies and influencing Government thinking to benefit Londoners.
- Spreading good practice and generally helping boroughs to improve the services they deliver.
- Providing excellent services on behalf of the boroughs.

Advocacy Really Works is a service user led mental health consultancy with considerable experience of working with providers and their clients in order to develop services that are more effective.

### Mental health issues in London

The social exclusion experienced by people with mental health needs arises from the complex interactions of a range of factors including: discrimination; few opportunities for employment; poor access to appropriate health care and support and the lack of good quality, affordable housing.

London has a higher level of mental health needs than other parts of the country. This difference is due to a range of factors, some of which are listed below:

- Poverty and deprivation are major determinants of mental illness. London includes 13 of the 20 most deprived districts in England and London's mental health services cater for much higher numbers of patients from deprived areas than the rest of England.<sup>3</sup>
- In London women are over one and a half times more likely than men to experience a neurotic disorder. Women in London experience neurotic disorders at a rate of 224 per 1,000 compared with 194 per 1,000 in Great Britain.<sup>4</sup>
- The London population has a younger age profile than other parts of the country. There are more inpatients in the 15 to 44 age group and fewer in the over 75 age group in London's mental health wards. The mental health issues of younger people differ from those of older people as they have higher levels of psychotic disorders.<sup>5</sup>
- Twenty nine per cent of London's population is of black and minority ethnic origin; this is 46 per cent of England's total black and minority population. Black and minority ethnic people are more likely than white people to be diagnosed as suffering from severe mental illness than depression, less likely to receive therapy and counselling treatments and more likely to be admitted to secure hospitals under sections of the Mental Health Act 1983.<sup>6</sup>
- Estimates by mental health trusts indicate that refugees account for as many as one in twelve of all service users in London.<sup>7</sup>
- London has high levels of dual diagnosis and high inpatient occupancy rates compared to other parts of the country.

### Origins and aims of the research

In recent years considerable attention has been focussed on the 'inefficient' use of mental health inpatient wards and crisis centres. It is widely acknowledged that people often end up staying in these settings for an inappropriate length of time when their needs could be met both more appropriately and more cost effectively elsewhere. This issue was highlighted in the *NHS National Service Framework for mental health*<sup>8</sup> published in September 1999:

*'Surveys of acute psychiatric wards also indicate that up to one third of inpatients would be better placed elsewhere. This is likely to reflect a tendency for patients to stay longer than they need to, with discharges delayed by inadequate rehabilitation services, and shortages of move-on accommodation, especially 24-hour staffed accommodation, or supported independent accommodation arranged by the local authority.'*

*Similar surveys in secure units also indicate patients placed inappropriately in levels of security which are higher than needed. There are gaps in medium secure provision, especially long stay medium secure provision, in local intensive care provision, in long stay low secure accommodation and in the number of supported community places, including day care. These shortfalls result in delayed discharge and transfer, put extra pressure on local inpatient services, and hinder the effective use of resources.'*

Stakeholder discussions conducted by the GLA prior to the decision to start this project highlighted two particular areas of concern which were thought to be causing the delays in the system described in the *National Service Framework*:

- 1) There are a number of problems with the existing mental health provision that hinder the ability of people with mental health needs to move appropriately through the system. For a start it would appear that the current mix of services does not match the needs of current users. It is suggested that a number of existing services which were set up to cater for people coming out of long stay hospitals do not adequately meet the needs of the new generation of service users who often wish to live more independently. In addition there would appear to have been a failure to develop the required level of services. There are widely acknowledged shortages in relation to some specific types of provision and in London there are major concerns in relation to the lack of affordable independent housing. There are also problems in relation to the recruitment, retention and training of staff that hinder their ability to deliver services effectively.
- 2) The care management process does not always run as smoothly as it should. There is room for improvement in the working relationships between statutory sector mental health services and supported housing providers. Even taking into account existing rules on confidentiality, the exchange of information about service users is often inefficient.

The purpose of this study was to examine these issues more closely, and to learn about effective ways to address them.

Due to the variety of support options available to someone with mental health needs the term move-on is used throughout this report to describe a wide range of accommodation including residential care homes offering 24-hour support and independent housing with little or no social care or health input.

### Research methodology

This project was designed to be a qualitative study aimed at identifying current experiences, procedures and practice relating to people moving on from acute mental health provision to supported housing in London. The research team was aware of the different approaches and terminology used by service providers. The Greater London Authority supports the social model of disability; this report acknowledges that problems and barriers encountered by people with mental health needs can arise from the stigma and discrimination that they face.

As a starting point we selected three learning areas: one from Outer London (Borough A) and two from Inner London (Boroughs B and C). Previous experience suggested that although focusing our study on a small number of boroughs would make it hard to generalise about the move-on process it would still be possible to learn a lot from the experiences of housing providers, statutory sector staff and service users in these boroughs.

A variety of data sources, notably the national service provision mapping data compiled by Local Implementation Teams (held at [www.dur.ac.uk/service.mapping](http://www.dur.ac.uk/service.mapping)) and the Care Homes Information Network at the ALG, were used to obtain details of the available provision for

people with mental health needs in the selected boroughs. From these, 18 housing projects were selected, six in Borough A, four in Borough B and eight in Borough C. The balance between Inner and Outer London boroughs was chosen to reflect the fact that people with mental health needs are more likely to be concentrated in Inner London.

Based on the information provided by staff, the housing projects were categorised as having high, medium or low levels of support. High support indicated 24-hour staffing including waking night staff, medium support consisted of staff being available during the whole day or visiting regularly, and low support meant peripatetic staff and/or an alarm or on-call system. Twelve high support projects were selected, along with four providing medium support and four low support. Since the majority of people coming out of acute inpatient mental health care are likely to need a high level of support, at least initially, it was appropriate for the balance of the housing projects studied to reflect this.

Most of the housing projects involved in the research were run by housing associations (HAs) and other voluntary sector organisations with a small number in the private and statutory sectors. This reflects the overall predominance of this type of housing provision being in the voluntary sector, as statutory provision has decreased over the years and the private sector is not well developed, especially in Inner London.

**Table 1 Housing projects by type of housing provider**

<b>Type of housing provider</b>	<b>Number</b>
Housing associations	11
Other voluntary sector/charity	2
Local authority Social Services Department	1
Partnership between local authority Social Services Department & HAs	1
Private sector	3
<b>Total number of housing projects</b>	<b>18</b>

Most of the projects were non-specialised, offering services to people with a wide range of mental health needs, while two were for men only and a further two catered for clients from particular ethnic or religious groups.

**Table 2 Housing projects by type of residents**

<b>Type of residents</b>	<b>Number</b>
Wide range of mental health needs (Non-specialised)	14
Men only	2
Specific ethnic group	1
Specific religious group	1
<b>Total number of housing projects</b>	<b>18</b>

In each borough we interviewed staff from the selected supported housing projects, focusing on their perception of the move-on process into and out of their service, asking them to highlight where they believe things work well and where problems remain. All the housing

project staff we interviewed were managers of sufficient seniority to have detailed knowledge of their service, the referral process, relationships with other organisations and sectors and the overall context in which supported housing for people with mental health needs operates.

We were not looking for a representative sample, but were concerned to make sure that the projects selected covered as many types of supported housing provision as possible (from residential care homes to low level supported housing) and that the interviewees from the statutory sector covered as much of the move-on process as possible. All those interviewed were asked about their perception of the move-on processes and about their concerns. They were also asked to discuss current or forthcoming developments that might go some way towards addressing these issues.

The statutory sector staff were from Health, Social Services and Housing Departments. Interviews were conducted with between two and four representatives of the statutory sector in each borough. Almost half of the statutory staff interviewed were Health Managers, while about a third were Social Services Managers and just under one fifth were Housing Managers. One of the Housing Managers was a Joint Commissioning Officer, located in the Housing Department with a role encompassing Health, Housing and Social Services.

**Table 3      Statutory sector staff interviewed**

<b>Type of staff</b>	<b>Number</b>
Health Manager	5
Local authority Social Services Manager	4
Local authority Housing Manager	2
<b>Total number of statutory staff</b>	<b>11</b>

In order to ensure that as many of the issues as possible raised by the housing project staff could be discussed with the statutory sector staff, and vice-versa, interviews were staggered in both sectors throughout period of the study. It is worth noting that in order to increase the likelihood that some positive learning points would be gained from our interviews it was decided to start by asking colleagues working in the sector to identify potential interviewees who they thought it would be useful to talk to in both the housing projects and the statutory sector.

Having selected the projects, we sent each of them a questionnaire aimed at finding out basic information about their work and establishing the main issues they might wish to discuss in an interview. This enabled us to focus our interviews on the issues they had already highlighted.

In order to obtain residents' views of the various stages of the move-on process, ARW used focus groups, questionnaires and one-to-one interviews to obtain the views of 28 residents from high support, low support and unsupported accommodation in the three selected boroughs.

## 2 Review of social policy and literature

### Introduction

Inpatient services form part of a continuum of care for people with mental health needs, other elements of which are services providing alternatives to hospital admission, and those which offer follow up and support after discharge. While hospital inpatient services are provided by the NHS, some recent residential alternatives to admission, such as crisis houses, are located in the voluntary sector, as are many housing projects and community-based support services for people with mental health needs. Local authority Social Services and Housing Departments have played a diminishing role in this type of provision in recent years. To function effectively, the system depends on people with mental health issues moving through the different levels of care as their needs change, but in practice people can get stuck in inappropriate settings, usually acute inpatient care, unable to move on due to factors unrelated to their mental health. The majority of the published literature describes the problems caused to individual service users and to the mental health services as a whole, when this system fails to work effectively.

### The NHS and Community Care Act 1990

The Sainsbury Centre for Mental Health (1997) examined the existing framework for providing housing and support for people with mental health needs.<sup>9</sup> It suggested that the NHS and Community Care Act of 1990, and the introduction in 1991 of the Care Programme Approach (CPA) for everyone in contact with specialist mental health services, challenged the concept of integrated housing and support, putting the focus on tailoring support to meet individual assessed needs. The Community Care Act emphasised the separation of housing from support, in theory allowing a more individual care plan to be drawn up by a designated Care Co-ordinator in which housing and support needs were separately assessed and, subsequently met, although in practice housing needs were often neglected.

The Community Care Act and the CPA also firmly identified people with severe and enduring mental illness as the main target group which mental health services should be working with, taking the focus away from people with less severe mental health needs, many of whom also had unmet housing needs. The SCMh report identified the need for providers to re-examine the model of care provided so as to meet the needs of today's service users, and recognised the value of detaching the support element from the housing component of individuals' care packages. It concluded that the *Housing, Care and Support Code* produced in 1996 by the National Housing Federation, the Mental Health Foundation and the Housing Corporation's 1996 *Tenants' Guarantee for Special Needs*, provided the framework for much good practice in this area.

### Delays in discharge

The shortage of move-on accommodation with support for people coming out of mental health inpatient units in London has been recognised as a problem for some time. In 1997, a comprehensive study of London's mental health by The King's Fund<sup>10</sup> found there was an average of seven weeks delay in accessing supportive accommodation across all the London NHS Trusts, while in the worst areas waits of six months were frequent, with a maximum of three years being reported. Johnson et al comment that this is an unacceptable level of delay, both for the individuals who no longer need the intensity of inpatient treatment, and for the

services whose beds are effectively 'blocked' and unable to admit those with more acute and pressing needs.

A 1998 survey of the quality of care in acute psychiatric wards by The Sainsbury Centre for Mental Health found that delayed discharge was due a number of factors, including problems finding accommodation with high levels of supervision, the lack of rehabilitation services, the lack of domiciliary support and the lack of suitable accommodation for those who were homeless.<sup>11</sup> It was additionally discovered that 70 per cent of patients who had been in hospital for more than eight weeks were judged by the ward staff to no longer need inpatient care, but staff were finding it difficult to arrange the necessary housing and support programmes to enable discharge to take place.

### 24-hour nursed care

In 1996, the Department of Health (DOH) was developing plans for a new type of residential provision, 24-hour nursed care, in response to concerns about a small number of people with severe mental health needs who also exhibited risk behaviour and could not manage successfully in the community without high levels of nursing and other specialist support. Such units would cater for around 12 people each, mixed in terms of gender, age and ethnicity, be located in the grounds of, or near, an existing hospital, provide residents with their own rooms, and have nursing and support staff on duty at all times with a specific remit to supervise medication and assist with activities of daily living such as cooking and doing laundry. It was anticipated that this type of care would ease the problem of delayed discharge for people whose need for accommodation and support could not currently be met. While still at the developmental stage, researchers were asked to gauge the acceptability of this model among current service users who might be potential candidates for 24-hour nursed care.

Rose and Muijen<sup>12</sup> interviewed a number of people, mostly in London, who were inappropriately placed in hospital, hostel or bed and breakfast accommodation while awaiting a suitable placement. A large majority said they would prefer independent accommodation, nearly a third did not want to live with others who had mental health needs, and most female interviewees preferred single sex accommodation, but in response to the proposals for 24-hour nursed care most people were willing to consider the idea, especially as it combined some features of privacy (own room) with support (medication supervision, help with activities such as cooking and doing laundry). Subsequently, the DoH published guidelines to commissioning such services.<sup>13</sup>

### A strategic framework

The 1997 joint publication by the Department of Health and Department of the Environment, *Housing and Community Care: Establishing a Strategic Framework*, set out the need for a range of care, housing and support services to be provided, and recommended the use of floating support in which support is separate from housing provision, aimed at enabling people to stay in their own homes as far as possible.<sup>14</sup> The themes of joint working between agencies, and of separately assessing and meeting individuals' needs for housing and support, have informed strategic thinking and service development since this publication, and are still current today.

The Care Programme Approach (CPA) was revised in 1999 and integrated with local authority Care Management to form a single care co-ordination approach for adults of working age with mental health needs.<sup>15</sup> It was also made clear that the CPA applied not only to the aftercare of services users in the community but also to those in residential facilities.

### Discharge from secure hospital

The position of people waiting to move on from secure hospital accommodation is also problematic. The Mental Health Act Commission has a remit to monitor the implementation of the 1983 Mental Health Act through an ongoing programme of visits to hospitals in which patients are detained under the Act. Their routine visiting between 1999 and 2001 found that the effectiveness of the CPA for individual patients' care was hampered by lack of co-operation from outside agencies, or lack of appropriate facilities for patients to go to when discharged from hospital, which resulted in patients remaining in hospital longer than was clinically indicated.<sup>16</sup>

The Mental Health Act Commission also found that a lack of funding for community placements and a shortage of suitable accommodation outlets were reported by hospital staff to be a significant and constant problem. Managers in one unit estimated that between 15 and 20 of their detained patients could be discharged were it not for these difficulties. With a steady increase over the past ten years in the number of people detained under the Act, which is likely to continue, the problem of moving on those who no longer need to be in a high secure hospital represents a serious challenge to services.

