Housing Policy Discussion Series

4

Review of the Housing and Support Options for People with Mental Health Related Housing Needs

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Foreword

In June 2008, the Department of the Environment, Heritage and Local Government requested the Centre for Housing Research (now part of the Housing Agency) to undertake three studies of housing issues for people with a disability in the context of its commitment to develop a Housing Strategy for People with a Disability. These projects were:

- Review of good practice models in the provision of housing and related supports
- Review of the potential role of the private rented sector in the provision of accommodation for people with a disability
- Review of support options for people with mental health related housing needs.

This report is the review of support options for people with mental health and related housing needs. It is based on a review of literature, interviews with stakeholders and case study visits. All three reports are available on www.housing.ie.

I would like to thank those who contributed to the completion of this study, in particular: the authors, Sean Carroll and Noëlle Cotter; the Housing Strategy for People with a Disability National Advisory Group and its sub-committee, the Research Steering Group, for their help and support throughout this project. I would also like to thank those who provided information to the researchers or who gave of their time to be interviewed as part of the study. These sources of information provided particularly valuable insights.

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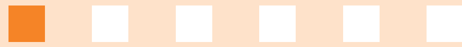
SECTION ONE



Introduction

The role of the Centre for Housing Research (now part of the Housing Agency) is to inform housing policy and practice and to improve the management of the social and affordable housing sectors through research, training and policy advice. It is a joint initiative between the Department of the Environment, Heritage and Local Government (DEHLG), local authorities and the voluntary and co-operative housing sector.

The Disability Act, 2005 stated that its purpose was to enable provision to be made for the assessment of health and education needs for people with disabilities with regard to their disability. On foot of the Act, six government departments, including the DEHLG, produced sectoral plans. These were published at around the same time as the Report of the Expert Group on Mental Health Policy (*A Vision for Change*, 2006).

In this context, as well as with regard to commitments made in *Towards 2016*, the DEHLG committed to the development of a National Housing Strategy for People with a Disability, to be prepared by end-2009. The DEHLG requested the Centre for Housing Research to undertake a programme of research to help inform the Strategy.[1]

1 Three research projects were identified: *Review of Good Practice Models in the Provision of Housing and Related Supports for People with a Disability, The Potential Role of the Private Rented Sector in the Provision of Accommodation for People with Disabilities, Review of the Housing and Support Options for People with Mental Health Related Housing Needs.*

This research programme was advised by a Research Steering Group, a sub-section of the National Advisory Group (NAG).[2]

The research programme was charged with considering accommodation and related support needs of people with mental health disabilities living in community settings. The Research Steering Group agreed the following terms of reference:

- Identify the specific accommodation-related support needs experienced by people with a mental illness living in community settings
- Identify good practice in responding to these needs
- Identify priorities related to mental health for the upcoming Housing Strategy for People with a Disability

The research focuses on community-based accommodation and related community-based supports. The report identifies these supports and suggests forms in which they can be provided as a means of supporting the individual's recovery plan. Due to the lack of Irish evidence-based empirical research regarding current practice in this area, it was not possible to identify definitive good practice models. Rather, through the available literature, interviews with stakeholders and case studies, it was possible to identify dimensions of what good practice might be.

A central consideration in the research was that the ability to live independently in the community is often seen as an indication of a successful recovery, although maintaining this status can be just as important.

2 This included representatives of the DEHLG, Mental Health Commission, Irish Council for Social Housing, Not for Profit Business Association, National Disability Authority, Private Residential Tenancies Board.

People with mental health disabilities require different types of supports depending on their circumstances or, for instance, at different stages in their lives. Consideration is also given to different types of supports. These can be practical supports – such as financial advice or advocacy – or personal and emotional supports. Examples of current practice in the area of supports provided by housing or community-based organisations throughout the country are documented and reviewed.

Two elements were found to be at the centre of successful support provision:

- the provision of clear information to people with a mental health disability, their advocates and associated support staff
- inter-agency co-operation.

1.1 Methods

The terms of reference for this report stated that the research would be undertaken by means of qualitative interviews with representatives of the following groups:

- People with mental health disabilities and groups representing their interests
- Carers
- Other service providers (e.g. voluntary, local authority or HSE)

As the research was exploratory in nature, interviews were conducted using an open interview guide covering three core themes: diversity of need, housing options and issues, and

supports required and in what form. Interviewees were selected based on consultations with members of the Research Advisory Group and other stakeholders. In total 30 interviews were undertaken. Interviewees included service users/tenants, local authority staff, HSE staff, advocates, service managers/outreach workers, psychiatrists, psychologists, occupational therapists and community nurses. A more detailed profile of these stakeholders is given in Section 4 below.

Based on the initial interviews, examples of current practice were selected using a snowballing technique to examine case studies. The resources available, including the relatively short time available to undertake fieldwork, the lack of previous empirical Irish research in this area and the lack of a comprehensive dataset from which to sample, led to the use of this method.
The limitation of this approach is that the findings cannot be considered as statistically representative.

The research does provide vignettes of current practice in this country in both urban and rural settings, and begins to address the gap in available documented information. This is a necessary step in moving towards a service more informed by best practice evidence.

A review of international practice did not fall within the originally agreed scope of this research. However, as part of the literature review some examples of practice in the UK and Australia were documented and considered of interest by the Research Steering Group; these are reported in Appendix 1. Such examples are intended to be illustrative only. A more detailed examination of international practice might prove a useful contribution to future debate in this area.

1.2 Report Outline

The report is structured as follows:

- Section 2 looks at the mental health, legislative, disability and housing policy context.
- Section 3 highlights the relevant literature and the recovery approach which underpins much of the contemporary mental health care practice.
- Section 4 outlines the important areas/themes identified from the perspective of the stakeholders interviewed over the course of the research.
- Section 5 highlights examples of practice identified by stakeholders in Ireland and outlines specific areas where operations are fulfilling their rehabilitative and therapeutic functions.
- Section 6 concludes the report and puts forward priorities for the National Housing Strategy for People with a Disability based on the findings emerging from the research.

