Imogen Blood &
Associates

Greater London Authority Mental Health Specialist and Supported Housing: Research & Market Development Project

Final Research Report

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1 Introduction

1.1 To this project and the evidence base

The Greater London Authority (GLA) commissioned Imogen Blood & Associates (IBA), with funding from the Department of Health and Social Care (DHSC) to carry out a research and market development project focused on mental health specialist and supported housing (MH SSH). The project ran from March to December 2024, though outward-facing activity was paused during mayoral and general pre-election periods.

1.1.1 Aims and objectives

The objectives of the project are to build an understanding of the needs, gaps and barriers to the provision of MH SSH for adult Londoners. The project also aims to support market development by identifying opportunities to bring together partners, and capital and revenue funding opportunities to better meet these needs. One of the desired, longer-term outcomes is an increase in the number of applications to the GLA from Registered Providers of Social Housing and Local Authorities for capital funding for MH SSH projects. More broadly, the project aims to promote the development of the sector by informing future MH SSH planning and delivery locally and regionally.

1.1.2 Project activities

IBA was commissioned to carry out four activities:

A. Baseline survey and analysis: to understand current MH SSH for adult Londoners.
B. Modelling of MH SSH need: at regional, subregional and local levels.
C. Stakeholder engagement and qualitative analysis of subregional and regional needs with a series of discussions with key stakeholders to build a picture.
D. Convening of relevant stakeholders and funding opportunities to enable delivery of housing for mental health client groups, focused on sub-regional and regional solutions under the GLA's capital funding programmes[1].

Our methodology for each of these activities is detailed in the appendices to this report, with full technical appendix available by request[2]. This final research report builds on the interim report (in which the findings of the engagement activity were summarised), and synthesises key findings from each activity, drawing implications and recommendations for the GLA and its pan London and locality-based partners.

Accompanying outputs include: a standalone report of research with people living and working in MH SSH, six case studies of relevant initiatives, and a briefing on the principles and enablers of cross-borough commissioning and an internal market development handover document for the Housing and Land team.

[1] For the purposes of this report, we refer to the **GLA's capital funding programmes**. This encompasses the Mayor's Affordable Homes Programme, currently in the 2021-26 iteration, as well as any bespoke capital funding programmes administered by the GLA to support the delivery of affordable housing, including specialist and supported (SSH) provision.

[2] Request can be made to Greater London Authority Housing and Land Team or Imogen Blood & Associates

The project has built substantial engagement, attempting to engage each borough (with 23 engaging through at least one strand of work), each Integrated Care Board (ICB) and NHS Trusts delivering mental health services (all five ICBs engaged, and the majority of Trusts, in qualitative work), along with Registered Provider landlords (RPs) and support providers, and a programme of visits to schemes to engage people living and working in them.

There is a lack of accurate data throughout the system in relation to housing, care and support needs of people with mental health needs. Limitations to the evidence are detailed throughout; quantitative findings and modelling results are indicative.

1.2 Definitions and scope

MHCLG[3] states that

> *'In supported housing, accommodation is provided alongside support, supervision or care to help people live as independently as possible in the community'.*

There is a lack of clarity and consensus across health and social care over what is meant by 'specialist supported housing' for people with mental health needs. For example, stakeholders queried whether Bed & Breakfast and other temporary accommodation was in scope. Whilst 'housing' was often recorded as a reason for delayed hospital discharge, people's specific needs within this were often unclear.

The following definition was agreed at the outset, to establish parameters of the mapping and modelling elements:

Project definition of Mental Health Specialist and Supported Housing (MH SSH)

Housing schemes for adults (18+) where there is a referral criterion that people have support needs arising from their mental health:

- These could be purpose-built/ group homes/ dispersed tenancies/ Housing First
- Provided the person needs and is receiving intensive housing management & support (additional services to enable someone to sustain their home)
- People must have a tenancy or licence condition and have the right to leave.

Out of scope:

- Registered care homes, wholly NHS funded schemes used primarily for treatment
- Schemes targeted at/ needs arising from dementia, learning disability, neurodiversity.

However, our engagement activity explored pathways into MH SSH, e.g. from hospital, residential care, etc. in engagement, and for people with co-occurring needs. Definitional grey areas, included:

[3] MHCLG (2020) Supported Housing: National Statement of Expectations, Guidance

- Where the NHS is wholly funding step-up/ down services, which it feels should be funded by London boroughs.
- Where providers (typically those which serve the spot placement market, as discussed below) list 'mental health needs' as one of several support needs which can be met by a service (e.g., alongside Learning Disability, Autism, etc), but it is not clear that this is a *required* referral criterion.

1.3 Context and drivers

1.3.1 Aims and effectiveness of MH SSH

The ethos of supported housing is to provide person-centred and planned support alongside accommodation in the community for people with mental health needs. It aims to maximise individuals' choice, independence and autonomy, whilst balancing these with the need to manage risk and promote safety and treatment compliance.

There is huge diversity in MH SSH; however, most schemes are – in theory - designed to be transitional, typically with an intended stay of around two years and with an aim to stabilise mental health or increase skills and confidence so that people can move into more independent housing. MH SSH occupies an ambiguous territory between 'home for life' models (such as those designed for people with learning disabilities or older people), and short-term transitional models (such as supported housing for people experiencing homelessness or domestic abuse). Some people with mental health needs are likely to need very long-term, even lifelong housing and support; others can and do recover fully; some experience cyclical mental health episodes. Diagnoses provide some indication of which of these categories a person might fall within, but cannot reliably predict individual journeys and needs.

The people we spoke to in our lived experience engagement had often experienced long periods in hospital, and several had experienced homelessness and rough sleeping. MH SSH was often a very positive contrast to previous settings, providing a combination of independence and support.

> *'The best thing is the element of freedom but knowing you have the support if you need it. Freedom and privacy so it's not smothering - the best of both worlds'.*

Some people spoke in terms of recovery and progression, but some were focused on managing as well as possible in their current situation. Getting the balance right between independence and support for people at different stages of their recovery requires multiple, flexible models.

There is some evidence in the research literature that supported accommodation is effective across a range of psychosocial outcomes; however, this is limited by the heterogeneity of service models, and a lack of quality research[4].
Residents interviewed for this project often reported that, for them, living in mental health supported housing had prevented: returns to hospital, risk of exploitation and bullying, signs of escalating need or crisis going unnoticed. These outcomes are achieved through ongoing daily contact and care by support staff, in some cases support to take medication and a quick response to any emerging issues, e.g., with medication or escalating needs.

1.3.2 Drivers for MH SSH expansion

Operational and strategic drivers for the expansion of MH SSH in London include:

- NHS England's draft Mental Health Strategy for London[5] prioritises quality care in the least restrictive setting close to home, and the wider determinants of health.
- Our Vision for London sets a target for 'Adults in contact with secondary mental health services who live in stable and appropriate accommodation'.
- The London Plan sets a policy (H12, p.197) to support the delivery, retention and refurbishment of supported and specialised housing which meets an identified need, including both short- and long-term accommodation for people with mental health issues who require intensive support.

There are significant costs and pressures for the NHS resulting from delayed discharges from mental health inpatient settings, due to a lack of suitable housing and support. This results in high levels of spending by the NHS and poor outcomes for individuals and their families from:

- Out of area private placements
- Lengthy stays in inpatient rehabilitation
- Bed & Breakfast accommodation.

Local authorities fund supported and temporary accommodation for people with mental health needs from their general budgets, within a context of substantial financial pressure, resulting from increased spending on homelessness and adult social care, against a backdrop of austerity.

The Supported Housing (Regulatory Oversight) Act 2023 which came into force in August 2023 will require local authorities to review the supply of and need for supported accommodation over the next five years, and develop strategies informed by this evidence. However, at the time of writing, the government has not yet published the regulations stating when local authorities must comply with this requirement or confirmed whether new burdens funding will be available for implementation.

[4] McPherson, P., Krotofil, J. & Killaspy, H. Mental health supported accommodation services: a systematic review of mental health and psychosocial outcomes. *BMC Psychiatry* **18**, 128 (2018). https://doi.org/10.1186/s12888-018-1725-8
[5] Slides from London Mental Health Strategy

2 Current landscape

In this section, we present quantitative findings from the mapping activity and qualitative findings from engagement activity to describe the current landscape of MH SSH provision across London. The approach taken to the mapping activity is described in detail in Appendix 1.

A total of 23 boroughs (72%, excluding City of London) provided us with *some* information but only 9 answered the survey or shared details of commissioned units *and* supplied information on the total number of people placed in MH SSH.

The research brief was to estimate the scale and scope of the commissioned and non-commissioned MH SSH sector in London. Challenges in this included:

- Difficulties identifying which officer (if any) is responsible for commissioning MH SSH in each borough and engaging them (due to lack of capacity, limited access to data, concerns about information sharing, etc).
- In most boroughs, no single officer has the whole picture – teams placing individuals are often separate from those commissioning schemes, where the borough still has block contracts.

2.1 Number of services and units

Our mapping activity has identified a total of 5,199 units or bedspaces of MH SSH across London, including both block and spot purchased provision (discussed in section 2.5). The actual number may be larger since we did not receive a return from all boroughs, and whilst we collected supplementary data from providers and online searches which we cross-referenced, it is unlikely that we have been able to capture all schemes.

This study has succeeded in identifying significantly more MH SSH in London than estimates from the recently published national Supported Housing Review 2023 would suggest[6]. The national study estimated a total of 74,600 units of supported housing in London (T3.4) which, if these follow national client group breakdowns (T3.5), would suggest around 2,680 units for people with mental health support needs, around half of our estimate.

The 5,199 units identified in our study are contained within 470 services. Sometimes a 'service' denotes just one property; sometimes it includes multiple properties run by the same provider as part of a contract or pathway, with the largest block commissioned service having over 160 units. It is therefore not possible to provide accurate data about the number of bedspaces per property. Most of the services visited in our fieldwork had around 15 bedspaces and residents compared this favourably with larger, more institutional settings, such as some homelessness hostels and hospitals.

[6] Beatty, C., Bimpson, E., Gilbertson, J., McCarthy, L., Sanderson, E. and Wilson, I. (2024) *Supported Housing Review 2023.* London: The Stationery Office. Available at Supported Housing Review

2.2 Geographical distribution

The following map shows the distribution of all physical units (i.e. regardless of whether and how commissioned) identified in the study by borough. The map shows a concentration of units in a discontinuous central North-to-South band from Enfield to Croydon.

Note there are some definitional caveats; for example, Royal Borough of Kensington & Chelsea included provision for people with multiple and complex needs in their returns, where others did not. A couple of the boroughs shown here as having the lowest number of units (LB Barking and Dagenham and LB Bexley) were non-responders, so these numbers could be an underestimate.

Figure 1 Map to show physical distribution of MH SSH units across London boroughs

- Population size did not appear to be closely associated with the number of units in a borough.
- Inner London boroughs have an average (mean) of 2.58 units per thousand households, compared to 0.84 for outer London boroughs, though there were outliers in this, such as Croydon and Enfield.
- The housing market was reported by commissioners to influence the volume of units, though again the relationship is not straightforward, and seems to be based on a combination of affordability, geography, property types and investment potential. However, it is reasonable to assume that the housing market has, if anything, more influence on the level of provision in an area (especially given the extent of the

provider-led market discussed below), than the size of the overall population and perhaps even the level of local mental health needs.

2.3 Gap between units and placements

As the extent of the (often inter-borough) spot purchased market became apparent during engagement activity, we understood the necessity to find out how many *people* are placed by each borough, as well as how many *units* there are in the local area. In most boroughs, estimating placements involved drawing intelligence from across different departments, some participants explained that this figure can fluctuate considerably over time; this also flagged up definitional grey areas, e.g. between 'supported living' and 'supported housing' (both of which we included).

Based on a recent (i.e. within the past 12 months) snapshot supplied by 14 boroughs, older published data from 7 boroughs and imputation based on population size for the remainder, we generated the following *estimates* of the number of people placed in MH SSH at pan London and ICS levels.

Table 1 MH SSH Units and Placements by ICS, 2024

ICS	MH SSH Units identified	MH SSH placements 2024	Difference between MH SSH placements and units identified
North West London	948	1,688	740
North Central London	943	1,145	202
North East London	774	1,526	719
South East London	1,920	2,153	233
South West London	581	1,048	467
Location unspecified	33	-	-
TOTAL	**5,199**	**7,560**	**2,361**

Caution is needed since we are comparing estimates with estimates here, nevertheless we can be confident that there is a significant gap between the number of units identified as specialist across London (supply) and the number of people currently placed in MH SSH (demand). The gap is likely to result in:

- Placements in MH SSH outside of London.
- Placements in non-commissioned or spot purchased provision, which was not included in our mapping since mental health appeared to be one of several needs which *could* be met by the scheme (i.e., not an essential referral criterion), and therefore did not meet the project's definition of 'specialist' provision (in S.1.2).

2.4 Scope and nature of existing provision

A huge range of different models fit within the project's definition of MH SSH. For example, our fieldwork visits covered:

- Highly supervised forensic services
- Other high support need services with 24/7 staffing
- Semi-independent services
- A supported house share (e.g. HMO-type property with support provided), and
- Dispersed housing with a package of support for individuals, referred to as 'move on' accommodation.

Our aim was to test and apply the typology we proposed during the project through the mapping activity (for further details see S.4.1.1). However, robustly determining the volume of different types of models is currently extremely challenging. There is no agreed typology of MH SSH provision or consistent descriptions of models across the sector; this makes it very difficult to categorise schemes by type in a meaningful and consistent way.

Our initial 'Tier 1' survey distributed to commissioners and larger providers, requested basic information about the location of schemes, number of units, providers/ landlords. Completing this level of detail proved to be particularly labour-intensive for many large providers or commissioners with multiple contracts. The original request was that these Tier 1 respondents would send the Tier 2 survey to scheme managers who could then provide much more detailed information about the building, the support model, target group, the referral mechanisms, funding arrangements, equalities information, rent and service charge. Despite our efforts, it took an extended period to engage with and follow up on the Tier 1 respondents (initially receiving only 3 responses), resulting in us continuing to collect responses much later in the research timeline. The result of this was that we received only 17 responses from services completing the Tier 2 survey. Although the responses provided a good deal of detail on schemes, with a sample size of just 3.6% of the total number of services identified (470), it falls significantly short of allowing generalisations to be drawn from this data.

Some boroughs volunteered information about scope of commissioned schemes in the spreadsheets they supplied; we also gleaned as much information as we could from our online searches of (typically spot purchased) MH SSH provision. However, there is little consistency in the terms used to describe target groups or support models in this information. Descriptions typically relate more generically to 'multiple and complex needs' and 'mental health support needs'; they sometimes describe a spectrum of support levels available, categorised as high, medium or low.

The project has succeeded in building a sample list of provider and commissioner contacts from scratch. There is an opportunity (presumably somewhat time-limited, given staff turnover in the sector) to roll out the Tier 2 survey to build a more detailed picture of current provision. We would recommend slightly modifying the survey approach in response to learning from this project, e.g., asking boroughs to include and identify both their block contracts and the spot-purchased placements of MH SSH. It was not possible to achieve this within the tight timeframe and resources of the current project.

2.5 Block v spot purchased provision

A block funded contract is one in which a care or support provider is commissioned to deliver a specified service to a type of service user over a period.

A spot-purchased contract is an arrangement under which a local authority procures care or support services for a specific individual.

In the 23 boroughs (72%) where we received a commissioner response, commissioners identified a total of 2,570 units which they block contract. There was wide variation in the amount of block contracting by local authority: ranging from 0 to 360. This meant that it was not possible to reliably impute estimates of block contracted units for non-responding boroughs.

As noted in section 2.3, it became evident that information on block contracts represented only a portion of the overall picture. Our online search, provider survey and the response of one borough detailing all the local provision used for spot purchasing identified a further 1,885 units in responding boroughs alone[7].

If these boroughs are typical of the whole of London, this suggests that around 58% of MH SSH is block contracted by boroughs, and a further 42% is effectively provider-led, serving a spot-purchasing market.

Our desk research gives some insights into non-responding boroughs. For several of these, we have verified contacts who have engaged with some, though not all, aspects of the project (e.g. signing up for but not attending the market development event) or we have found various online borough publications relating to MH SSH - one non-responder was mentioned by London Councils as having good practice in this area. This perhaps suggests lack of capacity to engage, misapprehension on the topic and/or perceived value of the project. In other non-responding boroughs, even neighbouring authorities could not identify a current contact, and we could find little mention of MH SSH on the council website, which may indicate a need for a clearer strategy and ownership of MH SSH.

Some boroughs told us that they do not have any block contracts for MH SSH services. Others with significant levels of block contracts told us that they are 'topping' up with considerable additional use of spot purchasing. Often the block contracts are overseen by a different part of the authority than the brokerage function, which identifies placements for individuals on behalf of adult social care/ integrated teams. In some localities, brokerage sits in Adult Social Care, in others it is located at the NHS Trust, and in others it sits in an ICB team. Several commissioners interviewed explained how fragmentation can lead to delays in sourcing placements, for example:

[7] NB: Given the challenges discussed in this section of imputing for missing boroughs, we excluded the non-responding boroughs from this calculation and only considered commissioned and non-commissioned units in the 23 boroughs which had responded.

> *'Our multi-disciplinary placement panel works well, but since our supported accommodation pathway sits with Housing, only they understand where the voids are at any given time….so that's very disjointed. We'll look to the block contracts first for a placement - if there's nothing suitable available, we'll do an e-referral to Brokerage….. They will then search for a suitable placement in neighbouring boroughs or beyond. That whole process takes time, which is frustrating for all concerned and often delays the discharge.'*
> *(Commissioner)*

Several providers described challenges with voids in their services; one local authority explained how they had 'tightened up' on spot placements being made where there are voids in block contracted provision.

2.6 Implications of a growth in spot purchasing

The growth of a 'provider-led' market, from which placements are purchased by boroughs and/or trusts for individuals has several implications for individuals and families, and public bodies.

Quality and oversight: our engagement findings suggest considerable diversity of quality within the spot purchased market. Some individual placements are offered by commissioned providers – sometimes even in the same scheme as block contracted units. However, much of the market is of unknown quality and, given the current lack of regulation in the sector (as described in some detail by the 2023 National Audit Office investigation[8]), stakeholders raised concerns about quality, risk and safeguarding.

Relationships with the market: Some boroughs and trusts expressed a desire to widen their engagement, but lacked the knowledge and resources to do so.

Some boroughs have developed ways of better managing the supply, quality and/or cost of spot-purchased placements. For example[9]:

- **Borough A** has an integrated multi-disciplinary team responsible for mental health placements and hospital discharge, whose functions also include brokerage, commissioning and market development. The team sources suitable placements for individuals and, vitally, provides ongoing support and oversight to these placements. Meeting fortnightly, they can quickly share and address any placement or provider issues.
- **Borough B** has built a distinct relationship with just three of the private non-commissioned providers of MH SSH from whom spot placements are purchased. This relationship means that, in return for access to social housing for move-on, and verification of legitimacy with Housing Benefit, these three providers submit a self-assessment every year, and voids and outcomes data quarterly and have agreed

[8] National Audit Office (2023) *Investigation into supported housing.* [HC 1318]. Available at https://www.nao.org.uk/reports/investigation-into-supported-housing/

[9] Please see our separate Case Studies output for detailed descriptions of Boroughs A and B.

100% nomination rights, overseen by the borough's Mental Health Pathway Manager who coordinates referrals across this and the council's block-contracted provision.

- **Borough C** runs an Approved Provider List (APL) for Supporting Living for people with mental health and/or learning disability needs, with different lots reflecting the type of support needed. They commission care and support for individuals by approaching the APL, and the provider then sources the accommodation. This is felt to enable a more person-centred approach, rather than trying to fit the person into the available spaces in block contracts and represents better value for money than spot purchasing outside of the framework. This approach is felt to have improved availability and choice of placements, but it has produced a large, 'organic' market which the council feels it needs to better understand and engage.

Cost: It is clear from our engagement that spot purchasing is significantly more expensive for commissioners than the unit costs of block purchasing. To give an indication, one borough published a few years ago that it was spending an average of over £50K per person per year on (mostly out of borough) spot placements of people who could be placed in local block placements if there was sufficient capacity, for which the average unit cost was around £18.5K. From the limited data we have been able to access in this project, it seems that spot placements are on average at least twice as expensive as unit costs in block placements, with one borough reporting that out-of- borough placements tend to be four times as expensive. A clear theme from providers, however, is that some of their existing block contracts do not provide enough funding to run a high quality and sustainable service (especially given inflation, minimum wage and proposed National Insurance increases). Some are developing for the spot purchased market in the hope that they can bolster their overall financial sustainability.

Strategic planning: one criticism of the trend towards spot placements is that there is limited strategic planning of services to respond to assessed and projected local needs – the market instead attempts to evolve organically to react to customer demand. However, without access to transparent intelligence to inform business planning, the provider-led market cannot function effectively; and it is a market which strongly favours those who can bring their own properties. Some boroughs, such as Enfield, have produced clear Market Position Statements to inform the market of their needs and intentions.