### The National Service Framework

*The National Service Framework (NSF) for Mental Health* (Department of Health, 1999) set out seven standards and identified models of care which people will be entitled to expect in every part of the country.<sup>17</sup> Standard four, referring to service users with a CPA, emphasises the need for assessments to include housing and support needs. Standard five deals with access to a hospital bed or other residential treatment provision, when necessary, which is in the least restrictive environment and as close to home as possible. It also identifies a lack of 24-hour staffed care and supported accommodation in many areas, while acknowledging the important role played by jointly commissioned housing and support schemes provided by housing associations and voluntary sector agencies.

### The NHS Plan

The Department of Health's *NHS Plan* (2000) outlined a ten-year programme of investing in and reforming the NHS, in which mental health was one of three specified clinical priorities.<sup>18</sup> The Plan announced the increased provision of beds in the high secure mental health facilities and in 24-hour staffed care services. It also heralded the establishment of assertive outreach teams to work with people who are hard to engage, crisis resolution services to provide an alternative to hospital admission, and early intervention services for people experiencing their first episode of psychosis. The thrust of these new community-based services was to provide alternatives to inpatient treatment, removing the necessity for some people to leave their own homes to receive treatment for their mental health needs. This approach has been extremely successful in some areas of the country, including London, where a large reduction in the number of hospital admissions has enabled some inpatient beds to be closed, and the funding

has been reinvested in community services. By implication, if people with mental health needs can remain in their current housing during a period of acute mental distress, the issue of move-on accommodation does not arise.

Another element of the *NHS Plan* was the creation of Social Care Trusts, in which NHS and local authority Social Services Departments can come together to form one organisation to work with a particular client group, such as people with mental health needs, with the aim of providing a seamless service. Only four such trusts have been established to date, one of which is in London. Partnership Trusts, in which Health and Social Services staff are committed to joint working with, for example, community mental health teams formed from both agencies, and with a common management structure, have become much more common nationally.

The problem of moving people on from inpatient care was still of concern to the Department of Health in 2002 when it published its *Policy Implementation Guide to adult acute inpatient care*<sup>19</sup>, in which it identified poor communication across the system of care as leading to delayed discharge. It recommended that planning for discharge and support after inpatient care should commence in the initial care plan, i.e. at the time of admission.

### Alternative types of move-on

Starfish Consulting produced a number of reports for the Move-on Housing Alternatives Project, an initiative supported by the London Housing Foundation, the Housing Corporation and several housing associations which aims to find practical solutions to the housing shortage through collaborative working with a wide range of stakeholders. In *Models for Shared Living*<sup>20</sup> they examined the scope for 'developing unsupported or low support shared housing as a move-on option', concluding that although this would be feasible to provide, it probably would not be the preferred option for most people in temporary supported housing who would prefer completely independent accommodation. Suggesting that this model may be of interest only to young single people on a temporary basis, the authors cautioned against further expansion without careful assessment of future demand.

Starfish Consulting's publication *Private Access*<sup>21</sup> described ways of increasing access to the private rented sector through overcoming financial and attitudinal barriers, and encouraging social landlords such as local authorities and housing associations to consider providing this type of accommodation. They also stressed the need for effective inter-agency partnership working, especially in London. Starfish Consulting also published *Facing Reality*<sup>22</sup> aimed at helping housing providers to create more realistic expectations of move-on accommodation for their clients, through the provision of better information for both staff and clients, thus opening up the possibilities of previously unconsidered types of move-on housing.

### Supporting People

1 April 2003 saw a fundamental change in the way housing and support was provided. From this date, local authorities took on the responsibility for funding, planning and commissioning all housing-related support services which were formerly the remit of Housing Benefit and the Housing Corporation, and a single Supporting People grant replaced the various funding schemes.<sup>23</sup> As a helpful preparation for this change, local councils were required to map all their local support services - including all providers - and identify service users' needs and any gaps

in provision. This was aimed at making it easier for referrers, including inpatient staff and Care Co-ordinators, to identify housing and support services to meet individuals' needs.

Supporting People ended the link between support services and housing tenure, aiming instead at enabling more flexibility for service users in terms of living in suitable accommodation and having their support needs met separately. Local authorities and the NHS were charged with establishing joint commissioning and funding of services, leading to seamless packages of care. However, some housing associations and voluntary organisations expressed concern that they would be excluded from the new system, leading to a reduction of choice for potential residents.<sup>24</sup>

### London housing research

The King's Fund comprehensively reviewed recent developments in the provision of housing for Londoners with mental health needs in 2003.<sup>25</sup> The authors analysed the supply of housing for people with mental health needs and compared it with the situation five years ago, commenting on how the supply is meeting current needs and making recommendations for future development of services. They found that the supply of specialist housing provided in London by housing associations has declined in real terms. Much of the existing supported housing was developed to meet the needs of a different group of people, those coming out of long-stay hospitals, and the group home service model is no longer appropriate for the needs of today's clients.

New models of provision have included schemes providing alternatives to hospital admission, such as crisis houses, and services for women only or for people from black and minority ethnic communities. They also found that provision was patchily distributed across the capital, with the largest concentration being in the inner city areas, and that the quality of services is variable. Additionally, the characteristics of clients seeking housing and support had changed, with more now having multiple and complex difficulties, such as mental health needs coupled with substance misuse, which housing providers were unable or reluctant to cater for.

The GLA commissioned the Resource Information Service to survey London hostels and homeless projects about move-on accommodation and support for single homeless people with a range of issues, including mental health needs.<sup>26</sup> The research looked at access to appropriate move-on and support and the future demand for move-on accommodation and support. The research reiterated the fact that there was a shortage of suitable move-on for people ready to leave supported accommodation and also that the lack of support for people with complex needs contributes to their remaining in accommodation that is no longer suitable for them.

### 3 The views of residents

#### Introduction

A total of 28 residents were interviewed individually; one in borough A, 10 in borough B and 17 in borough C. Focus groups were also held with those who were interviewed; one in borough B and two in borough C. It was not possible to arrange more interviews or a focus group in Borough A due to local staffing and organisational difficulties.

A wide range of residents were involved in the study including both men and women, people from different ethnic groups and a spread of people in both high and low support accommodation and also in independent housing. At the time of the interviews, 10 of the residents were living in their own flat or bedsit, 17 were in supported or hostel accommodation and one was still in hospital waiting to move.

#### Previous accommodation

The residents were asked about their accommodation prior to their current housing. Of the ten residents who were in their own accommodation, all had previously been in hospital followed by either bed and breakfast accommodation or a hostel. Some had also used low support accommodation.

The residents who were in supported accommodation had mostly come from hospital, although some had arrived there via bed and breakfast, the YMCA and the homes of friends. Six had lived with their family before going into hospital but had not been able to go back. One person had come from Broadmoor via a medium secure hospital. One had not had long hospital stays, but had lived in three hostels and a shared house before moving to their present accommodation.

One of the residents said:

*'I came from hospital but before that I was with the same housing association, my Social Worker felt that I needed to move to another place, I was too ill to realise what was happening so I didn't have a say.'*

#### Residents' most recent move and the key people in the move-on process

##### Waiting times for the present accommodation

The length of time the residents had had to wait for their present accommodation varied enormously. Eleven people had waited between six weeks and six months for accommodation, 13 had waited over a year while one person had waited more than three years. Two said that it took nearly five years to move into their present accommodation. One of these people had been homeless and then in bed and breakfast and was now in a supported hostel. The other person had been waiting in supported accommodation for his own tenancy but after nearly five years had accepted a flat with a housing association providing low support. He said however, that he was happy there.

Three of the respondents could not remember exactly how long they had waited, but other individual residents reported:

*'I waited 18 months after I had been told I was fit to leave the secure hospital, this was costing my home borough a lot of money - four thousand pounds per week.'*

*'I waited in bed and breakfast for two years.'*

*'I only waited six weeks, but I was in hospital and I think they needed the bed.'*

### How residents got their present accommodation and the key people in this process

When asked how they came to be allocated their present accommodation and the key people who were involved in the process, the majority of respondents said this was done through their Social Worker, although one woman had self-referred and three people had gone through voluntary sector housing workers. A few had a team of workers who were involved in the arrangements, but with the Social Worker or Key Worker leading the process.

Residents said:

*'The Social Worker told me about the place then I made an application myself (to MIND).'*

*'I was in a hostel in South London for a year and then was allocated this flat with the help of my Social Worker.'*

When asked who had helped them most to move to their present accommodation, again by far the most common answer was their Social Worker, although some said that the housing workers were most helpful, and two said that they felt that they had done most of the work themselves. The woman who had self-referred said that her daughter had helped most. One person who had been waiting to be moved from a private secure hospital for 18 months said that his solicitors were the most helpful as they had had to start legal proceedings before he was found a place to go to. Some respondents named individual workers.

One resident reported:

*'The Social Worker took a lot of interest and kept me informed though I wasn't very sure about what was happening, she always reassured me.'*

The residents were also asked what they found particularly helpful about what these people actually did. There were quite a variety of answers, but this was to be expected as this issue is about people's personal needs and perspectives. Some of the interviewees said that being kept informed about the progress of their case was the most helpful thing, whilst others said that more practical things, like taking them to see their prospective accommodation or helping them with transport to move their possessions, was more useful. Several said that the most helpful thing was getting information about the options available to them and then having help to apply for a tenancy which they found most useful and one person said that it was being involved in making decisions.

Residents said:

*'They involved me in making decisions, that's the first time I have ever felt involved in what happens to me.'*

*'They helped speed it up! It was quite quick, some people had waited four to five years to move from supported accommodation but I had only had to wait for a year.'*

### Quality of communication between agencies

The residents were asked to assess, where possible, how well all the agencies involved in the process, such as Health, Housing and Social Services, communicated with each other. Generally, the people who answered this felt that the agencies had communicated well with each other especially through case conferences. Some residents said that although the workers communicated with each other they had not communicated well with them. Over half of the residents said that they did not know. One respondent said that when she was transferred from one agency to another her files were lost.

Residents reported:

*'Sometimes they talked to each other – not all the time and they didn't really tell me a lot.'*

*'From what I could tell, they don't communicate at all, if you spoke to a different person you had to keep repeating yourself, and they never remembered you.'*

### Support from Key Workers and ease of contact

Asked about the way in which their Social Worker, Community Psychiatric Nurse (CPN) or other mental health workers kept in touch whilst they were living in their current accommodation, people who were living in 24-hour supported accommodation generally received their main support from the workers based there, although those waiting to move on had other workers. The people who were receiving complicated medication were usually monitored by a CPN and three said that they had outpatient appointments with their Psychiatrist.

One person said:

*'I can see my Key Worker at the project whenever I want to.'*

The people living in their own flats and bedsits had varied contact depending on their long-term needs. Some still had CPN visits while others had only outpatient appointments. Three of the residents in borough C had outreach workers from their previous project supporting them in their flats. It was interesting that the five people who said that the workers kept in touch with them by telephone were all from borough C.

A respondent commented:

*'My Social Worker will ring me if she needs to.'*

When asked how easy it was to contact the different agencies and to describe the factors that helped and those that hindered the move-on process, the people who lived in supported accommodation said that joint case conferences were held on a regular basis. Those who were living in their own accommodation, however, said that they often found it difficult to contact agencies. The person who was in a private hospital had real problems contacting the workers from his home borough. He found that his solicitors had to put pressure on the home Health Authority with help from the Manager of one of the hostels where he used to be.

Individuals reported:

*'My doctor referred me to the locality team, but there was some mix up with letters and it is very difficult to get an appointment when you have just left hospital – I have been waiting since last year and I don't know who to contact.'*

*'It can take time, and they are always short of staff at all of the agencies.'*

Others said that it was hard to contact agencies when they were in hospital or when they were not well. Three people said that English was not their first language and that it helped if there was an interpreter or if their Social Worker contacted the other agencies for them.

### **Residents' views of their present accommodation**

#### **Whether residents' needs are met by their present accommodation**

Only five people said that their present accommodation did not meet their needs. The others who were waiting to move on said that it was more about what they would really like than what they actually needed.

Of the five respondents who said that their housing needs were not being met, one said that she wanted a 'women only' hostel because she did not feel safe in a mixed-sex environment. Another said that he had only accepted the place in a high support hostel to get out of hospital although he did not need the high support. He was concerned that he was wasting a supported bed that might be better used for someone else, but he felt stuck there because of the financial limitations on him.

Respondents said:

*'This placement was taken because it got me out of hospital.'*

*'I am in hospital but they can't find me a woman's hostel, I don't want a mixed one.'*

Two of the residents complained about the condition of the property that they currently occupied. One said that it was cold and that the bills were high. The other, a physically disabled man who found it hard to climb the stairs, said that there were leaks, water running down the walls and that there were no lifts.

The remaining two residents said that there was not enough space and one of these could not have her children visit with her because she only had one room.

A female resident commented:

*'Yes, one bedroom is enough for me and my husband, but if I get access to my kids I might have to move again.'*

Most of the residents in supported accommodation who were happy with their housing said that it met their needs, because they always had a support worker around to talk to when they needed it. They explained that having workers on site meant that their benefits are sorted out and if they need it their medication could be dispensed for them daily. Others said their present accommodation was better than where they had lived previously. Most were just grateful to have a roof over their heads or to be out of hospital.

Residents reported:

*'I feel lucky when I hear about others' accommodation because I have a bedroom and separate living room, others are in bedsits or bed and breakfast.'*

*'It gives me greater independence because I can now live in the community.'*

*'It meets my needs because it is only a temporary stay with a view to move on.'*

*'I have support, but I can cook and I share a bathroom and kitchen.'*

#### What residents liked about their present accommodation

Most of the residents said that the best part of being in supported accommodation was having company, either from the other residents or from members of staff. Some said that having staff support was good for their mental health and that having assistance with practical things like cooking and cleaning helped. Several people said that the thing they liked best was that it was quiet compared with hospital wards that are often very chaotic and noisy. Five said that they liked it because they were living independently.

Some residents said:

*'It's quiet, it's new and it's mine! After being on the streets and then in bed and breakfast for so long it's great to be able to close my door and lock it!'*

*'It's central but in the quiet part of a busy road.'*

Some of the residents said that there was nothing good about their housing except that they were out of hospital or that it was better than nowhere.

One commented:

*'Nothing could be as bad as living on the streets.'*

### What residents disliked about their present accommodation

Most of the residents said that what they least liked about their accommodation was the limited space and the lack of privacy if they were in hostels or shared accommodation. Some said that they were afraid of other residents, either because of violence or because they were pressured into giving them money or cigarettes. Two complained that there was a problem with illegal drug taking and drinking of alcohol amongst other residents. Several of the people complained about noise from other residents and from the street outside. One person said that the alarms in the local area were always going off during the night. Two people who had their own flats said that they had problems with noise from the other tenants and some felt that their neighbourhoods were unsafe.

Respondents said:

*'My flat mate likes to play loud music which drives me up the wall.'*

*'There are a lot of undesirables who hang around the flats.'*

*'The two other residents are using drugs and drink. One was very psychotic but they only moved him out because the inspection was due.'*

Some of the respondents mentioned boredom as another problem and were keen to have more organised activities. One person said that no one bothers to go to the house meetings because the staff did not listen to the residents.

