Housing with support strategy

Chapter 3 – People with mental health issues

What needs do people with mental health issues have in terms of accommodation?

People with mental health issues need a range of different support: to manage and maintain their tenancies; to find, gain and maintain meaningful employment; to maintain relationships; to look after their own needs such as eating and exercising. For some people these support needs will be for a short period for others the condition is ongoing and their needs are therefore long term. The kind of difficulties they have can also fluctuate so that someone with long term needs will not need a continuous level of care – sometimes they will need intense intervention and at others they will need low level support. The very dynamic, changeable nature of the needs means that this group is particularly difficult to plan for. Snap shots of current needs can show considerable variation in the number of people receiving support from one month to the next.

People with mental health issues can have difficulties finding appropriate accommodation and are overrepresented in our homeless population:

“It is a fundamental fact that single homeless people are much more likely to have mental health issues compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common.”

One reason for this might be that this cohort of people can have difficulty maintaining a tenancy as their health fluctuates and often have joint diagnoses with other problems such as drug or alcohol dependency. Even where this is not the case there can be a reluctance on the part of housing providers to offer accommodation who might have perceptions that there might be rent arrears and/or damage to property.

It is not uncommon for individuals to be suffering from concurrent substance misuse and mental health problems (i.e. dual diagnosis):

- 75% of drug service users and 85% of alcohol service users experienced a mental health problem.

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1 Mental Health Foundation 10 Dec 2016
2 Weaver et al, 2002
• A person with substance misuse problems is 3 to 6 times more likely to have a mental health problem.\(^3\)

• "Dual diagnosis (…) affects a third of mental health service users, half of substance misuse service users\(^2\) and 70 per cent of prisoners".\(^4\)

In North Somerset an audit of services users accessing structured treatment for drug use in June 2014 revealed that 52.6% had concurrent mental health problems and 5.7% were engaged with the community mental health team. 25% of individuals accessing structured treatment with Addaction (a voluntary sector service providing treatment and support to those people who are affected by alcohol or drugs) reported that they either have no fixed abode (NFA) or a housing problem.

**How much housing with support is needed for people with mental health issues?**

Quantifying the amount of housing with support that is needed for people with mental health issues is complicated by the fact that support needs can fluctuate. Attaching different levels of support to accommodation (see appendix 2 for a description of housing with support available) supposes that a person’s mental health journey is linear and that they are thus able to progress through a scale of services designed to increase independence. In actual fact people can experience cycles of mental health need and might not be ready for a reduction of support at the point that a move is required to release the place for others.

• In 2015-16 1947 people were referred to Community MH teams for help due to a diagnosed mental health issue.

• In the same year adult social care reported 323 people in receipt of services for a primary reason of “mental health”. Of these people 54% were aged 65 and over which left 150 adults under 65 receiving services for mental health issues.

• Of all referrals to the community mental health teams with a primary reason of MH 47 were homeless, sofa surfing, staying with family as a temporary guest or staying in a night shelter. Of these individuals 30 were male and 17 female.

• Between 1 April 2015 and 31 March 2016 North Somerset Housing advice team worked with 113 people formally identified as homeless. 27 of these people (24%) had a mental health need and 19 of these were single and with a mental health need. Some of these individuals will have come into contact or be involved with the CMHT but figures could also include those for whom there is no CMHT involvement.

• In 2039 it is predicted that there will be 6% more people in North Somerset with a diagnosed mental health issue which would equate to 2064 referrals and 434 people in receipt of services of which 161 would be under 65.

• That means that 161 people with MH issues aged 18-64 will need services (11 more than 2015) and 273 people with MH issues aged over 65 will need services (100 more than 2015). It should be noted that the large increase in this latter cohort reflects the increase in numbers of older people and the

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\(^3\) DA Regier - 1990

increasing prevalence of dementia.

- North Somerset have placed 30 people in residential or nursing homes for whom MH is the primary need in 2016/17. Half of these are under 65.
- 5 people with a mental health difficulty were placed out of county in the year 2015-16 and another 5 people were placed out of county in 2016-17.
- There are 35 supported accommodation places in NS, these are usually fully occupied with voids rarely occurring.
- Figures from 2015/16 showed that 40% of the 429 current clients in the generic floating support service had Mental Health as the primary reason for involvement.