Inter-borough placements: Provider-led schemes respond to demand for spot purchased placements from across London and beyond, so many of the people placed in these will be outside their home borough. This has several implications – firstly, for the individual and their family, there is the impact of being at a distance from existing support networks, and from professionals working with you: where people are placed out of borough, there is a reduced likelihood that professionals will visit the placement to review how it is working. Host authorities described safeguarding, financial and performance risks, which are more likely to pass from inner to outer London borough and/or those with more affordable housing markets:

- Finding out for the first time that someone is placed in a MH SSH scheme (which the authority was perhaps unaware of) when safeguarding concerns are raised, or even a Safeguarding Adults Review triggered.

- Inheriting S.117 duties from the placing authority if the person returns to an inpatient setting under Mental Health Act section.
- Having no control over review, monitoring and potential move-on.

There is at present no equivalent of the Pan London Agreement on Inter Borough Accommodation Placements[10], though nationally ADASS has produced an excellent Advice Note[11] on this.

Capital funding: One clear value of this way of working from the local authority perspective is that the providers effectively bring the buildings, sourcing capital as needed. Some boroughs told us they have been able to influence provider-led developments on the basis that the 'market will bring the capital if we state the need'. Although this is then reflected in high placement costs, this type of arrangement can be attractive to local authorities who do not feel able to take on longer term financial commitments in the current fiscal climate. Furthermore, the lead-in time for local authority-led developments, given council decision-making, capital grant applications, business cases for match-funding and procurement means that new schemes may take at least 4-5 years in the pipeline. The market can deliver much more quickly by raising its own capital; where providers are willing and able to take the risk of non-guaranteed (spot purchased) revenue for the potential of high returns and are confident that Housing Benefit teams will approve 'exempt' rents. However, one traditional not-for-profit provider venturing into this model for the first time told us that they are dependent on good quality data to make the business case to their board and the bank, and good referral relationships with local authority brokerage teams.

2.7 Commissioning context

Commissioning in the NHS and social care is underpinned by the statutory duties set out in legislation such as the Care Act 2014 and the Health and Care Act 2022 for Better Joined up Care. Specifically relevant to MH SSH is the statutory guidance Discharge from Mental Health Inpatient Settings published January 2024 which pushes housing need up the hospital discharge planning agenda. Two other parts of legislation which are intended to support better joined up commissioning between local health and care systems are Sections 75 and 117.

Section 75 (s75) of the NHS Act (2006) is a vehicle by which the NHS and LA can delegate responsibilities and/or pool budgets to make the most effective use of resources to meet the needs of specific populations and improve outcomes e.g. The Better Care Fund.

S117 Aftercare is the statutory responsibility of local authorities (social services) and NHS commissioners to provide aftercare services to eligible people as defined by the Mental

[10] See p. 52 LGA (2017) *Council Innovation and learning in Housing our homeless households.* London: Local Government Association. Available at: https://www.local.gov.uk/sites/default/files/documents/5.12%20HOUSING%20AND%20HOMELESSNESS_v08_4.pdf

[11] ADASS Advice Note for Directors of Adult Social Services: Commissioning Out of Area Care and Support Services:

Health Act legislation. This includes commissioning care and support and supported accommodation (e.g., MH SSH).

In terms of MH SSH commissioning, we found a mixture of arrangements across London. In several boroughs engaged, statutory mental health social care functions have been delegated (via s75) to MH Trusts and, in some cases, this included procuring and commissioning the out of hospital pathways. In other cases, the s75 delegated the social care review function to the MH Trust and commissioning of housing, care and support remained the responsibility of the local authority. In other areas the health and social care functions remained separate. Where this was the case, the system was fragmented and the feedback generally pointed towards a desire for a more integrated and collaborative approach.

It takes strong leadership across health and care systems to set up robust agreements over how to manage the financial side of s117 so as to avoid bureaucratic complexities that can hinder innovation and, ultimately, outcomes for people; it is not always straightforward. Good practice examples were identified in some boroughs where there are jointly agreed processes regarding funding arrangements and, in some cases, a 50:50 funding split agreement between Health and Social Care is in place.

Responses from housing and support providers to our survey have identified a total of 90 units of MH SSH primarily offering step-down from inpatient rehabilitation for which the support element appears to be funded by the NHS, though it is not clear whether this is the sole source of funding. We also identified 280 units which are jointly commissioned by health and local authorities. Our online searches identified schemes described as 'step down', some of which appear to be solely health funded (e.g. CNWL Stepdown); others are commissioned by London boroughs (possibly using pooled budgets); the same appears to be true of 'crisis houses', e.g. MIND lists 9 of these in London, some with referral routes through the NHS, some through local authorities.

2.8 Pathways and referral routes

Typically, each borough has a specialist mental health accommodation and support pathway, which focuses on people under 'shared care' arrangements with the NHS (as described in the previous section) but may also include others being discharged from hospital with mental health needs, and people with housing and support needs in the community, assessed as eligible for funded support under the Care Act. Several borough commissioners explained how they had reviewed and designed this pathway with NHS colleagues; in some parts of London, this pathway is now being managed by an integrated team, sometimes at borough-level, sometimes at ICS geography (though not all boroughs have opted into these arrangements, some preferring to retain control).

The processes and structures to access the mental health pathway were felt to be cumbersome and fragmented in some authorities. For example, officers described multi-disciplinary panels which made broad decisions about housing, care and support needs, separate brokerage teams who worked to identify available placements, whilst the referrals into housing pathways sat with a commissioning team in a separate directorate. Accessing

Care Act assessments is hugely problematic and can also create delays. In some places (e.g., see Lambeth Alliance case study), these processes had been streamlined. We also heard that, in some parts of London, there is considerable tension between Trusts and boroughs and these partnerships are not working well.

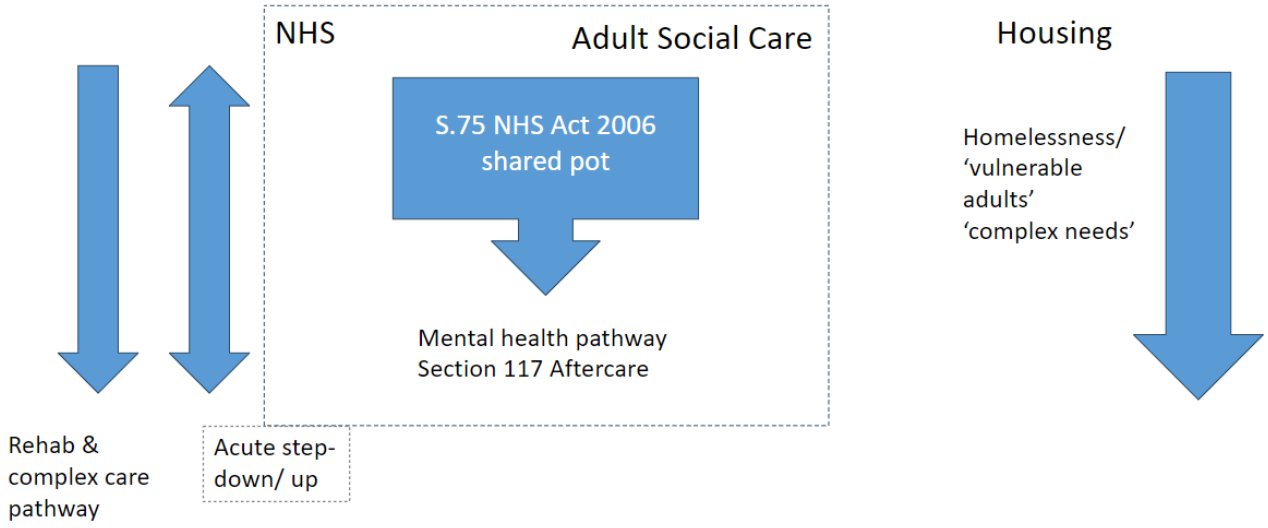
Alongside this, the boroughs typically have a separate pathway for single people experiencing homelessness – sometimes these are termed 'complex needs' or 'vulnerable adults'. A recurring theme was that this latter pathway also contained people who had significant mental health needs, but that these had not always been diagnosed or treated via clinical pathways, had not received a Care Act Assessment and/or that these people did not readily 'fit' in the specialist mental health pathway due to co-occurring substance use and associated behaviours, such as offending. As one commissioner explained:

> *'There are likely vulnerable adults in the homelessness pathway with Care Act eligible needs, however they are not getting assessed in this way and are falling through the gaps as they have needs which cannot be met in the homelessness system'.*

Several other commissioners reported a need to review how these pathways worked for this diverse cohort of people, and whether they needed to be merged. We reflect the unmet needs of this cohort in our modelling; though we do not assume that everyone with a mental health need or even a diagnosis in the homelessness pathway has unmet needs for specialist support or would be better placed in specialist MH SSH.

These different pathways are summarised in the following visual:

Figure 2 Diagram to show pathways to specialist mental health accommodation and support



2.9 Governance

As stated in the introduction, it is unclear who, if anyone, has population-level sight and 'ownership' of planning for and meeting the housing, care and support needs of people with mental health needs. This requires a joined-up approach and effective governance, which is happening only in pockets at present.

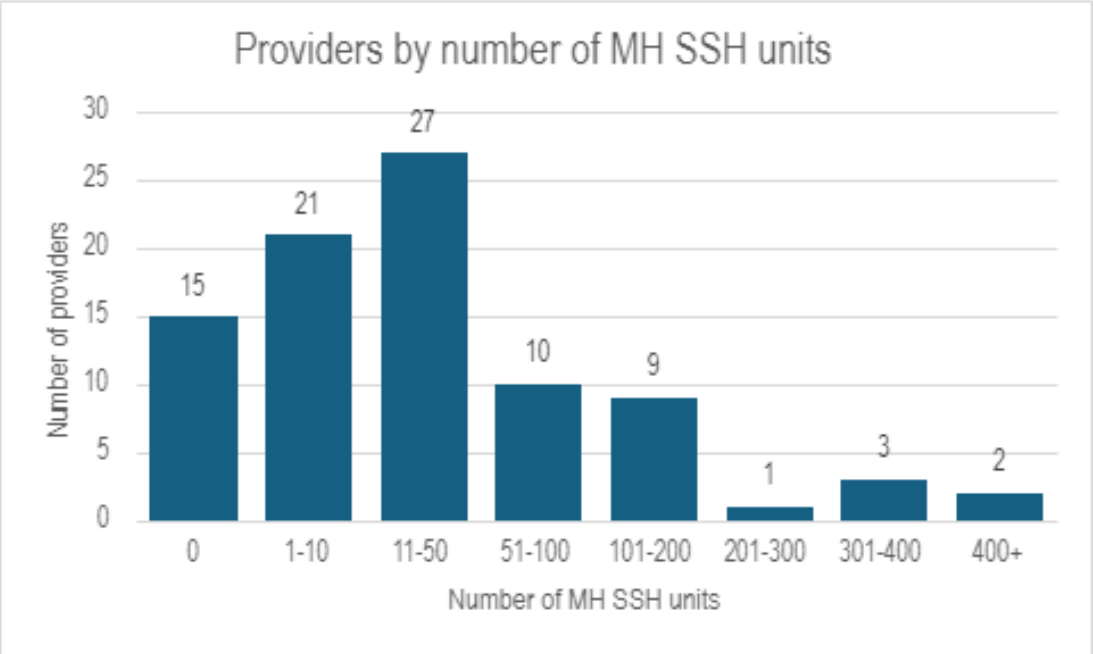
Elements of governance exist, for example in relation to populations and pathways for which the NHS and local authorities have joint responsibility, though it is not always clear whether these are based on a shared understanding of needs and the most effective models to meet them. There are integrated commissioners in some ICSs however, it is not yet clear the extent to which they commission for population groups rather than simply manage contracts.

There is an impetus to mobilise around this topic, both from the NHS Length of Stay group and NHS-led reviews, and from Directors of Adult Social Services groups looking at housing as a reason for delayed discharge. However, it is not yet clear whether and how NHS and social care stakeholders engage with housing, both in operational decision-making and strategic planning. Whilst there is appetite from Directors of Housing to engage with colleagues on the topic of supported housing, capacity has been particularly affected by rising homelessness and managing associated financial burdens.

2.10 MH SSH service providers and landlords

The mapping activity has identified 88 different providers who are delivering the support element of MH accommodation-based services in London. The following table summarises providers by the number of units they provide within their services.

Figure 3 Bar chart to show number of MH SSH units by number of providers from mapping activity



**Note where the number of units is zero – a specific provider has been noted in information used to compile the data, but no information was available on the number of units they supply.*

The largest 10 providers collectively have 55% market share. They are: Look Ahead, The Riverside Group, Dinardo, Certitude, St Mungo's, Hestia, Social Interest Group, QVT, Social Interest Group (Penrose), Shine Partnerships.

Landlord data was provided for 4,265 units (80% of the total number identified), identifying over 100 landlords; however, there were some issues with the data, e.g., where, multiple landlords were listed against one large service, and it was not clear how many units each owns individually. If we exclude two such groups of multiple landlords, there were 9 individual landlords who are known to own 100+ units of MH SSH. Collectively, they own 45% of the units for whom data is provided. They are Excel Holdings, The Riverside Group, L&Q, Peabody, Southern Housing, Sanctuary, Shine Partnerships, Metropolitan Thames Valley Housing and Look Ahead.

According to our mapping results, 17 landlords own MH SSH schemes across more than one borough, with a portfolio spanning 9 boroughs being the maximum identified. 67 landlords had property in just one borough[12].

Half a dozen London Boroughs and a couple of NHS Trusts are mentioned as landlords, along with a few references to 'private rented sector landlords'. Most remaining landlords are housing associations (RPs); some organisations reference 'care homes' in their title, and some appear to be religious charities, though it is possible they also have registered provider status.

[12] Please note that due to gaps in the data, these 2 figures do not total the 100+ landlords identified.

In cases where we have the data, in 27% of schemes, the provider is the same as the landlord. In 73%, there is a separation between landlord and provider, presumably with a managing agent agreement between them. Engagement with support providers acting as managing agents suggests that these agreements tend to be increasingly stretched, with landlords trying to push back or pass on costs to them.

2.11 Provision for equalities groups

We were asked to identify provision for different equalities groups in our mapping. Given significant gaps in the data, we cannot be confident what proportion of specialist provision we have identified, however our mapping has identified that there are at least:

- 51 units designated for women (of which 9 are for women of a specific ethnic background).
- 118 units designated for men (of which 6 were for men of a specific ethnic background).
- Around 80 units for people with learning disabilities (LD) and/or autistic people who also have mental health (and in some cases other co-occurring) needs.
- Around 200 units of accommodation for people with co-occurring mental health and substance use issues (179 units, plus 2 additional services for which units were not stated).

A lack of accessible MH SSH units for people with co-occurring physical disabilities was flagged as a key concern of the NHS trusts. Our Tier 2 survey asked service providers: *How many of these bed spaces are accessible (e.g., step-free, with internal and external doors wide enough to permit a wheelchair, in line with Building Regs 2010 M4 (2) standard)*? Providers identified 67 (out of 475, 9%) units which they felt were accessible to *some* degree. However, the response rate is too low (covering only 9% of all units identified in London) to draw generalised results, moreover 'accessibility' is a complex and ambiguous concept to assess without deeper investigation and ideally on-site inspection.

2.12 Rent and service charges

Rent is a payment for the right to live in a property (and this usually includes an element for general repairs). Service charges are additional payments which in supported housing may cover staff employed at the scheme, such as support workers, or costs associated with maintaining communal areas, such as gardens, laundry rooms and shared lounges.
The actual rent plus any eligible service charges can be covered by an individual's Housing Benefit claim provided the accommodation meets the DWP definition of 'specified accommodation' and the individual needs and is receiving a 'more than minimal' level of support. Specified accommodation claims are assessed using the same eligible rent rules as regular Housing Benefit claims, unless the accommodation is classed as 'exempt' in which case the rent can exceed the level set by these rules and the onus is on the local authority to make and evidence the case that this is 'unreasonably high'.

Eligible service charges include charges for communal areas, such as laundry facilities, water charges, cleaning and maintenance. The part of the service charge which relates to a resident's non-communal daily living expenses – their personal support, meals (if relevant),

utilities (if in a self-contained unit) are 'ineligible', i.e. must be funded outside of Housing Benefit.

The rules for the funding of supported accommodation through Housing Benefit are complex[13] and have been the subject of research and scrutiny by the National Audit Office[14] and the Department of Work and Pensions nationally.

Although it was intended that this project would collect data about rents and service charges within current provision in MH SSH across London, only a very small sample of schemes supplied this information. In the Tier 2 survey, we asked, *'What are the weekly gross rent levels for the service? The gross rent is the total figure payable as contained in the occupancy agreements. It includes both benefit-eligible and ineligible service charges as well as core rent. Please enter a figure in both boxes if this varies according to accommodation units'.* Only 15 services responded to this question, and there was a huge range in their responses, from £84 to £892 per week.

According to the Supported Housing Review's Provider Survey, national average rents in 2022/3 were £163 per week and service charges £78 for MH SSH[15]. Uplifting[16] these figures for the London context and to factor in inflation, suggests an average weekly gross rent (including service charge) of £323 in MH SSH in 2024/5.

2.13 Workforce

The housing support staff we interviewed placed a strong emphasis on supporting residents to become more independent and lead active lives. At first the question of '*what you are trying to achieve?*' was often answered in terms of independence, progression and move on, but further feedback highlighted that at a deeper level staff are more engaged about people's welfare, quality of life and relationships than move on planning. The aim for many teams is to create projects that 'feel like home' which help people move on from institutional experiences. Having an 'open door policy' and 'reducing physical barriers' were concepts mentioned by managers. Supporting (or in some cases ensuring) compliance with medication and maintaining daily contact to spot deterioration in people's mental health was a key activity.

High quality staff teams with low turnover are essential to support this work. Some of the staff we met on fieldwork had been in post for many years and were clearly very committed to their roles; however, workforce issues are common due to salaries offered and the pressures of the work. Some providers told us about steps they had taken to attract and

[13] For further details see DWP (2022) *Housing Benefit guidance for supported housing claims*. Available at https://www.gov.uk/government/publications/housing-benefit-guidance-for-supported-housing-claims/housing-benefit-guidance-for-supported-housing-claims

[14] National Audit Office (2023) *Investigation into supported housing.* [HC 1318]. Available at https://www.nao.org.uk/reports/investigation-into-supported-housing/

[15] See Tables 7.3 and 7.4

[16] We used a multiplier of 1.21 to reflect the difference between London and England in Table 7.6 of the Supported Housing Review and the Bank of England inflation calculator to bring the 2022 costs to Oct 2024.

retain good people, e.g., through paying the London Living Wage, offering performance-related pay and a comprehensive learning and development offer.

Concerns were expressed by representatives from adult social care about a lack of consistent quality and expertise in the supported housing workforce. NHS representatives recognised the importance of housing 'in-reach' to inpatient settings to plan upstream for discharge. Others highlighted the need for support, upskilling, quality assurance and challenge to help supported housing workers maintain 'therapeutic optimism', resilience and the 'culture of recovery and human rights' which research[17] suggests are key to successful move-on and other outcomes and can vary from scheme to scheme. We heard from one provider how a sub-contract with the local mental health trust to provide reflective practice to the housing support team had been built into an MH SSH contract, which had helped build mutual trust, operational communication and shared language. The Lambeth and Hounslow case studies also demonstrate multi-disciplinary approaches to supporting MH SSH placements.

2.14 Support and community integration: lived experience views

There was variation in the amount of choice and control people felt they had over their own living spaces, ranging from some spaces that were like any other home, and some where people felt more restricted. Some facilitators to achieving the valued sense of independence and support, included building design (discussed in more detail in Section 2.17), positive risk taking, reducing rules, caring, flexible, personalised approaches to support, activities programmes, constantly looking for opportunities to create choice, and encourage people in line with their own preferences.

While living in MH SSH was viewed as being more supportive than living independently, there was still a strong theme of people feeling isolated and lonely especially those without close, local family networks. However, a significant minority of participants do have a lot of contact with family members and felt it was often helpful for them to be involved in their care. The reduction in VCSE provision in recent years was felt to contribute to escalating needs and a lack of community contact for people with mental health needs.

For those in staffed projects, offers of activities were central to people's perceptions of the service. There was wide variation and some perceived decline post-COVID-19, but most services had a programme of activities for people to take part in. In the services that received the most positive feedback, people were proactively encouraged to undertake activities and in one service, to volunteer in the community. People valued one-to-one walks and visits to coffee shops with their support workers, as this encouraged them to get outside and build relationships.

[17] Killaspy H, Priebe S, King M, et al. *Supported accommodation for people with mental health problems: the QuEST research programme with feasibility RCT*. Southampton (UK): NIHR Journals Library; September 2019. Available at https://pubmed.ncbi.nlm.nih.gov/31553550/

2.15 Access to specialist health and social care

Residents interviewed reported limited contact with mental health services. This was also reflected in feedback from support staff who reported very varied effectiveness of these working relationships. Some services reported struggling to get the support and input they needed from mental health services; some felt they carried an unreasonable level of risk without enough external support, for example in relation to hoarding and unacceptable behaviour towards staff.

Most staff reported that it is easier to get the right input if the client has a Care Coordinator. However, both residents and staff reported frequent changes in Care Coordinators and resulting delays in progressing the things they needed or a lack of input. At the forensic high support service attended, the involvement of social services is more consistent, with each part of the process planned and coordinated and a rapid response to potential crisis.