One person said it was the poor condition of the property that concerned them most and two said they were too high up.

One person experienced:

*'Loneliness and a feeling of helplessness because others control my life; the lunch clubs and drop-ins in the area keep me going.'*

### Issues residents face in moving on

#### The kind of help needed while waiting to move on

When the residents were asked what they thought was the most helpful thing the agencies could do for them while they were waiting to move on, by far the most common answer was to keep them informed. Some said that the agencies had been very good about doing this.

One respondent wanted to know that staff were:

*'Agreeing things at a case conference when everyone is present, then I know that all of the agencies involved are informed of the plans.'*

Others wanted more involvement in the process and wished that they had had more choice in the type of accommodation they were allocated. Others said they felt that they needed openness and honesty and to be listened to. Four people felt that better planning for their

move would have helped, especially with funding and benefits. One person had to wait over three months for their benefits to be properly sorted. Some felt that they had been pushed into accepting inferior accommodation because of their mental health needs or because of funding issues.

Interviewees said they thought the following would have helped:

*'A bit more understanding of our needs and not pushing us into accepting temporary accommodation, we need some security as our mental health suffers if we are not in permanent accommodation, or if we are in poor housing like high rise flats with drugs and violence around.'*

*'Planning the next step in advance and having the funding sorted before being offered a place would prevent such long delays.'*

Three of the respondents said that they needed to be kept occupied when waiting and that a programme of activities would have helped. Two people said that to have visits beforehand to the new accommodation would have improved the situation, as they then would have had something to look forward to. Practical help with forms and interviews was thought to be useful by many, especially those whose first language was not English or those who had literacy difficulties.

### Waiting to move on again

When asked whether they were currently waiting to move on again, 15 of the residents said they were and one said that if he thought he was likely to be offered something better, then he would like to move on. The residents described the type of accommodation they were waiting for. Fourteen of the 15 respondents who were waiting wanted independent accommodation and one, who was still in hospital, was waiting for accommodation with a high level of support.

Two people reported:

*'I am waiting for my own flat, I would settle for low supported accommodation, if I have my own space.'*

*'I need a ground floor flat of my own as I can't climb the stairs, my doctor has sent a letter saying so.'*

The length of time they had been waiting varied from two weeks to four years, with most waiting between six months and one year. However, two people had been waiting to move for four years; both were in supported accommodation and were waiting for their own tenancies. This was discussed in the focus groups and many said that it was funding which prevented them from moving on quickly. The people in the focus groups explained that unless the mental health team arranges the tenancy, then the benefits will not pay for private accommodation and the only other way that this could be financed is by having a job. Many of the residents said that they would like to be in work, but they could not afford to as they were in supported

accommodation and their wages would not be high enough to cover costs. Others said that though they were not well enough to work, they were well enough to live independently.

### The lack of independent housing

Another major concern was the shortage of independent housing in the areas where the residents lived.

One interviewee remarked:

*'You are lucky to get housing, if you don't get it you are on the streets.'*

One person explained that there was a regular newsletter available in their borough that was meant to have details of available accommodation in it, but in reality there was little or nothing in this newsletter. Some people said that their Key Workers tried to be helpful and were doing good work, but *'they couldn't produce housing that didn't exist!'* Another person explained that housing associations were not very keen on tenants with mental health needs because there were perceived as *'bad tenants'*.

### Residents' views on the most suitable accommodation

#### The best place that the residents had ever lived in this borough

Most of the residents said that the housing they presently lived in was the best they had ever had in the area. Some said this was because they were in hospital or homeless previously. Three named other hostels and four said that their family home was best.

Other interviewees reported the place they liked best was:

*'Where I am now in my own flat. It's nice and quiet – no noise.'*

*'My own house with my first wife, but I still felt a bit out of place. I am comfortable where I am now.'*

The most common reason that people gave for liking a certain hostel was the support or friends that they had had at the hostel. Four said that their present accommodation was best because it met their needs. They also did not have to manage the payment of bills and they had the right amount of support. One person liked to be in bed and breakfast because he got his meals.

### Residents' ideal type of housing and support

When asked what kind of housing and support they would like if they could have anything they wished for, seven of the residents said that their present accommodation was their ideal. The rest said their ideal was to be in their own place, preferably with more room or in a quieter area. The main criticism seemed to be the location for those who already had their own place, or lack of space. One respondent said that a home help would be useful.

Some of the residents said that their ideal would be:

*'The housing I have now (own flat) but with a home help.'*

*'A house with a garden so my grandkids could stay.'*

*'My flat, without my flatmate!'*

### Summary of the residents' views

The interviews and focus groups gathered the views of 28 people with mental health needs in the three boroughs.

Most of the residents had come into their supported accommodation from hospital, although some had also had failed tenancies and others had come from living with their family.

Eleven people had waited between six weeks and six months to be allocated their present housing, while 16 had waited for between one and five years. One person was still in hospital waiting to move.

Most of the residents found their present accommodation via their Social Worker, CPN or Key Worker. In general, they had a favourable attitude towards the people helping them, particularly Social Workers and Key Workers from housing projects. Interviewees were concerned about a lack of continuity of staff, with workers changing often, and about a lack of communication between agencies.

One of the main issues highlighted by all the residents was that they faced significant problems when they arrived at the point where they needed to move to their own independent tenancy. The whole process seemed to take a long time, with residents being stuck in supported accommodation for longer than necessary. This was felt to be partly due to the shortage of independent accommodation to move to, which they seemed to be very aware of, and also to result from difficulties with funding from Social Services and problems with the inflexible benefits system that made it difficult for people with mental needs to work and afford to pay private rents. They felt this discouraged them from trying to find work, something they saw as an important part of their rehabilitation process.

Those residents who were most content with their present situation were in supported accommodation with some degree of independence, including their own living space, where they had support, which they valued, from other residents and project staff. The people living in independent or low support accommodation also tended to be happy with their situation, although they said that generally it had been a difficult process getting to where they were now. The most commonly mentioned problems included feelings of isolation, being subjected to noise from other residents and the perception that the local area was unsafe.

Most of the people who were happy with their housing had previously lived in hospital, on the streets or in bed and breakfast accommodation, so having supported housing or their own flat, however small, was a great improvement.

## 4 The views of project staff

### Introduction

We examined the referral processes into a number of mental health housing projects in three boroughs, and the experiences of these projects in helping people to move on. The projects included residential care homes, supported housing and hostels. Two of the projects accepted only men with mental health needs and two accepted people from specific ethnic or religious groups.

Prior to the interviews, the projects completed a questionnaire to provide background information on their history, their services and any eligibility criteria for accessing their services.

### The referral process

Each project had developed their own criteria for accepting referrals, but the main components of the actual referral process varied little between them. The process usually consisted of an initial referral followed by information gathering and sharing, trial visits and stays in the projects and then a final decision about the placement.

### The initial referral

An officer from Social Services usually made the initial referral; in most cases this was a Social Worker. Referrals also came directly from inpatient wards, rehabilitation units, GPs, Psychiatrists and Community Nurses. In borough B panels comprising senior staff from the statutory sector were notified of vacancies in the projects and these panels referred people with mental health needs to projects that were able to meet their support and accommodation needs. Two projects in borough A, one residential home and one hostel, reported that they accepted self-referrals, with one of these projects also accepting referrals from relatives.

### Information sharing and joint working

Once an initial referral was received, the project then requested information about the potential residents. The information gathered about a potential resident enables an initial assessment to be made of their suitability for acceptance into the project by the project staff. Assessment continues during face-to-face meetings with the potential resident, their Care Co-ordinator or Social Worker and existing residents.

Problems with obtaining complete information on referrals were mentioned by several of the projects. It was said to be important that the person making the referral and the staff at the project communicate effectively. This does not necessarily mean that referrers have to visit but they should provide the information required and respond to phone calls and other forms of contact. The projects indicated that regular meetings between all providers were useful in highlighting problems and finding solutions. Particularly successful referrals were said to take place if good individual relationships developed between the particular referrer and the project, and when good relationships existed across teams.

### Gaps and delays in information

A couple of the projects that had been set up recently reported delays in terms of obtaining information. This could be due to the fact that relationships with referrers were at an early

stage and effective working relationships had not yet developed. It was suggested by some of the projects that agreed deadlines with Social Workers and other staff for provision of relevant reports can help to combat such delays and information omissions.

Gaps in information to support referrals were reported as an issue by just over one third of the projects. The majority of these were in boroughs B and C. Only one project in borough A reported problems.

Some projects encountered referrers who appeared to have deliberately withheld information about the service users they refer. A supported housing project in borough C stated that occasionally, information had been omitted or played down and staff believed that this was done in order to give the service user a better chance of being placed:

*'There have been occasions where there has been conflicting information on clients. Also some professionals provide subjective information, as they want to avoid giving negative impressions. The perception varies depending on the professional.'*

Projects sometimes had to chase up missing or unclear information by telephone. In these cases, projects reported that it was sometimes difficult to contact the relevant people and set up meetings. Social Workers were identified as being particularly difficult to contact in some cases. Staff from a residential care home in borough B stated:

*'It can be difficult to contact Social Workers. Although there is a placement officer in Social Services, for general enquiries, all too often the specific worker is the one needed.'*

Another project stated that:

*'Delays can be caused by local mental health teams being unavailable for joint assessment or our own staff being thin on the ground.'*

### Impact of gaps or delays in information

Many of the projects felt that where inappropriate referrals took place they resulted in their staff wasting time and resources on these residents. One project mentioned that the omission of medical information in referrals could be problematic and in one case had a tragic outcome:

*'We were not told of the drink problem of one new person. He died a few weeks after coming here.'*

### Appropriate referrals

Most of the projects described the referral process as generally working well. The assessment procedures that act as a filter for inappropriate referrals and ensure that clients are placed appropriately were highlighted as an important aspect of this process.

A residential care home in borough C highlighted the importance of experienced staff in filtering out inappropriate referrals:

*'We have experienced staff carrying out assessments here and the people who refer to us are also very experienced. A referral is unlikely to be inappropriate.'*

Projects reported that problems during the referral process arose when referrals were made by Social Workers in other boroughs, or when residents had different expectations about their care and support needs than those of the staff of the project. Referrals tended to be more successful where the person making the referral had real knowledge of the project and what it had to offer. A number of different types of projects pointed out that the referrers that they had the most successful relationships with were those that were clear about their expectations. They were also willing to participate in regular meetings to review whether people need different support or should move on.

In borough A, three projects indicated problems with referrals. Two projects reported problems with funding, with one of these stating, *'the difficulty of obtaining spot contracts for out of borough referrals causes delays'*. The other project that experienced funding problems claimed that, *'health professionals often do not understand that funding needs to be approved before placement'*.

### Panels

Panels were identified by a number of projects as a solution to some of the information sharing and decision-making problems encountered in the referral process and a way to avoid inappropriate referrals. Borough C saw a named person with an in-depth knowledge about the acceptance criteria of each project, which enables them to make suitable matches as the key to a successful panel system. This named worker was well regarded amongst those we interviewed.

### Staggered introductions

Amongst the majority of the projects, a staggered introduction was found to be the most useful way to create a successful relationship between the new resident, staff and existing residents. One project operated a 'buddy' system of befriending by existing residents that helped people to settle in more effectively. One residential care home in borough B summed up why a structured referral process was necessary by saying it allows for:

*'Clear expressions of expectations of engagement from the client which contributes to the success of placements.'*

Initially most of the potential residents made day, and sometimes overnight, visits to the projects to which they had been referred. Eventually in most cases, the length of the visits would increase, to a four-week trial period. A project in borough B was unusual in that they would issue a six-month tenancy *'like a trial period'* upon the potential resident's acceptance after an informal visit. One other project in the same borough found a two night trial tenancy to be enough to make a decision about a placement.

### Trial periods

Trial periods were considered by all but three of the projects to be a good way to ensure that new residents are placed appropriately in projects that provide the accommodation and support that they need and where they feel comfortable. Trial periods provide an opportunity for close assessment of the potential residents by project staff to ensure that they are placed appropriately. The profile of the people already living in the project is considered before a trial period takes place to ensure that potential residents fit in.

Two of the projects without trial periods reported no problems with inappropriate referrals or placements. One of these projects, a recently established supported housing project in borough C, preferred to grant new residents with what it described as *'proper tenancies'*, the intention being *'to empower them to live with proper rights. As soon as someone moves in it is his or hers'*.

The other project that had no problems with inappropriate referrals was in borough B and admitted that:

*'You'd think there would be (a trial period) but basically when they're accepted that's it. It could be something we should have because you can't be absolutely sure how things will work out.'*

The third project that did not use trial periods, located in borough C, had a brief referral and assessment period of one to two weeks, and reported that *'we seem to get a lot of clients who are extremely unwell'*.

### Funding and the staggered introduction process

The staggered introduction process appears to work well, although a number of projects suggested that funding arrangements caused problems because referring bodies were often reluctant or unable to fund a trial placement whilst at the same time maintaining an existing place for the potential resident to return to should the trial be unsuccessful.

### Issues in appropriate accommodation and support

#### The types of accommodation available and length of tenancy

The length of tenancy granted to new residents varied widely between the projects. Some of the residential care homes allowed people to stay for as long as they needed, with one in borough C offering a home for life. When residents did leave the residential care homes we looked at, this was sometimes because they became ill or required a level of physical care that the projects were unable to provide. In these cases, the people moved into care homes for older people, nursing homes or group homes, or they returned to their own homes or to live with family.

Six residential care homes and one hostel in borough A provided medium term rehabilitation with the expectation that people would stay for up to two years, although in most cases people stayed for longer periods. In such cases, the preparatory work done in advance of a move meant that extended stays were more often a consequence of the continuing needs of the individual than due to the lack of appropriate accommodation to move to. In contrast a residential care

home in borough A acknowledged that the lack of appropriate move-on accommodation meant that their residents stayed there for longer than had been planned when they moved in. They suggested that people tend to *'go into semi-supported accommodation rather than independent living. This could be because there is a shortage and what is available perhaps goes to needier groups'*.

The projects with shorter-term rehabilitation goals provided clients with six-month tenancies and conducted reviews of the residents' needs and progress every six months. One supported housing project in borough C had been established with a view to move residents to accommodation with lower support after 18 months. At the time of the interview, the project had only been in existence for a few months and so had no instances of people moving on to more independent accommodation.

### Access to appropriate accommodation and support

Project staff felt that there needed to be a wider range of accommodation in local areas to cater for residents at all stages in the rehabilitation process from crisis to independence, with the flexibility to enable more or less support as required, particularly as people move closer to independence.