SECTION TWO

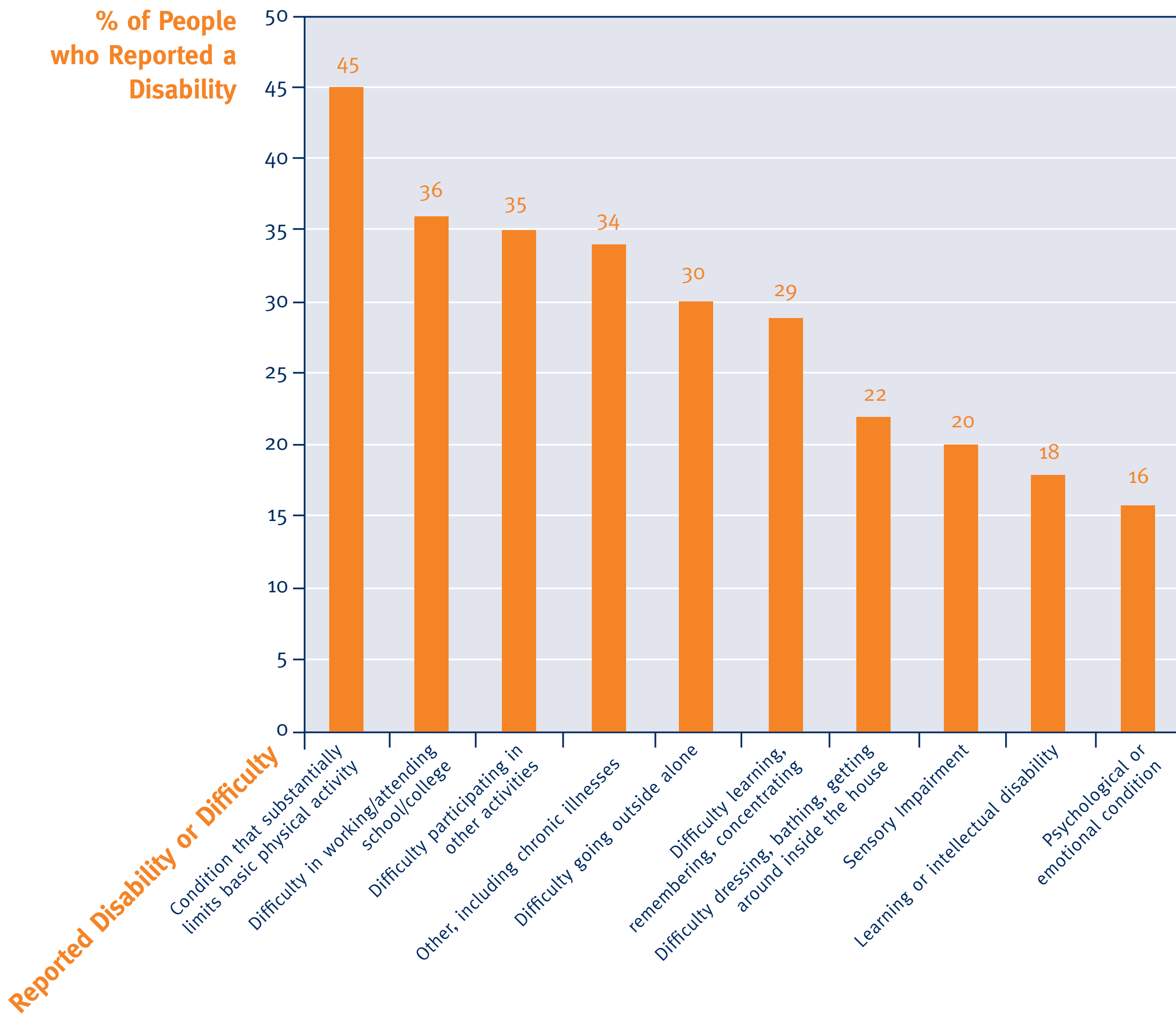
Policy Context

While everyone has mental health needs, there is a smaller section of the population with mental ill-health. Previous reports have acknowledged the difficulties in the validity of measurement of mental ill-health (see NESF, 2007). This can be attributed to the differences in diagnosis and the tendency of existing measures to focus on levels of illness rather than on well-being (ibid). It is also illustrative to acknowledge that the term mental illness is regarded as problematic, and the focus of recent policy has centred on replacing the notion of mental illness with mental health (DOHC, 2006).[3] This section will outline current practice and service provision in the context of the research aims covered in the previous section.

Exact figures on the number of individuals with mental health disabilities are difficult to collate. Figure 2.1 below shows that 16 per cent of those who reported a disability in the 2006 Census reported a psychological or emotional condition – that is approximately 65,000 people.

3 In the context of informing the forthcoming National Housing Strategy for People with Disabilities, this report refers to people having mental health disabilities, within the framework of the social model of disability.

Figure 2.1 Disability types reported in the 2006 Census expressed as a percentage of those who reported a disability



Base: Total Persons with Disabilities (393,785)
Source: Fennell et al, 2010 – from CSO, 2007

The 2006 Census states that of the population who reported psychological or emotional conditions 35,077 were single; this figure includes 3,456 people 0-14 years old, as well as 4,903 people 15-24 years old. There were 17,025 married people, 6,598 widowers and 6,255 people who were separated.

In the National Disability Survey (NDS) (2008), which included a broader range of disabilities but also introduced a threshold of severity,[4] a third (34 per cent) of respondents reported an emotional, psychological and mental health disability (110,600 persons). The NDS states that the percentage breakdown of its population with emotional, psychological and mental health disabilities is 53.3 per cent female and 46.7 per cent male. Among this same sample 89.5 per cent live in private households, and 10.5 per cent live in nursing homes, hospitals or children's homes. The following table shows the age breakdown for this sample – it can be seen that the largest cohort is 45-54 years old.

Table 2.1

Age profile of those with emotional, psychological and mental health difficulties

Age Group	0-17	18-34	35-44	45-54	55-64	65-74	75 & over
Emotional, psychological and mental health	9%	15.8%	16.5%	18.1%	17.3%	10.4%	13.1%

Source: National Disability Survey, 2008

There are currently no data on the number of people accessing outpatient psychiatric services and no specific national figures on those with mental illness who also have a housing need. In addition, very few services have ICT infrastructure and many are reliant on paper-based systems. This hampers information requirements and can cause difficulties when individuals have been discharged. Current population figures are drawn from:

4 For details regarding the sampling and associated methodological issues involved in the National Disability Survey see *First Results Report* (CSO, 2008:14).

- Self-reported surveys, the census and ad hoc research studies
- In-patient admissions and databases

Emotional, psychological and mental ill-health is listed as one of the nine disability types in the National Disability Survey 2006. A total of 110,600 persons (out of 325,800 respondents) reported such a disability. This accounted for 34 per cent of the overall population of people with a disability. Of this figure, 90 per cent of respondents – the highest usage of the nine categories – reported using at least one aid.[5]

There were 20,769 admissions to Irish psychiatric units and hospitals in 2007, a rate of 489.9 per 100,000 of the population. These figures have been steadily declining since they peaked in 1986 (HRB, 2008a). Admission to hospital is only a very small proportion of the need as approximately 90 per cent of mental health needs are addressed in primary care (with a GP) and 10 per cent are referred on to community-based specialist services. Of these, approximately 10 per cent will be admitted (11 per cent on a detained basis) – amounting to the annual admission rate (72 per cent of which are re-admissions). As a consequence, admission data are seen as too narrow to reflect the extent of need (source: HSE, personal correspondence).

There are currently 19 large psychiatric hospitals in Ireland. They all provide long-term care and 10 also provide acute care. There are currently 1,131 beds available nationally in long-stay wards. The age profile of the group has not been recorded but the occupants in older age groups may be more likely to be seeking to access nursing home rather than independent accommodation.

5 The list of aids on the survey report included: Support groups; Medical services; Social services; Occupational therapist; Counselling; Psychotherapist; Psychologist; Psychiatrist; Medication; Addiction Services; Exercise programmes or relaxation therapies and Physiotherapy.

A summary of the various available statistics on mental illness in Ireland pertaining to this study is contained in Box 2.1 below:

Box 2.1

Sources of data on mental illness

Source	Data	Description	Figure
Census 2006	Self-reported	Reported psychological or emotional condition	64,955 (16% of the population)
National Disability Survey 2006	Self-reported	Reported emotional, psychological, mental health disability	110,600 (34% of respondents)
Inpatient Census (HRB, 2006)	Inpatient psychiatric and hospitals census	Residents in private and public psychiatric units and hospitals	3,389 (106 per 100,000 of population)
Residents in Community Residential (Expert Group on Mental Health Policy, 2006)	Number and rate of community residences (2004)	Number of people in community residences as a proxy for number of places	3,065 people in community residencies in 2004 (78.2 per 100,000 of total population)
Residents in Community Residential Accommodation (MHC, 2008a)	High support community residences	Residents in 24-hour nurse-care community residential facilities	1,664 places
HRB Study 2006 (source HRB, 2008)	Self-reported mental health problems	Self-reported mental health problems in previous year	448,533 (13,999 per 100,000 of population)
HRB Study 2006 (source HRB, 2008)	Reported attendance at GP	Self-reported attendance at GP with mental health problems	320,881 (10,000 per 100,000 of population)
NPIRS 2007 (source HRB, 2008)	Admissions to psychiatric units and hospitals	Admissions to private and public psychiatric units and hospitals	20,769 (489.9 per 100,000 of population)
HIPE (2002-2003) (source HRB, 2008:51)	Discharges from general hospitals	Patients discharged with a principal psychiatric diagnosis	Approximately 2,213 per year (69 per 100,000 of population over age 18)

The HRB (2007) notes the lack of comprehensive community-based data on psychiatric morbidity in Ireland's general adult population. The World Health Organisation (WHO) estimates that there are 450 million people worldwide with mental health problems, and that mental health problems will increase from 12 per cent of the total burden of disease to 15 per cent by 2020. The WHO considers psychiatric disorders to be one of the leading causes of disease and disability (HRB, 2007). Although useful, these data (Box 2.1) are gathered using different methods and definitions and cannot be considered definitive.