How is accommodation with support funded?

Development costs
There has been generally less investment in the supported living model for this group and it has been felt that there is a gap in the market for long term supported accommodation for people with MH issues. There does not seem to be a sustainable business model for providing accommodation for people with mental health issues unless you are providing the support as well and are guaranteed a certain level of funding from the commissioners. General needs housing is often privately resourced and always oversubscribed so there is no incentives for providers to offer it to people with specific needs. There is a question as to whether accommodation with support is required or whether more available accommodation and a flexible support service that can provide wrap around care at home when required would be more effective. Such a service is not yet in place locally and a thorough analysis of costs and benefit has yet to be undertaken.

Accommodation costs
Many users of MH services are reliant on housing benefit to access accommodation. Supported accommodation is currently able to charge a higher rent to meet some of the additional requirements of the property. Tenants can claim a higher level of housing benefit to meet this cost. This system is changing however and the government propose to cap housing allowance at a standard level. In future funding for housing support will be given to the council who will allocate it on an individual basis according to support needs. This might not alter things for individuals who will continue to have their support needs met but it will mean there is a finite amount of money with which to do so. The effect of this change might be a further reduction in appetite from the housing market to develop supported housing as they will not have a business model based on certain funding.

In addition the Local Housing Allowance limits the amount of housing benefit which tenants in the private sector can claim to help pay their rent. The extension of this cap in October 2016 to limit housing benefit to a “shared accommodation rate” for tenants under 35 with no children. This further limit will be likely to have an impact that further impedes the provision of accommodation to those in need as many landlords will re-consider who they are letting to in order to assure a sustainable rent.

Care and support costs
Nationally only 3% of gross current expenditure on long term care support settings is
spent on supported accommodation with £1.17billion being spent on mental health support last year.\(^5\)

Locally the annual spend on MH services by the council is £6.5m. Just over £5m of this is spent on residential or nursing care, just over £0.5m is on supported living. The average weekly cost to the authority for a person with MH issues for supported living is £254 whereas the average weekly cost of a residential place is £662 and a hospital bed for people with MH issues averages at £400 a day. The levels of need met by these different provisions are not the same and therefore not directly comparable but it can still be seen that a relatively small amount is spent supporting people to remain in the community. If hospital and high cost placements can be avoided by increased community provision some resources might be redirected to achieve efficiency of spend.

The needs of this group are met by health and social care and there is therefore a complication with regards to savings being made. For instance if more supported living (a service predominantly funded by the LA) results in less hospital admission the health authority might reap savings but if these are not reinvested into supported living it is unlikely that the LA can sustain an increased level of service with no additional resource.

**What can be learned from good practice in this area?**

A recent paper\(^6\) from the PRSSU (Personal Social Services Research Unit, London School of Economics and Political Science) published by Housing and Health identifies several points along the existing care pathway where there are opportunities for housing based provision to contribute savings to current expenditure on mental health care. The paper proposes that a significant reduction in in-patient and institutional care could free up funding that, if reinvested in supporting people in the community could lead to more independent and less costly outcomes.

**Housing First:**

“Housing First is an evidence-based approach to successfully supporting homeless people with high needs and histories of entrenched or repeat homelessness to live in their own homes. It has been widely adopted across the US, is central to the national homelessness strategies in Canada, Denmark, Finland and France, and is growing in popularity in countries including Italy, Sweden, Spain and, increasingly, the UK. Successful Housing First pilots are operating in Newcastle, London, the Midlands, Greater Manchester, on the South Coast and in Wales and Scotland. The overall philosophy of Housing First is to provide a stable, independent home and intensive personalised support and case management to homeless people with multiple and complex needs. Housing is seen as a human right by Housing First services. There are no conditions around ‘housing readiness’ before providing someone with a home; rather, secure housing is viewed as a stable platform from which other issues can be addressed.”