Project staff indicated that there seems to be a big gap in the area of supported housing. More housing is needed that provides support on site and additional input from clinical staff working in partnership with the housing provider. Staff from a supported housing project in borough C stressed that:

*'The borough does not need any more residential care, rather the need is for more supported separate flats...its such a desperate need.'*

The projects indicated that the accommodation that is on offer is sometimes of poor quality and in areas that clients are reluctant to accept. Project staff indicated that people with mental health needs sometimes prefer to stay in a residential setting rather than live in housing with lower support in an area that they are unsure of, for example an area with high crime rates. One low level supported housing project in borough A consisting of separate bedsits with shared amenities found that their residents declined to take properties further away and preferred to remain in the local area and to live with relatives and friends. Another project stressed the need to provide places that are *'attractive, where people actually want to live'*. For people with mental health needs, maintaining their networks of friends and other support in a familiar area can be an important factor in the successful transition to higher levels of independence, maintaining tenancies and avoiding crises.

### Gaps in appropriate accommodation and support

Only four of the projects that participated in the research offered services targeted at specific groups; one in borough C for a specific minority ethnic group, one in borough A for a religious group and two were projects in borough B that only accepted male clients. Support and accommodation for specific ethnic groups was considered a gap in provision by a few projects, mainly in the areas with large black and minority ethnic communities. The residential care home

targeting a specific religious group in borough A identified a need for more culturally specific housing schemes that catered for younger people.

### Accommodation and support for people with dual diagnoses

Projects reported getting increasing numbers of referrals for people with complex needs. They found particular problems in providing suitable accommodation for people with dual diagnoses, such as mental health needs and drug or alcohol problems. The acceptance of such clients by projects was more limited in borough A, but more widespread in boroughs C and B. This could be the result of the characteristics of the population of the boroughs: borough A is in Outer London, boroughs B and C in Inner London. Eleven of the projects that participated in the research accepted either people with mental health needs and drug problems or mental health needs and alcohol problems. Eight projects accepted people with mental health needs with both drug and alcohol problems, three projects accepted disabled people (with sensory or physical impairments) and one project accepted people with learning difficulties and mental health needs.

One project in borough B felt that the lack of *'real provision for dual diagnosis clients'* resulted in people in this category being unfortunately labelled as *'difficult to place'*; a label that was also condemned by respondents from two other projects. The three projects that provided support and accommodation for people with a dual diagnosis indicated that there was no move-on accommodation available for their residents, with one project in borough B elaborating further:

*'The problem is that if this group move on they continue to need some level of support. This may not be available to them within independent accommodation.'*

### Flexible support provision

The need for flexibility in support provision and accommodation was highlighted:

*'Some move on because they have become worse rather than better and are unable to live in the community, so they have to go to the hospital or a residential unit.'*

Four projects specifically highlighted local shortages in low and medium level support as problematic. One project in borough B that provided accommodation with high level support for men with mental health needs, some of whom also had forensic histories, found it, *'quite difficult to find appropriate medium support move-on within the borough, although there is a fair amount of high support'*. The staff within this project felt that the definition of medium support needs clarification and consistency.

### The impact of the lack of appropriate accommodation and support

Project staff indicated that the lack of move-on opportunities can cause residents to become frustrated, which can in turn lead to setbacks in the rehabilitation process. These setbacks can create more delays in moving on to greater independence.

For a high support residential care home for men in borough B the lack of move-on meant that:

*'Some of the service users' earlier problems will start to boil up again with challenging behaviour...they start to feel claustrophobic and it's like some of the support and rehab has been in vain and that's not very helpful for anybody. It's very de-motivating and it's very demoralising for staff and service users.'*

As a solution to the lack of appropriate accommodation, one project suggested that there should be ring-fenced housing in communities, for people with mental health needs.

### The 'Not in my backyard' attitude

The stigma surrounding mental health needs can have an impact on the provision of appropriate accommodation. Some of the projects reported facing opposition to their development arising from fear and prejudice in the local community. The management and staff of housing projects overcame such problems by meeting with members of the local community.

*'At first the community was very 'NIMBY' (not in my backyard), but after meetings with the community and the head of mental health, along with leaflets etc, their objections and fears were assuaged. Neighbours complained about the untidiness of the grounds and the tenants themselves tidied and cleaned it up.'*

*'We initially had problems with neighbours, one of whom officially complained but who is now on the management committee.'*

*'We had no problems. In fact the community is accepting of the clients. This is an unusual project as it has a mix of tenants including four owner occupiers at the top of the building and all the tenants have a good relationship.'*

### Out of borough placements

All of the projects that accepted out of borough placements were residential care homes, the majority of which were in borough A. These homes were split into two camps: five that took out of borough placements as a matter of course and four that took them as the situation dictated. All of the projects that took out of borough referrals primarily to fill voids were in borough C. One of these borough C projects promoted their project in neighbouring boroughs in an attempt to reduce the incidence of voids.

Three projects stated that they did not accept out of borough referrals. Projects objected to out of borough placements on the grounds that removing people from their networks and familiar surroundings can be counter-productive in the rehabilitation process. Two projects that take out of borough placements mentioned that such placements could put pressure on resources and upset local service planning. One supported housing scheme in borough C had no plans to advertise outside of the borough, as their criteria demanded that the service users who are referred to them must be residents of the borough. They also operated a waiting list, which meant that voids were an unlikely occurrence for them.

Six of the projects did not specify whether they took placements from outside of their borough.

### Follow-up support for people who have moved on

Amongst the projects provision of follow-up support to residents after they moved to less supported accommodation varied widely and depended on the availability of staff and funding. Follow-up support placed pressure on already hard-pressed resources.

One supported housing project in borough A:

*'In terms of being able to help people once they're in the community to have the necessary support to stay there, we do not have the funds to provide really good follow-up care.'*

A residential care home in borough A provided their clients with four weeks of free follow-up care to ensure that they were settling into their new homes and that Social Services maintained contact with them. After the four weeks passed, aftercare had to be paid for because it was not funded and because of the impact on staff resources.

### Relationships between projects, statutory bodies and other organisations

Effective partnerships between all of the relevant organisations are needed to ensure that people with mental health needs obtain both appropriate housing and support. Overall, the projects reported maintaining good relationships with mental health professionals in the statutory sector, and with other voluntary organisations.

Relationships with Social Services care management teams were generally described as good in all of the boroughs. Some projects praised the professional approach of the statutory teams. According to a staff member at a residential care home in borough C:

*'I cannot identify a team that has not been co-operative.'*

A supported housing project in borough A did not miss the opportunity to put the blame where they felt it belonged for problems in the referral and move-on process:

*'People on the frontline are fantastic and helpful. Where problems occur it's funding.'*

*'There are good relationships with individuals on the Community Mental Health Teams.'*

*'We have good relationships with rehab teams and have found that good leadership has been the key as Managers encourage and support the individuals of the team.'*

### Care Programme Approach

Project staff provide feedback at CPA (Care Programme Approach) meetings every six months to monitor the progress of the residents. The CPA and the relationship with the care co-ordinator can be central to a successful move. In spite of this, one residential care home in borough A found that the six-month cycle is a slow process and that a three-month cycle could speed up the rehabilitation process and therefore the move-on process. The staff of one 24-hour supported hostel seemed to lay sole responsibility for the outcome of the move-on process on the care co-ordinator describing them as the person who *'ultimately makes the decision as to where the people end up in the long run'*.

### Approaches to rehabilitation

One of the residential homes in borough A reported that tensions could arise due to the differences in approach between the home's staff and the Community Support Team. The Community Support Team in the borough were seen as wanting to 'promote stability', whereas the staff at the home preferred to see change and progress amongst the residents. Another supported housing project in borough C echoed this, 'individual workers will not take risks with clients, break down barriers and provide alternative flexible support because of safety'. Projects reported that this tension between the proactive and reactive approach to rehabilitation could have an adverse impact on the progress of residents in the move-on process. One project suggested that placing authorities sometimes take a reactive rather than preventative approach to the needs of residents because they have limited funds:

*'The statutory sector has a fire fighting, reactive approach that concentrates on dealing with crises. They are not pro-active and long-term relationships are rare. If planning was done on a longer-term support basis more of our clients could be in independent situations. This approach continues because of pressures in the mental health services like staff shortages.'*

One residential care home in borough C said that while they have no problems in accessing Psychiatrists, they do have a problem with the high turnover of Psychiatrists and this means that there is often little continuity of service.

### Meetings and communication

Regular meetings were presented as an effective way to develop and maintain good relationships with professional and statutory organisations and individuals. It was considered important that the same people attend these meetings to ensure the development of good working relationships. One residential care home in borough B described their attendance at the multi-agency meeting with the statutory and voluntary sectors as 'a good way of meeting people that gives (them) the idea strategically of what's happening borough wide'. However, despite active participation in multi-agency meetings where they can highlight gaps in provision and other concerns, the projects felt that their contributions at meetings were all too often played down or ignored.

As has already been noted there were sometimes delays in arranging important meetings due to the unavailability of project staff or Social Workers.

The projects had different experiences that suggest that the quality of the referral process was inconsistent across statutory teams and was very dependent upon the individuals involved. A supported housing project in borough B commented on their relationship with the statutory team, 'though some individuals are more effective than others, a strong team leader ensures that teams have been consistent in terms of working'. Also in borough B, a men only project with high support stated that the information provided by the statutory services 'can be erratic depending on who the Care Manager or Social Worker is'.

One project with residents who came from four London boroughs, found that the various statutory teams worked in different ways and experienced variable levels of success in working

with them. In one residential home providing a high level of care in borough B the staff stated that:

*'Floating support isn't brilliant. Social Workers' contact varies, some have lots of contact, others they are never seen.'*

### Involvement of residents

Almost all of the projects interviewed encouraged the participation of their residents in the development and delivery of services. Their involvement can be an effective way of providing support and rehabilitation. It was seen as important to empower residents by implementing their ideas. Residents from two of the projects were involved in the selection of staff and two other projects encouraged existing residents to assist with the selection of new residents. One project stated that:

*'Current residents get the chance to meet the potential client and decide whether they would fit in.'*

Most of the projects encouraged informal feedback to staff by the residents and made the residents aware of the complaints procedure. Three of the projects had conducted at least one formal survey of their residents' opinions. The residents within four of the projects have meetings at varying intervals, some on a weekly basis, others twice weekly or once a month. One supported housing project in borough C stated that:

*'Feedback from service users is useful... the more we involve service users, the more we learn.'*

### Residents involvement at staff meetings

Resident involvement in meetings with staff was thought to complement the work of the key/support workers by ensuring that the residents' concerns are raised in as wide a forum as possible. Involvement of people with mental health needs in their CPA was seen as an important part of the rehabilitation process in one of the projects. In one supported housing project in borough C, the residents had raised concerns about the low level of support provided by staff at weekends and during bank holidays. The staff team are currently considering this issue and seeking ways to improve the situation.

Even when consulted, the residents were not always viewed as positive about their relationship with staff. A member of staff at a supported housing project in borough C admitted:

*'Service users complain that some staff do not do anything unless they have to. This could be because of resource issues. They are told that lots will happen & it doesn't. This inaction can contribute to relapses amongst residents and they have to return to inpatient units.'*

## The impact of legislation, policy and funding changes

### Supporting People

The most commonly mentioned policy programme was Supporting People. The projects varied in their attitudes towards it. Some of them considered Supporting People to be the most

helpful piece of Government policy and hoped that it would provide solutions to some of the problems that they currently face. Six projects stated that they still had to come to grips with the implications of Supporting People and that they did not know what the impact would be. Of these six, four were in borough A and two in borough C. The fact that some projects still needed clarification about Supporting People is obviously a concern considering that at the time of the interviews Supporting People was nearing full implementation.

In the six projects that stated that Supporting People would have an impact, there was a tentatively positive attitude to the new regime. A residential care home in Borough A said:

*'I am not sure how Supporting People will affect move-on after care. My impression when it first came out was that the possibilities for being creative and flexible were enormous and enabling.'*

A supported housing project in borough C said:

*'It is probably going to be good. It will make sure that we review and report more regularly. However, it is difficult; the forms are difficult and the administration is difficult.'*

One borough B hostel reported that:

*'Nobody will give us definite answers. The inspection and performance indicators are all very vague. We would like clarification and we can't develop the outreach service until we know more. However, it should in theory allow us much greater flexibility with budgets.'*

Changes to funding were a recurring issue amongst the projects. Some projects agreed that Supporting People will have a positive effect on funds and will enable the projects to redirect funds to develop new services. One project feared that they would lose funding for a project worker.

A borough B project that provides accommodation and support for people who need provision *'between the traditional support and independent support'* cited further problems.

This project expects that there will be an adverse impact on recruitment and training of staff and also on residents:

*'Supporting People will involve recruitment and training for staff to get NVQs. It is going to involve a great deal of time to train these staff. If Managers develop these courses they are going to stretch themselves, but the training will also provide opportunities. To cover these costs it means we will have to strike an agreement whereby the rent is increased for a transitional period.'*

Under Supporting People a few projects stated that they were considering changing their registration status, either deregistering or registering to correspond with their changing roles in terms of provision of support and care.

### The Care Standards Act

The Care Standards Act heralded changes for some of the projects interviewed. One project in borough C that provides a home for life for their residents expressed concern about meeting the standards contained within the Care Standards Act. It felt that the Act would have an impact on staff qualifications and have financial implications for the home.

### Funding issues

The majority of projects identified funding as a key issue in the move-on process. Having adequate funding in place before potential residents are offered a place is essential for avoiding delays in the referral and move-on process. One supported housing project in borough C felt that:

*'Funding is not a problem. It is more to do with the management of money.'*

Some projects reported difficulty in securing funding for placements for people with forensic histories and put this down to joint funding issues. In borough C a residential care home reported that *'people with a forensic history are normally refused placements jointly funded by Social Services and Health Authorities because of the specific criteria required by this type of funding.'* A residential care home in borough A reported that they were accepting more referrals for this client group than they had done previously and had no problems in securing funding for forensic places, saying that:

*'Forensic services are well funded in a way that local Social Services aren't now.'*

### The impact of the benefits system on residents

Benefits were raised as a major issue and project staff reported that the funding arrangements of the benefits system and brought about by new legislation and policies have had a direct impact on residents.

At the time of the research, one supported housing project in borough C suggested that the benefits system had an adverse impact on *'the ability of clients to work. They would only be able to do therapeutic work and earn a limited amount of money without affecting their benefit'*. In April 2002, however, the Government introduced the Permitted Work Rules to make it easier for disabled people and people with long-term illness to work without affecting their benefits (for example Incapacity Benefit and Income Support). Such work is no longer required to be therapeutic.

A couple of projects believed that the benefits system created a two-tiered system that was inconsistent and unfair and had an adverse effect on their residents. A low support scheme in borough A stated that upon securing move-on accommodation, people in receipt of Income Support were entitled to a Community Care Grant to furnish their new home, whereas people in receipt of Incapacity Benefit were not entitled to the grant.

The staff from a project in borough C explained that although people were able to appeal against decisions, the inconsistency could be hard for their residents to deal with.