With this caveat, and bearing in mind that the National Disability Survey, as a follow-on to the 2006 Census information, derived figures of population disability in-line with international figures, it can be noted that 36 per cent of people surveyed who stated they had emotional, psychological and mental health disabilities also stated that their disability caused a lot of difficulty or that they could not 'do at all' some everyday tasks. This equates to 39,816 people at the upper end of the severity scale. Forty per cent of people with a reported emotional, psychological and mental health disability stated that the cause was a disease or illness, with 18 per cent stating it was attributable to stress. Within the disease/illness category, 28 per cent of respondents recorded they had depression and 11 per cent had anxiety disorders.

The support needs of people with mental health disabilities vary significantly in accordance with their level of need. For those in community residential settings, three levels of support have been identified – high, medium and low support.

High-Support Residences – Accommodation in the community where nursing care is provided on a 24-hour basis with staff staying awake at night-time. There are 132 HSE 24-hour nurse-staffed residences in Ireland. Twenty-two residences are dedicated to people with an intellectual disability who are in receipt of care from mental health services and there is a total of 1,664 places provided (MHC, 2008:78). These residences provide alternative accommodation to institutional care and active rehabilitation.

Medium-Support Residences – Staffed 24-hours with staff sleeping at night-time.

Low-Support Residences – Not staffed. But on-call staff are available where necessary and can visit on a regular basis during the day (Source: HRB, 2007:30).

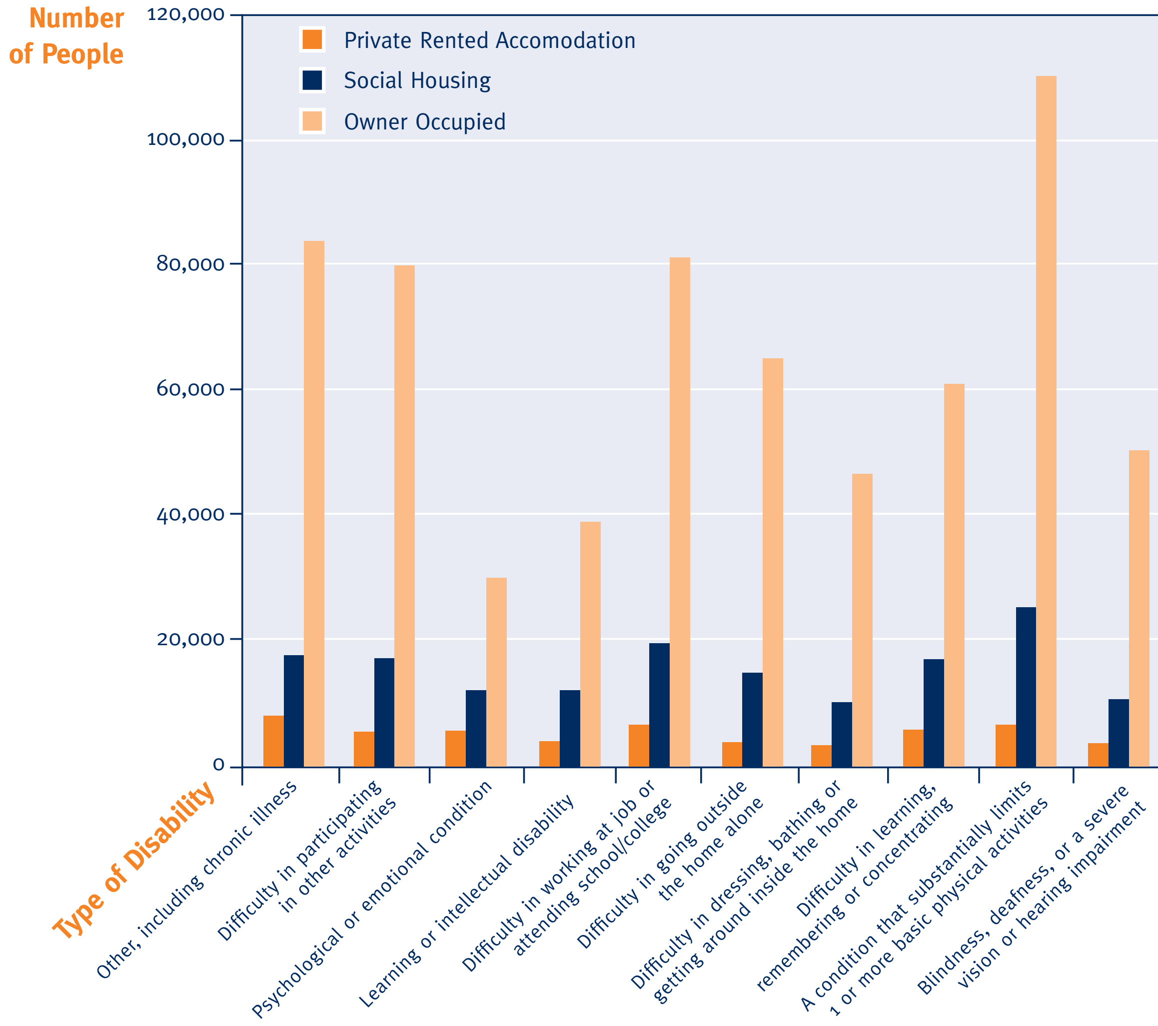
While we know that there has been a shift away from institutional to community-based care of people with mental health disabilities, there is little systematic information available on the housing situation, problems and preferences of this group and no existing European overview (Anderson and Wynne, 2004). Indeed many people with mental health disabilities are living independently in the community. From Census 2006 we know that most of those reporting psychological or emotional conditions are living in owner-occupied accommodation, as indicated in Figure 2.2 below[6] and mirroring the general trend as can be seen.

Policy changes, in line with good practice recommendations, have led to the provision of various forms of housing – with or without support – as well as efforts to maintain individuals in the family home. In the midst of these developments, the challenges faced by people with mental health disabilities settling into communities are often underpinned by lack of education and fear among the general public. A National Disability Authority public attitudes survey (Insight, 2007) revealed that the most negative attitudes related to people with mental health disabilities over other forms of disability with regard to educational, employment and neighbourhood proximity.

As a rule, experiences, needs and support requirements of people with mental health disabilities vary significantly depending on the severity of their condition, their family situation and the availability of services in their area (see HRB, 2006). In addition, various authors have argued for more choice and flexibility in housing provision for people with mental illness (see Watson and Tarpey, 1998; Watson et al, 2003), e.g. more development of self-contained flats and networks of flats or houses, reflecting the need for some forms of purpose-designed housing and also the need to access support services. This chapter will look at policy and research covering and related to the housing options available for mental health service users.

6 See also Cotter, Silke and Browne (2010) for further information. Here, the focus is on people in the category 'psychological or emotional condition'. However, it is recognised that people with mental health issues may be in other categories too.