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\(^5\) NHS Digital, Personal social services: expenditure and unit costs 2016

\(^6\) Potential economic benefits of improved transitions along the acute care pathway to support recovery for people with mental health needs September 2016
can be addressed. Housing First is a different model because it provides housing ‘first’, as a matter of right, rather than ‘last’ or as a reward.”

Shelter recognised the value of this approach in 2008:

This approach has many merits in addressing some of the difficulties we experience in NS, particularly with regard to dual diagnosis and chaotic lifestyles. The model is of a flexible support service built around the individual wherever they are living. The support is more intensive than conventional floating support with support workers having much smaller caseloads (5-7 people as opposed to 20-40) and crucially accommodation is offered as a right.

“There is evidence that Housing First provides strong and consistent outcomes for tenancy sustainment. Outcomes in relation to mental and physical health, substance misuse and social integration are more mixed but are generally positive (Johnsen and Teixeira, 2010).”

Whilst this model offers a clear alternative to the traditional “staircase” approach to support there does not yet seem to be empirical evidence of its cost effectiveness in the UK, although American evidence is that is it is:

“Finally, permanent supportive housing has been found to be cost efficient. Providing access to housing generally results in cost savings for communities because housed people are less likely to use emergency services, including hospitals, jails, and emergency shelter, than those who are homeless. One study found an average cost savings on emergency services of $31,545 per person housed in a Housing First program over the course of two years. Another study showed that a Housing First program could cost up to $23,000 less per consumer per year than a shelter program.”

The reasons that UK evidence is scarce might include the fact that the approach is a long term one and projects facing difficulties in financial stability are not always long lived. A successful scheme would require long term investment as it is resource intensive and might not report results for some years.

Floating Support provided through supporting people funding was reviewed in 2008 by Communities and Local Government. The review concluded that floating support is effective in a number of ways:

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8 http://england.shelter.org.uk/__data/assets/pdf_file/0008/145853/GP_Briefing_Housing_First.pdf
9 ‘Housing First’ or ‘Housing Led’? The current picture of Housing First in England June 2015 Homeless Link Policy and Research Team
“Floating support services can help achieve strategic targets such as the prevention of homelessness, support service users to maintain independent accommodation, achieve health and social care outcomes such as reducing hospital admissions, improve wider community outcomes such as preventing anti-social behaviour and underpin a number of user centred outcomes such as improving self-esteem.”

However, there are also limitations to the model:
“There are some individuals for whom floating support services can do very little either because their problems are so overwhelming or because they disengage from the service – in these circumstances an accommodation based service may be more effective. Where floating support services are withdrawn too early tenancy breakdown can sometimes result, while long term support can result in creating dependency. Where service users require a period of stability before moving into their own independent accommodation, an accommodation based service is more appropriate.”

The same review gave some guidance about accommodation based services:

“The review has concluded that accommodation based services are effective in providing a place where an individual can be assessed, cost effective high support services, stability for individuals before moving onto independent housing and easy access to housing for homeless people (i.e. into the accommodation based service), particularly for those without any local connection … There continues to be a role for accommodation based services, particularly those that provide a high level of support, specialist services and support to people who are homeless.”

Clearly there is a balance to be achieved between floating support and accommodation based services but it should be acknowledged that the review was conducted prior to the advent of the “Housing First” model and therefore may have reached different conclusions had it been in place.

With regard to the availability of rented accommodation “Homeless link” suggest we need to improve the quality and security of tenure in the private rented sector by:

- Implementing measures in the Housing and Planning Act 2016 to remove rogue landlords or agents from operating
- Encouraging longer-term tenancies in private rental homes delivered by housing associations and institutional investors.¹²

Crisis House
In May 2017 North Somerset CCG was awarded a grant by the Department of Health to develop a Mental Health Crisis House, as part of a programme of work to improve services for people in mental health crisis. The crisis house project formed

part of the Crisis Care Concordat, various models were considered and a model of a 4 bed unit where people of either gender could receive 24 hour support in a safe environment for a week or up to a fortnight was agreed. Unfortunately North Somerset CCG is unable to proceed with developing this service, due to an issue with the grant awarded. There remains both a need for and an aspiration to develop this service in the future and it is still seen as an important part of a mental health crisis pathway.