*'One lady feels guilty about getting DLA. She was awarded a low level of Housing Benefit and she didn't want to appeal because she felt that she's getting another benefit that she's not entitled to and she's frightened that if she appeals about Housing Benefit they'll take the other money off her.'*

### Delays in Housing Benefit

Delays in Housing Benefit can create problems in two key stages of the move-on process for the potential resident, both during the trial period before a move into a project and during the move from the project to another place with the required change in the level of support. These delays in funding impact financially on the individual who is moving and on the project, as they both have to make up the shortfall using their already limited resources.

### Section 117, Mental Health Act 1983

The judicial decision around the funding of aftercare (Section 117 of the Mental Health Act<sup>27</sup>) was raised as an issue by several projects. A residential care home in one borough commented:

*'Some residents receive Section 117 money and others do not. This makes it a bit difficult as others go without extra money. They feel it, as there is a big difference in the money. You have an environment like this, where people feel like they have been stigmatised.'*

## Organisational issues that affect the projects

### Working as part of an umbrella organisation

A number of projects we interviewed felt that the advantages of being part of a larger umbrella organisation outweighed the disadvantages. Being part of a larger organisation could help with issues such as recruitment and training and in some cases, provide the important financial support necessary to develop new services like move-on accommodation where this was lacking. There was however, some concern expressed that being part of umbrella organisation could damage the shared ethos of a project and its links with the local community by imposing too many ideas from outside.

### Staffing

Eleven of the projects we interviewed provided on site support, with staff either on call or on site 24 hours a day, three in borough A, three in borough C and five in borough B. A stable core of suitable and skilled staff was said to be a key factor in ensuring an effective and timely move-on process. It is easier to retain high quality staff where there is a stable and effective management team, there are sufficient numbers of staff to avoid excessive work pressure and these staff receive training and realistic rates of pay. Experienced and well-trained staff are able to identify needs, rehabilitate residents, work well with the staff from the statutory sector and contribute towards moving residents on to higher levels of independence.

### Recruitment and retention

Projects indicated that the lack of career development and low pay were factors affecting staff recruitment and retention. All of the projects that reported problems with the recruitment of qualified staff were in borough C and made up half of the projects interviewed in that borough. Where this was a problem, temporary agency staff filled the vacancies. A supported housing project in borough C stated that they had not had *'a good response to recruitment. People with*

*severe and enduring mental health needs and with specific issues require skilled people to be able to identify early indicators of relapse etc*. This project actually had an applicant turn down a position with them declaring that they did not want to work in that borough as it had a reputation for high crime rates.

One project in borough C that provides services primarily for people of a specific ethnic group reported that the problems in recruiting staff of the same origin stems from the fact that they are *'fishing from a smaller pool'* in terms of the number of applicants for the vacancies, although they have no problems in retaining staff once they are employed.

### Impact of staff issues on move-on

In most of the projects, support or Key Workers used a team approach. Residents had their own assigned Key Worker who would share information on progress or issues of concern with the rest of the team. The team approach model, as opposed to a link worker seemed to be preferred as this meant that the service is continuous regardless of whether a Key Worker is there or not.

The provision of aftercare by some projects was limited within all three boroughs sometimes because of the lack of staff available to undertake follow-up visits once the resident had moved out into a less supported or totally independent environment.

### How projects are adapting their services

#### Changes in clientele

A responsive service that changes to meet the needs of clients is a key factor in effective service provision. It is notable that whilst many of the projects had been established to cater for people who left long-stay hospitals, over time the characteristics of the people accepted and referred have changed, with a consequent shift towards more self-contained supported accommodation.

In order to fill vacancies in their project one of the residential care homes in borough C changed their criteria to cater for the increasing number of referrals they were receiving for people with dual diagnoses and complex needs. However, the resources and staff available to them limit the number of people with such needs that they can accept. Another project in borough C reported:

*'Our current residents have increased needs and are challenging. They are also younger and more independent. They require a much greater input of staff time and increased supervision.'*

In borough A, the residential care home reported that they had to develop their strength as a rehabilitation home. This happened because their original clientele had grown older and developed physical needs and they had moved on and their places had been taken by a new group of younger people with more rehabilitation needs.

One borough A supported housing project that currently provides low support is *'looking to provide medium support in order to reduce the void level'*. Conversely, a hostel in borough B

now provides lower support than before, with no food or medication provided by staff. No reason was given for this change.

Two residential care homes were considering deregistration, as they have found that their roles have changed and that they now provide more support than care.

### Changes to premises

Changes in clientele and the levels of support can mean that some projects are providing services within outmoded physical structures. Making adaptations is not always straightforward as a borough C residential care home explained:

*'Changes to the building have meant that there are some voids but there are some changes that had to be abandoned because of cost or planning problems.'*

Unfortunately for some of the older projects, restrictions on changing the current premises that they occupy (e.g. because they are located within a conservation area) prevent alterations that would make the projects better suited to fulfil the changing needs of their residents. Projects in borough B were particularly keen on improving the sites and services provided to their residents. A project in borough B had to abandon plans to create self-contained flats with support because of the cost.

A hostel in borough B stated that although the ideal model of accommodation for clients referred to them is self-contained with support, they are unable to provide this within their current premises. This project plans not to open any other communal facilities preferring to work on *'helping people to have a different concept of home. We will be trying to work with people in their own studio flats with assertive support going in'*. Another borough B hostel said that they would like to extend their outreach programme, *'as a starting point in improving services for dual diagnosis clients'*. This is subject to obtaining funding.

In Borough A one of the hostels will be moving to a purpose built home that project staff likened to *'a five star hotel. All rooms have their own bath and ensuite facilities'*.

### Changes led by residents' requests

In addition to being directed by shifts in demand in the type of accommodation and levels of support required by people with mental health needs, changes in projects can also be governed by what the residents prefer. One residential care home in borough B claimed that they had responded to their residents' wishes by adapting their service to provide the reduction in support that some of the residents requested.

## Specific recommendations made by the staff from individual housing projects

*'The referral process should be standardised and streamlined to reduce delays.'*

*'It would help if referrals were speeded up. This would reduce the number of voids that affects the money coming into the project.'*

*'To avoid inappropriate referrals they should all go through a named person who is aware of the suitability of the project for particular needs and can monitor vacancies.'*

*'To avoid delays in the process there should be agreed deadlines with Social Workers and hospitals regarding reports. Care Managers should have control over a nominal budget.'*

*'The two week overlap period for Housing Benefit payments made to clients moving into new accommodation needs to be extended as this can be stressful for clients.'*

*'A mental health worker in the Housing Department would be helpful.'*

*'Future planning should be based on projections and knowledge. There needs to be more of a proactive approach.'*

*'We need ring-fenced housing for people with mental health needs locally.'*

*'I would like to see a range of un-staffed flats with outreach support, which could be tailored on an individual basis.'*

*'Projects need to have sufficient resources to provide all the support and activities that their residents need to become fully functional when they return to their communities.'*

*'Initiatives are needed to tackle the stigma facing people with mental health needs.'*

### Summary of views of the staff in the projects

Many of the projects had been established to accommodate people who needed a place to live on the closure of long-stay hospitals within the boroughs. A few had been set up to fulfil the needs of a particular target group, such as men with forensic histories, or people from specific ethnic groups. Some of the projects are now seeing a change in their clientele as they receive more referrals for people who have increasingly complex needs and who prefer their own self-contained space. Shortages of certain types of accommodation and support were viewed as a major barrier in the move-on process.

Other factors contribute to problems in the move-on process including delays in funding for placements, shortages of staff and other resources, administrative delays and the issues relating to the benefits system. Projects recommended that the referral process be speeded up. There was a strong emphasis on funding issues in their comments and a suggestion that funding should be streamlined to reduce delays.

Most of the projects experienced good working relationships with statutory and other agencies and reported obtaining efficient, up to date and honest communication regarding referrals. These were key aspects in ensuring that the whole move-on process worked well. However, problems arose where there were difficulties in contacting statutory staff and where information about potential residents was incomplete or inaccurate. Problematic relationships lead not only to delays but also to inappropriate referrals and placements. Wasting time and money was a consequence of such problems. Projects managed the problems of inappropriate referrals and placements through assessment procedures that included a period during which the potential resident was introduced to the project and the expectations of all were discussed and clarified.

Although most of the projects expressed a largely positive attitude towards Supporting People, most were unsure about how it would affect them. For the projects that had an idea about the new regime, it was viewed as useful in terms of funding, care provision and the review and reporting process. The Care Standards Act imposed staff qualification requirements that some of the projects viewed as compounding existing problems with staff recruitment and retention.

## 5 The views of staff in Social Services, Health and Housing

Key members of staff working in mental health from Social Services, Health and Housing Departments in each of the boroughs were interviewed. These included senior staff in the acute sector of the NHS, and the mental health team in the Social Services Department, and in two boroughs the rehabilitation and supported housing development Managers who co-ordinated the placement of people with mental health needs.

### Procedures for moving on

In all three boroughs procedures had been developed for moving people with mental health needs out of hospitals and crisis centres and through the range of residential care and supported housing and finally back to independence. The overall aim of these procedures was to try to find an appropriate place to match the current needs of the individual and to do so as quickly as possible. However, since in many instances an ideal place either did not exist or did not have a vacancy, these procedures were geared towards helping staff place clients in the accommodation which matched their needs most closely and making the best use possible of the available vacant provision.

All three boroughs had set up panels or forums comprising differing selections of representatives from Social Services, Health, Housing and mental health providers. These panels met regularly to discuss those clients who they felt were most in need of being moved from their current accommodation and into a more independent, or in some cases a more supportive environment. The panels generally focussed on a particular level of need at one time. The staff we interviewed described these panels as follows:

#### Borough C

*'We have a formal assessment panel which makes appropriate placement decisions. We regularly review processes on the wards and ensure that people move on effectively.'*

#### Borough C

*'There's a supported housing for mental health forum which I chair. It's a bi-monthly meeting. The idea is to get the providers of supported housing and residential care together because they were previously very isolated from each other and they knew very little of what each other were actually doing. Previously there wasn't any way staff could find out about vacancies in other projects for their residents to move on to. The forum has been running for about two years. A fairly representative core group of people (the providers and team leaders from the locality) come along regularly. My role is to co-ordinate the work and rather than solve accommodation problems with just the individual, do it in an organised way with all those clients who need to move on.'*

### Two-tiered panel system

#### Borough B

*'The way that's handled here is we have two panels – a high support panel and a low support panel. The high support panel is chaired by one of my sector Managers – the budget is held by me with input from the Primary Care Trust (PCT) to joint fund a number of placements where there are continuing care needs. There are representatives from the Trust,*

*the Local Authority, PCT, the acute services and also some input from forensic services. There is also a placements officer from within Social Services who both maintains the placement budget for me and also acts as a link for Community Mental Health Teams (CMHTs) who are looking for placements at that time. He also acts as a contracts person. The high support panel has details of the current vacancies for the local units and sometimes for other boroughs.'*

*'The low support panel is chaired by the Housing Department with input from Social Services and the Trust. There is some PCT involvement in this as well. That is the mechanism by which allocations are made to low or medium support.'*

*'Those two mechanisms for accessing places are pretty well established, quite tightly structured. I think we have the right kind of input to try and work out what the most appropriate placements might be. The only problem is that we're up against the buffers and it's a kind of one in, one out scenario.'*

Another representative from Borough B said:

*'We already had a high care panel. We applied a similar principle to low and medium support accommodation called the low support panel. It involves all providers in the borough who provide any kind of supported mental health accommodation from group homes to floating support, self-contained units etc.'*

*'The meetings occur monthly. The way they operate is that we have referral criteria and terms of reference. The main referral criteria being that people have recognised enduring mental health needs. They would usually be linked into psychiatric services and have a Social Worker, a Psychiatrist, a CPN or other recognised professionals working with them. They could be in a range of situations: they could be in hospital; they could be in bed and breakfast or they could be in their own accommodation, but not coping very well. Anyone who is a recognised mental health professional can make a referral. They just complete a form and they send it through to the administrator within the housing special needs team and request a booking at the panel. We have a maximum of six referrals, but it's normally four or five to consider at each meeting.'*

*'We consider the background papers, any social work reports, psychiatric reports, information or reports provided by support workers who may know the individual. We consider all this alongside the kind of criteria for the projects. We use the expertise of the actual providers as to whether the individual looks like they're eligible to be accepted. We also try and determine what would be the best sort of suggested course of action, such as a group home, floating support. It also takes into account their own needs and their wishes around accommodation.'*

*'Part of the reason for having the panels was that there's a steady stream of people who are requiring accommodation and voids kept coming up and being carried for some length of time. There wasn't really a co-ordinated approach as to how these voids were considered or allocated. I think it was probably more a case of Social Workers in certain teams who knew someone who worked in the project and they would let them know when a vacancy came*

*up. If there wasn't that relationship referrals didn't necessarily happen and they probably weren't made on the basis of who was in greatest need.'*

### The impact of panels on procedures

Some staff felt the panels were an improvement on the ways in which people had previously been placed in accommodation. For example, before these panels existed it was usual for the Social Workers to refer their clients directly to projects, but this was now being discouraged:

#### Borough B

*'There are still occasions when CMHTs try and make referrals directly to projects. I can understand the pressure they're under. You're keen to do the best for your client and get them somewhere to live but it can sometimes be detrimental to the process of identifying voids and filling them. You could be someone who's been on the waiting list for a group home vacancy for six months or more, and suddenly someone's jumped into your place.'*

*'I think providers are generally pretty good. Most of our provision is delivered by the private sector. They generally flag up if they're being badgered by the CMHTs to accept people who haven't been considered by the panel. Occasionally providers who also deliver schemes in other boroughs move people into voids rather sneakily through the back door.'*

A best value report in one of the boroughs had resulted in the setting up of a joint funded post to assist the panels.