Figure 2.2 Nature of occupancy for people with disabilities broken down by disability type, Census 2006



Source: Fennell et al, 2010

2.1 Legal Context

As stated, the mental health service in Ireland has changed considerably over the past 20 years but the majority of institutional and community-based accommodation costs are borne by the HSE. Health and public policy in relation to mental illness cannot be separated from its general legal framework. While the Mental Health Act 2001 deals predominantly with the issue of involuntary admissions, Section 28(4) states: *'Where a consultant psychiatrist discharges a patient under this section, he or she shall cause copies of the order made under subsection (1) and the notice referred to in subsection (3) to be given to the Commission and, where appropriate, the relevant health board and housing authority.'*

The aforementioned sub-sections refer to discharge orders which are generally issued to the individual or his/her legal representative in a form specified by the Mental Health Commission. The provision of such information to a relevant housing authority would provide some indication that ancillary housing supports – identified later in this report – may be required to successfully maintain a tenancy. It is important that this be done in a universal way.

Disability Act 2005
The Disability Act 2005 (Part 1 Section 2) interprets disability as:
'... a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment.'

In Part 2 Section 7 of this Act, 'substantial restriction' as stated above is further
... construed for the purposes of this Part as meaning a restriction which – (a) is permanent or likely to be permanent, results in a significant difficulty in communication, learning or mobility or in significantly disordered cognitive processes, and (b) gives rise to the need for services to be provided continually to the person whether or not a child or, if the person is a child, to the need for services to be provided early in life to ameliorate the disability.

Section 12 of the Disability Act 2005 provides for the exchange of information between the HSE and public bodies (including housing authorities) for the purpose of assisting a person with disabilities when applying for personal or individual services provided by the body. It requires that, where a public body has been notified of a possible need such as housing, someone from the body must contact the person with a disability to facilitate or co-ordinate the provision of any services to which he/she is considered to be entitled.

As has been already stated, the Act required six government departments to produce disability sectoral plans to make provision for people with disabilities with regard to their disability and to provide for appeal mechanisms where it is felt these needs are not met. Access to services and employment in the public sector were made priorities, as was the requirement for all public buildings to be accessible.

2.2 Mental Health Care Policy

Policy regarding care for the mentally ill encompasses a series of related areas, of which housing forms a crucial part. The policy framework has emphasised the need to move towards a system of community care since the *Report of the Commission of Enquiry on Mental Illness* in 1966. This shift was underpinned by the 1984 national policy document *Planning for the Future*, which proposed that four categories of person would be more suitably placed in community residential services run by Health Services:

- Persons living in psychiatric hospitals who have no homes of their own to go to but who, with adequate preparation and training, would be capable of living a reasonable life in the community
- Persons coming forward for psychiatric care with chronic psychiatric disability, who have inadequate, inappropriate or no homes and who would be capable of living with varying degrees of independence in accommodation in the community

- Persons with psychiatric problems whose treatment requires that they live apart from their family or normal associates for a while; such persons include disturbed teenagers who have family difficulties and patients in need of temporary accommodation due to any of a variety of social reasons
- The small group of new long-stay patients for whom high-support hostels will provide an alternative to long-stay hospital care.

Source: (DOHC, 1984:60)

The 1989 policy document *Shaping a Healthier Future* shifted policy further with the establishment of departments of psychiatry in general hospitals. While progress was made in pursuit of the provision of care in community settings the closure of all large psychiatric hospitals was not fully implemented (HRB, 2007).

2.3 A Vision for Change

A *Vision for Change* (Expert Group on Mental Health Policy, 2006)[7] contains over 160 recommendations and provides a framework for the restructuring of Mental Health Services over 7-10 years from its publication. The Report takes a holistic view of mental health that addresses the biological, psychological and social factors and focuses on a person-centred treatment approach based on best practice agreed with service users and their carers. It advocates a multidisciplinary approach to services and refers to the importance of community and social networks and the difficulties of stigma.

7 *A Vision for Change* covers mental health services across a variety of different areas including: general, mental health services for people with severe and enduring mental illness, services for older people, services for people with intellectual disability, forensic mental health services and mental health services for people with co-morbid severe mental illness and substance abuse problems.

The report recommended that housing for persons with or recovering from mental illness would be supplied by local authorities in standard social houses, as stipulated under the Housing Act 2002. A summary of the recommendations related to housing and supports and an overview of the proposed new HSE Mental Health structures is contained in Box 2.2 below:

Box 2.2

A Vision for Change Accommodation-related recommendations

- Access to employment, housing and education for individuals with mental health problems should be on the same basis as for every other citizen.
- The provision of social housing is the responsibility of the local authority. Mental health services should work in liaison with local authorities to ensure housing is provided for people with mental health problems who require it.
- Community and personal development initiatives which impact positively on mental health status should be supported, e.g. housing improvement schemes, local environment planning and the provision of local facilities.
- Arrangements should be evolved and agreed within each Community Mental Health Team (CMHT) for the provision of 24/7 multidisciplinary crisis intervention. Each catchment area should have the facility of a crisis house to offer temporary low-support accommodation if appropriate.
- Some 39 rehabilitation and recovery CMHTs should be established nationally, with assigned sector populations of 100,000. Assertive outreach teams providing community-based interventions should be the principal modality through which these teams work.
- Rehabilitation and recovery services should develop local connections through linking with local statutory and voluntary service providers, and support networks for people with a mental illness are required in order to support community integration.
- Opportunities for independent housing should be provided by appropriate authorities, with flexible tenancy agreements being drawn up in accordance with each service user's needs. Arrangements that best enable service users to move from high-support to low-support and independent accommodation need to be considered.
- Integration and co-ordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.

The report pointed out that health service resources had deviated as a consequence of the traditional practice of mental health services providing accommodation which is statutorily the responsibility of housing authorities. It recommended a restructure of HSE residential services for high-support patients which would reduce the requirement for high-support accommodation. In turn, local authorities would work in collaboration with mental health services to provide individualised, independent accommodation, with some support as required. The housing supplied by local housing authorities would be no different from those available to other clients housed by them.

An independent monitoring group was commissioned by the Government to report on the progress of the strategy. The third annual report of the independent monitoring committee (covering 2008) was published in April 2009, and while the committee noted that some progress had been made, disappointment was also recorded at the slow pace of implementation. The group emphasised the need for a detailed plan with targets, timeframes and resource commitments (*A Vision for Change* Monitoring Group, 2009).

2.4 Disability Policy Context

Mental ill-health falls under the heading of disability and is therefore included in the National Disability Strategy. This includes the Disability Act 2005, which seeks to ensure that by 2015 public bodies deliver integrated accessible services and assistance, purchase of accessible goods and services and accessible premises. To meet these commitments, Disability Sectoral Plans have been prepared by six Government Departments: Communications, Energy and Natural Resources; Enterprise, Trade and Employment; Health and Children; Social and Family Affairs; Transport; and Environment, Heritage and Local Government. These plans set out clear goals for the provision of mainstream services.

The plans are broad-ranging in scope and have principally impacted areas such as employment, services and carers (all of which are crucial components of the recovery approach discussed in the next chapter). The Department of the Environment, Heritage and Local Government, reflecting pledges in *Towards 2016*, have committed to developing a Housing Strategy for People with a Disability by the end of 2009. The DEHLG Sectoral Plan outlines specific commitments in relation to the development of inter-agency protocols.

The Housing Strategy for People with a Disability was originally recommended by the NESC in *Housing in Ireland: Performance and Policy* (2004). The strategy will be progressed by a national group under the aegis of the Housing Forum, a mechanism through which social partners input to housing policy development and implementation. The Housing Forum is chaired by the Minister of State with responsibility for Housing and Urban Renewal and Developing Areas.

2.5 Housing Policy Context

There is no policy document or statement that specifically addresses the housing needs of those with mental health disabilities. *Delivering Homes, Sustaining Communities* (2007) outlines a vision aimed at building sustainable communities. These are defined as 'safe and inclusive, well-planned, built and run, offer equality of opportunity and good services for all'. The framework advocates delivering accommodation choices for a wide range of households as a means of underpinning community participation. Both *Towards 2016* and *Delivering Homes, Sustaining Communities* recognise the important role played by the voluntary housing sector in meeting special need housing requirements and have committed to 3,000 new sites or individual units between 2007 and 2009.