There is limited research into the use of assistive technology for people with mental health issues but the Nordic centre for welfare and social issues proposes that devices which support people with concentration and focus and equipment to calm and soothe can address some difficulties for some individuals and in some cases will reduce need for other services.¹³ Whilst it is apparent that assistive technology cannot treat acute mental health conditions in some cases it might prevent the development of more acute symptoms, for example if a “ball blanket” enables an individual to relax and get more sleep it could prevent the spiralling of anxiety that can occur with sleep deprivation.

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¹³ [http://www.sjukra.is/media/notendaleidbeiningar/assistive_technology.pdf](http://www.sjukra.is/media/notendaleidbeiningar/assistive_technology.pdf)
What is are strategic ambitions of North Somerset regarding housing with support for people with mental health issues?

This chapter has considered how housing with support can be beneficial for people with mental health issues, how much is required in North Somerset and what is needed to make it come about. It has also considered the different models of housing with support for people with mental health issues. The following table summarises the key issues and the strategic ambitions to resolve them.

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<thead>
<tr>
<th>Issue</th>
<th>Evidence</th>
<th>Ambition for future</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>1</td>
<td>Some individuals have dual or multiple diagnoses and have very complex needs and or chaotic lifestyles. It can be resource intensive for multiple agencies to meet the needs of these individuals.</td>
<td>Homelessness Strategy identifies that for the last six years people with mental health needs and most particularly those with complex needs or chaotic lifestyles, have represented one fifth of all priority need cases.</td>
<td>A reduction in the impact of people with complex needs and chaotic lifestyles on statutory services. It is noted however that the level of motivation of the individual can impact on the effectiveness of provision.</td>
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<td>2</td>
<td>There is a lack of short term high level support to facilitate people leaving accommodation such as hospital or residential care in becoming less dependent.</td>
<td>A recent development of a 5 bed unit in North of the county has been slow to fill.</td>
<td>There is sufficient provision to support people leaving hospital or residential care to prevent delays in discharge.</td>
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<td>3</td>
<td>There are a large number of hospital inpatients whose needs are not for medical treatment but a safe and nurturing environment.</td>
<td>Awaiting data</td>
<td>In future a crisis house will be available to enable people to manage a MH crisis in a safe environment whilst avoiding hospital admission.</td>
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<td>4</td>
<td>Savings can be made to health budgets by hospital avoidance. Local authority does not have budget to invest in preventative schemes without making savings.</td>
<td>Cost benefit analysis to be completed.</td>
<td>Investment in preventative solutions to reduce deterioration in mental health and avoid hospital admissions.</td>
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<td>5</td>
<td>People sometimes need immediate short term support in the event of a crisis, particularly at night.</td>
<td>Awaiting data</td>
<td>To give full consideration to the development of an out of hours crisis drop in centre.</td>
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<td>6</td>
<td>Whilst there is low level floating support in NS there is not a higher level or more intense floating support service that can support people in their own home over 24 hours to enable them to recover at home without losing their tenancy.</td>
<td>See appendix 3, market analysis.</td>
<td>Ensure that future provision of supported housing meets the needs identified including avoiding hospital admission and preventing homelessness. Consideration will be given to the use of assistive technology where appropriate.</td>
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<td>7</td>
<td>Changes to housing benefit and introduction of universal credit have an impact on appetite of housing providers to offer properties to this group.</td>
<td>Difficulty felt by health and SP services in sourcing move-on accommodation for people with mental health issues.</td>
<td>New funding models for development of housing with support will be considered including health investment if it will result in hospital avoidance.</td>
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<td>8</td>
<td>There is a lack of general accommodation that is suitable and can be accessed by people with MH issues. This has a knock on effect on other</td>
<td>Existing short term supported accommodation is full as demand for one bedroom accommodation outstrips supply. For</td>
<td>People with mental health issues can find suitable mainstream accommodation.</td>
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<td>resources such as inpatient facilities.</td>
<td>example for the last financial year there were 1096 clients registered on HomeChoice for one bedroom accommodation but only 117 lets.</td>
<td>Consider re-purposing some existing provision and prioritising this group for accommodation where possible.</td>
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