Prematurely discharging people to GP care was felt to be risky and impedes quick support at times of crisis. Staff and residents felt that decisions including discharging cases to GPs and sustaining placements following incidents, were made by clinicians without giving enough weight to skills of support staff, especially given their unique perspective resulting from close contact.

2.16 Buildings

2.16.1 Self-contained v shared facilities

Generally, people reported that having fully self-contained flats was highly beneficial to their sense of independence. However, several people sharing in low ratios did not feel this was a problem, where effective cleaning services and support through a care package helped to mitigate some of the potential flashpoints in communal living. Most people appreciated the freedom to create personalised spaces and valued a sense of having their own home within a wider supported housing project that is also homely and inviting.

> *'My room is basically like a studio flat...Only for me to use. No one is coming to my room to share my bathroom, no one is going to share my kitchen. Everything is for me to use for myself. So that's what makes it amazing.'*

Living in accommodation where others are also experiencing mental health problems was specifically mentioned as providing a supportive environment by several people; but for those ready and planning to move on this could be detrimental. Staff reported that, where people share in higher ratios or in buildings not suitable for the level and type of use, it causes tension and sometimes conflict. Several workers reflected that, where people have

complex needs, including substance use, sharing is not a favourable model, a point reflected in Housing First research[18].

2.16.2 Communal spaces

In more supervised settings, large, multi-purpose communal spaces are important, and residents valued a sense of homeliness and warmth in the design of these spaces. In semi-independent settings, communal spaces were sometimes felt to be less important.

> *'At the [the other] service I lived at, the communal space was never used. A lot of them look really clinical; white, beige walls and brown leather sofas – random pictures, but no books! Here there is the TV, the computer, crafts, books – staff come in here too sometimes just to eat lunch – there is not that divide between us and staff that you often have.'*

High quality communal areas can encourage social contact for people who have social anxiety; cooking and eating together was a popular activity and having a variety of different spaces for different purposes, including outdoor space was valued. Most of the services we visited where multiple units were located within the same scheme had some form of reception and office which created the sense of a professional staff team being present. Support providers attending our housing requirements focus group highlighted the impact of this not being considered and costed into the model at the outset. In contrast one of the services attended was a shared home for three people, with no real sense of the home being a 'service'.

2.16.3 Building layout, quality and upkeep

Most of our fieldwork visits were to services that providers would consider to be high quality and often purpose-built. One provider supported a visit to a more challenging building which was very insightful, demonstrating the critical need to improve or replace some existing schemes as well as developing new services. The unsuitable structure and layout of the building and a lack of upkeep made it impossible for staff to provide a comfortable homely environment. For example, in one property, the shared spaces looked uninviting and sad; there were no pictures, and the furnishings were old and stained. The environment was reminiscent of a run-down hostel or a poorly maintained temporary accommodation property.

> *'We get referrals sometimes but due to state of building people turn them down… unfortunately the buildings we operate from are not purpose built for some of the roles they have – cramped spaces, steep stairwells, and some of the rooms are not that big...That's why when I heard about capital funding for MH I was very interested and wanted to know more - I think there is a need to improve our facilities.' (Support provider)*

[18] See for example chapter 2 & 3 of Blood et al (2017) *Housing First Feasibility Study for the Liverpool City Region*. London: Crisis UK. Available at https://www.crisis.org.uk/media/237545/housing_first_feasibility_study_for_the_liverpool_city_region_2017.pdf

There was generally poor feedback on older houses which had been converted into MH SSH, especially in relation to lack of accessibility for those with mobility issues; however, one project was a very old, converted building but was of a high quality - it had been radically altered and had not previously been a private dwelling.

Buildings in poor repair were reported to be a low priority for renovation by some landlords. Issues with repairs and maintenance were quite common; usually these were minor issues. Where there are serious issues with the standard of accommodation (usually given as an example from previous accommodation) this can become the focus of residents' interaction with staff and detract from the quality of support relationships. Shared spaces need far more upkeep than standard accommodation, but this is not always considered by landlords – even high-quality accommodation would benefit from more investment in upkeep.

Concerns about MH SSH buildings were also expressed by stakeholders across the system:
by commissioners – who felt they may need to withdraw support contracts from poor quality buildings in future; by NHS trusts, who were concerned about a lack of accessible accommodation.

2.17 Utilisation, length of stay and move-on

Our engagement identified issues with under-occupation in some schemes. Sometimes this was due to the challenges of matching people to vacancies in small, shared settings; and sometimes (as discussed in a previous section), this was due to a lack of coordination and information sharing regarding vacancies in block contracted and/or in-borough provision. Sometimes we heard that people are placed initially in spot-purchased placements, then moved to block-contracted placements as spaces become available. This may be more efficient for the authority, but can be very disruptive for the person, unless it aligns with their personal preferences. Social landlords also reported that support providers sometimes run with voids rather than accept referrals for people whose needs they cannot meet, and that this impacts on the sustainability of the scheme from the landlord's perspective. One commissioner who was new to an authority felt that capital developments had previously been authorised without sufficient understanding of strategic needs, so when schemes come online, there are voids.

Most supported housing is intended for shorter term stays (e.g., two years) when it is commissioned. However, move on was a huge challenge for most of the services included in the consultation and this was recognised by commissioners. Lack of 'flow' through pathways was a recurring issue for most commissioners we interviewed; some of whom went so far as to say that there is 'no shortage of MH SSH' - the challenge is more about how to enable suitable move-on from that which they already commission. Barriers include a gap in longer term supported housing options, care and support services for those with complex health needs; a lack of suitable social housing and tenancy sustainment support to reduce the risk of 'cuckooing'; and affordability barriers and concerns about 'setting people up to fail' in the private rented sector, where they have fewer rights and are less likely to receive supportive housing management from their landlord, compared to social landlords

who have safeguarding policies and structures in place. Many people have tenancy rights in their current placements and the process of supporting people to move out would be substantial.

Some of the people we interviewed had been living in MH SSH for many years: 7-10 years was not uncommon - and this was sometimes preceded by long hospital stays or unsettled accommodation or homelessness. Some had not experienced independent living. This means there is a tension between the sense of a service being intended for short-term 'progression' and the situation of some residents.

> *'It depends on every person. You can't say two years. Some people go back to hospital. I don't want to go back. …The two years hangs over you even if you are not ready. I didn't take two years to get that bad it's not going to be two years to fix me.' (MH SSH resident)*

Move on was a difficult area to explore with some people who felt worried about having to move on before they were ready. Whilst for those who are ready to move out, long waits and a lack of choice can be frustrating. The main challenges people anticipate when moving on are isolation and lack of support. However, we met two individuals who had moved on from MH SSH (many years ago) after very long periods in hospital and MH SSH, and were managing well with daily visiting social care packages and support from a voluntary sector mental health service, including a weekly lunch club.

Most commissioners and larger providers replying to our survey confirmed that they do collect some data about length of stay, and numbers, reasons and destinations for move-on. One larger provider shared data about turnover (i.e. tenancy ends/ starts as a proportion of total number of tenancies/ licences) within their MH SSH schemes, suggesting that this is just under 20% in a 12-month period. One of the challenges here is that much of the movement in and out of MH SSH schemes is likely to be between MH SSH schemes (one borough shared figures suggesting around a third of new placements in the past year had come from other supported housing settings) and so the start date for the current tenancy may not capture the overall length of stay in a supported setting. Findings from the national longitudinal QUEST study[19] suggest that around 16% of MH SSH residents move on in a 12-month period. Interestingly the study also concluded that:

> *'Successful move-on was positively associated with scores on two QuIRC-SA domains: the degree to which the service promoted 'human rights' (e.g. facilitating access to advocacy) and 'recovery-based practice' (e.g. holding therapeutic optimism and providing collaborative, individualised care planning). Service use costs for those who moved on were significantly lower than for those who did not'.*

[19] Killaspy H, Priebe S, King M, et al. Supported accommodation for people with mental health problems: the QuEST research programme with feasibility RCT. Southampton (UK): NIHR Journals Library; 2019 Sep. (Programme Grants for Applied Research, No. 7.7.) Work package 2: national survey of supported accommodation services across England (work package 2i) and cohort study to investigate service user outcomes (work package 2ii) Available from: https://www.ncbi.nlm.nih.gov/books/NBK546979/

The importance of building a better understanding of needs and preferences for move-on to inform investment in developing a range of models to meet these needs, is a key recommendation from this project. Whilst it has not been possible within the scope of this study to gather definitive data on what is needed, we present emerging ideas, a projection of the total number of move on accommodation units needed, and recommendations to fill the evidence gaps in the following sections. However, it is also vital to recognise and plan for the fact that some people will need a relatively high intensity service long term.

3 Understanding the need for MH SSH

Our system-wide engagement highlighted a common interest in what effective models of MH SSH look like and where these are best-placed in people's journeys and system pathways. However, there is limited understanding, and certainly not a shared understanding across sectors of what these should look like. A key finding from the research is that, whilst NHS Trusts flag the need for supported housing as a reason for delayed discharge from mental health inpatient settings, they are not able to specify in any detail which supported housing interventions are needed. We make recommendations about how this position may be improved moving forwards in Section 5.

3.1 Existing initiatives to understand needs

Various projects to better understand needs for MH SSH are being carried across in different parts of the capital and in different pathways. For example:

- 'Housing' is the focus of work to improve outcomes for 'complex care' (severe and enduring) patients currently in out of area placements or other inappropriate settings in North-East London, and through the South London Partnership. In both instances, mapping and needs assessment work is understood to have been undertaken through sub-contracts with HACT.
- Three NHS Trusts have sought to understand more about the specific housing needs of people who are Clinically Ready for Discharge. The North West Collaborative attempted a snap-shot audit and survey during Summer 2024, and SLAM has commissioned a short piece of work to understand room for improvement in the discharge process.
- The North London Forensic Provider Collaborative is seeking to understand the accommodation needs of patients in secure and residential care settings, with a view to developing joint accommodation plans with ICS partners. The ambition now is to bring together budgets and responsibilities for assessment, placement and market shaping, but engagement with local authorities (housing) and with housing providers still needs to happen.
- At borough-level, there is considerable variation in progress in understanding needs: there is a wealth of operational knowledge within some integrated or alliance teams; some local authorities have carried out systematic needs assessments (e.g. LB Barnet), developed clear, evidence-based Market Position Statements (e.g. LB Enfield), and made it clear what is (and is not) needed from the market in their areas.

Some have carried out consultation with people living in MH SSH, alongside market engagement (e.g. LB Southwark).
- A small number of SSH providers (e.g., Look Ahead, One Housing/ Riverside, Certitude) have been able to build more strategic relationships with the NHS and local authorities. In partnership, they have reviewed and transformed pathways (e.g. see case study of Look Ahead in LB Newham/ ELFT), being part of an alliance contract and cross-sector leadership team (e.g. Certitude in Lambeth). In these examples, there is a realisation that housing and support providers need to be around the table and cannot just be viewed as participants in a procurement processes; they have the knowledge of what is needed to make this work and are taking risks by making capital investments or leasing buildings.

We have built on this data and expertise as far as possible, though some of these projects have not yet been able to share findings and we have observed a lack of a consistent and transparent model for conceptualising needs.

3.2 What is influencing need?

There was a general sense from the engagement that there is increasing demand for MH SSH across London. Recurring themes regarding the drivers for this include:

- Increasing mental health needs in the wake of Covid and the cost-of-living crisis – reports from NHS Trusts of an increase in first-time contact with acute mental health services.
- Lack of affordable housing and rising levels of homelessness, including rough sleeping.
- Challenges accessing community mental health care increasing the risk of mental health crisis, hospital admission and loss of tenancies.
- Lack of tenancy sustainment, floating support.
- Increasing acuity and levels of co-occurring conditions.
- Migration, including increasing numbers of people whose immigration status means that they are ineligible for public funds.

3.3 Under-served cohorts

A recurring theme from the engagement work was that the following cohorts of people with mental health needs as part of co-occurring conditions are currently under-served:

- Mental health and substance use (with a particular lack of gender-specific provision)[20]
- Mental health and autistic spectrum disorders (with increasing incidence amongst younger adults[21], and a need for gender-specific provision).
- Mental health and physical ill-health/ impairments (especially amongst the over 55s).

[20] Transformation Partners in Health & Care (2023). *Market Position Statement for people experiencing homelessness with co-occurring conditions in London*. London Co-occurring Conditions Programme.
[21] Mosner MG, Kinard JL, Shah JS, et al. Rates of Co-occurring Psychiatric Disorders in Autism Spectrum Disorder Using the Mini International Neuropsychiatric Interview. *J Autism Dev Disord*. 2019;49(9):3819-3832. doi:10.1007/s10803-019-04090-1

The lack of specialist supported housing services in London for these cohorts results in poor outcomes for individuals (e.g., where they are staying for long periods of time in over-restrictive and/or out of area placements, or in properties which are not fully accessible for them, or are experiencing homelessness), and poor value for money for systems.

The modelling activity conducted within this project has not been able to reach the stage of estimating the specific types of MH SSH services needed for these sub-groups, or the numbers of units needed, given lack of data and consensus about how different models are defined and how they should be matched to needs. To reach this point would require further research to develop and implement the snapshot survey designed within this project in order to gather data about the support needs of a sample of individuals who require MH SSH.

3.4 Introduction to our approach to modelling

As stated in S.3.2 above, the need for MH SSH is not fixed, and based on population health needs alone.

Our approach to modelling the need for MH SSH,[22] recognises that the amount of MH SSH required is influenced by how the whole system is functioning, for example:

- If people with mental health needs lose their existing tenancies, then more MH SSH places will be required – whether immediately, or following a hospital admission. Tenancy breakdown (and the feasibility of taking up a new tenancy) is likely to be influenced by the availability of community mental healthcare and tenancy sustainment/ floating support. We heard in our engagement that, due to a lack of community mental healthcare, people are reaching crisis point in the community, having to give up their tenancies as a result and be admitted to hospital to access the care they need.
- Where there is a shortage of affordable, secure and suitable housing, people may end up overstaying in MH SSH or spending longer periods in homelessness and housing instability, with a negative impact on their mental health.
- If there is a policy decision to maximise stepdown wherever possible from inpatient rehabilitation settings and/or registered care homes in the community, there will be a corresponding increase in the need for MH SSH places.

[22] Which has been developed by Mark Goldup of HGO consultancy, working in partnership with IBA over the past 8 years

The overall approach is to:

- Identify the population at risk of needing a MH SSH intervention, based on data flows into the system.
- Estimate the proportion of the population at risk who are likely to need MH SSH.
- Identify what *type* of MH SSH interventions are needed by looking in detail at the support needs of those receiving/ in need of services.

Given the lack of data and consensus regarding specific needs for MH SSH in the system at present, it has only been possible to achieve the first two steps of this process within the time frame of this project; however, we have developed and tested tools to estimate the third stage of the process and have produced an illustrative case study using these, which is included at Appendix 5.

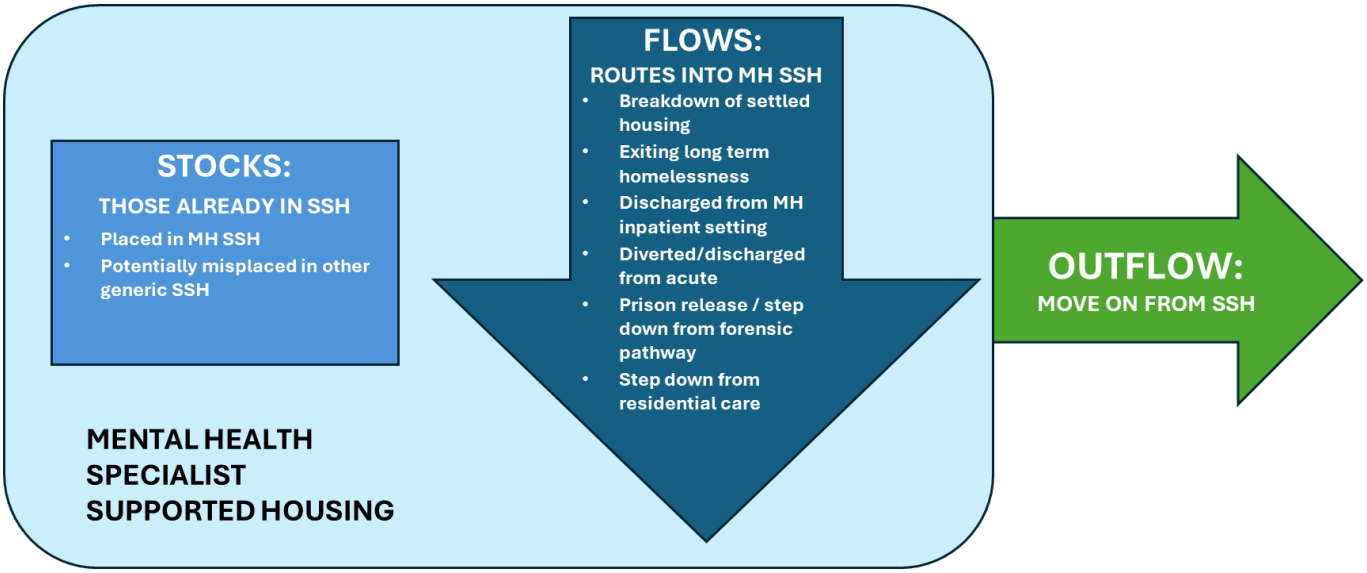
Our model takes account of current unmet needs for specialist MH SSH occurring in the wider system, for example amongst populations who are sleeping rough and/or experiencing long-term homelessness, in generic homelessness services, or on release from prison.

To capture this complexity and allow for different scenarios to be tested, our model includes:

- ‘Stocks’ – numbers of people who are, or should be in MH SSH (but are currently in generic SSH, such as homelessness hostels) at the start of a base year.
- 'Flows’ – newly arising need over the course of each year from different routes or pathways.
- ‘Outflows’ – the pace at which people are ready to move on from MH SSH to alternative models of housing and support.

This is summarised in the following visual:

Figure 4 Diagram to show the model summary of stock and flows for MH SSH



We have validated and where necessary revised the assumptions with insights from operational staff across the system. The quality assurance process and the changes made to the approach as a result of this are described in Appendix 2.

The figures generated by the model are estimates and caution must be applied when interpreting them. A strength of our approach is that the model can be updated with more accurate information and different scenarios can be tested. Feedback throughout the process has been that the structure of the model makes sense to people and reflects the realities of local systems.

3.5 Base year estimates: methods and assumptions

The starting point for the modelling ('stocks') is the number of people estimated to have a need for MH SSH at the start of the base year (i.e. 2024/5), whether or not this is currently being met in London-based MH SSH. We have estimated this by adding:

- The estimated number of people currently placed in MH SSH by London boroughs collected or imputed from this study see S.2.3 (i.e., not just the number of units identified by our mapping) and
- An estimate of people currently in generic (i.e. non-specialist mental health) homelessness supported accommodation who would ideally need a specialist mental health offer.

We are aware that there are a range of models within the homelessness sector: some boroughs provided information about 'complex needs' services commissioned to bridge the gap between mental health and homelessness pathways; we are aware that some supported housing providers have been able to build good partnerships with specialist mental health services or employ in-house specialists. However, national research is clear that there is significant unmet need for specialist mental health support within homelessness pathways – a point raised by several boroughs engaged. For example,

Homeless Link[23] found that 82% of people accessing a range of homelessness services had a diagnosed mental health condition, and 49% of them said they had unmet needs for mental health support.

In previous national research carried out by IBA and the University of York for the National Housing Federation[24], we asked keyworkers in a range of supported housing settings to identify those who needed input from specialist mental health services and then asked them how well this was working. Excluding people in MH SSH (but including people in homelessness, domestic abuse, learning disability, etc settings, n=1815), 13% were felt to need specialist mental health services and 'this was proving difficult'. There were separate categories for people who were unwilling to engage with mental health services or were finding these inaccessible, and we did not include these, which we feel represents a conservative approach. Our modelling estimates assume that 13% of those in homelessness supported housing need[25] a more specialist offer.

As discussed below, we recognise that a move to specialist MH SSH would not necessarily be the ideal solution for many of these individuals – we are suggesting that, for many, improved specialist support within their current placement, or a Housing First offer might be a more effective option. However, we believe it is important that the housing and support needs of these adult Londoners with mental health needs be considered within this modelling exercise.

Over the course of the year, there is newly arising need for MH SSH from the following pathways or 'flows':

- Those discharged from a mental health inpatient setting/ rehabilitation ward
- Those for whom settled housing breaks down
- Those exiting long term homelessness/ rough sleeping
- Those released from justice (prison or forensic) settings
- Those diverted from acute care (e.g. via a step-up/ crisis house)
- Those stepping down from residential care homes

For each of these flows, we have used existing published data both:

- To estimate the total number of people coming through these pathways ('the population at risk', and
- To estimate the proportion of them likely to need a MH SSH (e.g. wherever possible, based on a combination of housing and mental health needs) ('the population in need').