To facilitate this, local authorities are required to make changes in the provision of housing support to tailor options for residents' respective needs. This is achieved through adopting a holistic perspective, as specified in *Towards 2016*, on people's needs as they move through the various phases of their life cycle – childhood, working age, older people including people with disabilities.[8]

The National Development Plan 2007-2013 committed €18 billion in social and affordable housing programmes. Each local authority highlights its specific requirements for special needs housing in the Housing Action Plans. The Housing Needs Assessment, which is conducted by each local authority every three years in accordance with the Housing Act 1988, has been updated to include broader categories of people with special needs. The results of the assessments feed into the authorities' Housing Action Plans. The 2008 assessment has a category for disability although mental health is not specifically measured and the type or levels of supports required are also not specified.[9]

Delivering Homes, Sustaining Communities advocates an inter-agency response to the care dimension of supports and highlights 'persons with mental health issues'[10] as a specific vulnerable group. The document reaffirms the core objectives of housing policy: to enable every household to have available an affordable dwelling of good quality, suitable to their needs, in a good environment and, as far as possible, at tenure of its choice. This is achieved, where possible, through equality of access. The document also refers to local authority waiting lists, in line with new needs assessments. The use of a segregated waiting list (according to priority of need) 'may be inevitable'.[11] Currently, local authorities operate a variety of allocation systems, the most common of which are 'merit-based' (on qualitative individual assessment); 'points-based' (household type and nature of need) and 'time on list'.

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8 *The National Action Plan for Social Inclusion 2007-2016* identifies people with disabilities in addition to the life cycle approach.

9 See Cotter, Silke and Browne (2010) for further details of the Housing Needs Assessment as it relates to people with disabilities.

10 2007:56.

11 2007:68.

The Housing (Miscellaneous Provisions) Act 2009 includes provision for the making of housing services' plans and new provisions on the assessment of social housing needs and updating housing authority management and control powers, including the adoption of anti-social behaviour strategies. It also broadens the choices available to those seeking social housing by providing a more developed legislative basis for the Rental Accommodation Scheme (RAS) and by expanding paths to home ownership through the new incremental purchase scheme. The Act does not specifically contain sections relating to the housing needs of people with disabilities.

2.6 Homelessness Policy

The Housing Needs Assessment 2008 states that there are 1,394 homeless households on local authority waiting lists. Of these, 187 are households with a child or children. Since 2000, over €620 million has been provided for day-to-day accommodation and care costs of homeless services (DEHLG, 2008). The Irish Council for Social Housing (ICSH)[12] estimates that there are 60 ICSH members providing housing-related services to homeless people nationwide. The provision of accommodation by voluntary housing associations has been underpinned by the Capital Assistance Scheme.

The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008-2013 (DEHLG, 2008) was prepared under the aegis of the Cross-Departmental Team on Homelessness with input from the National Homeless Consultative Committee. This strategy places considerable emphasis on the need to prevent homelessness and provides that as well as seeking to prevent homelessness among people being discharged from state care, measures will also be developed in each local area to identify households at risk of homelessness and to prevent them becoming homeless. The strategy recognises mental health disability as a risk factor in becoming homeless and refers to the fact that mental health and addiction problems have a higher prevalence in the homeless population than in the general population.

12 ICSH Submission to the Homeless Agency's Action Plan (2007-2010), 2006.

The Way Home sets out a series of actions that aim to reduce the risk of homelessness among patients being discharged from acute hospitals. This builds on the main theme of the *Homeless Preventative Strategy* (2002) which was to ensure that no one is released or discharged from state care without the appropriate measures in place to ensure they have a suitable place to live. Lack of co-ordination between hospital and community-based mental health services was reported by Pillinger (2007) as a factor contributing to homelessness.

The other main aim of the strategy is to provide for the elimination of long-term occupation of emergency accommodation and to provide long-term housing solutions. In the context of housing accommodation for homeless persons the strategy recognises that mainstream accommodation will not be an appropriate solution for some people and that housing accommodation with additional supports and in some cases nursing care will be necessary. It is envisaged that such accommodation will be provided as part of the strategy to address the housing needs of older people and people with a disability and will be funded and supported according to the developing policies in relation to those specific groups. People who are homeless may have disabilities and it is not always possible for them to live on their own. These disabilities may be mental health disabilities or physical, sensory or intellectual disabilities. Again, where appropriate, their needs for housing and support services may be addressed as part of mainstream housing provision, with responsibility for support services being taken by the local HSE. A range of supports is required in order that people who experience mental health disabilities can sustain tenancies, thereby reducing the risk of becoming homeless.

In the context of homeless people with a disability, including mental ill-health, the strategy references the development by the DEHLG of the National Housing Strategy for People with a Disability.

The aims of *The Way Home* have been further delineated in the *National Implementation Plan* (DEHLG, 2009), and a series of priority actions with supporting measures, timelines and key performance indicators has been developed. For instance, priority action 1.3 refers to the improvement of effectiveness of discharge planning and its focus in preventing homelessness, and provides that the HSE will put in place appropriate and effective policies/procedures for homeless persons discharged from mental health facilities.

The strategy states: 'it is acknowledged that there has been some confusion about which funding agency is responsible for certain ongoing revenue funding elements,' but does set out the division of funding responsibilities between the DEHLG/local authorities and the Health Service Executive. This refers to ambiguity which arose from the Housing Act 1988, which placed responsibility for tackling homelessness on local authorities in addition to the existing 1953 Health Act, which did similarly for health authorities.

Priority Action 6.4 of the *National Implementation Plan* promises review of 'the assignment of responsibility between the DEHLG and Department of Health and Children in relation to funding for non-core care functions having regard to the need for adequate budgets'.

The Homeless Agency *Evaluation of Homeless Services* (Brooke et al, 2008) concluded that the roles of the HSE and local authorities have not been adequately delineated and recommended: 'The National Housing Strategy for People with a Disability should incorporate a dedicated funding stream for the revenue costs of the provision of supported housing for people whose non-housing needs are such that they are unable to sustain a tenancy in mainstream housing' (Brooke et al, 2008:119). A *Vision for Change* (2006:144) noted that mental health services were funding and staffing over 3,000 places in over 400 residences for persons whose housing needs would be more appropriately met by local authorities.

The 2001 WHO annual report highlights three essential components to a sound de-institutionalisation process:

- Prevention of inappropriate mental hospital admissions through the provision of community facilities
- Discharge to the community of long-term institutional patients who have received adequate preparation
- Establishment and maintenance of community support systems for non-institutionalised patients.

(Source: cited in Amnesty International, 2003:24)

The recommendations made in *A Vision for Change* in relation to homeless and mental health services are outlined in Box 2.3 below:

Box 2.3

***A Vision for Change* (2006) Recommendations on homeless services**

- A database should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.
- In light of this information – scientifically acquired and analysed – recommendations should be made and requirements laid down to implement them.
- The Action Plan on Homelessness in Dublin should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.
- A range of suitable, affordable housing options should be available to prevent the mentally ill from becoming homeless.
- The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.
- All community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.
- Integration and co-ordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.

Some developments have taken place since the publication of *A Vision for Change*. To consider two examples:

- Homeless services in Dublin have been evaluated and the Homeless Agency has produced an implementation plan, *Pathway to Home*, to address these recommendations. The recommendations highlighted that there was a need for change to move from the way in which services are currently configured into a model of service delivery that provides better access to long-term housing and the provision of supports to people within housing. At the core of the implementation plan is a person-centred focus and a clearly delineated care and case management approach.
- The introduction of a new support scheme SLÍ (Support to Live Independently) was announced in June 2009. As well as providing appropriate accommodation, the new scheme, which will target persons (300 households in 2009) with low to medium support needs, will involve the provision of the necessary supports, reducing over time, to help formerly homeless people (mainly in emergency and transitional accommodation) to sustain their tenancies and make a successful transition to independent living. A key feature of the SLÍ scheme is that accommodation will be under the control and management of the local authority, a housing association or an appropriate service provider organisation. Further details are provided in Box 2.4.