#### Borough B

*'There has recently been a best value report done on mental health accommodation and one of the action points was to appoint somebody who is triple funded (Health, Housing and Social Services). He's like a joint commissioning officer, but he's also probably getting to be the most knowledgeable in this area of mental health accommodation.'*

### Preventing crises to reduce demands on the system

Although not a specific focus of this study, some of the Managers explained how their staff were already working with people with mental health needs in independent housing in order to try and prevent them going into a crisis centre in the first place and consequently avoid the need to get them back into their own housing. This was seen as an important measure to reduce the demands on the system:

#### Borough B

*'We do also have a new team within housing special needs of mental health support workers based at the area offices. This has been developed through an identified need that there are fair numbers of vulnerable people within our own stock who have mental health needs and would benefit from certain intervention support to maintain their tenancies. We have a couple of workers based here at the main Housing Office and other workers based at each Housing Office. If there's a situation where someone's in a council tenancy and it looks like they are failing, the appropriate course of action is to intervene before that breaks down and they are admitted to hospital.'*

## Relationships between statutory organisations

Senior staff were asked for their views on the way in which staff as a whole in the various statutory services worked with each other. Overall, those interviewed tended to think that the relationships in most areas were good:

### Borough B

*'The relationships work well between Social Workers and the Community Psychiatric Nurses. The relationship is quite good with the Police. The Social Workers have police liaison meetings and have to do assessments at Police stations when people are brought in under Section 136 of the Mental Health Act.'*

*'Social Services and Housing are separate, but we do have good relations on the mental health side. Social Services and Health do have some level of integration in terms of their budgets. My post is three-way funded between Health, Social Services and Housing. This is because mental health accommodation is very much a cross-cutting issue. We have pretty good relationships.'*

*'Relationships with the Health Authority and the PCT (primary care team) work reasonably well. There is a fairly flexible and responsive position from the Health Authority and the PCT when looking for joint funding. There are very clear continuing care criteria setting out when someone is going to be fully funded by the Health Authority.'*

*'Working relationships with the Housing Department I wouldn't characterise as a problem generally. We have quite positive relationships with them. The Housing liaison person is actually based in the hospital as well. That acts as an important catalyst, so it helps a lot.'*

### Borough C

*'There is a good relationship with local Housing Officers. Also with housing associations.'*

## Problems in relationships and solutions to problems

Some staff however, described difficulties in the past and highlighted areas where problems appeared to still exist. They also explained the solutions they were seeking to employ:

### Borough A

*'The key factor is communication. You need to have proper communication between all the agents, the housing provider, the Key Worker, the service user, the care staff and the families. It also needs to be in the appropriate language.'*

*'We are working towards integrating care management and the Care Programme Approach (CPA). There needs to be a system in which CPA is properly implemented and you've got multi-disciplinary teams working with people. You need to have shared aims and quality needs to be monitored.'*

### Borough B

*'There's work going on to make sure that our CPA and care management processes are properly followed. There have been difficulties in the past, not so much now, around working relationships between the CMHTs and the inpatient services.'*

*'During the reorganisation process communication suffered and links between the community and the inpatient services became more separate. It was less of a seamless service. There is improvement in this area. We've got the crisis team coming on board and the assertive outreach team. There is a lot of work to be done to clarify the lines of communication and management accountability, so that staff don't get lost about whose responsibility everything is.'*

*'There has to be a balance (between Health and Social Services staff). There is clearly an issue around this. Social Services staff think that Health are totally dominant. It's understandable because Health is so much larger. It's harder to stereotype people when you are actually working next to them.'*

*'If you don't get good communication between the wards and the CMHTs, then people's ability to move on from crisis is totally impaired and that's nothing to do with their mental illness. You need multi-disciplinary input and people need to share information with each other.'*

### Relationships with projects

Statutory sector staff were asked to describe the relationships between the staff in their departments and the staff in the projects who are providing the care and support for their residents. Overall, they felt that relationships with projects were satisfactory, but they also highlighted a number of areas of concern:

### Borough A

*'There needs to be more co-ordination between the private sector and the PCT etc. When private sector homes take people from other boroughs this puts a strain on the services in the borough. It is key that the private sector works with the people who are commissioning services.'*

### Borough B

*'In the past there were difficulties between our department and providers. This was about how to engage relevant providers to get low support housing and to identify resources to provide high support.'*

### Borough C

*'We're quite lucky in our area. We've got good services and a wide range of services. The voluntary sector provides supported housing and some of their projects are very good. Some look after people who not only have a long-term illness, but have quite difficult illnesses as well.'*

*'We have good working relationships with projects in our area.'*

*'Problems arise where projects have very restrictive criteria when deciding who to accept. There needs to be more training for staff in the projects so that they can care for more clients.'*

### Information sharing

Our interviews with the housing project staff had found that they did not always receive complete information about the people who were being referred to them. This was thought to be because the referral agencies were so keen to place people with what they considered to be difficult, high risk mental health needs that on occasion they failed to reveal their entire past history, especially if they had been involved in arson or violence. We therefore asked the staff in the statutory services for their views on this. Although it was not described as a significant problem, policies had been produced to address the issue of information sharing. This suggests that it may have been seen as a problem in the past:

#### Borough C

*'We also have to be realistic about people. You have to pass on accurate information. If you think people need residential care rather than going into supported housing you need to say so. It's a huge disappointment for the service user if it doesn't work out in the more independent setting and they may never try again.'*

Borough C had developed a policy to address the issue of sharing information:

*'We have an information sharing policy that has been around for at least one year. The Trust and the voluntary organisations have all signed up to this.'*

### Discharge of people with mental health needs from hospital

The staff in the three boroughs differed somewhat in their views about whether there were currently problems in their area in relation to the lack of appropriate accommodation for people occupying acute beds when they were ready for discharge. One NHS Mental Health Trust Manager felt that in their area there was a problem at this stage of the process:

#### Borough A

*'There are about 14 people currently in the unit who do not need to be here, as they only need support, they could be here for two to six months waiting for suitable housing. There is a great need for supported housing for people who do not need to be in hospital.'*

In borough B they stated that there was a need for more provision to prevent delayed discharge of people (some staff referred to delayed discharge as 'bed blocking'):

#### Borough B

*'We also need to have enough provision so that we can move people through our acute beds, because otherwise we are simply stuck with 'bed blocking' and we have a lot of that and because the demand for acute beds is high in this area, we then end up placing people in private hospital places, which is very expensive.'*

On the other hand, borough C stated that they were not experiencing serious problems in this area. They were holding delayed discharge meetings and also undertook regular reviews of the situation.

The monitoring of the extent of delayed discharge was a normal part of the process in all three boroughs. A member of staff in borough C explained how he first became responsible for the process in his borough before it became routine across London:

#### Borough C

*'I did some surveys of people on the wards and looked at people who stayed for a long period (over 90 days). Now it's being done quite regularly. I look at each ward and I identify the reasons for delayed discharge. We find that there are not masses of people waiting for accommodation. It's a bit tedious but it gives you factual information and actual numbers and you can see where some people are caught up in the system.'*

This member of staff provided an analysis of why some people had been in the local acute wards for more than 40 days. The reasons included, 51 per cent of the people needed further treatment, 21 per cent home on leave and 13 per cent for other reasons. This accounted for 85 per cent of the total. The remaining 15 per cent had issues to do with accommodation as the reason for their continued inpatient stay. Four per cent had not had suitable accommodation identified for them, six per cent had had accommodation identified but were awaiting assessment, four per cent had had accommodation identified and were waiting for a vacancy and one per cent had not received agreement about funding.

Another member of staff in this borough reported that they reduced the problem of delayed discharge by using temporary accommodation prior to a permanent placement. Borough C reported that delayed discharges could, *'silt up hospital places. Most people have a plan to move on. People normally get temporary accommodation. Delays can happen in sorting out permanent accommodation'*.

### Out of borough placements

As a result of the shortage of suitable projects or of affordable housing in their area to move people to, staff said that reluctantly they had to place clients in other parts of London or even further afield. They felt this was not ideal for a variety of reasons, and also believed that the situation in their area was unlikely to improve in the near future:

#### Borough A

*'This area is very short of special needs housing. People are sent to two adjoining boroughs, but this is not good for them as they are removed from their networks and the local area. When they move out of the borough, they cannot access the support services, such as day services provided by us.'*

### Borough B

*'There is a need for an increase in the level of high care provision, because we don't have enough and are still placing people out of the borough.'*

*'We have quite a lot of people placed outside of London. Clearly our preference would be to be able to offer them places in our own borough. We use schemes in the West Country and in Nottinghamshire. Some of it's partly driven by the particular needs of the individual. We don't have enough provision in the borough and that comes back to identifying properties and land. It's an unfortunate reality and I can't see it changing.'*

Other staff described the problems of providing client support when cross-borough placements are made:

### Borough A

*'If they (the staff from the referring borough) have got someone on the other side of London there's not a lot they can do really. They might do reviews, but on a day-to-day basis it is difficult for them to help clients.'*

*'Some people with quite risky histories move in from out of the borough, who we don't know anything about, and there have been some incidents at one particular establishment. It's something we have no control over.'*

### Gaps in specialist provision

Staff were asked to describe what they saw as the current gaps in provision for people with housing and support needs in their particular area and, if possible, to say where there was a need for more accommodation for specific clients in London as a whole. All the staff interviewed said that there was a lack of appropriate resources in their area and across the whole of London for people at various levels of need. In borough B they stated:

*'There is not just a need for the high support end, but also medium and low support that people can move into...high support will need to be taken forward in tandem with whatever we do around the low and medium support.'*

Other staff in this borough agreed that there were problems around high and medium level supported accommodation:

*'We have some quite high support placements, I'm not sure that we necessarily have enough but we do have several projects...what I think is missing is step down accommodation and cluster housing...after five to six years in high support they don't need that intensive level of support but need more than a low support place can offer.'*

All three boroughs identified gaps in provision for people with specific diagnoses or needs. The following groups were mentioned most frequently:

- Forensic history
- Complex needs and high risk
- Brain injury
- Mental health needs and alcohol or substance misuse
- Young people with psychosis needing early intervention.

The staff in the boroughs described the situation in various ways:

#### Borough A

*'I wish we had three different possibilities to look at. Sometimes people have to wait several weeks for a particular project. We've got a couple of higher level needs establishments...one of which takes people with a forensic history and another for dual diagnosis. We do need more places for these groups. It's not a huge area for delayed discharge unless you come across something like brain injury or very special needs.'*

#### Borough B

*'Those are the sort of schemes which I think would possibly be partly down to demand and the economies of scale...they are going to have to be considered on a cross-borough basis...certainly around forensic provision...(we are working on a forensic strategy for this part of London at the moment)...and early intervention projects for younger people with psychosis.'*

#### Borough C

*'The idea was originally to have some kind of respite facility for young people as an alternative to hospital which would be linked to the early intervention psychosis service. This would be set up within the Trust, but there was a problem because the Trust didn't have any revenue funding for that. As a result it was changed into the proposal to set up a supported housing scheme for young people to give them stability and support linked with the early intervention psychosis service. That's being explored at the moment.'*

### Accommodation for specific groups of people

The need for more accommodation for people from specific ethnic and religious groups and for women only was frequently mentioned:

#### Borough A

*'In terms of meeting minority ethnic needs, we've got Jewish Care, but we haven't really got any more specialised units for other minorities.'*

#### Borough C

*'We have a good scheme for ethnic minority residents, but it is only for people from black ethnic minorities. Also there isn't as far as I know, a women only resource, which again under the National Service Framework would be a priority.'*

### New models of housing

Many of the staff interviewed emphasised the need for new models of housing where people have their own front doors:

#### Borough B

*'The clients prefer self-contained accommodation with a bit of support. It has worked well in one of our areas where we have a house with en-suite facilities for 10-12 people. The staff are on-site for 24 hours and it is for those with severe and enduring mental health needs. These schemes are very expensive and clients are on assured shorthold tenancies.'*

#### Borough C

*'Some staff will have a feeling that they are looking after people as opposed to seeing it as a person's home and they are here to provide for them. I think the model of supported housing that is new is where people have their own flat and their own front door...even though there is a communal area...and they know they are supported as well.'*

*'I am aware that there has been a shift in culture and more and more clients want independent accommodation with support and this is going to be difficult to provide for everyone, but again it is part of our strategy to address this need.'*

*'There is a demand for more supported accommodation where people have their own flats. They claim Housing Benefit and gain the full range of benefits such as Income Support, like anyone else. That's very popular.'*

### The need for independent housing

When staff were asked for their views on the move into independent housing, most described this stage as one of the most challenging in the whole process and had a number of concerns about the way in which this stage operated and the effect this had on their clients:

#### Borough A

*'Some places are telling us that people don't necessarily want to go to the accommodation that's offered to them by the Housing Department – perhaps it's less desirable than where they actually are.'*

*'There is a shortage of long-term housing, which is important for stability. This puts pressure on the resources and the patient. Our borough has also moved to a choice based system of letting local authority housing. I wonder how this will affect people with mental health needs.'*

*'In terms of moving people towards independence, there is the issue of the prioritising for council accommodation. I imagine every borough has a way of prioritising, but within our borough, if people are waiting as inpatients, they get a higher priority for their housing. That doesn't happen if they're in a residential home or in sheltered accommodation, they don't get that extra weighting. So there can be a bottleneck at the other end, because they're adequately housed and there's no other priority given, so it's not easy to get people out and I think that's an issue that has to be addressed with local Housing Departments.'*

### Shortage of specific services that affect the move-on process

A number of the staff expressed concerns about the shortages of specific services within their area that they felt were necessary to facilitate the process of moving people out of hospital and at other stages in the move-on process:

#### Borough B

*'One of the difficulties we've had with our inpatient service is that it has not been providing a really good rehab service, and so we have to work at improving that. This will help when people leave.'*

*'There is a problem with the psychological services shortage and there is a long waiting list for therapy and counselling. A Therapy Service is to be launched and this will improve the situation somewhat and help people move towards independence.'*

*'We don't yet have a crisis team, but that has got to be one of our priorities.'*

*'We're looking at the sort of forensic strategy for this area at the moment and... it will almost certainly have to be considered on a cross-borough basis.'*

### Funding issues

As with all the other participants in this study, the funding of placements was said by the senior staff we interviewed in the three boroughs to be one of the most important issues that affected the process of moving people smoothly from crisis back to independence. The lack of sufficient funds meant that staff were always juggling the budgets to cope with the demand for services, occasionally delaying joint schemes where one participant (usually Social Services) was out of funds:

#### Borough A

*'I think there's always problems with funding. You've got a finite budget and if you're not having anybody move out you've got funding problems. I think things seem to have got particularly bad over the last six months for some reason. We don't want to leave people in hospital on delayed discharge, apart from the fact that eventually we're going to be charged for it. So we've got overspending issues, and there's less money available for people who need Community Care packages.'*

#### Borough B

*'Section 117 of the Mental Health Act imposes a duty of after care on local authorities, but there is no budget to meet this duty.'*

*'It's been skewed in the last couple of years by the Section 117 decision and the loss of income. We had to find an extra £500,000. By supporting the level of demand that there is locally, the budget is fully committed... and there is a very high level of demand for acute inpatient beds. Over the last year we've been running our inpatient beds at about 120/130 per cent occupancy. Also, on top of that, we are still having to place people in the private sector. So the funding is one the most important issues.'*

*'And the Local Authority is also under some cost pressures as well – it's got very slim reserves and it's also looking to make savings over the course of the coming year. I hope that mental health services will be protected as they have been in previous years, but there's no guarantee.'*

*'Funding is important. It ranges from people who just need residential care whose placements will cost between £350 and £450 a week to those with more complex needs whose placements can cost anything up to £1,200 per week.'*

#### Borough C

*'The application to the Housing Corporation for money to pay for the building was supported by the Local Authority. That's the normal model, but we came unstuck with one project because Social Services just didn't have any funding to run the project.'*

*'In 2001 there was a problem in that the care homes in the borough which had been set up specifically for people in this borough were having voids. Reluctantly we had to open them up to neighbouring boroughs.'*

Concerns had been raised in one borough about the development of new services generating increased demand:

#### Borough C

*'There was a concern from within our borough that the development of further resources in the area would actually make further demands on the Social Services Department. I think this is not true because the new developments would actually be catering for people who are already in the system.'*

The boroughs we spoke to agreed that financial constraints were only part of the cause of delayed discharge:

#### Borough A

*'I think the delayed discharges are not all tied up with financial problems, some of it's trying to find an appropriate place, and then all the other reasons why people stay in hospital – sometimes they don't want to move.'*

### Staffing issues

The senior staff in all three boroughs identified staffing across the sector as an important factor in the effective running of the move-on process. They felt that the recruitment and retention of the right mix of staff was vital to the smooth running of the procedures that had been developed. Most of the staff interviewed said that they currently had staffing difficulties, which caused them considerable concern.