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[23] Homeless Link (2022) *The Unhealthy State of Homelessness 2022.* London: Homeless Link. Available at https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf

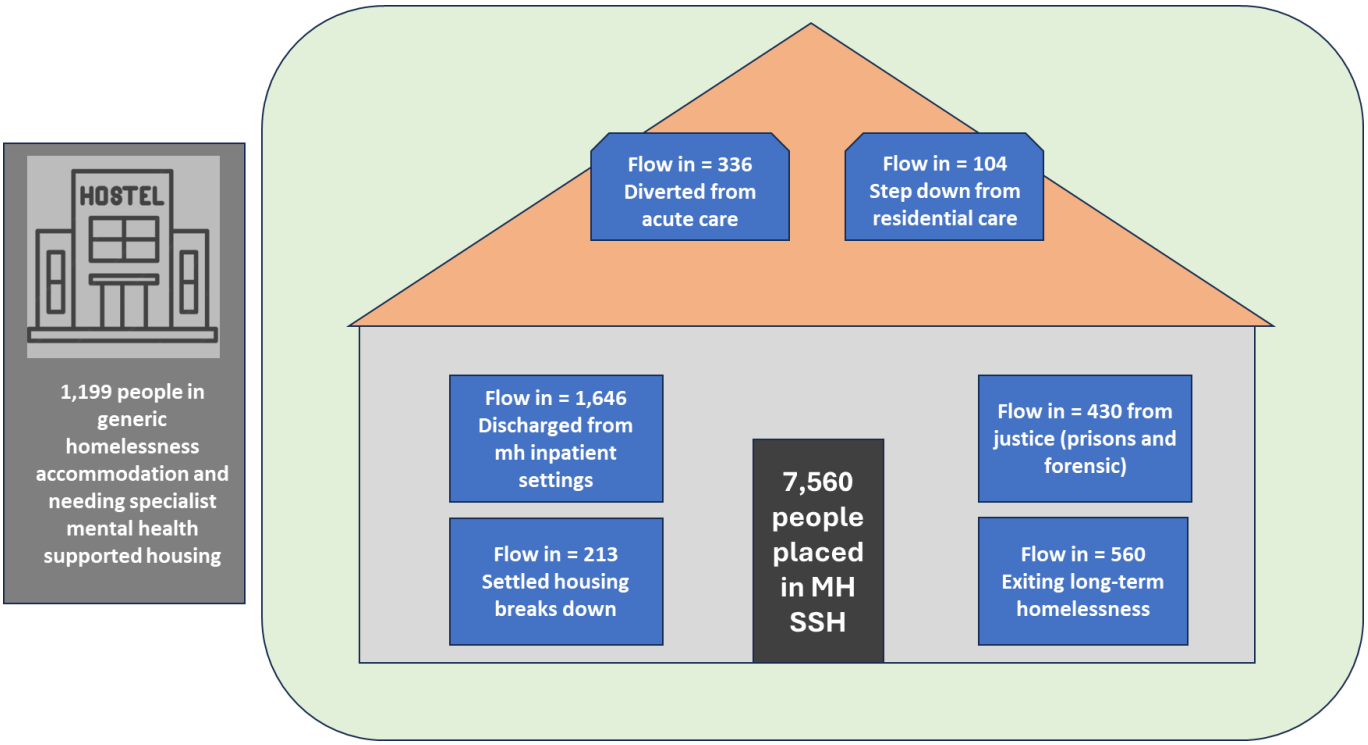
[24] Blood, I., Goldup, M., Pleace, N., and Chalmers-Page, S. (2023) *Research into the supported housing sector's impact on homelessness prevention, health and wellbeing*. National Housing Federation. Available at https://www.housing.org.uk/globalassets/files/resource-files/imogen-blood-research-into-the-supported-housing-sectors-impact-on-homelessness-prevention-health-and-wellbeing.pdf

[25] Based on 90% assumed occupancy of the GLA's ATLAS figures for the number of Accommodation (Hostels/ supported) bed spaces, by borough, as published in October 2023

Published data sources used have included Mental Health Act statistics, statutory homelessness (H-CLIC data), prison release, social care (SALT), CHAIN (rough sleeper), Public Health data, Adult Psychiatric Morbidity and census data, along with the findings of previous research, data supplied by local authorities (or found in their publications) to estimate numbers of people at pan London and borough/ ICS levels. This has been particularly challenging in relation to mental health inpatient discharges; we have assumed (following validation described in Appendix 2) that 20% of those being discharged need MH SSH.

The pan London estimates for the base year's stocks and flows are shown in the following visual:

Figure 5 Diagram to show pan London estimates for model base year stocks and flows



3.6 Modelling assumptions about move-on

The rate at which people can, should and do 'move-on' from MH SSH and what this would look like is the most contested aspect of the model: we have discussed in Section 2.17 findings from this study and others as to the current rate of move-on and the issues this raises. Whilst recognising these operational and personal sensitivities, we have also been asked to estimate *need* for MH SSH and so we have to take account of the fact that there are people currently living in MH SSH who, **with the right housing and support available to move to**, could – over time – be facilitated to do so. For example:

- The national, longitudinal QUEST study found that 30.5% of those participants who had not moved on from MH SSH after their 30-month follow-up period were considered ready to move on[26],
- In national research conducted by IBA for National Housing Federation, we found that 39% of a sample of 295 people in MH SSH setting intended to be transitional were felt to be ready to move on by their key workers – though just over half of this group were not able to due to a lack of suitable move-on options.
- In the small sample (n=85) snapshot carried out in London for this current study (discussed in more detail below), 38% of people were felt to be ready to move.

It is worth acknowledging here the absence of the service user voice in the quantitative research cited above – our qualitative engagement with people with lived experience has

[26] See Table 8: Killaspy H, Priebe S, King M, et al. Supported accommodation for people with mental health problems: the QuEST research programme with feasibility RCT. Southampton (UK): NIHR Journals Library; 2019 Sep. (Programme Grants for Applied Research, No. 7.7.) Appendix 3, Results from work package 2ii. Available from: https://www.ncbi.nlm.nih.gov/books/NBK546975/

sought to balance this, however, we have not attempted to collect a large sample of individuals' views and preferences regarding move-on and this will be key in determining needs. Nonetheless, it seems reasonable to assume that, with the right support in place, a significant number of individuals currently placed within MH SSH would be ready to transition to alternative support/accommodation if this was in place.

The size of this group will clearly vary from borough to borough, depending on practice, policy and housing market. For example, one borough involved in our validation process has a team in place to review all placements and has worked with providers to develop move-on options; their commissioner felt that only 4% of MH SSH residents placed by them are ready to move on.

In trying to determine a reasonable length of stay to incorporate within our modelling assumptions, we were also mindful that there will be a gap between average length of stay (given that some people will leave, for positive and negative reasons, after shorter stays) and the length of time which current residents have been in situ.

We have extended our original assumptions regarding lengths of stay in response to feedback (as detailed in Appendix 2).

In our 10-year model, length of stay is based on two theoretical cohorts:

- A transitional cohort, which needs an average (i.e. some will need more, some less – this is not a fixed or upper limit) of 18 months in a MH SSH setting before stepping down to a move on option. We have assumed that 40% of those already living in MH SSH fit into this cohort, starting the 'clock' on their assumed length of stay at the start of the projection years; and that 60% of the other stocks and flows will need this transitional intervention.
- A longer-term cohort, which needs an average (i.e. some will need more, some less – this is not fixed or upper limit) of 5 years in a MH SSH setting. We have assumed that 60% of those already living in MH SSH in the projection years fit this cohort, given the lifelong histories of institutionalisation and the lengths of time which some have already been in MH SSH for. We have assumed that this reduces to 40% for the other stocks and flows in our model.

The key point here is that place-based systems can and should replace the estimates with their own actual data or local estimates where they can, though it was not practicable to facilitate this process during the project.

3.7 Base year: pan London and ICB level results

The following chart shows the stocks, flows and outflows at pan London and ICB level for the first (base) year of the model. We used estimates provided by boroughs (or imputed where not supplied) for those placed in MH SSH, then sought to find published borough-level data for each flow. Where data was only available at pan London level, we developed a synthetic model to estimate borough-level figures. Following consultation with our Advisory Group and a sample of boroughs (through the validation exercise described in

Appendix 2), the GLA decided not to publish borough-level estimates; the following table sums borough estimates to give estimates by ICB area.

Table 2 Estimates of the number of people needing MH SSH at the end of Year 1

	Stocks		Flow						Outflow	
London ICBs	Placed in MH SSH	Mis-placed in generic SSH	Settled housing breaks down	Exit RS	Inpatient	Justice	Acute	Reg Care	Moved out of MH SSH in year	Total stocks for start of the next year
North West	1688	340	30	194	401	102	81	25	814	2048
North Central	1145	232	48	69	251	72	54	19	552	1338
North East	1526	297	46	159	357	95	90	21	736	1855
South East	2153	194	70	113	302	89	59	23	1038	1965
South West	1048	136	20	25	335	72	51	17	505	1200
London	7560	1199	213	560	1646	430	336	104	3644	8405

NB: Figures have been rounded

Key points:

- Even with this assumed level of move-out (and we discuss what this might mean in terms of housing and support requirements in Section 4.2), there is a need to expand the number of placements (from the current number in the far left column at the start of the year to the number in the far right hand column) in order to meet the total estimated need from across the system in Year 1 of the model.
- This is largely driven by the estimated unmet need from the homelessness pathway for a specialist MH intervention. This 'backlog' is (theoretically) met within the first year of the model, since this is the clearest way to represent it.
- The number of people needing a place at any given time is theoretically the number of units needed; however, operationally there would need to be slightly more bedspaces than people needing them in order to maximise the ability to respond to needs when they arise. Providers typically aim for 90-95% occupancy at any given time.
- If 20% move-on were achieved, an additional 845 places (8405-7560) to those currently commissioned are estimated to be needed at the end of Year 1, were occupancy to run at 100%. For an average occupancy of 95%, 1287 additional places would be needed at the end of Year 1; rising to 1779 for 90% occupancy.

- Given our qualitative findings about the extent of inter-borough placements, and provider-led provision (which typically accepts spot placements from a wide geographical catchment), it is clearly over-simplistic to assume that each ICB is utilising or could readily utilise the identified units in its area for its population alone. For example, one London Borough told us that they had conducted an audit of provider-led MH SSH schemes in their area and were 'reassured' that 60% of those placed were from their local population.
- The demand and shortfall play out somewhat differently across the London ICBs, as illustrated in the table below. This shows the placements at the start of the year, and those estimated to be needed at the end of the year (from the table above) and compares this with the actual units identified in our mapping (which may, of course, be an under-estimate of the real level of provision, nevertheless it is still highly likely there is a significant shortfall). Please refer back to Section 2.3 where we explain the gap between placements made (i.e. people) and units (i.e. bedspaces) identified. The estimated increase in placements needed and the shortfall in locally based units are shown in the two right-hand columns.

Table 3 MH SSH placements, requirements in base year and shortfall as identified by mapping exercise

London ICBs	MH SSH placements at start of year	MH SSH units required to meet identified needs in base year	MH SSH Units identified in mapping	Increase in no. of placements needed	Shortfall of local units
North West	1688	2048	948	21%	1100
North Central	1145	1338	943	17%	395
North East	1526	1855	774	22%	1081
South East	2153	1965	1920	-9%	45
South West	1048	1200	581	14%	619
Location unspecified	-	-	33		
London	7560	8405	5199	11%	3206

It is noticeable in the above table that South East London appears to have a much smaller shortfall of current units than the other ICBs; in fact, the findings suggest that the number of placements needed may even decrease slightly over the next decade. Several factors appear to be driving this:

- South East London differs from the other ICBs in that it does not experience the hypothetical 'bump' in demand in the first year of the model, resulting from 'misplaced' need in the homelessness sector. The four boroughs of Bexley, Bromley, Lambeth and Lewisham have a relatively small number of people in need of MH SSH who are 'misplaced' in homelessness provision and exiting long-term

homelessness (based on the location of homelessness accommodation and of rough sleeping, according to ATLAS and CHAIN data sets). Though Southwark and Greenwich do show a projected 'hump' due to misplacement/ exiting homelessness, this is balanced by the projections for the other four boroughs. Based on the move-on assumptions underpinning this scenario, the number of people (theoretically) moving on from MH SSH in SEL in the first year or two of the scenario is greater than the estimated in-flows. The relatively high number of existing units of MH SSH in the inner London SEL boroughs is clearly a driver here, since the numbers moving out are in proportion to this, and the assumption is that all those in need of MH SSH are accessing it within SEL.

- MH SSH needs are projected to start to rise slowly from 2029 onwards for all ICBs (driven by projected increases in both population size and severe mental illness trends), however, for South East London, the projected increase does not fully offset the decrease described above in the first year or two of our scenario.
- Clearly these projections are estimated and theoretical; however, they do reflect qualitative findings from stakeholders in South East London, which suggest that some boroughs are characterised by:
    - Housing markets which have attracted provider-led supported housing and people from out of borough who have been placed in them (so not all current units are available to meet local demand).
    - A substantial volume of MH SSH being commissioned, but with limited move-on and a lack of specialist models (e.g. for rehabilitation step-down or for people with complex co-occurring conditions)
    - Pressure from NHS trusts in relation to hospital discharge, as in other areas.
- According to the findings of our mapping exercise), South East London has a higher level of current provision than the other ICB areas. The estimated shortfall in local units (i.e. were needs to be met within South East London) is much smaller than the other ICB areas. However, more detailed need assessments would be required to assess whether the *type* of provision matches those needs, and whether and under what conditions our move-on assumptions might be feasible in the different local contexts of South East London, and to assess the proportion of the SEL population which is accessing the provision within SEL.

3.8 Projections of future need: methods and assumptions

Starting from the 'base year' as described above, our 10-year model for projecting future needs is based on the following assumptions:

The number of people presenting with newly arising needs for MH SSH (i.e., via the different routes or flows into MH SSH) in each year following the baseline year will be influenced equally by population and mental health incidence trends.

We have used trend data on the number of people with severe mental illness[27] , alongside projections of population growth. We assume that future MH SSH needs rise in line with the

[27] Quality and Outcomes Framework (QOF prevalence, which includes patients with schizophrenia, bipolar affective disorder and other psychoses)

trends in mental illness data for five years, and after that the mental illness trends level off and any increase in needs is entirely driven by population growth for the next five years.

We have produced a snapshot of MH SSH needs at the end of each year (having taken account of flows in and out during that year): the units needed at that point in time are equal to the number of people in need of MH SSH, notwithstanding the need to build in a level of voids to manage demand over time, as discussed above. Assumptions about length of stay and the rate at which people move out of MH SSH are presented earlier, at the end of S3.6.

These assumptions can be changed within the modelling tool to assess the impact which a higher proportion of people needing to stay for longer would have on the total number of units needed.

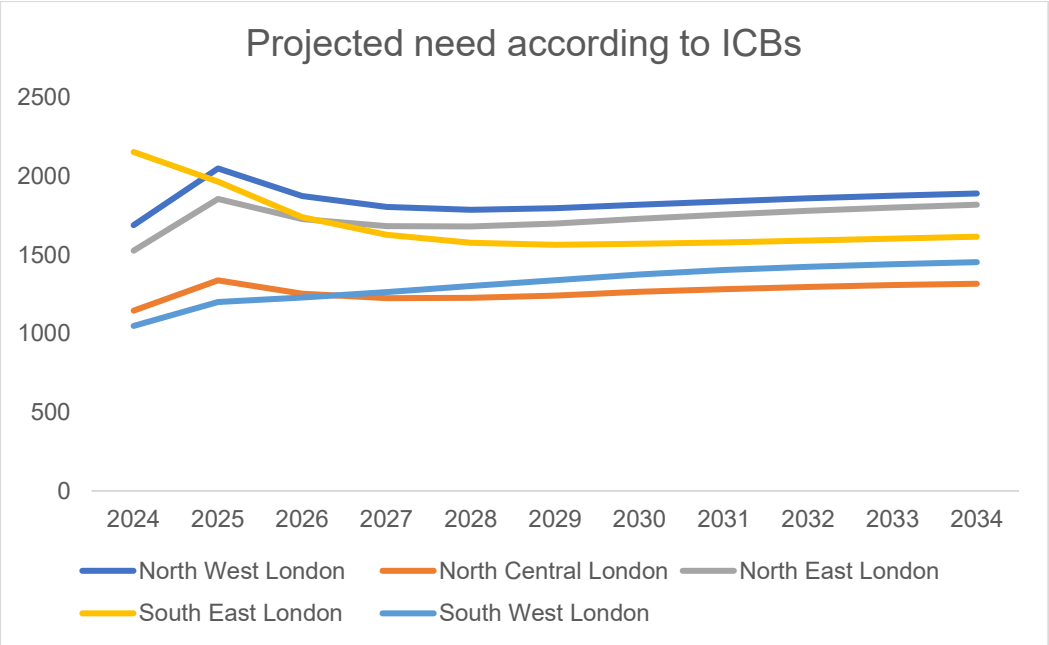
3.9 Projections of future need: pan London and ICB level results

The following table and graph show the results of the 10-year projections, based on the scenario described above.

Table 4 Projected MH SSH needs broken down by ICBs, 2024-2034

London ICBs	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	% increase over 10 years
North West	1688	2048	1874	1803	1786	1795	1819	1839	1858	1874	1889	12%
North Central	1145	1338	1252	1224	1225	1241	1264	1282	1296	1307	1316	15%
North East	1526	1855	1726	1681	1679	1699	1729	1755	1779	1800	1818	19%
South East	2153	1965	1739	1627	1577	1563	1570	1579	1590	1602	1614	-25%
South West	1048	1200	1228	1264	1302	1339	1376	1403	1424	1440	1453	39%
London	7560	8405	7818	7599	7570	7638	7757	7858	7946	8023	8091	7%

Figure 6 Line graph to show projected MH SSH needs by ICBs, 2024-2034



Overall, this shows:

- A 7% increase in the required number of placements/ units from the start of year 1 (7560) to the end of year 10 (8091). However, it should also be noted that there is considerable variation in need over the 10 years modelled, with 2028 close to 2024 levels.
- A 'bump' in demand over the course of year 1, which is caused by adding the unmet need from the 'backlog' of rough sleepers and people misplaced in generic homelessness accommodation to the in-flow in this year. This levels off as a proportion of this cohort and a proportion of those in MH SSH at the start of the base year begin to move out.
- When the projections are broken down by borough, there is considerable variation, based on the geographical distribution of rough sleeping and generic homeless accommodation[28] in the 'backlog' of unmet need at the outset. This reflects the fact that homeless cohorts are, by definition, far more mobile and needs arising from homelessness may not relate to needs arising in that locality. Local variations also reflect projected population growth (or decrease) and trends in relation to the incidence of serious mental illness. So, for South East London, whilst there is a 'bump' from unmet need amongst people experiencing homelessness in Southwark and Greenwich, this is offset by relatively small numbers joining the flows from homelessness in the other four South East London boroughs.
- The model suggests that, *if* the system can better meet the mental health needs of those experiencing homelessness, and achieve 20% move on from MH SSH, that we broadly have (or are spot purchasing, some from out of area which is not ideal) enough MH SSH placements in the system. However, we do need additionally to plan to meet the projected growth in demand from population and mental health trends of 7% over the next ten years. There is considerable work to do to further refine these estimates, given the gaps in accurate data around current placements, identified provision in London, and the feasibility of move-on assumptions (which depend on adequate supply of housing and support to facilitate sustainable move-on for those ready to do so). We discuss move-on requirements in more detail in section 4.2.
- Our projections fall between the Supported Housing Review's assessment that a 3% increase in MH SSH is needed by 2035 to maintain existing levels of provision, and their assessment of the need for a 42% increase by 2040 for working age supported housing generally to address unmet need. Recent projections by the National Housing Federation[29] suggest a 4% increase in the number of working age people in need of supported housing from 2020 to 2035.

However, it is crucial to remember that our projections hinge on people being supported to move out of MH SSH to suitable long term housing options, with support where needed, at scale.

Equally noteworthy in the model is the projection of the corresponding number of people moving out of MH SSH over the 10 years of this scenario, as shown in the graph below. In

[28] Based on CHAIN and ATLAS data respectively.

[29] National Housing Federation (2024) *How much supported housing will we need by 2040?* Available at https://www.housing.org.uk/resources/how-much-supported-housing-will-we-need-by-2040/

the following sections we discuss what might be needed in terms of housing and support to facilitate this.

Table 5 Number of people moving out of MH SSH in the modelling scenario, by ICB, 2024-2034

London ICBs	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
North West London	814	844	752	713	700	700	707	715	721	727	733
North Central	552	547	500	482	479	484	492	498	503	507	511
North East London	736	761	691	664	657	662	672	682	691	698	706
South East London	1038	790	689	639	616	609	610	613	617	622	626
South West London	505	481	484	494	507	521	534	545	552	559	564
London	3644	3422	3117	2992	2959	2975	3016	3052	3085	3114	3140

If the estimates of current move-on rates are accurate (these suggest around 15-20% annual turnover, (see S.2.17), equating to between 1300 and 1500 people annually moving out of MH SSH across London) this model would require that number to multiply by about 2.5 times. If this level of move-on is to be feasible and support the sustainability of recovery and wellbeing outcomes for individuals, it will be necessary to invest substantially in housing and support options for people stepping down from specialist MH SSH. In section 4.3, we discuss these in more detail.