Box 2.4

Development of a Housing Support Service

The Housing Support Service(s) to be made available under the SLÍ scheme has recently been tendered (September 2009). The intent is that these services will visit households to assist them to occupy or continue to occupy their housing and progress from homelessness towards independent living. They are to be organised so that they can be deployed flexibly between locations in the local authorities, across a range of support needs that may arise for the household over time. These services will include, but are not limited to the following:

- Ensuring the housing support plan is implemented and regularly reviewed and is appropriate to current needs
- Maintaining contact with the local authority as appropriate and assisting with access to relevant local authority services (e.g. housing, welfare, housing information and advice)
- Subject to other agencies, and as appropriate, providing housing information and advice as well as referral to mainstream/specialist housing information and advice providers
- Providing input as appropriate to pre-tenancy preparation in order to assist tenants in developing and maintaining positive interaction and assisting the tenant in accessing estate/housing management, maintenance and repair services as required
- Advising the tenant on day-to-day tasks relating to food preparation and storage, general household duties relating to cleanliness, hygiene, storage and safety
- Assisting the tenant with security, maintaining safety, arranging minor repairs and servicing in addition to use of domestic appliances
- Assisting the tenant with arranging and attending meetings, appointments, shopping and errands
- Advising and assisting tenants to build positive relations with neighbours, including avoiding/resolving disputes

Box 2.4 *Continued*

- Assisting service users to understand their rights, roles and responsibilities as tenants
- Assisting with linking in with other relevant mainstream services, including (but not limited to) the following:
  - Assisting with obtaining entitlement for social welfare payments or other financial support
  - Assisting with access to training, education and employment schemes or programmes
  - Assisting with access to other relevant sources of advice and information such as MABS and Citizens' Information services
  - Accessing appropriate health and care facilities
  - Fostering access to befriending services and social networks, local community facilities and services that help ensure people settle into their new home
  - Where appropriate, broker on behalf of the tenant with regard to accessing specialist or mainstream services.

Source: Dublin City Council/Homeless Agency Invitation to Tender for a Multi-Provider Framework Agreement for the Provision of Housing Support Services (21 August 2009)

2.7 Social Inclusion and Mental Health

The structural and community-related determinants of mental health and well-being will be highlighted in the next chapter and have been covered extensively in reports by the National Economic and Social Forum and *A Vision for Change*. *The National Action Plan for Social Inclusion 2007-2016* sets out a programme to address poverty and social exclusion. The plan notes that 'there is a strong body of evidence linking poverty and poor mental health and poverty is associated with a greater use of mental health services' (2007:45).

The report places emphasis on the CMHTs targeted under the *Vision for Change* strategy. Housing-related supports are a crucial complement to medical or therapeutic care and vary in accordance with each client's point in the life cycle.

In the context of community participation, as advocated in *Delivering Homes, Sustaining Communities* (2007), an integrated approach to rehabilitation services plays an important role in maintaining mental health and in turn maintaining a consistent living situation. *Towards 2016* calls for a multi-annual investment programme with a view to supporting people back to employment where appropriate, through early intervention and enhanced service provision. The Social Partnership Agreement recommends person-centred supports for long-stay residents in psychiatric hospitals with a view to their movement back into the community.

Accessing available services and supports requires access to information delivered through an appropriate medium. The Disability Act 2005 included provision for the establishment by Comhairle (now Citizens' Information) of a personal advocate to those with a disability who have difficulty accessing a social service. The Citizens Information Act 2007 gave the Citizens Information Board (CIB) legislative responsibility for the development of such advocates.

2.8 Conclusion

As specified previously in this section, the central policy aspiration in relation to mental health and housing in recent years is for local authorities to assume the responsibility for accommodation provision that has traditionally been provided by mental health services. Such a policy shift would require implementation of the various aspirations outlined in the homeless strategies. Of particular importance is the assessment of housing need for people suffering from mental illness as advocated in *A Vision for Change* and highlighted in *The Way Home*. Mental health is not mentioned specifically as one of the eight categories in the Housing Needs Assessment (2008), although individuals with mental health needs would potentially be recorded under the 'Homeless', 'Persons with a Disability' or 'Medical/Compassionate' categories.

Evaluation studies in relation to homelessness services have stressed the need for dedicated funding streams for supported housing or advocacy services for people whose non-housing needs are such that they are unable to sustain a tenancy in mainstream housing. Housing policy emphasises inclusiveness, community participation and diversity and this should be reflected and underpinned by the upcoming Housing Strategy for People with a Disability. Personal advocates – as provided by the Citizens Information Act 2007 – may be utilised by people with a mental health disability to avail of services to which they are entitled. While these services are drawn upon voluntarily, the specification under the Mental Health Act that a patient's discharge order can be made available in some instances to a housing authority would go some way towards assisting with the assessment of his/her need.

SECTION THREE

Literature Review

3.1 Introduction

The focus of this section is on the domestic literature in relation to the housing and support needs of people with mental health disabilities. A comprehensive international literature review was outside the scope of this research, and in any case, 'best fit' models identified in international research may not transfer appropriately to other countries (Warren and Bell, 2000; National Disability Authority, 2005:112). However, a small number of studies have been identified that provide an overview of international trends. This section begins by outlining these international studies, before concentrating on the Irish literature. Appendix 1 also documents more detailed information collected in relation to Australia and the UK.

3.2 International Studies

Waegemakers Schiff et al (2007) conducted an international literature review on 'housing persons with a mental illness, with and without co-occurring substance abuse'. Drawing on research studies from many disparate locations (Australia, the US, the UK, Canada, the Netherlands, New Zealand, Norway and Sweden), a wide level of support is reported for the 'housing first' model for most persons disabled by mental illness, based on the conclusion that, for this group, stable housing is a precondition to participating successfully in psychiatric treatment and dealing with addictions. That said, the authors also recognised that an important sub-group of high-needs individuals will require supervised, sheltered accommodation.

The authors, using over 150 research studies, found a strong and consistent pattern in evidence-based 'best practice' for housing for persons with persistent mental illness:

- Individualised living units should be provided
- Preferably these should not be clustered in large projects which are stigmatising
- Units should be of the occupant's choosing
- Units should be readily accessible to community services and amenities
- Housing should not be contingent upon meeting pre-conditions of 'housing readiness', sobriety, treatment compliance or use of mandatory services

This model consistently showed greater housing stability, reduced need for hospitalisation and ancillary services, greater community integration and significantly higher satisfaction with quality of life (Waegemakers Schiff et al, 2007:32).

The second international literature review to be discussed focused on the housing aspirations and preferences of people with psychiatric disability moving from institutional to community care (Arthurson et al, 2007). It reported findings from numerous studies which noted a preference for independent living (e.g. living alone, with family, or with friends) among people with mental health disabilities, but difficulties in achieving this. The review details reports of people feeling that they were socially excluded, stigmatised and isolated as well as disliking being housed among low-income groups. The study concluded that:

... as long as some basic criteria are met, a variety of models of housing and support can successfully sustain people with psychiatric disability within the community and avoid social exclusion. These criteria include stable, affordable and long-term housing, key supports, risk management strategies and providing some choice for people about where they live. (Arthurson et al, 2007:971)

The study concludes that having appropriate housing and support services in place is central to successfully supporting people with mental health disabilities to live in the community. The review also quoted studies which concluded that having choice over the type of housing one lives in and control within the housing situation leads to greater satisfaction with the housing and higher quality of life.

Box 3.1 draws together the research findings and is taken directly from the review.