The staffing difficulties were frequently thought to be the result of the high cost of living in most parts of London, which particularly affected staff moving in from outside and those at the beginning of their career on lower salaries:

#### Borough A

*'We have recruitment problems because of the cost of living in the area...the pay is worse than other areas of London...it's difficult to attract people as housing is expensive...but once they are here people do tend to stay a long time.'*

*'One problem is that there are not enough doctors in this area.'*

#### Borough B

*'It's important that you have the right staff mix...it's also easier if you aren't facing chronic recruitment and retention problems. You also need enough staff in the wards in order to provide proper rehabilitation to the patients.'*

*'The staffing problems I'm referring to are mainly found in the wards and clearly that creates pressure for the Trust. In terms of the residential units, we have had difficulties – for a long period we were carrying a lot of agency staff in one unit. However, with stable management that's begun to turn round, and I think the key seems to be having a good and relatively stable period of management at local frontline level, and being able to then put some concerted effort into recruitment, and obviously then supporting the staff once they get in.'*

*'We have difficulty in recruiting across the board...at the moment we're not too bad; it goes through dips and troughs. It's one of the problems that we've got in our area because we are in a city with some very expensive housing. We've got people commuting huge distances...they do it while they get their experience and then they go and find a job closer to home. Housing for Key Workers is a major issue in the borough. I've just recruited and one guy is going to be travelling from Oxford.'*

#### Borough C

*'They have a very stable group in the local mental health team, but when they use agency staff they have a high turnover. The work is very demanding, unrelenting and stressful.'*

### **The ideal range of housing and support provision**

During our discussions about the projects for people with mental health needs in their area all the statutory staff interviewed had an ideal picture of the kind of provision they would like to be available in order to cater for the needs of all their clients. This included a range of accommodation with high, medium and low levels of support, access to local authority or housing association flats with funding for furniture and 24-hour floating support. They also wanted to be able to find places that would accept people with dual diagnosis, brain injury or a forensic history. In addition, they wanted to know of resources that catered for a range of different ethnic or religious groups. They were however, keen that mental health projects should not accept people who they could not really cater for in order to fill voids.

One solution, which was suggested by a senior manager in Social Services, was to have a range of accommodation on the same site or close by which provided different levels of support:

#### Borough A

*'I suppose the best sort of residential care will have semi-independent set ups within it...so that you have a full range of 24-hour care, whatever that encompasses. Then when you are in that setting you have a more independent unit you can move into. That would be the ideal.'*

#### Borough C

*'I think we need to improve supported accommodation and provide less residential accommodation. We actually need to have a range of different supported accommodation some with very high support.'*

### Recent developments and plans for the future

Staff in all three boroughs said that they conducted regular reviews of the accommodation needed in their area, which resulted in them drawing up plans for future developments. They then discussed the type of accommodation they needed with voluntary organisations, housing associations and their own Housing Departments:

#### Borough C

*'We have a five year plan that is reviewed annually. Over the last five years we have moved from more residential based accommodation to supporting people in their own tenancy commissioned from the voluntary sector. The reason we have done this is actually because the service users themselves have said that's what they want. They would prefer to live in their own accommodation. They prefer to have the independence. We've also found that we get better outcomes and there is less chance of them relapsing and going back into hospital.'*

The staff in all three boroughs mentioned existing services that they wanted to improve or expand and new types of work they wanted to initiate that they felt would contribute to the effectiveness of the move-on process. These staff also spoke of exploring ways in which they could reorganise provision so that the funds they already had could be spent more creatively and efficiently. New ways of getting funds were also at the forefront of their thinking:

#### Borough B

*'Our priority for the Approved Development Programme bid this year is to deliver more high care mental health beds. This bid goes to the Housing Corporation. This was something identified in the best value review and we're prioritising it for this year's allocation funding. We've got a couple of bids and there's a possibility we may want to support both of them strongly.'*

*'The biggest issue for our area is that suitable properties to convert into accommodation are extremely difficult to identify. Land is virtually non-existent or the cost of land is very high. This is the major factor in terms of delivering extra units. We are looking at creative ways of utilising existing buildings and looking at the much bigger picture in terms of the whole*

*range of supported housing and deciding whether we have got the right sort of mix of what we need.'*

A member of staff in borough C described how he had played a key role in developing new projects in the area to cater for people who they had previously been unable to place:

*'We have opened two new innovative supported housing schemes in the past two years, some residents have come from acute wards and some have come from residential care homes. These schemes both provided self-contained flats with staff on call 24 hours.'*

### The involvement of people with mental health needs

The involvement of people with mental health needs in the provision of new accommodation was sometimes mentioned:

Borough A

*'The service user movement is working on starting up a crisis house. They've got some funding – I'm not sure if it's sufficient, but it's certainly a project that's being developed.'*

### New legislation and policy directives

The staff interviewed were all asked for their views on how any new legislation and policy directives would impact on the way in which the move-on process works and the provision of accommodation and support for people with mental health needs.

### Supporting People

The main Government policy that was mentioned by those interviewed was Supporting People and they tended to be positive about how it would affect the move-on process in the future:

Borough A

*'There are a number of Supporting People projects in the pipeline. There's a dual diagnosis one amongst them.'*

Borough B

*'Supporting People is extremely complex. It is hoped that savings will accrue.'*

*'We would want to look at the opportunities to have a seamless process for people and I think there should be opportunity and scope to do that under Supporting People reviews. We may seek to enhance some of the support in the lower support group homes.'*

*'I think in the longer term, some of the more visionary stuff around the IT systems which will support the whole Supporting People process could well lend themselves to a much more effective means of identifying and allocating voids – adopting the sort of process of a low support panel, but doing it in a much more integrated way using IT systems.'*

*'It's going to take time before we see the impact of Supporting People, maybe three to five years. It could be positive for clients, if they are able to consider different schemes. You can imagine someone being in hospital with the hospital liaison worker sitting them down and*

*saying let's have a look at all the different projects.'*

*'One of the first things we're going to look at once Supporting People goes live from 1 April 2003 are the floating support schemes which are tied to particular units of accommodation. We need to identify clients who no longer need their current level of support. If we could also identify units in our own general stock or in the various housing associations which can deliver a basic sort of tenancy support, we could float off some of the support from the units to the clients in the independent housing.'*

*'There are going to be opportunities around monitoring and reviewing of schemes and working with providers to begin to address under performance.'*

*'There has to be the opportunity to continue to develop new schemes and attract new revenue funding for schemes where it's justified. I think that can be one of the other good things that comes out of Supporting People it will actually bring to light those schemes that you probably don't need, but have always been there, probably not been best used and probably don't provide particularly good support. It could benefit the clients in terms of shaking up the quality of the provision.'*

#### Borough C

*'I hope Supporting People will have a positive effect. I think it is moving in the right direction. I think it will need time to see how it works out. There needs to be a project tracking people through the system and looking at outcomes.'*

*'Supporting People has opened up a new possibility and made people think about what it is they are providing. Certainly there are schemes which should really come out of registration, not just because it saves money, but also because it provides a better deal for the people living there. However, you then have to be careful, because it carries its own risks.'*

#### Potential problems of Supporting People

Some staff felt that there were potential risks involved with this policy:

#### Borough A

*'If it's not regulated, it's quite a nice little earner for someone really. They don't have to register with anybody; they don't have to prove anything. They buy a big house, put some locks on the doors and a sink in the corner of the room and get all their money from Transitional Housing Benefit. These providers can actually charge quite a lot of money for quite high levels of support. I think there's an issue about the way these things are monitored, because they don't come under the National Care Standards. At the moment there isn't actually active monitoring of the overall establishment because they don't have to be registered.'*

#### Borough B

*'Shifting to a grant-funded programme is not without risks. You will rely on an ongoing commitment to current levels of grant funding, adequate inflationary increases and future growth within that pot of money. Previously when projects were being funded by Housing*

*Benefit you had a demand-led funding stream. I also have some concerns around the smaller providers' ability to cope with the administrative burden. It is our responsibility to try and work with providers to make sure that they can cope with that side of things.'*

*'I think my major concern would be any lack of commitment to ongoing funding of accommodation for people with mental health needs. There needs to be a commitment to growth.'*

### Other policy changes, the National Care Standards Act and other legislation

The National Care Standards, the National Service Framework (NSF) and the proposed new Mental Health Act were the other changes which some of the staff interviewed said had an impact on their work in the past year:

#### Borough A

*'There's always changes. There's implementing the National Service Framework, especially crisis resolution services. We have a crisis resolution team, but we don't have any accommodation. I think that's the major re-organisation that everybody's going through at the minute.'*

*'There seems to be a never-ending climate of change. I think service integration is a fairly major thing for local authority staff. Meeting the demands of the NSF is a pretty major challenge really. The other thing that's going to hit us once we reorganise and get ourselves sorted out will be the new Mental Health Act. So nothing is stable.'*

*'The NSF standards four and five (having a CPA and access to a bed near home) have led to changes. This borough now has a system where people who are known to the services have direct access to mental health services. This would be used by someone after leaving hospital. They have access to crisis teams for a short period. It is also useful for someone who is ill and in the community but does not need hospitalisation. There is also a nurse available at night to talk to people who need help. So this is about supporting people generally.'*

#### Borough B

*'The other new policy development that is affecting the way we work is the National Service Framework. This has involved us in lots of new ways of working.'*

The National Care Standards Act was generally considered to be a worthwhile piece of legislation, but it had caused problems for some of the projects that staff had contact with:

#### Borough A

*'The National Standards are a step in the right direction really.'*

*'The Care Standards have changed and at the beginning of the year everybody (in the homes) was panicking about having to do all this. There was a huge cost pressure on the homes.'*

Some staff also felt that the volume of legislative and policy change could cause overload and that some areas were becoming incredibly complex to understand:

#### Borough B

*'The biggest problem we have at the moment is that with all these new policies the funding system has become incredibly complex. The Government wants integrated services but a lot of the new things are actually impinging on that process.'*

*'You've got Supporting People, the Care Standards Act and the (new) Mental Health Act, if it ever gets off the ground. There are so many legislative changes at the moment it's difficult.'*

### Summary of views of staff in Social Services, Health and Housing

All three boroughs had developed procedures for moving clients out of acute mental health care, through the range of supported housing and finally to independence.

All three boroughs had set up panels comprising representatives from Social Services, Health Services, Housing Departments and housing providers, meeting regularly to consider placement of people with specific needs, including mental health needs. In one borough, a joint funded post had been set up to assist the panels.

Staff mainly reported good working relationships with other agencies, although some problems of poor communication and the need for better co-ordination of services were also raised.

Recruitment and retention of staff was also a major issue in the sector.

Staff in the three boroughs reported different levels of delayed discharge from hospital, with two reporting significant numbers of people waiting for accommodation. The third borough described regular delayed discharge meetings and regular reviews, suggesting this helped them to reduce their numbers.

Staff reported reluctantly having to place some clients out of the borough because of the shortage of suitable local housing and admitted that this was not ideal as it impeded continuity of care. Similarly, they reported difficulties in providing support to people placed locally from other boroughs.

Statutory sector staff identified gaps in provision for groups of people with particular needs. They also described the need for new models of housing in which individuals had more independence. They identified the ideal range of accommodation needed, including different levels of support, access to local authority or housing association flats with funding for furniture and 24-hour floating support.

Staff in all three boroughs identified improvements they wanted to make to existing services, and new types of work they wanted to initiate, to contribute to the effectiveness of the move-on process. They were also exploring how to reorganise provision to enable more creative and efficient spending, as well as new ways of getting funds. Staff identified problems in obtaining funding for placements as an obstacle to people moving on. Compliance with Section 117 of the Mental Health Act 1983 was also cited as a problem because it had not been linked to extra resources.

All three boroughs regularly used local needs assessments to inform their planning of future developments, and one mentioned involving service users in the planning process.

Statutory staff generally felt positive about Supporting People. The National Care Standards Act was generally considered a worthwhile piece of legislation, although it had caused problems for some of the housing projects with whom they had contact.

## 6 Conclusions and recommendations

In the light of our research findings, we make recommendations in the following areas:

- Views on the movement of people with mental health needs through the system
- The lack of accommodation, support and other resources
- Information about existing provision
- Trial periods
- Working relationships
- Changes in service provision
- Staff in the projects
- Approaches to rehabilitation and the impact on the move-on process
- Input from people with mental health needs
- Supporting People and other policy and legislative changes
- Allocations procedures.

### Views on the movement of people with mental health needs through the system

Although the impression given by the majority of the interviewees in this study was largely positive about the processes involved in providing people with the services they need at the times when they are required, there were also clear examples of delays in the system and services not entirely matching the needs of clients.

#### Recommendation 1:

The GLA, the ALG and the London Development Centre for Mental Health should work together on mental health and housing issues and support the implementation of relevant recommendations.

### The lack of accommodation, support and other resources

Those interviewed in the study attributed delays in the system primarily to gaps in existing provision. The groups that were particularly mentioned as not being well catered for were those with complex needs, brain injury, a dual diagnosis or a forensic history. There was also said to be insufficient resources for people from minority ethnic or religious groups and those requiring single sex accommodation. The project staff, the statutory sector staff and residents all highlighted the inadequate supply of affordable independent accommodation in London as a key concern.

#### Recommendation 2:

Accurate needs mapping, incorporating unmet needs, must take place at a local, sub-regional and regional level in order to plan services for all client groups effectively. The *National Service Framework Mapping Database* (see: <http://www.dur.ac.uk/service.mapping/amh/index.php>) and information collected as a result of the implementation of Supporting People has led to the bringing together of some valuable information about existing supply. However, it is still unclear how well the existing supply matches the needs of Londoners with mental health needs. The Government should work closely with all those involved with people with mental health needs to make sure that the shortfalls between supply and demand in the full range of services (everything from high care residential to day centres) are accurately assessed. Regular reviews of the match between provision and needs should be undertaken.

**Recommendation 3:**

London has its own unique requirements for mental health services. It is important that these requirements are reflected in the allocation of Central Government funds. The London local authorities' Social Services and Housing formulae should be reviewed to make sure that they are fair and they enable adequate services to be developed within the capital. It is also important that the Supporting People programme receives adequate long-term funding to allow appropriate improvements to be made and sustained. By providing a better assessment of needs and available provision, Supporting People is likely to highlight important areas of previous under-funding.