4 Meeting needs for MH SSH

4.1 What types of MH SSH might be needed?

4.1.1 Proposing a typology of MH SSH

We were asked to estimate needs for different types of MH SSH model and the associated building types. As stated in section 2.4, there is currently no consistent way of categorising the different types of MH SSH to understand the nature of current provision or to estimate future needs for specific types of provision.

We have proposed a high-level typology through this project, informed by a review of the existing, limited literature on this topic, including publications by iriss, Rethink, Mental Health Foundation, NIHR-funded work to develop the STAX-SA taxonomy, and web pages by national specialist providers describing their models. It was also informed by the engagement findings, feedback from providers and the team's prior knowledge.

One of the limitations with previous attempts at developing typologies is that they either include a huge number of model characteristics, or they are limited to one or two characteristics, which may not be the most important ones. We sought to prioritise characteristics into primary characteristics – those which most coherently describe where and how different services function together as part of a service offer, pathway or system – from secondary and tertiary characteristics, which may be important for evaluating impacts or measuring value for money but are not core to a typology.
Our typology is based on the following **primary characteristics**:

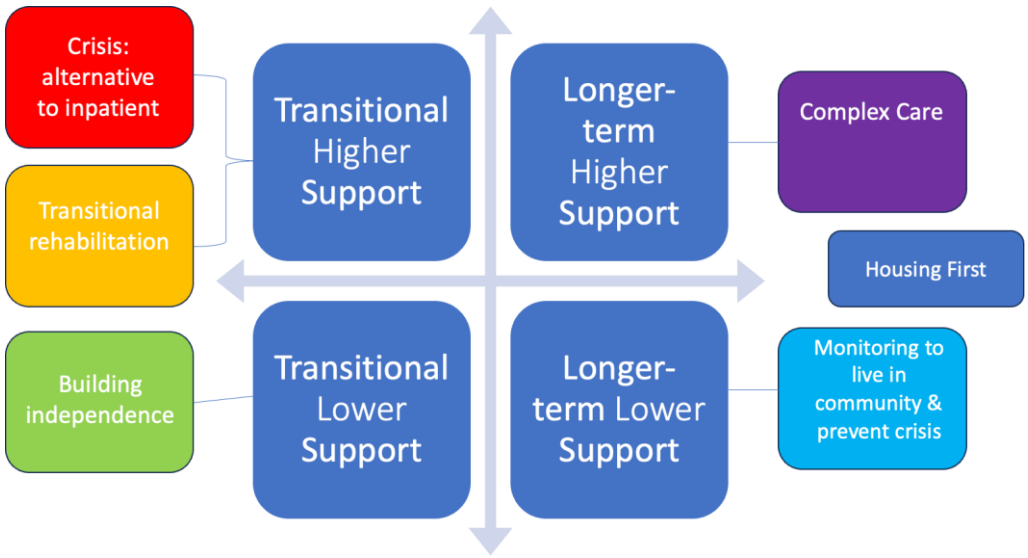
- **Duration** - transitional v. longer term, or settled
- **Objectives** – what the project is trying to achieve
- **Target group** – which cohort(s) it is intended to work with within in a pathway
- **Level of assistance** – e.g. higher or lower levels of support

Secondary characteristics include property type (we discuss this in more detail in section 4.5) associated facilities and activities, type of support model (e.g. clinical/ professionally qualified staff; medication administration/ oversight, etc)

Tertiary characteristics include responsibilities (e.g., for housing management and support), size of scheme, user characteristics (e.g. women-only, younger people or co-occurring conditions), revenue funding source, and intended outcomes.

The simplified version of the typology is shown below – a more detailed version is appended.

Figure 7 Diagram to show proposed typology of MH SSH



To build our understanding of the purpose and function of different MH SSH models and how people's needs might be matched to them, we developed and piloted two slightly different versions of a snapshot survey. We made targeted approaches to MH SSH

providers and operational staff involved in making and reviewing MH SSH placements that we had identified through the survey and engagement work.

We asked supported housing key workers to complete the survey on behalf of each of the residents they keywork. The provider survey was carried out by 32 operational workers for a total of 85 individuals currently living in MH SSH. We are extremely cautious about the size and representativeness of this sample – for example, we are not confident that the model types included in the typology were represented equally in this exercise. We would strongly advise that a larger snapshot be carried out in future to inform more reliable estimates (see recommendations). Nevertheless, the responses to this exercise enable us to demonstrate how this approach might be used to estimate the need for different types of MH SSH, according to our proposed typology. We have also used the insights from this exercise alongside the team's expertise in modelling needs for supported housing to inform some tentative, high-level estimates as to the types of models required to meet the estimated projected needs – this illustrative case study is included as Appendix 5.

- For 59% of this sample, the worker felt that the primary reason for them needing MH SSH at the time of referral was that they 'Needed an environment that allowed monitoring of wellbeing': each of the above models could potentially offer this, but at different levels of intensity and for different lengths of time, though this corresponds most closely to the 'Monitoring to live in the community and prevent crisis model'.
- For 20%, the primary need was that they 'Lacked the skill and confidence to live independently' – this aligns with the 'Building Independence' (Transitional Lower Support) model.
- 8% needed a 'safe and highly supervised environment', aligning to the higher support models.
- 6% needed alternatives to inpatient care in a non-clinical setting (e.g. Crisis: alternative to inpatient).

This starts to give a sense of how the need for different types of MH SSH might be identified through this type of exercise, but the sample size is not large enough to break the categories down further, e.g. and explore how many of those primarily needing an environment that allows for monitoring might – based on their other assessed needs – require this at higher or lower levels of intensity. However, it was interesting to note that 25% of the sample were felt by keyworkers to need longer-term supported housing (aligning with the right-hand side of our typology).

We were asked to estimate the level of need for different models of MH SSH. In the absence of any reliable existing data, for example, on the housing and support needs of people being discharged from psychiatric hospitals, we tried to implement the snapshot with health, care and housing workers overseeing the different 'flows' into MH SSH. We asked workers making or reviewing placements to complete the snapshot for 10% - 20% of their caseload. Although there was interest in this exercise, with the more engaged boroughs/ integrated teams agreeing that this would provide them with useful data, there was insufficient capacity to generate more than a few responses to this survey in the timescales available.

In Appendix 5, we have tried to demonstrate how this might be done using the typology, the snap-shot survey (see Appendix 6), and our populated flows model, if a sufficiently large and representative sample of snapshot responses could be gathered. We have appended this case study to emphasise that, given the lack of this data at present, this is highly tentative, and the results of this scenario cannot be treated as 'the answer'. However, they do provide some interesting insights, not least that there likely to be is significant need for transitional rehabilitation model to enable step down from hospital discharge. As discussed in our Recommendations section, we recommend areas conduct their own analysis of move on needs, using or adapting this snapshot tool.

The process of developing a model has highlighted the limitations of drawing on existing datasets from different systems and services, none of which 'speak' to each other, nor are intended to inform SSH commissioning for all populations experiencing mental health needs.

Whilst there is scope for localities to add their data to the model, this will be dependent on capacity and commitment. The model needs to be as simple and easy as possible for this to be adopted for routine use. There is further work to be done with information 'owners' e.g., MHCLG, the NHS, MOJ and HMPPS to enable relevant data to 'flow' into the model; this should not be something that each local authority should be expected to search for.

Until there is 'real time' and higher quality data available from NHS services (see medium-term recommendation for a housing team), NHS Trusts should be required to make use of available Mental Health Service Dataset coding, including accommodation status, and reasons for 'Clinically Ready for Discharge – supported housing' categorisation. NHS staff would benefit from training to inform their enquiries of patients, and data capture. The questions from the 'snapshot' tool developed and piloted within this project could form the basis of this, to inform modelling and strategic planning, with individuals' preferences and priorities added to this, to inform their personal plans.

The data generated through this research prompted discussion at the market development event. Feedback suggests that this can provide a focus for relationships to develop, including with providers.

4.2 Estimating the type of move-on options required

The results of the snapshot survey also provide some interesting insights into the proportion of residents who might be ready to move out of their current placement, were the right options available and what, in the view of the keyworker, is needed to facilitate that.

32 (38%) of the 85 individuals in the snapshot were felt to be ready to move out (were the right move-on options available):

- 22 (69% of those ready to move out) were felt to need independent housing but still with some ongoing support
- 7 (22% of those ready to move out) were felt to need independent housing alone
- 3 (9% of those ready to move out) were felt to need higher care settings.

If we apply these proportions to the projected 'outflow' from our model, this suggests the following estimated numbers at pan London and ICB level (see further caveats on interpretation of these below):

Need for move-on housing-only units, by ICB, assuming 22% of the model 'outflow' need this. **Given relatively small numbers, we present the total pan London estimates only and these must be treated as indicative given the sample size.**
NB. *Ideally these would be general needs social tenancies, but could include private sector properties, ideally with a lease held by an intermediary body, bringing greater security and more supportive housing management:*

Table 6 Illustrative estimated need for move-on housing-only units, by ICB

Housing only (assuming 22%)										
	2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**
London total	802	753	686	658	651	655	663	671	679	685	691

Need for 'supportive housing' (move-on units of housing and some support), by ICB, assuming 69% of the model 'outflow' need this. *We discuss a range of possible models for this below.*

Table 7 Illustrative estimated need for "supportive housing", by ICB

Housing and support (assuming 69%)											
London ICBs	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**
North West	561	582	519	492	483	483	488	493	498	502	506
North Central	381	377	345	333	331	334	339	344	347	350	352
North East	508	525	477	458	454	457	464	470	477	482	487
South East	716	545	476	441	425	420	421	423	426	429	432
South West	349	332	334	341	350	359	369	376	381	386	389
London	2514	2361	2151	2064	2042	2053	2081	2106	2129	2148	2166

Note: the figures in the table above are provided as illustrations based on limited data collected via our snapshot survey. **Local areas will need to undertake their own needs assessments**, and we make recommendations to this effect at the end of the report.

In addition to the substantial caveats with the sample size outlined above, there are other methodological challenges in applying these figures to the 'outflow' from the model:

- For better or for worse, some people will leave MH SSH and make their own arrangements, perhaps moving back to a family home, in with a partner, to a different area or unknown location. Some people will return to hospital or be recalled

to prison/ a forensic setting; some – as our snapshot results indicate – will need to move to higher care settings.

- Unlike for MH SSH, where our mapping work provides a baseline estimate of current provision both in terms of units in London and numbers of placements, there is currently insufficient data on the existing provision of move-on options to be able assess what proportion of the figures in the above table would be *additional* to the current offer.
- There is an important distinction between units of housing required and units of support required, especially when informing capital programmes. These clearly need to align to facilitate the majority of those potentially ready to move from MH SSH to do so positively and sustainably. We discuss potential building requirements in the following section, where we argue that those who require housing and ongoing support would benefit from a range of hybrid housing models, not just general needs provision + floating support. Estimating the overall caseload for ongoing commissioned support to sustain 'move-on' is beyond the scope of the current project and would require further consideration. Clearly it would not be sustainable for this to accumulate annually at the rate our figures suggest and that is another reason why it is so important to consider how the required housing units might be designed to reduce the need for an ongoing traditional floating support offer – a point we discuss below.
- We have not attempted to factor into our projections the positive impact which significant investment in high-quality, long-term housing with support where needed might have on the number of people circling around the system in later years of the model. If people with ongoing mental health needs have suitable and supportive tenancies, we might expect that they will be less likely to reach crisis point and require hospitalisation and that, where they do, most will be able to return to their tenancies, perhaps after a stay in transitional rehabilitation.

4.3 Potential models of supportive housing

In the previous section, we highlighted the need for a range of long-term/ settled 'supportive housing' models to cater for those who might be ready to move out of supported housing but need some degree of ongoing support. Qualitative engagement suggests that the typical issues here are social isolation, harassment, cuckooing, or victimisation, and the need to identify deteriorating mental health before it becomes a crisis.

A range of different models, which could be described as fitting in this hybrid category between general needs housing and traditional supported accommodation models include:

- Sheltered/extra care style models, with own tenancy, some communal facilities, intensive housing management/ security features and the potential for an onsite care and support team if the volume of need is sufficient. This type of model could be dedicated to people with mental health needs or might be for mixed client groups. Providers suggested that around 40-60 units are needed in schemes like this for them to stack up financially within affordable rents.

- Cardiff City Council[30] has developed a number of 'managed schemes' to provide a secure home to people with multiple and complex needs, including mental health support needs. They have worked in partnership with RPs to develop new blocks, typically containing around 60 self-contained flats, let with a furniture package and white goods. These are let on ordinary social tenancies, at around the Local Housing Allowance level. A housing support worker is on site at the scheme between 9am and 5pm and, outside of these hours, a concierge service is provided. Individual tenants can access additional support as and where needed from the wider housing, care and support service offer. This might, for example, include floating support, assistance from the multi-disciplinary team or a Housing First support offer, as well as ongoing support from statutory and voluntary sector services, such as community mental health services or adult social care.
- There are also interesting models within the VCSE and community-led sectors, including KeyRing (where a group of around 10 people living in dispersed properties in a neighbourhood are supported by a volunteer who receives paid-for or subsidised housing in return for coordinating a network of mutual support).
- The proposed model co-produced by Homes in Mind (see case study), in which a cluster of 5 or 6 small homes form an intentional community (similar to co-housing but organised and supported by a local VCSE organisation), in this case Mind in Harrow. A group of people with lived experience have co-produced the design of the proposed sites to fit on small land sites, maximising mutual support whilst preserving privacy and integrating the development within an existing neighbourhood.
- Other interesting ideas raised during this project include house shares based on common interests (rather than deficit-based needs assessments), such as music, art or sport, or on existing friendships. There are examples from the Learning Disability sector about people living in shared supported housing forming cooperatives and funding their support using individual budgets[31].

There are a range of building requirements for these models, e.g.:

- Ordinary (possibly ring-fenced) general needs properties in the same neighbourhood (e.g., see for example the KeyRing model in which a mutually supportive network is facilitated).
- House shares, and smaller intentional community clusters.
- New build or re-modelled sheltered/ extra care type models or managed blocks (which, unlike sheltered/ extra care models do not include communal social spaces).

4.4 Estimating the level of need from different equality groups

We were asked to consider the potential needs for MH SSH arising from different equalities groups.

[30] Featured in IBA research for Welsh Government: Evaluation of Homeless Interventions: Value for Money (2024): see page https://www.gov.wales/sites/default/files/statistics-and-research/2024-05/evaluation-of-homelessness-interventions-value-for-money_0.pdf

[31] E.g., https://impact.bham.ac.uk/2023/12/13/friends-united-together/

Most of the published data sources we used to populate our flows model contain data on ethnicity, gender and age, though there are challenges aligning the latter due to different age categories in use. The following table shows the results of using published data to estimate how the newly arising needs ('flows') in our model break down by gender and broad ethnic group (based on Census categories).

Table 8 Estimated breakdown of newly arising need in base year, by ethnicity and gender, based on analysis of published data

Equality group	Settled housing breaks down	Exiting long term homelessness	Discharge from inpatient care	Released from prison/ forensic stepdown	Diverted from acute care	Stepdown from registered care	Total newly arising need Year 1
Ethnic group							
Asian	27	62	270	56	70	21	505
Black	71	149	518	122	46	14	919
Mixed*	10	20	151	43	20	6	249
White	80	293	587	163	183	54	1359
Other	22	37	119	22	22	6	228
Total	***213***	***560***	***1646***	***430***	***336***	***104***	***3289***
Gender							
Men	95	470	796	327	163	50	1900
Women	118	90	850	103	173	54	1389
Total	***213***	***560***	***1646***	***430***	***336***	***104***	***3289***

** 'Mixed' denotes people from mixed or multiple ethnic groups, e.g. White & Black Caribbean, White and Black African, etc.*

We do not have a data source to estimate the protected characteristics of those currently placed in MH SSH or for those 'misplaced' in generic homelessness accommodation. Our snapshot exercise involving 85 individuals living in supported housing suggests that men may be over-represented in MH SSH, given the breakdowns suggested by the published data above. The snapshot also confirms ethnic diversity in existing schemes: people from Black/ Black British ethnic backgrounds were the largest ethnic group in this sample, making up 39% of the group of 85. By age, the snapshot sample was fairly evenly split across 26-35, 36-45, 46-55 and 55+ age groups.

4.5 Building requirements

We ran a focus group discussion to understand whether and how building requirements might be linked to our proposed typology. This was attended by 7 representatives of 5 specialist provider organisations and 2 officers from London boroughs (one inner North; one outer South, one commissioner and one officer who had recently reviewed MH SSH stock).

Overall feedback from this discussion was that:

- Transitional settings can be larger with more of a service feel – and need to be larger in order to achieve the necessary economies of scale in terms of staffing models.
- Longer term settings need to feel homely, but individuals have diverse needs, preferences and non-negotiables in terms of what this means to them and therefore a range of options is required.
- Key considerations at design and costing stage include:
    - Suitable space for staff/ private meetings
    - Physical accessibility, including ceiling height
    - Safety, security, including location
    - Sound-proofing, light, access to views/outdoor spaces, private & social spaces
    - Building in technology from the outset
- The importance of designing models in response to the varying housing markets and available land across London and in response to neighbourhood contexts.
- The value of engaging people with lived experience in co-design, see for example our case study on Homes in Mind. LB Hackney also described co-production with people from the Orthodox Jewish community and how this had highlighted cultural needs and preferences which would otherwise have been missed.
- There may be scope to 'pepper-pot' designated dispersed properties for people with mental health needs in and around other general needs, or supported properties for other client groups, such as people with a learning disability.

4.6 Challenges with supply and development

Three-quarters of commissioners replying to our survey said they had plans over the next 12-24 months to increase or enhance provision for people with mental health needs. All providers responding to our Tier 1 survey confirmed they are interested in increasing their provision.

In addition to factors affecting the cost of all development in London, such as wages/ labour shortages, construction material prices, land availability and costs due to competition from other uses, supported housing is likely to cost more to develop than social housing, due to higher specifications (e.g., for soundproofing, accessibility requirements, to allow for wear and tear). Supported housing also has a higher cost of non-chargeable communal space than general needs accommodation, for example space for staff[6].

Some of the commissioners and providers interviewed told us that the withdrawal of buildings from use as supported accommodation is a major concern. There are multiple reasons for this, but the common theme is that it is not financially viable for providers to retain their building as SSH.

Releasing capital to invest elsewhere in the business is one reason for disposal: the Regulator of Social Housing's most recent quarterly survey shows that, 'Providers continue to face pressure to improve the quality and energy efficiency of existing stock, which is increasingly resulting in boards having to make difficult decisions as to how to use cash

resources most effectively as well as limiting their ability to further manage additional costs' (para. 5[32]).

We have heard of multiple examples of suitable buildings becoming available because of local authority de-commissioning of support services (including homelessness services). Providers have sought to offer these for alternative population use, but these offers are not taken up in a timely manner by the local authority, and there is often not support for these properties to be used by people from outside the borough. Whatever the reason, unable to pay void costs indefinitely, properties are 'flipped' for general needs use or sold.

The process of securing grants through the GLA's capital funding programmes, in addition to build time, was perceived by some stakeholders to be lengthy. Timelines vary depending on building availability, providers' internal governance and due diligence processes, raising provider contributions, and ensuring compliance with GLA standards. The GLA Housing and Land team point out that if applicants have the relevant information, the process can take as little as 1-3 months. We discuss the role of these programmes in the following section.

In this context, decisions not to invest, or to invest differently are taken: an example was given of a local authority deciding to do the bare minimum instead of future proofing a building. Generally, there is felt to be a need to future proof existing SSH, but additional capital investment needs security in the form of future use and sustainable revenue, and local authorities are not always able to give this. This is felt to be associated with insufficient, short term and multiple pot nature of government funding.

The lack of capacity in local authorities to proactively support bids and development is a barrier, whether this be to enable the right approvals for SSH or other property to be used for a different population, to address complex legal/ownership matters, to support bids etc. Commissioning and market development capacity at a cross-local authority level would also be helpful: it could identify and address needs for SSH that could be best met at a larger geography; it would be helpful to providers who own stock across local authority boundaries, and to NHS stakeholders who deliver services across these boundaries.

Concerns about workforce, and insufficient support from wider health and social care systems also act as a barrier to expansion of MH SSH. As one provider explained,

[32] Quarterly survey for Q1 (April to June 2024) - GOV.UK

'NHS support isn't there in the way that it used to be…… so what that leads to for us smaller RPs, the complexity of resident needs had increased, puts more pressure on staff – so although strategically we'd like to expand, it doesn't feel support is there to make it work'.

Despite these challenges, stakeholders are keen to continue the conversations they have engaged in during this research, feeling this is just the start. Action is needed to harness London's 'assets' more effectively: system stakeholders have valued sharing their experiences, knowledge and practice, and would like further opportunities; without local capacity to manage assets currently associated with SSH, buildings are being lost.

4.7 The role of the GLA's capital funding programmes

The GLA's role in relation to supported and specialist housing delivery involves:

- Making use of its strategic position in terms of policy, planning and lobbying.
- Delivering regionally, e.g., in relation to rough sleeping services; and
- Investing locally, sub-regionally and regionally through capital funding and limited revenue funding.