Box 3.1

The links between housing, mental health illness and social exclusion

Key elements of housing	Relationship to social exclusion for people with mental health illness	Outcomes
Cost/Affordability Capacity to meet housing costs out of available income and have sufficient income for other basic needs	– if rental payments in relation to income too high: Reduced income for other needs, e.g. health, food, support services	– Eviction/homelessness – Hospital/institution/prison – Trapped on benefits – Negative impact on mental and physical health
Accessibility/Availability Whether or not appropriate housing is available	– Participation in consumption and recreational activities compromised – Inability to pay rent arrears – Lack of access to affordable housing – Needs-based allocation policies for social housing potentially inclusive but leads to stigma and poverty concentrations	– Homelessness – Poverty – Residualisation – Feelings of not fitting into community – 'Revolving door' of hospitalisation due to lack of housing – Discharge from hospital directly to homelessness – Remaining in congregate housing where no other viable option is available – Negative impact on mental health
Stability of housing Extent to which person is guaranteed continued occupation of housing	– Where no security of tenure may have to move sporadically - housing at risk – Insecure accommodation affects ability to maintain supports, employment	– Educational outcomes compromised – Income levels likely to be affected adversely – Social isolation (loss of natural supports)
Appropriateness Whether housing meets needs of occupants in terms of: – Appearance – Locality – Quality – Suitability - household size/age of occupants, congregate/independent – Safety – Choice over housing, who to live with	– Housing aggravates person's illness, e.g. phobia – Concentrated with low-income groups – Lack of services, e.g. shops – Reliable support not available for medication and other informal support – Poor social/physical environments due to poorly maintained housing – Overcrowded	– Disruptive behaviour – Housing at risk – Access to employment and education and other services compromised – Poor health, educational, employment prospects – Breakdown in relationship with neighbours, conflict with neighbours – Stigma

Source: Arthurson et al, 2007

The third review involved a meta-analysis based on 30 studies covering 44 unique housing alternatives and including more than 13,000 individuals with mental health disabilities in the US (Leff et al, 2009). It found that different housing models or interventions achieve different outcomes for different sub-groups of people but concluded that further empirical research was needed to tease out what models work best, in what ways and for whom. Not surprising, 'nonmodel housing' (living on the street, using shelter beds and in non-supportive housing) was found to be the least effective in achieving housing stability.

3.3 Irish Research

Research focusing on the housing needs of people with mental health disabilities in Ireland has not been widespread. However, there has been some evidence-based research conducted. Here, the following areas are covered:

- The recovery approach
- Service users research evidence
- Homelessness and mental health
- Housing supports
- Family supports

3.3.1 The Recovery Approach

Public policy in Ireland places a strong emphasis on the recovery model – based on the idea that people can recover from 'mental illness', and that the service delivery system must be constructed on this knowledge (Mental Health Commission, 2005).

The Mental Health Commission (2008) published a framework for the development of the recovery approach within Irish mental health services. The paper based its findings on existing recovery literature including longitudinal studies, international practice and contributions of service users. The model places firm emphasis on individual choice and taking risks in care provision to facilitate independence. Fisher (1998) defined the recovery approach as 'multi-level, strength-building planning to genuinely assist a person to gain a meaningful role in society. This planning is contrasted to maintenance-based treatment planning which by its nature is professionally directed to correct pathology' (cited in MHC, 2005:25).

Housing – together with education and employment – is repeatedly cited as a key component of the multi-faceted and interconnected recovery process. In many cases making the transition to independent accommodation represents a final step in the rehabilitation procedure. In a framework for training and employment for people with mental health difficulties (Eve Limited, 2007), residential instability was highlighted as a key personal barrier which can impact negatively upon the individual's capacity to function effectively in employment and other settings.

The concepts of self-help and peer support, which longitudinal studies have shown can greatly enhance rehabilitation and reduce risks of re-hospitalisation, are explored as a complement to professional health services. This idea was embodied by the GROW movement, which was established in Sydney in 1957 and has been the basis for subsequent worldwide rehabilitation (including Irish) projects. Such movements have origins in the social model of disability. An extensive recovery network currently exists in Ireland (including groups such as Grow, Aware, Shine and Recovery Ireland) and has been covered in detail elsewhere (see HRB, 2007).

3.3.2 Service Users' Research Evidence

As the following section will explore, mental health care service provision has changed significantly in the last 25 years. In an effort to move patients from hospitals to community residences, occupation of the latter increased from 900 in 1984 to 3,065 in 2004. A review of the residences, *Happy Living Here*, was undertaken by the Health Research Board (2007) on behalf of the Mental Health Commission to evaluate whether the residents' needs were being met and the centres were fulfilling their therapeutic functions.

The residences were evaluated in the context of the recovery model and the findings support mainstreaming housing provision for people with mental health disabilities. The researchers conducted 138 interviews with residents across three HSE local mental health service areas. In the context of this study, their findings showed that while the majority of residents were satisfied with their treatment and care and their current accommodation, a significant number would prefer independent living arrangements. However, residents made limited use of community resources. Almost a quarter of the respondents were reported to have no system of support outside the residences. In addition, few of the residences were reported as providing activities that promoted community integration, mainstream employment or mainstream housing.

As highlighted, the most significant commitment in *A Vision for Change* pertinent to housing is recommendation 4.7 which calls upon local authorities to take responsibility for the accommodation of mental health service users with medium- and low-support needs. Management in community residences felt that this housing responsibility should lie solely with the local housing authorities and not with mental health services. The authors of *Happy Living Here* note that this would mean 1,827 residents in the HSE community residential facilities in accordance with the 2003 figures. The difficulties of achieving this ideal using existing local authority social housing stock were listed as follows:

- People requiring special needs or sheltered social housing in rural areas do not always apply, for a variety of reasons (e.g. stigma, preference for other types of housing) (see Heaune, 2006 – cited in HRB, 2007).

- Families are given priority for social housing, as single persons are not perceived as comprising a household. This is a result of the three-bedroom house being the conventional model, which is more appropriate to the needs of a family.
- Some local authorities consider persons in mental health community residences as housed and, therefore, not a priority for housing despite the fact that a large proportion of these people – notably those in group homes – are already on the housing waiting list.
- Local authorities see some people with psychiatric histories as troublesome and even if they were to provide for their accommodation needs fear that adequate mental health services would not be provided and that they would be ill-equipped to provide for the adjunct support needs. (HRB, 2007:36)

The majority of high-support residences covered in the study were located on large, private grounds owned by the HSE. The medium- and low-support residences were also owned by the HSE but were mainly semi-detached houses in mixed housing estates. The research was quantitative but responses on residents' living situations were open-ended. The report concluded that although the residents reported satisfaction with their current living situations this may have been a result of their feeling that they had nowhere else to go in the absence of suitable independent accommodation options. Residents also expressed that while they would prefer to live in their own homes, they feared that this would result in a loss of support and consequently they felt better placed in their current accommodation.

The authors noted that people who have spent long periods of time in a culture of dependency and guardianship as opposed to one of independence and control can have difficulty seeing change in such a system. This conclusion should be considered in the context of the life-cycle approach as advocated by *Towards 2016*. The need for training in the principles of recovery rather than maintenance is repeatedly emphasised in the report. The report recommends a reduction in the number of high-support places, noting that the recovery of such residents would be better provided in their own environment (HRB, 2007:115).

As a solution to the aforementioned problems the authors recommend that local authorities take possession of some of the low-support residences and assume responsibility for their management and maintenance. This would represent a strong contribution towards fulfilling the special needs commitments set out in *Delivering Homes, Sustaining Communities*. Such a commitment would require a partnership with local mental health services and an assurance that this stock would remain exclusively for use of patients with mental health disabilities.