**Recommendation 4:**

Where a gap in provision has been identified, local authorities, health agencies, the Housing Corporation and voluntary and private sector providers should work closely together to identify how best to develop and fund these new services. If a highly specialist service is required that is beyond the means of an individual borough to develop, it is important that appropriate regional and sub-regional groupings are working together to develop such services. Opportunities for the development of such arrangements should be maximised by all concerned as part of the move towards the full implementation of Supporting People.

**Recommendation 5:**

Expansion of the supply of affordable long-term independent housing for people with mental health needs must be prioritised to ensure appropriate housing opportunities for clients at the final stage in the move-on process, in both the social rented and private housing sectors. It is important that the Mayor's plans for 23,000 new homes to be built in London each year are achieved and 50 per cent of these must be affordable housing. The requirements of people with mental health needs should be considered in the planning of these homes.

**Information about existing provision**

Up to date and accurate information about the available provision for people with mental health needs and good procedures for sharing this information were highly valued by those we interviewed. Information about the availability of provision and the knowledge to match the needs of clients to this provision is essential to a successful move-on process.

**Recommendation 6:**

The leads of Local Implementation Teams (LIT) should ensure that they meet their responsibility to make sure that the *National Service Mapping Database* is accurate and kept up to date to ensure that information about the full range of provision for people with mental health needs is available.

**Recommendation 7:**

Robust procedures should be in place in all boroughs for allocating accommodation, using full data on people with mental health needs and up to date information on provision. A useful model being used in the study areas was the establishment of regular panels where key personnel are brought together in order to match the needs of clients with well organised information on current vacancies collated by a key person with a specific responsibility for this

work.

#### **Recommendation 8:**

The viability of providing an online database of mental health provision containing up to date information about vacancies and waiting lists should be explored. The Hostels Online website which includes information about hostel vacancies for homeless people could provide a useful model for this.<sup>1</sup>

#### **Trial periods**

Trial periods in new accommodation were widely regarded by interviewees as an important step in making a successful placement. However, there was considerable financial pressure on those funding placements to keep trial periods to a minimum because the cost of such placements needs to be met whilst at the same time maintaining an original placement in case the new placement breaks down.

#### **Recommendation 9:**

The value of trial periods in avoiding placement breakdowns in supported housing may need further investigation, but if, as seems likely, they do lead to more successful placements, then further ways of funding them should be explored. For trial periods not to cause delays in the system a small permanent surplus of places in all types of accommodation may need to be maintained. The sub-regional groups established as part of the Supporting People process could explore ways in which such a surplus might be maintained if appropriate.

#### **Working relationships**

Although most interviewees described good working relationships with others in the mental health sector, there were a few examples of poor communication and delays in the exchange of key information. In the case of inappropriate referrals the cause was often a lack of information about the potential resident. This could be addressed through an improvement in the information available (see 'Information about existing provision' above). There were some delays in holding key meetings because people were on leave or off sick, or because of incomplete paperwork.

#### **Recommendation 10:**

A shared and agreed approach to defining needs would reduce the level of confusion around the needs of individual clients and make it easier for them to access appropriate accommodation and support. Where they do not currently exist, protocols should be developed on how information is to be shared between statutory agencies and with the voluntary and private sector. These should include appropriate arrangements to cover for staff absences and delays in completing relevant paperwork. A London-wide approach to these issues is recommended.

#### **Changes in service provision**

A number of projects felt that the dependency levels of those being referred to them were higher than previously and in some cases they planned to modify their service to meet these demands.

**Recommendation 11:**

Commissioning approaches should encourage the market to offer a wider range of provision as closely matched to the needs of the community as possible. Those planning services on a regional/sub-regional/local level should closely monitor shifts in the market and make sure that important types of provision are not lost because of such shifts.

**Staff in the projects**

Most of the projects had encountered problems both with recruiting qualified staff and with funding adequate training for existing staff. The value of a skilled workforce in relation to facilitating the move-on process should not be underestimated. Staff working in projects have a key role to play in helping people with mental health needs move towards independence.

**Recommendation 12:**

Both recruitment and training issues in the sector need to be explored at a regional/sub regional level. Creative ways need to be developed to attract staff and provide them with the incentives to remain in the capital. Addressing the affordable housing shortage discussed above is clearly a key part of this. Special attention should be paid to the needs of smaller providers to assist them in the adoption of a more professional approach to staff development issues.

**Approaches to rehabilitation and the impact on move-on**

Some interviewees suggested there was an overly cautious attitude in the system, with statutory sector workers on occasion reluctant to place people in new situations, residents sometimes reluctant to move into less supportive settings, and project Managers from time to time employing restrictive acceptance criteria to prevent the introduction of residents with complex needs. This tendency towards the status quo from all those involved may have a negative impact on the move-on process.

**Recommendation 13:**

Clients' long-term goals should remain of paramount importance. More checks may need to be built into the system in order to review regularly the progress towards greater independence.

**Recommendation 14:**

When move-on is planned, there should be appropriate consideration of a resident's needs with particular attention paid to figuring out what might help to make each stage of their move less daunting and how best to provide this help.

**Input from people with mental health needs**

A significant number of the residents interviewed identified things they were unhappy about in relation to their existing accommodation such as noise levels and problems in relation to maintaining their privacy.

**Recommendation 15:**

People with mental health needs should be regularly consulted about the services that they receive and wherever possible their views should be taken into account when making improvements in existing services or developing new ones.

### **Supporting People and other policy and legislative changes**

Some concern was expressed that the new Supporting People contracts arranged with providers may limit the referral routes into projects, thus making it more difficult for out of borough placements to take place. Whilst an emphasis on local placements is welcomed, it is important that people with mental health needs in boroughs with an inadequate supply of local provision are not penalised. There should not be a situation where projects have vacancies because they cannot accept referrals from those whom they would otherwise wish to accommodate.

The Care Standards Act was reported to impose staff qualification requirements that some projects viewed as compounding existing recruitment and retention problems.

#### **Recommendation 16:**

Local authorities and the ALG should carefully monitor the effect of new Supporting People contracts on provision in London. This is particularly important over the next three years of protected funding and service reviews when there are unlikely to be major shifts in the supply of different types of accommodation in each area, but any changes in arrangements for accessing it could restrict new placements.

### **Allocations procedures**

It is currently unclear what impact the development of Choice Based Housing Letting Schemes will have on the ability of people with mental health needs to access appropriate housing, but it is important they are not disadvantaged either by complex processes or by discrimination.

#### **Recommendation 17:**

Those who establish Choice Based Housing Letting Schemes should pay close attention to the findings from the 27 Office of the Deputy Prime Minister (ODPM) funded pilot schemes and their impact on people with mental health needs and other vulnerable groups.<sup>2</sup> They should also consult, and preferably involve, people with mental health needs and the agencies working with them when developing and implementing such schemes.

#### **Recommendation 18:**

People with mental health needs must be provided with the necessary support in relation to these schemes; both in terms of making applications and also in maintaining tenancies once they are in their new homes.

#### **Recommendation 19:**

Where Choice Based Letting is not seen as a viable option, individuals should be able to opt out and have alternative arrangements made on their behalf.

#### **Recommendation 20:**

Mechanisms should be established to monitor the effects of all schemes. These should include regular consultation with disadvantaged groups to make sure that they understand the schemes and close scrutiny of their bidding activity.

## 7 Glossary

### Agency staff

Agency staff refers to social and healthcare workers recruited from private agencies and employed on a temporary basis.

### Care co-ordinator (or Key Worker)

A worker (team member) with responsibility for co-ordinating the CPA process, including CPA reviews, for mental health service users with complex needs and for communicating with others involved in the service user's care. Care co-ordinators usually have the most contact with the service user.

### Care Programme Approach (CPA)

The CPA provides a framework for care co-ordination of service users under specialist mental health services. The main elements are a care co-ordinator, a written care plan, and regular reviews by the multi-disciplinary team. Updated and simplified guidelines, with two levels of CPA, standard and enhanced, have been published by the Department of Health and the CPA has been integrated with the Social Services Care Management system.

### Community Care Grant

A grant for people who are in receipt of Income Support or income based Jobseeker's Allowance, when they leave hospital. People can claim for a range of items including clothing, furniture and removal expenses.

### Community Mental Health Team

A multi-disciplinary team that provides a comprehensive service to meet the needs of people with mental health issues in the community and to facilitate access to relevant services. Teams generally include Nurses and Social Workers and may also include Psychiatrists, Occupational Therapists and Support Workers.

### Delayed discharge

A term used by professionals to refer to an inappropriate delay in discharging people from hospital who no longer have a clinical need to be there, with the result that it prevents someone else from being admitted to hospital. Some professionals also refer to delayed discharge as 'bed blocking'.

### Disability Living Allowance

A benefit for people who have difficulty in looking after themselves or in getting around. The amount awarded depends on the effect of the disability on the individual.

### Dual Diagnosis

Dual Diagnosis is the existence at the same time of more than one kind of diagnosis. In psychiatry, it is used to refer to the co-existence of mental health needs and substance misuse or mental health needs and learning disabilities.

### Forensic services

Provide treatment and care for people with mental health needs who have had contact with the criminal justice system as offenders.

### Local Implementation Team (LITs)

Local Implementation Teams were set up to implement the National Service Framework, with members drawn from Health and Social Care Services. In each area the LIT Lead is responsible for co-ordinating the work of the LIT. They are also responsible for assessing the need for mental health services in their locality, and for contributing to the national database on services provided locally by the statutory, voluntary and independent sectors.

### Mental Health Act Section 117

Under Mental Health Act 1983 Section 117 the local authority has a duty to provide aftercare for people who have left hospital after having been detained under certain sections of the Mental Health Act 1983.

### Mental health needs

The Mental Health Act 1983 defines four forms of mental disorder: mental illness, mental impairment, psychopathic disorder and severe mental impairment. This report primarily uses the term 'mental health needs', as it is a wide and inclusive term that goes beyond the diagnosis and encompasses the individual's social and other needs.

### The NHS and Community Care Act 1990

Implemented to bring about changes in the approach to community care provision. Community care aims to help people who need care and support to live independently in the community. Through the introduction of the Community Care system, the Act placed the responsibility for community care with Social Services Departments to ensure value for money and the provision of quality care.

### National Service Framework

In 1999, the Department of Health published the National Service Framework (NSF) for Mental Health. It set out seven standards relating to mental health services, and described models of care and examples of good practice. It also outlined how providers of mental health services would be monitored to ensure they met the standards.

### Primary Care Trust

Primary Care Trusts nationally are taking over from Health Authorities the responsibility for purchasing mental health and learning disability services.

### Rehabilitation

Care intended to improve the lives of people with physical or mental health needs in order to develop their independent living skills.

### Residential Care Home

All care homes have to register with the National Care Standards Commission. Residents are usually people who need long-term accommodation and support. The residents usually have their own room, and share communal areas.

### Residents

In the report, this refers to people living in designated accommodation for people with mental health needs with various levels of support.

### Service User/Client

People with mental health needs describe themselves and are described in a range of ways. Service user refers to individuals who use or are given health and social care for their mental health needs in a range of settings, including their own homes or in hospital.

### Social model of disability

A social model encourages explanations in terms of characteristics of social organisation, whereas a medical model of disability encourages explanations in terms of the features of an individual's body. A disabled person is someone who has an impairment, experiences externally imposed barriers and self-identifies as a disabled person. Disability is caused by 'barriers' or elements of social organisation that take no or little account of people who have impairments. It follows that if disabled people are to be able to join in mainstream society, which is their human right, the way society is organised must be changed. Removing the barriers that exclude (disable) people who have impairments will bring about this change.

### Supported housing

There are many different types of supported accommodation with a range of levels of support. People may have self-contained units or shared rooms and there may be a communal area for use by all residents and staff.

### Supporting People

The Supporting People programme was developed by central Government to enable vulnerable people to improve their quality of life through greater independence. Partnerships of local government, service users and support agencies, aim to promote cost-effective and reliable housing-related services that complement existing care services.<sup>28</sup>

### Support levels

Levels of support provided by staff to the resident or service user are determined by the number of hours during which the support is provided, the type of service provided, the abilities of the individual and the extent to which they can take care of themselves. Low support can be peripatetic staff and/or alarm or on-call systems. Medium support can refer to staff who are on-site or who visit the site during the day. High support can mean that there is staff cover available on a 24-hour basis.

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## 9 Appendix

### The steering group

Helen Davies, Health Policy Manager, Greater London Authority, Richard Ford, Director of Research, Sainsbury Centre for Mental Health and Brendan McLoughlin, Head of Resources and Development Manager, London Development Centre for Mental Health.

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### Vietnamese

Tiếng Việt  
Nếu bạn muốn bản sao của tài liệu này bằng  
ngôn ngữ của bạn, hãy gọi điện theo số hoặc  
liên lạc với địa chỉ dưới đây.

### Greek

Αν θα θέλατε ένα αντίγραφο του  
παρόντος εγγράφου στη γλώσσα  
σας, παρακαλώ να τηλεφωνήσετε  
στον αριθμό ή να επικοινωνήσετε  
στην παρακάτω διεύθυνση.

### Turkish

Bu broşürü Türkçe olarak edinmek  
için lütfen aşağıdaki numaraya  
telefon edin ya da adrese başvurun.

### Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੀ ਕਾਪੀ ਪੜ੍ਹਾਈ ਆਪਣੀ ਭਾਸ਼ਾ  
ਵਿੱਚ ਹਾਹੀਦੀ ਹੈ, ਤਾਂ ਹੇਠ ਲਿਖੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਹੇਠ  
ਲਿਖੇ ਪਤੇ 'ਤੇ ਰਾਬਤਾ ਕਰੋ:

### Hindi

यदि आप इस दस्तावेज़ की प्रति अपनी भाषा में चाहते हैं,  
तो कृपया निम्नलिखित नम्बर पर फोन करें अथवा दिये  
गये पता पर सम्पर्क करें।

### Bengali

আপনি যদি আপনার ভাষায় এই দলিলের প্রতিলিপি  
(কপি) চান, তা হলে নীচের ফোন নম্বরে  
বা ঠিকানায় অনুগ্রহ করে যোগাযোগ করুন।

### Urdu

اگر آپ اس دستاویز کی نقل اپنی زبان میں چاہتے  
ہیں، تو براہ کرم نیچے دیئے گئے نمبر پر فون کریں  
یا دیئے گئے پتہ پر رابطہ قائم کریں۔

### Arabic

إذا أردت نسخة من هذه الوثيقة بلغتك، الرجاء  
الاتصال برقم الهاتف أو الكتابة الى العنوان  
أدناه:

### Gujarati

જો તમને આ દસ્તાવેજની નકલ તમારી ભાષામાં  
જોઈતી હોય તો, કૃપા કરી આપેલ નંબર ઉપર  
ફોન કરો અથવા નીચેના સરનામે સંપર્ક સાધો.

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