The Care and Support Specialised Housing Programme (CASSH) which has previously provided capital funding for the delivery of homes for older and/or disabled Londoners (including people with mental health conditions) is not currently open for bidding. However, the Affordable Homes Programme (AHP), 2021-2026 provides capital funding for social or affordable housing, including all types of specialist and supported housing.

This research has identified people from across the system who are interested in making use of the available capital, but do not have the knowledge, contacts, expertise and/or capacity to progress this. This interest extends to developing MH SSH to meet the needs of populations across local authority boundaries. Learning more about the GLA's capital funding programmes has been of interest – and an outcome – from the research. Stakeholder feedback suggests that more questions remain, and these are specific to projects, populations, and places, and that there is an ongoing need for 'myth-busting'. See Appendix 4 for detailed feedback from the Market Development event.

In this section, we highlight key funding requirements for the AHP and reflect on the implications of these, based on the findings of this study.

- Capital grant recipients must be Registered Providers (RPs) or Local Authorities

This requirement provides some regulatory oversight by the Regulator of Social Housing in the case of non-Local Authority landlords, and it reduces the risk of subsidy loss to London boroughs resulting from Housing Benefit rules[33]. However, VCSE organisations wanting to

[33] NB: Local Authorities can only fully recover from the Department of Work and Pensions, the Enhanced Housing Benefit they pay when the landlord is a registered provider; if the landlord is a

develop specialist and supported housing reported finding it difficult to identify RPs interested in developing in partnership with them. This is likely to be driven by the financial challenges faced by RPs and the barriers to development outlined in the previous section. Nevertheless, it suggests that a more proactive match-making capability at GLA level may help to initiate such partnerships.

- Recipients must be (or apply to become) GLA Investment Partners; the Housing and Land Team offer informal support through this and the bidding process.

The GLA currently offers support to smaller organisations applying for Investment Partner status, though others considering bidding may be reassured to understand specifically what support is on offer and how much capacity they will need to complete this process. One borough interviewed felt strongly about the extent of what they described as 'secondary regulation' by the GLA in assuring itself that the boroughs were suitable investment partners. The GLA responded to this point by highlighting that, since local authorities do sometimes receive Regulatory Judgements from the Regulator of Social Housing and some have issued Section 114 notices[34], it is still important to consider a local authority applicant's financial and technical capacity to undertake an agreed programme of new housing supply.

- A range of delivery models can be funded, including new-build, refurbishment/ remodelling of existing stock (excluding cyclical repairs), acquisition (purchase and lease), ring-fenced general needs and modular.

This feels highly significant in the light of the findings of this research, i.e., that there are challenges with accessibility, space/ layout, and quality of some of the buildings currently used as MH SSH; and that there is an urgent need to develop a range of 'supportive' settled housing options for people with mental health support needs to facilitate people to move out of MH SSH where this is appropriate.

- Projects must meet minimum space standards, design and sustainability standards, building safety standards, and equality, diversity and inclusion standards (unless exempted where applicable).
- Schemes must be provided in perpetuity for the agreed client group and as affordable (or social) housing.

These two requirements have clear benefits for the quality, security and accessibility of MH SSH, and reduce the risk of stock being lost due to changes in government, social housing regulation, or escalating costs. However, the flipside of this is that they may make it harder to design and make a scheme stack up within high land value parts of London. An architect interviewed said of the GLA standards:

voluntary agency or charity, the local authority can only recover 60% of the difference between the Local Housing Allowance and the actual rent being charged.

[34] A Section 114 notice is a report issued by a local authority's chief financial officer when the council's projected income is not enough to cover its projected spending for the following year.

> *'If you are designing well, you would provide the things they require, so they do take us in the right direction…….. but they could make it a lot easier to demonstrate compliance'.*

Having to commit to providing the service for the agreed client group may act as a barrier to developers who worry about their exit strategy if they find themselves carrying high numbers of voids or there are changes to the funding of supported housing. For example, one RP explained that projected income levels are higher and more secure in relation to supported housing for people with a learning disability, than for MH SSH.

- GLA capital grants can typically fund up to 50% of total scheme costs, but there is flexibility to go above this, where the funding gap is justified.

Making the case for provider contributions was mentioned as a particular challenge for local authorities in the current financial context. A senior manager in one borough highlighted how difficult it is to lever in capital funding for this cohort, when the scale of the Temporary Accommodation crisis is the current focus. RPs are usually better able to borrow additional funding from banks, if they can demonstrate a solid business plan to their boards and potential lenders. However, this can be challenging – especially where it is hard to access sufficient market intelligence to support the business case. The potential role of private investors was mentioned by one RP interviewed and social investment featured as an area for exploration in a recent report on the future of MH SSH by ReThink[35]. The GLA may be well-placed to broker introductions with investors who might be willing to provide additional funding.

- Build must start by 31 March 2026, completions by March 2030.
- Current programmes do not include revenue funding; applicants must set out level of support needs and how proposed support arrangements will be funded.

As one provider who would like to expand from generic supported housing into the specialist mental health sector explained, '*the reason why it is so difficult to develop specialist supported housing is the revenue funding – the capital funding is there to a degree, but to make supported housing work, you need revenue funding*'.

Where there is support attached to a scheme, the GLA's bid assessment process seeks to understand the support model and the funding package, length of commitment and exit strategy.

Stakeholders described challenges securing revenue commitments. Many of the local authorities we interviewed were either struggling to make the case for ongoing funding for existing block contracts, or – as explained earlier in the report – do not (or no longer) block contract provision. Another provider suggested that the sector needs to 'try harder with the NHS', though inevitably Trusts focus mostly on step-up/ step-down MH SSH.

[35] ReThink (2024) The Long Journey Home: understanding and improving the supported housing system for people living with mental illness.

One RP which had developed a MH SSH scheme for the spot purchased market in London described the challenges they faced trying to get an in-principle decision from the Housing Benefit Department *('they said they wouldn't confirm until the tenants are in and make a claim'*) and some commitment from the local authority that they would refer/ spot purchase placements from them.
A potential lever for commissioners to commit to spot purchasing placements within a proposed development is that, with capital grant from the GLA, future placement costs can be reduced.

Transferring revenue funding from reactive spending on poor value for money placements (e.g. out-of-area or Bed & Breakfast placements) to planned MH SSH developments requires system-wide governance and strategic planning, which is still at an early stage in most parts of London.

The GLA also welcomes bids for specialist schemes which do not contain an integrated support package – e.g., those that are specialist by design, ring-fenced for a specific client group or where individuals' care and support is funded by personal budgets. This creates a significant opportunity to use GLA capital funding for the development of long-term 'supportive housing' models to facilitate people to move out of more traditional forms of supported housing.

5 Recommendations

Recommendations are grouped under three headings:
1. Recommendations for the GLA's management of their capital funding programmes (for the Housing and Land team)
2. Recommendations to improve the understanding of the need for MH SSH
3. Recommendations to address systemic barriers to developing MH SSH, and develop the market in London

There are relationships between recommendations, for example:
- Those presented under the second two headings will inform the future capital funding programmes, and as such, should be designed and delivered with input from the Housing and Land team, alongside other system stakeholders
- There are a number of shorter-term recommendations for action intended to enable more immediate effective use of the GLA's capital funding programmes; learning from these should inform longer-term and more in-depth recommendations for action to understand the need for MH SSH, and to address systemic barriers and improve the market.

In the absence of governance for MH SSH, and lack of capacity to commission strategically, at all geographies in London, it has not been possible to suggest who, in all recommendations, should take the lead or be a partner. We are recommending that the governance and strategic commissioning gaps are addressed, but in the short term and as the commissioner of this research, we have suggested how the GLA may consider acting, even if this is simply to initiate a conversation, and activate others to take a lead.

1) Recommendations for the GLA's management and development of its capital funding programmes

a. To improve the system stakeholders' understanding of the GLA's capital funding programmes and the contribution they might make to meeting the needs identified in this report, we recommend the GLA more clearly communicates the offer, in person, on its website, in published documents and in partnership with others e.g., the G15, the G320, National Housing Federation, Supporting Housing in Partnership and Placeshapers.

This could include:
- Providing case studies of different SSH funded models, including those without commissioned revenue, and perhaps including feedback from bidders about the process.
- Describing opportunities for the GLA's capital funding programmes to support move-on pathways, and the models that may be appropriate, for example co-housing.

Communications should aim to tackle the key questions or misconceptions which the research findings suggest may currently get in the way of bid development.

b. **To follow up potential bid leads identified through the research**

c. **To address the limited capacity and capability of smaller providers and London boroughs to produce bids,** we recommend the GLA more clearly defines and communicates what an enhanced support offer looks like for small providers.

d. **To assist in generating future bids** (for new MH SSH, to improve the quality of existing buildings and to increase move-on accommodation), at all geographies, we recommend that GLA plays a role in:
   - Convening RPs, local authorities, and charities – including a matching service, support with consortium bids and a drop-in surgery
   - Holding a 'SSH at risk' register, and using this in conversations with commissioners and providers to identify opportunities to improve/sustain this accommodation.
   - Facilitating conversations between housing and adult social care teams and mental health teams in boroughs around supported housing – though there is also a need for sub-regional/ local governance to ensure local join-up (recommendations for governance are presented under Section 3 below).
   - Identifying and sharing innovative models for move-on and long-term housing and support to inspire new partnerships and models of supported housing.

This study has identified existing and potential models to provide long-term housing with flexible support for people with mental health needs, including those stepping down from MH SSH. These have included: BRiLL flats (Lambeth/ Thames Reach), Homes for Mind, KeyRing, concierge models, intentional shared housing (in which house-shares are developed around people's existing relationships or interests), different approaches to commissioning floating support.

A next step would be to bring together CVS organisations leading innovation in this field via the Association of Mental Health Providers, people with lived experience, Registered Providers, managers/ multi-disciplinary health and care professionals to develop a series of 'blueprint' models to inspire partnerships to apply to the GLA's capital funding programmes. It will be important to include representatives of Community Rehabilitation Teams in visioning move-on models and how they might be supported by the wider health and care systems, e.g. as part of plans for increased investment in community rehabilitation teams for people with complex psychosis, and the development by trusts of new models of care.

e. **To address the limited capacity and capability in London to generate future cross-local authority bids to meet identified unmet needs for SSH from people with co-occurring conditions**, we recommend that the GLA initiates a conversation with other relevant system partners. The aim of this would be to identify:
   - The action can be taken to begin to meet these needs through:
     - The GLA's capital funding programmes (including investment in existing stock, and move-on)
     - Current revenue streams, including NHS, local authority (adult social care, public health, homelessness and housing) and the Better Care Fund

- What other action is needed to enable needs to be met, and to agree who is best placed to lead and contribute.

In more detail, for each of the populations with identified unmet need:

People with co-occurring conditions of mental health needs and substance use, especially women

A conversation should include:

- The NHS London region, NHS Trusts - delivering better care for this population has been proposed as one of eight priorities for a mental health strategy for London
- OHID and ADPH London (commissioning substance use services)
- MHCLG and local authority homelessness commissioners: this population is also a priority
- NHS Forensic provider collaboratives and HMPPS

The Government funded pan-London co-occurring conditions programme hosted by TPHC (focussed on people experiencing homelessness) is expected to receive future funding. This programme has already undertaken some work towards understanding needs; it may be there is an opportunity for this revenue resource to be more specifically targeted towards the development of supported and specialist housing options to meet these needs, working more closely with the GLA's housing team.

Those with co-occurring mental health needs and autistic spectrum disorder (gender specific)

The GLA should work with the London Strategic Learning Disability and Autism Partnership Board (SPB), initially to review findings from this research and Board's research commissioned from NDTi in 2024 to inform a foundation for a new strategy centred on care, support and housing for people of all ages with learning disabilities and autistic people. The latter has identified unmet housing (including supported and specialist) needs, alongside other actions to improve outcomes for these populations.

Work with the London housing lead for the national NHS Learning Disability and Autism Programme to share experiences and knowledge of partnerships and progress, with a view to optimising the NHS and GLA's capital funding programme(s) for this population.

People with mental health needs who are ageing with physical ill-health and impairments which require accessible accommodation and care.

A conversation should include:

- Relevant pan-London stakeholders/governance for people in later life, for example London ADASS, to share knowledge of this population and what action is needed to develop and translate this into action

- Stakeholders engaged in this research to develop a plan to meet current (identifiable) needs through the GLA's capital funding programmes and likely future need.
    - This could include developing relevant questions for the audit of quality and accessibility in existing specialist and supported housing (see recommendation 4).
    - It may be that accessibility could be improved using local authority funding, for example the Disabled Facilities Grant, if an individual's existing home is considered settled (government guidance is usually five years, but this can be shorter)

2) Recommendations to improve the understanding of the need for MH SSH

As greater clarity emerges about the timescales and resources for implementation of the Supported Housing (Regulatory Oversight) Act 2023, the GLA could develop an enabling role to support London boroughs in their needs assessments and strategy development.

a. To more accurately understand the unmet need for MH SSH, we recommend the GLA promotes the use (and where necessary refinement) of the typology developed in this project.

The lack of a consistent way to describe different models of MH SSH makes it difficult to assess existing provision and identify gaps; it also gets in the way of rigorous evaluation of what works for whom under which conditions. Some stakeholders also suggested that it would be useful to attach standards (e.g. minimum staff: resident ratios) to these model types, though this will require further consultation and will need to align with the government's forthcoming regulatory standards.
We recommend the GLA and its partners (London Council, ADASS, NHS England and the National Housing Federation) promote and refine as necessary the typology proposed by the project by, for example:

- Asking bidders to explain which type of model they are proposing to develop in relation to the typology
- Using (and where necessary refining) the categories suggested by the typology within future research, mapping and evaluation projects and communicating these to others involved in commissioning or delivering such projects in London
- Influencing local and sub-regional commissioners to refer to the typology in their specifications
- Consider working across systems to co-produce a set of minimum standards or parameters describing the support models in the different models, e.g. levels of staffing, whether or not medication can be supervised, etc).

b. To further develop the needs model, we recommend the GLA convenes system stakeholders to agree what action is needed, associated additional costs and how these might be met.

The modelling tool developed within the project has been populated by the research team using the best possible current sources of published data; however, the ideal would be for local systems to plug in their own local data and assumptions and run different scenarios to test how these variables impact on the need for MH SSH over time. Take-up will depend on capacity and commitment within boroughs and integrated teams.

The GLA could consider investing in the development of an interactive user interface for the tool, which would prompt localities to add their data and assumptions, without needing to understand the inner workings of the model (both to improve accessibility and protect IP). Guidance for users of the tool would also need to be produced and this would need to be communicated with key players across systems.

There is further work to be done with information 'owners' e.g., MHCLG, the NHS, MOJ and HMPPS to enable relevant data to 'flow' into the model; this should not be something that each local authority should be expected to search for. Ideally, updated data sources would be added directly to the 'back-end' of such an online tool.

Until there is 'real time' and higher quality data available from NHS services, NHS Trusts should be required to make use of available Mental Health Service Dataset coding, including accommodation status, and reasons for 'Clinically Ready for Discharge – supported housing'.

NHS staff would benefit from training to inform their enquiries of patients, and data capture. The questions from the 'snapshot' tool developed and piloted within this project could form the basis of this, to inform modelling and strategic planning, with individuals' preferences and priorities added to this, to inform their personal plans.

c. **To further develop shared knowledge of what MH SSH is already available in London, and the high-level needs (i.e., to inform place-based strategies, rather than person-centred plans) that relate to this e.g., move-on,** we recommend the GLA considers rolling out a modified version of the mapping surveys for both providers at scheme level and for commissioners.

A key output from this project has been the building from scratch of what we believe to be a reasonably comprehensive sample/ contact list for data collection from and on the MH SSH sector across London. Building this and engaging commissioners with very limited capacity has required far more time and effort than was anticipated at the outset, meaning that there remain huge gaps in the evidence base. There is an important and time-limited (given staff turnover) opportunity to roll out again a modified survey.

Evidence gaps which could be addressed by this exercise include:

- A better understanding of the scope of existing provision, e.g. support models, target groups, building type (though the detail of this would be covered by the audit in recommended next)
- Source and volume of referrals, void levels
- Rent and service charges, sources of funding for support (and whether block or spot commissioned)

- Average length of stay, turnover and move-on destinations
- Demographic profile (by broad age and ethnic groups, and gender) at a snapshot
- Proportion of people deemed ready for move-on and a high-level indication of housing and/or support model ideally needed to facilitate this (though again, this would be covered in more detail by the move-on audit recommendation)
- A high-level rating by provider/ managing agent of building quality/ suitability.

d. **To develop a more detailed understanding of the move-on requirements of people already in MH SSH in London,** we recommend the GLA, with London Councils, considers the use of a move-on audit.

In 2004 with Government funding, Homeless Link developed the Move-On Protocol Project (MOPP), providing stakeholders at a local level with the tools to take a strategic look at the problem of move on, and to inform action planning. This has been successfully used to understand move-on requirements from a range of supported housing, not just homelessness provision, and it is still used by some local authorities, for example, Newcastle (none specifically identified in London).

On a practical level support providers ask their staff to provide information about their service users' move on requirements based on their support plans, expected availability of move on in the area and any barriers being experienced to effective move on.

In partnership, consideration should be given to:

- The ways in which local authorities and providers currently understand move-on requirements from MH SSH, and how these are communicated to stakeholders who can act to meet needs in practice:
    - This should consider the extent to which, and when, service users are engaged in conversations about moving on, and the scope of these conversations
    - If a 'model' approach exists in London, identify what is needed to adopt this approach across London
- Approaches taken by MHCLG funded Supported Housing Pilots, where move-on from supported housing formed part of local authority logic models e.g., Hull, Bristol, and from other localities where such a protocol remains in place.

With learning from London and further afield, it is recommended that a revised move-on audit tool is adopted and used in MH SSH. It may be appropriate to test this in several localities, with different populations and/or service models. It may be that additional commissioned support is required for providers to conduct their service audits, capturing and reporting information at appropriate geographies.

e. **To develop a more detailed understanding of the quality, accessibility and suitability of existing supported and specialist housing, and plans for investment in this housing,** we recommend the GLA, with London Councils and providers develops and delivers an audit, as the basis for a more dynamic understanding of what is available.

Such an audit has the potential to inform:

- The GLA's and others' (e.g., the NHS) capital funding programmes, now and in the future, with an expectation that bids for capital grant have considered current provision, best use of this and gaps.
- Future asks of the government for capital funding for existing, and new, homes.
- A shared understanding at locality level of current provision, and more effective use of this
- The development of a comprehensive and dynamic 'directory' of provision, with relevant information to support decision making by referring organisations, and by people in need and those who care for them.

Using the Supported Housing National Statement of Expectations: checklist of accommodation standards as the basis, the development of an audit tool could draw on:

- Positive practice identified through the course of this work, for example in LB Lewisham (council in partnership with SLAM), LB Hackney and the work of Metropolitan Thames Valley Housing to understand its own supported housing provision
- Professional expertise, for example there are occupational therapists working in London who specialise in accessible and inclusively designed home e.g., employed in LB Richmond and Wandsworth
- The voice of people with lived experience
- Learning from the Supported Housing Pilots, for example the 'Scores of the Doors' initiative – a rating system which also considered standard of accommodation.

Stakeholders in localities (at appropriate geographies) should complete the audit working in partnership. Audit data should be compiled and analysed at London, ICS/sub-regional and place-level, as appropriate to the audit intentions, for example, analysis at London-level would be necessary to inform the GLA's plans for its capital funding programmes and asks of government.

3) Recommendations to address systemic barriers to developing MH SSH, and to develop the market in London

a. To establish appropriate governance for the outcome of 'enabling independence through MH SSH' and associated capital and revenue investment in London to ensure this offers value for money, it is recommended that the GLA lead a conversation about what governance functions are required, and at what geography.

Such a conversation may require:

- An appraisal of existing relevant London governance and informal partnerships, with a view to:
    - Establishing options for these to adapt/develop to govern MH SSH, OR
    - Concluding that new and distinct governance is needed
        - What the scope would be of new governance
        - How this would relate to existing governance

- Requesting that ICPs, and Health and Wellbeing Boards describe their current ICS and local governance arrangements for MH SSH, including roles, duties and powers of stakeholders in these arrangements.

Early priorities for the pan London governance group might include:

- Considering the implementation of a pan London agreement for inter-borough MH SSH placements, along the lines of the existing Pan London Agreement on Inter-borough Accommodation Placements
- Collating data about total system spend on housing and support for people with mental health support needs (including temporary accommodation, non-commissioned exempt accommodation, out of area placements, spot and block purchasing)
- Considering the scope to re-direct some of this reactive spending to a more strategic use of revenue funding for MH SSH and how this might work
- Building the business case for investment in MH SSH (see also next recommendation)

On the latter point, feedback from the market development event included the need for a tool to make the case for the cost effectiveness/ social value of MH SSH. We understand that MHCLG has commissioned Sheffield Hallam University to conduct research into outcomes from supported housing. There is an opportunity to draw from the outputs of this national study (we understand an interim output is expected by April 2025) and the work carried out by HACT in relation to social value and ensure learning and resources are shared with those trying to evidence the business case for capital investment locally.

b. To address gaps in strategic commissioning capacity for MH SSH in London it is recommended that London partners should seek additional government funding.

The ideal model would include:

- A regional SSH housing lead, and supporting capacity, with sufficient authority to:
  - Lead a programme of work which would include bringing together system stakeholders to agree a shared vision, and objectives
  - Establish and support appropriate governance,
  - Lead on the delivery of recommended pan-London activity, and escalate barriers to delivery, including to Government
  - Develop and manage stakeholder networking
- Integrated Care System-level integrated and strategic commissioning leads and/or ICS locality leads (focussing on specific places in an ICS), specifically to support stakeholders and localities in developing/managing SSH to meet needs, including leading on cross-authority matters such as use of housing, development proposals etc.
- A pan-London team of frontline housing professionals, developed and supported to identify and meet peoples' housing and support needs whilst they are in health and social care settings/services (see later recommendation)

- Data science expertise, able to access and analyse data from across health care, social care, housing and other relevant systems (would support the needs model to develop further).
- Supported and regular engagement with people with lived experience of SSH.
- Including the supported housing and related (e.g., homelessness) workforces within health and care workforce planning, and learning and development.

c. **To achieve the dual outcomes of a better understanding of people's MH SSH whilst they are in health and care settings to benefit individuals, and to address the lack of a dynamic and shared understanding to inform strategic commissioning,** we recommend London partners, with the GLA and London Councils leading the conversation, seek government funding for a pan-London and/or ICS-level team of frontline housing professionals.

With additional capacity for a minimum of three years delivery, this team of professionals would have a dual purpose:

- On a day-to-day basis, they would enable a better understanding of people's housing and support needs and ensure that these are practically met as far as possible.
- With additional support, knowledge generated through such capacity could rapidly address gaps in London's current knowledge of both needs and supply of SSH, and move-on.

This recommendation is for cross-authority teams, which may be appropriate at London-level or ICS-level depending on the population and/or setting/service; this will be for stakeholders in London to agree. Such team/s will require appropriate governance and supervision to be in place, with relevant stakeholders committed to supporting the development of an integrated workforce.

To develop the service model, the lead organisation/s should:

- Draw on the evidence of 'what works' in employing housing expertise in health and social care settings and services, for older people, people with a learning disability and people experiencing homelessness.
- Review the core service principles established through the GLA's Rough Sleeping and Mental Health programme (RAMHP), and learn from the implementation of this programme.
- Work with councils, RPs and council landlords, and housing service providers, and NHS providers to:
    - Understand what current housing expertise is available in health and care settings in London, for all populations, by population type, how posts are resourced and for how long
    - Identify existing and effective housing, care and support assessment tools, protocols and policies, including cross-borough dynamic purchasing
    - Identify opportunities for a better use of housing, health and care professional time in existing pathways of care (this may be best facilitated with first agreeing what housing knowledge and competencies are required and where in pathways)

- Enable people with lived experience to inform the shape of this resource, including the role of people with experience in delivery, would be essential.
- Seek opportunities to integrate the housing (and homelessness) professionals into workforce planning for health and social care, including through training and development opportunities
- Commission the development of learning, for example establishing an evaluation framework with ongoing support, regular reporting to the project's management and governance etc, with a view to informing future investment.

Appendix 1: Baseline mapping activity

IBA was commissioned to carry out a baseline mapping survey to understand current provision of accommodation across London within the agreed definition (see S.1.2).

We designed our approach to this exercise in the knowledge that we needed to gather some information from commissioners and some information from providers, and that there is no pre-existing contact list for either. This picture is further complicated by the fact that the landlord and support provider (managing agent) functions are often carried out by different organisations, and that provider organisations vary enormously in their size and the number of schemes they operate. Furthermore, the commissioning function may sit in either Housing, Adult Social Care, or an integrated team/ alliance, and sometimes straddles more than one of these.

We created a Tier 1 survey for commissioners, in which we asked for their contact details, basic information about each relevant scheme they commission (e.g., number of units, name of support provider/ landlord, location, ideally postcode); what performance data they collect (e.g. on referrals, demographic profile, move-on/ other outcomes) and whether they might be willing to share it; contact details of providers or other key stakeholders, and a request to share the Tier 2 survey link with providers.

A Tier 1 survey for larger providers asked those with multiple schemes to provide similar overview information centrally, then send the Tier 2 survey link to scheme or area managers who could provide more detailed information at scheme level.

The Tier 2 survey asked for the following information at scheme level:

- The service's objectives and target service users
- Referrals into the service
- Staffing model and facilities
- Funding arrangements
- The building(s) and who owns it/ them

Initially, the communications strategy was to cascade tailored invitations to take part in this process via the advisory and senior sponsorship groups, which included representatives of:

- London ADASS
- The National Housing Federation
- London Councils, and also included a London Borough commissioning representative
- NHS England (London)
- NHS Trusts and Integrated Care Boards

These were supplemented with IBA's existing contacts at the Supported Housing in Partnership – a network of housing associations providing supported housing.

This generated a limited number of contacts, and has since been supplemented with:

- Snowballing from the IBA team's existing contacts with boroughs and providers
- Asking providers to put us in touch with commissioners
- Internet and LinkedIn searches for commissioners at each borough
- Targeted communications from the GLA via its Housing and Land team
- Asking ICB Mental Health leads to reach out to their local authority contacts

Alongside this, we have carried out an extensive online mapping process in which we searched for 'mental health supported housing' against the name of each borough, listing any which may fit our definition, searching their websites for as much information as possible on schemes, emailing contact addresses and carrying out Google and LinkedIn Sales Navigator searches to try and connect with senior people. Alongside this, we have searched online borough-by-borough for recently published information about current provision (e.g. Market Position Statements, Supported Housing strategies, Invitations to Tender, needs assessments, FOI requests, cabinet reports). We have used this where we have not been to get a commissioner response and have cross-referenced scheme information from different sources to eliminate duplicates.

As the extent of spot-purchasing in this sector became evident, we realised that we needed to try to build a picture of the total number of *people* being placed in MH SSH, not just the total number of physical units in a locality. At this stage, we prioritised asking new contacts and returning to existing ones for information about the total number of placements. It became clear that many London boroughs needed to draw information from two or more different teams or departments to answer this question. In boroughs where we did not have a contact, or the contact did not or could not supply this information, we searched online documents such as market position statements, cabinet reports, etc to try and find the most recent figure available.

This has been an extremely time-consuming process, which has required considerable relationship-building; for example, where we have reached commissioners via providers or LinkedIn, they have needed reassurance about the objectives and confidentiality of the process. Some stakeholders have not had capacity to provide lists of schemes in our format (despite offering both in-survey and spreadsheet templates to support this), so we have been willing to receive existing lists of provision and extract data from these. The original survey was intended to finish in July/ August, but updates were still being supplied at the end of November. To summarise, at the end of the project:

- 17 local authorities responded; however, 2 completed the survey but did not provide details of provision; 3 sent details of provision but did not complete the survey.
- 15 providers completed the Tier 1 survey, of whom 12 supplied full information on their schemes. Another 3 partially completed the survey, and another 1 provider completed a template of their schemes but did not complete the survey.
- 17 scheme managers completed the Tier 2 provider survey.
- 14 boroughs supplied total placement data (or we were able to find a published figure from within the past 12 months).
- For 7 boroughs, we could only find a published figure (which was more than 12 months old), or we were provided with a figure but the commissioner was uncertain

about this. For the remaining 12 boroughs, we had to impute figures. We did this by dividing the number of placements by the total number of households (2021 Census) for the boroughs where we had data, generating a mean multiplier of 0.2% which we then multiplied by the number of households in the remaining boroughs to generate an estimate of the total number of placements.
- A total of 23 boroughs provided some information but only 9 answered the survey, shared details of commissioned units and gave us the total number of people placed in MH SSH.

The mapping information was collated and organised by:
- Pulling out the details of each scheme identified by commissioners and providers in the survey and in the additional lists supplied or found online into a single, row-per-scheme spreadsheet
- Combining information where there were duplicates (i.e. both provider and commissioner have told us about a scheme)
- Cross-referencing the above with the list of schemes identified online in order to combine/ verify information sources and build a better understanding of which of these are block versus spot purchased.

There are significant gaps in the scheme-level data at the end of the project; however, with further time and resource there is an opportunity to utilise the list of contacts compiled through the project and roll out a possibly revised version of the Tier 2 survey across those services identified. Given that this is a rapidly changing landscape with schemes being re-commissioned and turnover amongst commissioner contacts, the window of opportunity is likely to be time limited.

Appendix 2: Modelling validation process

Process taken

The following steps have been taken to peer review the modelling process:

- A team of experts from a range of settings were appointed as **associates within the project's modelling team** to work with Mark Goldup, overseen by Imogen Blood, to ensure checks and balances throughout the design and implementation of the modelling. This included:
    - Dr Bo Hu, Assistant Professorial Research Fellow, Care Policy and Evaluation Centre (LSE) who has a long track record of using quantitative methods to build models to project needs and costs in relation to supported housing (e.g. Projected Demand for Supported Housing in Great Britain (2017)), mental health and adult social care needs. Bo has implemented the modelling for this project.
    - Professor Glen Bramley, Professor of Urban Studies at I-SPHERE, Heriot-Watt University Heriot-Watt University. Glen has carried out modelling for the ongoing Homelessness Monitor, produced Hard Edges for Lankelly Chase (on overlap between mental health and other complex needs), Gender Matters (on how disadvantages might cluster differently for women), and Destitution in London 2020. Glen has provided advice and challenge to the team and worked directly on the analysis of H-CLIC homelessness statistics and the development of a synthetic model to predict needs across the London boroughs, where published data was only available at pan London level.
    - Dr Richard Turkington (Housing Vision) specialises in housing market/ needs assessments, developing interactive toolkits to model future housing and care needs for local authorities and other agencies. He acted as a critical friend during the model design process.

- **Presentation to Advisory Group on model design, 3rd October 2024**

- **Presentation of emerging modelling results at the Market Development Event** (6/11/24), with a modelling exhibition stand to which delegates were invited to look at the detailed figures and give their feedback. A 'modelling key' was produced to support this activity which described the data sources and assumptions made in the model.

- **Validation panel**: contacts from 9 boroughs/ place-based teams and one NHS Trust were invited to take part in a validation exercise in November 2024, selected on the basis of their operational knowledge of multiple pathways, range of borough types (geographical spread, inner/ outer location, size, commissioning approach) and level of engagement with the project. Panellists were sent in confidence: draft figures for the base year broken down by ICS and borough; the modelling key (described above); and a set of validation questions. 5 people from 4 localities attended a 2-hour online validation discussion on 19th November. A further 4 people from 2 localities fed back their comments by email.

- **Involving NHS London**: Given the challenges identifying reliable data about the number of people being discharged from mental health inpatient settings and the proportion of them likely to require a MH SSH intervention, we shared a draft 9-page document detailing the approach taken to populating the model with NHS England/ London and worked with them to validate the assumptions taken and agree how best to present them

- **Peer reviewer**: We invited Professor Helen Killaspy of University College London to act as peer reviewer for the model. Helen is a clinical academic working in the field of rehabilitation psychiatry. Her research has provided crucial evidence for the effectiveness of specialist services, including MH SSH for people with complex mental health needs. We shared the draft 9-page document and the initial round of modelling results, and she provided feedback in a meeting on 27 November and via comments sent by email.

- **Feedback on draft report**: representatives from ADASS, London Councils and NHS England/ London made comments on the full draft research report.

Responding to feedback from the validation process

Overall, the structure of the model was well-received and welcomed by reviewers: the general sense was that the flows made sense but that, inevitably the use of published data to make estimates does not accurately predict the actual numbers in each borough, though for the most part, these appeared to be a reasonable mid-point. It was evident from the validation discussions that models of provision vary considerably across London, so for example flows may be very different in an area which has moved away from inpatient rehabilitation to an area which has not. The design of the model means that localities can add their own data or adjust assumptions; however, in the absence of this granularity the project has had to make and apply consistent assumptions which will not always reflect current realities.

Four key issues were raised in the process; these and our response to them are presented in the table below.

Point raised	Response
Assumptions about levels of people ready to move on/ rate of move-on in current system too high, but varies from borough to borough (and very difficult to anticipate for individuals, e.g., based on diagnosis or other factors)	Changed modelling assumptions from 70% with an average 18 month stay and 30% needing a longer stay (avg. 5 years) to 40% of existing MH SSH residents and 60% of newly arising need requiring an avg. 18 month stay and 60% of existing residents/ 40% of newly arising need needing a 5 year (avg.) stay.
Concerns about impact of publishing borough level	Removed previous column from model estimating numbers of people 'ready to move on' and provided more nuanced

Point raised	Response
estimates, given threat of cuts to services and the ethical risks of adding further pressure to residents/ frontline services to move on.	commentary on this, emphasising that this would only be possible with the right housing models and community support available. Decision to publish breakdowns to ICB level only, since it did not make sense to publish a mix of estimates based on our methodology and individual borough's updates.
Missing flow/ pathway within the model: forensic step-down.	Despite ongoing efforts, we have not been able to access reliable data on the scale of forensic stepdown within the timescales of the project; we also received feedback that our estimates of the prison release flow were too high. Based on the rough estimates of forensic flow from operational staff in the validation panel, these two potential changes seem very roughly to balance each other out, so we have widened prison release to a broader 'justice' label, including forensic, using the original numbers.
Missing flow/ pathway within the model: inpatient rehabilitation (which would not necessarily get picked up via main psychiatric discharge route)	We are aware of work carried out to estimate the size and needs of this cohort, e.g. by Getting it Right First Time and the South London Partnership. Unfortunately, the latter project has not been able to share findings with us. In the absence of this and combined with huge challenges estimating the size of the inpatient discharge flow itself, we decided to increase our assumptions about the proportion of those discharged from 14% in our original version of the model to 20% to make some allowance for the size of this additional pathway. Clearly the volume of people being discharged from inpatient rehabilitation will depend on policy/ investment decisions by the NHS and local authorities. For example, some boroughs involved in the validation process explained that they now no longer have any inpatient rehabilitation in their local area, having moved towards community alternatives.

Limitations of the validation

- Having updated the model as described above in response to feedback, and in response to the specification which asked for a breakdown of the types of MH SSH required, the team has since attempted to apply findings of relatively small sample size 'snapshot' exercise to estimate at very high level the different types of move-on required. We ran the illustrative case study presented in Appendix 5 after the validation exercise to demonstrate how the findings of a larger sample and more rigorous snapshot of individuals' needs might be used to estimate the proportion of different models of MH SSH required to meet needs. Please note that neither the assumptions on which this case study has been based, nor the results of that exercise have been validated by system stakeholders and results are experimental.

Appendix 3: Engagement

IBA and the GLA developed a joint engagement plan and a stakeholder management spreadsheet at the start of the project. A topic guide for conversation was developed for use by all IBA team members.

The GLA identified members of an Advisory Group (this met three times during the project) and project sponsors in senior system stakeholder roles to provide direction and overcome barriers.
Through the GLA, Advisory Group and IBA team knowledge, initial leads and other key informants were identified. It quickly became clear that no individual had oversight of all MH SSH, at ICS, NHS Trust and local authority level; instead, we relied on those we engaged with to advise who else may have a useful perspective, and we followed up on these. In addition, those we engaged had very different levels of understanding of MH SSH, we therefore used the topic guide as appropriate.

All IBA team members documented interviews/group conversations and logged these on the spreadsheet. We held several internal meetings to discuss what we were hearing, to identify common themes and share perspectives that we'd not heard before: the latter led to follow-up engagement to ensure we'd understood what we'd heard and/or to understand if this was an individual's view not shared by others. At Advisory Group, interim report, stakeholder event stages these notes were reviewed and common themes identified; these stages enabled us to test what we'd heard with a wider audience.

As of 28 November, we have engaged at least 113 stakeholders through a mix of 1-1 and small group discussions (all held via Teams). The breakdown of individuals by role is shown in the following table:

Sector/ stakeholder type	Number of individuals engaged
Local Authorities	23
NHS London region incl. justice	6
NHS ICB and integrated roles	15
NHS Trusts	20
Supported housing providers	18
People with lived experience	35
CVS/ other	7
Cross-LA, pan-London networks/ policy roles	9
National roles in DHSC, NHSE, MOJ	6
Grand Total	139

Fieldwork visits were made to supported accommodation delivered by eight organisations: Hestia, Bridges, Peabody, Riverside, SHP, St Martin of Tours, Look Ahead and Evolve. These services covered eleven local authority areas and four Integrated Care Systems. They included forensic services, high support need services, 24/7 staffed services, semi-independent services and a supported house share. During these visits, conversations were held with project staff, 33 people currently living in supported housing, and two people who had moved on.

Key findings from the research with people with lived experience and staff supporting them are presented within this report; a full stand-alone report of this strand of the project is separately available.

In addition, we have presented an overview of the project and sought feedback within the following forums:

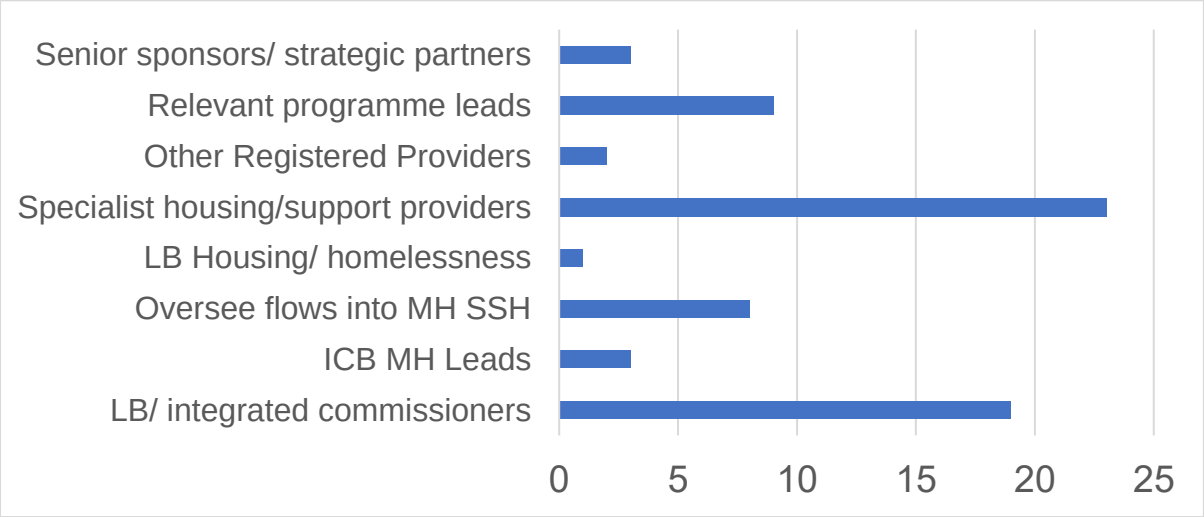
- ADASS Mental Health Leads (two meetings)
- Lambeth Alliance
- Cavendish Square Chief Operating Officers Group
- London ADPH
- Local Authority Rough Sleeping Leads
- NHS London Region Length of Stay group (two meetings)
- Association of Mental Health Providers
- London Directors of Housing Network – co-chairs meeting

Appendix 4: Market Development Event

Held on Wednesday 6 November 2024 at Coin Street, London, this in-person event was an opportunity for system-wide stakeholders to consider how the GLA, through their capital funding programmes, could address unmet need through enabling new and improved supported and specialist housing provision for adult Londoners with mental health needs.

Participants and programme

90 people booked to attend the event: 64 people attended on the day, in the following roles:



In summary, the programme for the day included:

- Strategic scene setting
- Presentations from
    - The GLA - capital funding programmes
    - IBA – emerging findings, findings from lived experience research
- Four case studies
    - Lambeth Alliance: embedding MH SSH within a whole system approach
    - LB Lewisham: Pathway oversight & partnerships with non-commissioned providers
    - Newham: LB Newham, ELFT and Look Ahead partnership to remodel their pathway
    - Look Ahead: use of GLA capital funding programmes to develop a new scheme for young adults in Ealing
- Networking lunch with stall showcasing modelling & mapping results
- Short plenary: Duncan Tree, AMHP and Raymond Sheehy, Bridge Support
- Small group discussions, considering:
    - Overcoming barriers to developing more supported and specialist housing provision
    - The role of GLA capital funding programmes in reaching solutions
    - Governance: what needs to exist to further develop the market?

The detailed programme is shown below:

9.30	**Registration and coffee**
10.00	***Welcome & housekeeping from chair, Gill Leng*** ***Strategic context:*** Paul Calaminus – CEO of NELFT, Chair of Cavendish Square Group Reena Manjania - Area Manager, GLA Housing & Land Team Emma De Zoete – Public Health Specialist, GLA
10.20	***Overview of the GLA's Affordable Homes Capital Funding Programmes*** Chloe Nyman – Senior Project and Policy Officer, GLA
10.35	***Findings from the research*** Imogen Blood, Director of IBA
11:00	***Questions, comments and discussion from the floor***
11.15	**Comfort break**
11.30	***Learning from lived experience and practice – chaired by Imogen Blood*** ***Lived experience consultation:*** Findings from our research with people living and working in mental health specialist and supported housing with Becky Rice (IBA associate) & Stephan Morrison (Groundswell)
11.45	***Working together to overcome barriers: case studies*** • Lambeth Alliance: embedding MH SSH within a whole system approach • LB Lewisham: Oversight of the MH SSH pathway, including partnerships with non-commissioned MH SSH providers • Newham: Partnership between LB Newham, ELFT and Look Ahead to remodel the MH SSH pathway • Look Ahead: Using GLA capital funding programmes to develop a new scheme for young adults with mental health needs in Ealing ***Questions and discussion from the floor***
12.45	**Lunch and opportunities for structured networking**
13.30	***Solutions and next steps - chaired by Gill Leng / Imogen Blood*** ***The VCSE contribution:*** A short word from Duncan Tree, Director of Strategy & Relationships, Association of Mental Health Providers ***Small group discussions:*** • How do we overcome the barriers to develop more MH SSH to meet identified needs? • What's the role of GLA capital funding programmes in reaching solutions? What questions, clarifications or feedback arise in relation to capital funding programmes? • At what geographical level and by whom should actions take place and/or governance sit to further develop the market?
14.50	***Reflections, thanks and next steps from the GLA***
15.00	**Close**

Summary of group discussion

The following content was derived from notes taken during table discussions, and feedback to all participants after each discussion. These reflect participants experiences and perceptions, the latter may not be accurate but are recorded here so that they can be addressed.

1) How do we overcome the barriers to develop more MH SSH to meet identified needs?

a) Share intelligence

- Data systems should enable sharing
- System partners should be able to clearly communicate current and future needs to providers e.g., through integrated dashboard
- Data from this work
    - A stepping stone to more systemic relationships
    - Iterative, as focus, to engage with providers

b) Pool national budgets for local area use

- Pool from across MHCLG rough sleeping/homelessness, adult social care, justice – and add £
- Local and joint governance/structure to relationships and plans
- Supportive of collaborative and joint commissioning e.g., alliancing
- Simplify the system where we can e.g., in relation to Housing Benefit & DWP
- Needs national strategy
    - Overall vision underpinning housing and health policy
    - Public Health approach in the mainstream (population health approach)
    - Planning reform

c) Make better use of existing suitable properties

- Need robust knowledge of assets across the mental health and related pathways e.g., homelessness
- Quality and need for investment are enormous issues with the core stock (see also next question re: GLA capital funding programmes).
- Proposed changes to the asset base, for example when looking to review/revise pathways, may present an opportunity for alternative use

d) Work more with the voluntary and community sector and social enterprise (VCSE)

- To co-design self-contained, affordable and lasting accommodation options
- Need to design the offer in communities to people when they move-on from supported housing
- Move-on in the private rented sector presents risks, leading people straight back into acute services and supported housing – a vicious cycle

e) Increase workforce capacity to develop and sustain relationships, and networks

- Maturity of relationships between councils and the NHS isn't the same everywhere
- Workforce retention and recruitment; we need people to feel held, and valued
- Lack of knowledge/capacity to begin working across boroughs to develop plans
- Difficult to be proactive in meeting needs

f) Explore options for people in later life and those needing long-term support i.e., will not move-on

- We need additional capacity to review/understand
    - What people need and want, if not moving on is not the best option for them
    - If remaining in current accommodation, does the service need to change, for example if it is under-utilised?
    - Impact elsewhere in the system if there isn't move-on e.g., less availability for new people discharged from hospital
- High representation of people over 55 in accommodation, requiring long-term support
    - Pressure to move-on when people are happy & living their best lives
    - Targets around move-on and flow are not helpful – why are we so insistent about this?
    - What is the role of extra care? No move-on expected from this model

2) What's the role of the GLA's capital funding programmes in reaching solutions?

a) Communicate the GLA capital funding programme offer more clearly, proactively, regularly

- Need to bust myths e.g., funding can be used for refurb, adaptation
- Clarity about who can access the funding, in which circumstances and how much grant could be available
- Need to be creative, for example invite support and registered providers and councils etc, to go through GLA guidance in more detail

b) GLA funding offer needs recognise diversity in, and changes to, the housing provider market

- Current GLA funding is understood to be for larger registered providers but there are few remaining in the market. What is the strategy to fill the gap, particularly as becoming an RP is an onerous process?
- Different experiences of accessing capital – RPs are more tied to rent standards so those conditions are not so different, where affordability and rents is more of a barrier for LBs
- Quality of some existing schemes is an issue
    - GLA role to engage more with RPs to understand quality issues
    - Could be potential for GLA £ to maintain existing capacity (not currently in scope)
- It needs to be clearer if funding is available to newer/ smaller non-registered providers: more likely to meet diverse needs and ambition for SSH and move-on to offer more community-wise
- Those who can take advantage of the capital funding programmes don't have the asset base to start with

c) Use capital funding programmes to invest in solutions that support the workforce

- Staff retention and recruitment challenges in health, care and supported housing workforces

- Can GLA capital grant programmes support specific (supported housing) keyworker programmes?
- Design in staff space in supported housing so they are safe and healthy environments - a good place to work as well as live

d) Recognise different revenue solutions

- Existing services delivered in new supported housing could be considered as revenue funding
- Are there savings to be made from spot purchasing/decant to cover revenue?

3) Governance: what needs to exist to further develop the market?

a) Understand role and impact of existing governance and regulation on the market

- Registered Providers leaving the market owing to burden of governance/regulation e.g., Regulator for Social Housing (RSH), the Care Quality Commission etc.
- RSH – what is their role in oversight of RPs & their existing SSH?
    - Quality
    - View of the tenants & support providers who are delivering support in this provision
    - Referring agencies: experience of RPs meeting needs of those being referred
- The GLA's grant conditions are onerous in current context

b) *Explore scope for sub-regional/regional governance, in context of available capacity in councils*

- The ambition for a 'bottom-up' approach needs to be tempered with available capacity in system
- Local authority <should> know their local population across adult social care, health, housing.
    - Working with neighbourhoods, role of the VCS and coproduction
    - Local capacity to commission across services is a challenge given pressures
    - Cabinet reporting at councils is a time-consuming process and acts a barrier.
- Subregional e.g., Integrated Care Systems
    - S117 efficiencies
    - Providers work across and people live across LA boundaries
    - Capacity to get local LAs to work together, to develop joint bids
- Regional role
    - Developing and sustaining networks and relationships
        - Maintaining database of LAs, NHS, providers (who's who?)
        - More structure for ongoing ideas and relationships
    - Building on IBA work to improve needs data capture, analysis, communication
        - Housing Needs Assessment on hospital admission
        - Housing workforce in health pathways
    - Value for money
        - Identify, research, share positive practice
        - Generate/enable access to evidence of what works

        - Calculator to support economic business case and social return on investment, making the case to funders
    - Devolved power to Mayor (e.g., Manchester)

Post-event feedback
Twenty-six people provided feedback, indicating that, having attended the event, they felt more confident in knowing:

Source: Mentimeter survey

Twenty-two people provided additional, open, comments. The following are reflective of these:

'Well-attended and good structure. Really interesting and much-needed work. Data and analytics to drive decision-making'

'The event was invaluable in getting the right people in the room all speaking to one another. Attempting to have these conversations outside this space can be impossible!'

'I found the event very empowering. I learnt that I was not alone in struggling to make sense of this work and was given information and connections to help think creatively to move forward.'

'It was a good opportunity to meet people across the sector and listen to different perspectives – I'm looking forward to the final report'

'Would welcome ongoing opportunities to work across London and sectors on this.'

'We could do with more meetings like this!'

Appendix 5: Estimating the type of MH SSH needed for the identified 'inflow' pathways: an illustrative case study

In the following table, we make tentative proposals about the estimated proportions of the different types of MH SSH which might ideally be needed for cohorts identified in our model to inform a high-level estimate of what the ideal balance between these models might be.

Cohort	Assumption of Type of MH SSH needed
'Stocks' within the model (groups in need of MH SSH at the start of the base year)	
Those 'misplaced' in generic supported accommodation	We assume that about 50% of this need could be met by wrapping specialist support around existing accommodation units; 10% by a Housing First offer, with 20% in Transitional Rehabilitation and 20% in Building Independence models.
'Flows' – those with newly arising needs	
Loss of settled housing	This cohort has not come via an inpatient setting, so we are assuming that most will need a lower support model, but 10% might need a crisis/ step-up model to prevent admission, with 50% Building Independence; 40% Longer term monitoring
Exiting long-term homelessness/ rough sleeping	We have assumed 60% need a longer-term intervention, e.g. Housing First (which has a strong evidence base for people with mental health issues[36]); we have assumed 20% transitional rehabilitation and 20% would benefit from a hostel setting with access to specialist mental health support.
Discharge from inpatient settings	We are proposing that 70% would need Transitional Rehabilitation; 30% the longer-term Complex Care model
Prison release/ forensic step-down	We have assumed a mix of models will be needed, depending on risks, 30% Transitional Rehabilitation; 30% Building Independence; 10% Complex Care; 30% Longer-term monitoring
Diverting from acute	100% Crisis (alternative to inpatient)
Stepdown from residential care homes	Recognising that people will enter residential care for a wide range of reasons, we have assumed 25% for each of Transitional Rehabilitation, Complex Care, Building Independence and Monitoring to Live Well.

[36] Loubière S, Lemoine C, Boucekine M, Boyer L, Girard V, Tinland A, Auquier P; French Housing First Study Group. Housing First for homeless people with severe mental illness: extended 4-year follow-up and analysis of recovery and housing stability from the randomized *Un Chez Soi d'Abord* trial. Epidemiol Psychiatr Sci. 2022 Feb 7;31:e14. doi: 10.1017/S2045796022000026. PMID: 35125129; PMCID: PMC8851060

We have applied the above estimates to the base year estimates in the table below for newly arising and misplaced need only (i.e. they do not attempt to estimate the current breakdown of provision by model, given the methodological challenges of this highlighted previously from the mapping activity).

Estimated newly arising/ misplaced need for different models by ICB in the base year (2024/5)

London ICBs	Crisis	Transitional Rehab	Building Independence	Complex care	Monitoring in community	Housing First	Specialist input in generic	Total
North West	84	425	120	137	49	150	209	1174
North Central	59	262	97	87	45	65	130	744
North East	94	375	116	122	52	125	180	1064
South East	66	305	106	105	60	87	119	849
South West	53	293	63	112	34	29	73	657
London	357	1659	502	563	241	456	711	4489

The breakdowns for the base year shown in the table above include what is effectively a 'backlog' of people from the homelessness sector, who have been long-term rough sleepers and/or have arguably been misplaced in generic homelessness accommodation. These estimates should be useful in informing parallel exercises within the GLA to model the need for Housing First and similar models.

For comparison, we also ran the same exercise with a later year, Year 3 (2027/8), when the need from the homelessness pathway is much reduced, based on those of the original cohort who needed a 5-year (on average) intervention and newly arising need.

Estimated newly arising/ misplaced need for different models by ICB in the third year of the scenario (2027/8)

London ICBs	Crisis	Transitional Rehab	Building Independence	Complex care	Monitoring in community	Housing First	Specialist input in generic	Total
North West	90	369	74	145	52	47	58	835
North Central	63	234	66	94	49	21	36	562
North East	101	329	77	130	56	38	50	781
South East	71	278	82	112	64	28	34	669
South West	57	288	46	120	36	8	20	575

London ICBs	Crisis	Transitional Rehab	Building Independence	Complex care	Monitoring in community	Housing First	Specialist input in generic	Total
London	382	1498	344	601	257	142	198	3423

- The need for transitional rehabilitation, primarily to enable stepdown from inpatient settings, consistently shows as the greatest need, which seems to reflect the feedback from our qualitative engagement.
- However, we know there is a huge amount of movement between MH SSH settings, and we have not attempted to take account of this. Since the estimates above are based on first service required, they probably underestimate demand for stepdown from transitional models to longer term models on the right-hand side of the typology, especially the 'monitoring to live well in the community and prevent crisis' model.
- There is also likely to be an overlap in practice between models which fit this longer-term lower support MH SSH category and the need for 'move-on housing with some support' which we explore in Section 4.3.

Appendix 6: Snapshot survey information

In an attempt to generate evidence for our assumptions about the proportion of people in different settings/ pathways needing different types of MH SSH intervention, we developed the following questions/ response options, alongside asking for basic information about gender, age group and ethnicity, and asked operational staff – both those making and reviewing placements - to complete these online for a random sample of their caseloads.

In the time available, this generated 85 responses, which allowed us to pilot the approach and provided some interesting insights, but not a sufficient sample size to provide reliable assumptions. Nevertheless, we feel there is merit in this approach and that these questions could form the basis of a more systematic audit, alongside more open questions about individuals' preferences and priorities to inform modelling, strategic and person-centred planning.

For those coming through identified 'flows' within our model, i.e., and not (yet) placed in MH SSH:

1. Which of the following best describes their current housing situation? [Which pathway ['in-flow' route within our model]
   - Currently adequately housed or with appropriate accommodation to return to
   - Currently housed in independent accommodation but at severe and imminent risk of homelessness
   - Currently housed in supported housing but at risk of eviction or in need of moving for other reason
   - Currently in mental health inpatient setting but awaiting accommodation in order to be discharged
   - Currently in prison and due for release without stable accommodation to return to or recently released and now homeless
   - Currently homeless and living in some form of temporary accommodation
   - Currently rough sleeping or has been rough sleeping on and off for some time

2. What do you think would be the best solution for their current housing problem? [Whether/ which MH SSH intervention needed]
   - Action to enable them to retain their current accommodation
   - A move to short term / transitional supported housing
   - A move to longer-term supported housing
   - A move to a care home or other health/care facility
   - A return to their family or live with partner
   - A move into independent accommodation, with additional support when needed
   - A move into independent accommodation, with no support required
   - Housing First provision
   - No obvious solution or individual not interested in finding a solution

3. If you are considering or have made a referral to supported housing, then what are the reasons that you think this is/was appropriate? [Rationale for intervention required]

- Not appropriate because this is not the right option for the person
- Their mental health is such that they need an environment where it is possible to monitor their wellbeing and respond quickly if there are any signs of deterioration
- It is felt that they would benefit from the mutual support of other people living in supported housing
- They are ready to move from an intensive care or institutional setting but need a safe secure and highly supervised environment to minimise any risk of harm
- Their mental health has deteriorated to the point that they require acute care but would benefit from this being provided in a non-clinical setting.
- They have begun to respond to treatment and are on the path to recovery but lack the skills or confidence to live independently at the moment
- They need immediate housing while they work through their longer-term housing options.
- There is little alternative or choice to a supported housing placement at the moment

4. If they need a supporting housing placement, which of the following types of support do you think they need from the placement? [Aspects of support needed]
   Please select all relevant options from the below.
   - Regular but minimal contact with staff
   - High levels of supervision
   - Electronic monitoring and capacity to call for assistance when needed
   - Careful control of access to property
   - Staff to take responsibility for aspects of daily living e.g. providing meals,
   - Active support plans to address the need for the development of independence skills
   - Co-ordination / advocacy in relation to other services
   - Access to therapeutic or training programmes
   - Staff that are experienced / trained in relation to supporting people with a mental health condition
   - Ready access to clinical advice and support in relation to mental health
   - Access to a range of on-site services to maintain health and wellbeing
   - Not applicable

5. If a supported housing placement is needed, how long do you think this is likely to be for? [Duration]
   - Not applicable
   - Transitional - i.e. a stepping stone to independent living eventually
   - Longer Term - i.e. with no assumption about moving to independent living

6. In which ways do they need assistance to live more independently? [Level of assistance needed, based on how many of the following areas of assistance needed]
   Please select all relevant options from the below.
   - Assistance to develop the independence skills required to sustain independent housing
   - Assistance to manage their finances more effectively
   - Assistance to improve family and other personal/ supportive social relationships

- Assistance to overcome social isolation and lack of confidence in order to enhance the capacity to achieve personal goals
- Assistance to access appropriate health and/or social care services or enhance their capacity to manage their health
- Assistance to manage substance use more effectively
- Assistance to access or sustain employment, education or training
- Assistance to convince landlords that they would make good tenants

7. Do any of the following apply? Please select all relevant options from the list below. [Co-occurring conditions]
   - Long term experience of / or repeated incidence of homelessness
   - Current or recent history of abusing alcohol or drugs
   - Experience of domestic abuse
   - Significant record of criminal convictions
   - Learning disabilities
   - Autism
   - Other impairment/ disability or long term health condition

For those currently living in MH SSH:

1. Which of the following best describes their housing situation immediately before they moved into their current accommodation?
   - At home with parents, foster parents or other family members on a long-term basis
   - In settled accommodation of their own as householder in owner-occupied property or as tenant in rented accommodation
   - Living in night shelter, / hostel for people experiencing homelessness or some other form of emergency accommodation or rough sleeping
   - Living in other supported housing or a refuge or domestic abuse service
   - Sofa surfing with friends or In some other form of temporary accommodation family
   - In prison
   - In mental health inpatient setting
   - In general /acute hospital or some other form of medical facility
   - Resident in registered care or nursing home
   - Other
   - Not known

2. What do you think is the reason as to why they most needed supported housing at this point?
   - Their mental health was such that they needed an environment where it was possible to monitor their wellbeing and respond quickly if there were any signs of deterioration
   - It was felt that they would benefit from the mutual support of other people living in supported housing
   - They were ready to move from an intensive care or institutional setting but needed a safe secure and highly supervised environment to minimise any risk of harm

- Their mental health had deteriorated to the point that they required acute care but would benefit from this being provided in a non-clinical setting.
- They have begun to respond to treatment and were on the path to recovery but lacked the skills or confidence to live independently at that time
- They needed immediate housing while they worked through their longer-term housing options.
- There was little alternative or choice to a supported housing placement

3. In which ways do they currently need assistance to live more independently? Please select all the relevant options below
   - Assistance to develop the independence skills required to sustain independent housing
   - Assistance to manage their finances more effectively
   - Assistance to improve family and other personal/ supportive social relationships
   - Assistance to overcome social isolation and lack of confidence in order to enhance the capacity to achieve personal goals
   - Assistance to access appropriate health and/or social care services or enhance their capacity to manage their health
   - Assistance to manage substance use more effectively
   - Assistance to access or sustain employment, education or training
   - Assistance to convince landlords that they would make good tenants

4. Do any of the following apply? Please select all relevant options from the below.
   - Long term experience of / or repeated incidence of homelessness
   - Current or recent history of abusing alcohol or drugs
   - Experience of domestic abuse
   - Significant record of criminal convictions
   - Learning disabilities
   - Autism
   - Other inhibiting disability or long term health condition

5. Which of the following types of support do you think they need from their supported housing placement? Please select all relevant options from the below.
   - Regular but minimal contact with staff
   - High levels of supervision
   - Electronic monitoring and capacity to call for assistance when needed
   - Careful control of access to property
   - Staff to take responsibility for aspects of daily living e.g. providing meals,
   - Active support plans to address the need for the development of independence skills
   - Co-ordination / advocacy in relation to other services
   - Access to therapeutic or training programmes
   - Staff that are experienced / trained in relation to supporting people with a mental health condition
   - Ready access to clinical advice and support in relation to mental health
   - Access to a range of on-site services to maintain health and wellbeing

6. Would you say that they are ready to move on or move out from their current accommodation?
   - No - because they need their current supported housing on a long-term basis
   - No - because they are not ready yet to live in any alternative situation
   - Yes - because they are able to live in more independent accommodation but will need on ongoing support when they move
   - Yes - because they are able to live in more independent accommodation without necessarily any ongoing support when they leave
   - Yes - because they need a higher level of support or greater access to care

7. Is there some other way in which you think the current placement is not appropriate? Please tell us about this below.

Appendix 7: Proposed typology: detailed version

Working title	Descriptor	Duration	Rationale	Target Group	Support Model
Community living with monitoring	Longer Term Lower Support	Longer Term	Facilitating easy monitoring of health and wellbeing with a view to proactively responding should there be signs of deterioration	**Community**: Those needing ongoing support to live well in the community (without any anticipation of significant change)	Frequent contact, perhaps backed up by electronic monitoring, linked to ability to escalate assistance quickly Emphasis on management of medication Non-clinical staff skilled up and/or clear referral routes
Complex care	Long Term High Support	Longer Term	Providing a safe, and highly supervised environment that minimises the risk of harm	**Complex Care**: Those requiring alternative to longer-term in-patient care/ longer term model of transitional higher support rehabilitation MH SSH	High levels of supervision. Staff take responsibility for daily living tasks Inbuilt access to clinical expertise
Transitional rehabilitation	Transitional High Support	Transitional	Providing a safe, and highly supervised environment that minimises the risk of harm	**Rehabilitation**: People who have (or have begun) to respond to treatment and need active intervention to assist ongoing recovery	High levels of supervision. Staff take responsibility for daily living tasks Professionally qualified staff
Building independence	Transitional Lower Support	Transitional	Promotion of recovery from mental health episodes/ trauma; development of skills and confidence to manage in more independent setting	**Rehabilitation** – people who have (or have begun) to respond to treatment and need active intervention to assist ongoing recovery	Focus on individual support plans Therapeutic programmes
Crisis housing	Alternative to in-patient care	Transitional	Providing a safe and highly supervised environment that minimises the risk of harm	Acute Care – those requiring alternative to in-patient care due to crisis– instead of hospital	High levels of supervision. Staff take responsibility for daily living tasks Inbuilt access to clinical expertise