3.3.3 Homelessness and Mental Health

The causal link between mental illness and homelessness has been widely covered in previous research (see Amnesty International, 2003; Pillinger, 2007). Reports have warned, however, that it is important to make a distinction between 'mental health problems' induced by homelessness and 'mental illness' which may be a factor in becoming or remaining homeless. Research has shown that homelessness can contribute to anxiety or depressive illnesses, while mental illness is a significant factor in precipitating homelessness. The evidence also suggests that the longer the period of untreated mental illness the more difficult it is for people to return to their pre-morbid degree of well-being (Amnesty International, 2003:17).

Mental health disorders prevent people from carrying out essential aspects of daily life, such as self-care, household management and interpersonal relationships. Homeless people with mental health disorders remain homeless for longer periods of time and have less contact with family and friends.[13] In some cases the mentally ill (especially those with severe disorders such as schizophrenia, bi-polar disorder and major depression) can misinterpret the guidance of others and react irrationally because of their condition(s). This rejection of caregivers can occasionally result in or lead to a longer period of homelessness. In addition, the combination of substance abuse and mental illness – referred to as a dual diagnosis – also increases the risk of homelessness.[14]

13 National Coalition for the Homeless, http://nationalhomeless.org

14 Folsom et al (2005) examined the risk factors for homelessness and patterns of service for 10,340 homeless people in Southern California. The researchers found that 60.5 per cent of homeless people who were diagnosed as mentally ill showed substance abuse disorder, compared to 20.9 per cent of the non-homeless mentally-ill group. Further analysis revealed that those with mental illness and substance abuse were four times more likely to be homeless than patients who did not abuse substances.

The Homeless Agency's *Evaluation of Homeless Services* (Brooke et al, 2008) concluded that inadequate community mental health services were a major barrier preventing people moving out of homelessness. The research also concluded that the lack of availability of such services posed a similar threat to people in mainstream or supported housing (ibid:123). The report recommended further investment in outreach mental health teams to work with people who do not currently access services. Such spending, it was argued, will save resources in the long-term by fostering health and well-being for those most at risk of homelessness.

Research has noted that many individuals in general or psychiatric long-stay hospital care, or in community-based residences and other such environments, while meeting the definition of homelessness laid out in the Housing Act 1988, are not recorded in the official count as being homeless (Amnesty International, 2003:16). An Irish study on hostel dwellers, cited in *A Vision for Change* (2006:146), found for example that 72 per cent of homeless men in hostels, who met criteria for serious mental health disabilities, were not in receipt of care.

The most recent official count of the homeless population in Dublin listed 2,144 households in homeless services (Homeless Agency, 2008). A quarter of those in homeless services of working age presented evidence of a disability in the household and for those aged over 50, nearly half did so. However, the survey relies on self-reporting and does not distinguish between different types of disability.

Pillinger (2007) examined the pathways to homelessness by taking a life-course approach. The report cited Anderson and Tulloch (2000) who identified three age-related pathways. In the 'adult and later life pathways', mental health disabilities were cited as causal factors for homelessness. The research used biographical methods which bring the interviewees' experiences to the centre of the research with the intention of helping policy-makers understand the impact of housing policy on people's behaviour and housing pathways. The link-up of biographies with the needs assessment was identified in previous research by the same author as integral to the prevention of homelessness.

Using qualitative methods, Pillinger (2007) interviewed 22 people who had become homeless as a result of a range of interlinking factors. In addition to its causal relationship with homelessness, biographies revealed that mental health disabilities were an additional barrier to the progress of people's pathways through homelessness by keeping them away from mainstream services. It found that some of those included in the study had lived for long periods of time in emergency homeless services, hostel and bed-and-breakfast accommodation, because of a lack of suitable alternative accommodation. The report warned of the correlation between homelessness and social exclusion and the adverse relationship between length of time in homelessness and engagement with services. Respondents identified the following factors as working to facilitate their journey out of homelessness:

- Good quality temporary, transitional and permanent accommodation
- Limits on time spent in temporary accommodation
- Choices in where they lived and the type of housing they lived in
- Building capacity and skills to be independent and autonomous
- Having needs met in a person-centred way
- Having access to information, advice and assistance
- Support in daily living, cooking, budgeting, managing resources, managing tenancies and independent living
- Ongoing support, advocacy and assistance once permanently settled and access to support workers when a crisis occurs or support after permanent settlement
- Housing information and advice in prisons, and support leaving institutional care

The Homeless Agency's *Evaluation of Homeless Services* included a question to service managers regarding barriers preventing service users (all, not just those with mental health disabilities) progressing through and out of homelessness.

Lack of detoxification and rehabilitation services (54 per cent), lack of access to mental health services (43 per cent) and lack of long-term supported housing (37 per cent), problems regarding the private rented sector (37 per cent) and lack of accommodation (34 per cent) were the most frequent replies (Brooke et al, 2008:30). The profiles of interviewees revealed the importance of tenancy sustainment services, which in this case were provided by Focus Ireland. These worked in tandem with a co-ordination of HSE mental health services and the local authority, which, in this case, provided the service user with long-term accommodation. This example falls in line with the policy ideal of *A Vision for Change*. The report also emphasised the need for improved access to private rented housing, through an extension of programmes such as the Rental Accommodation Scheme (RAS) and access to accommodation with rent allowance and assistance through the Access Housing Unit.

A related theme from the international research literature – the importance of asking service users about their preferences and developing customer-driven systems – has recently been picked up in Irish research. Based on 73 homeless mental health service users in Dublin (51 of whom were living in mental health settings), Cowman (2008) found high levels of satisfaction with current accommodation (two-thirds of respondents were satisfied with their current accommodation). When asked, however, the preferred living situation of just over half of those interviewed (38 respondents) was an apartment or house, 24 preferred a mental health supported residence and eight wanted to live in their family home. Autonomy and privacy and care/support/company were the two most important aspects in respondents' choice of ideal living situation. The majority stated that they would need support from mental health services to be able to live in their preferred living situation, but most expressed a preference to live independently rather than with other mentally-ill people. Cowman argues that:

The first step in developing a menu approach is, in partnership with the local authority, and other stakeholders, to clearly identify the variety of possible models which work and present these choices to the service user and his/her carers as a possible goal to be worked towards (Cowman, 2008:63).

3.3.4 Family Supports

While there are no definitive or reliable statistics on the living situations of people with mental health disabilities, it has been noted that most are living in the community or in mainstream housing (see Anderson and Wynne, 2004). This underlines the importance of family supports. Studies have emphasised the importance of family support services which would provide assistance to relatives of people with a mental health disability. These are particularly important in some instances where the difficult behaviour associated with schizophrenia can strain family tolerance to breaking point (European Federation of Associations of Families of People with a Mental Illness, Madrid, October 2001 – cited in Amnesty International, 2003).

A study on the experiences, needs and support requirements of families with enduring mental illness in Ireland (HRB, 2006) found that the discharge of persons with mental health disabilities to their homes was the most difficult stage. The researchers conducted 38 qualitative interviews with family members of 33 persons with enduring mental illness in Dublin. On discharge, a perceived lack of support services for the family was reported by most participants. Twenty-two of the 29 service users who first used inpatient services had been discharged to relatives after first admission. Some respondents in the study expressed an opinion that their relatives should not have returned to the family after discharge because of the negative effects on both parties. Others reported situations where service users had been sent to their family home to wait for a place in a hostel. In this context, it is clear that the establishment of appropriate and effective discharge planning should be a priority in the National Housing Strategy for People with a Disability, with in-built evaluation to ensure the development of good practice.

Participants also reported advice and help with housing for persons with mental health disabilities as a central need in the rehabilitation programme. Such requirements are buttressed by tenancy sustainment programmes and complemented health services in the context of multi-disciplinary teams and individual case management. The 'revolving door' phenomenon – where service users are frequently leaving and returning to acute care with no improvement in their condition – is a challenge for future mental health care policy.

A list of supports identified in the above literature at different stages of the recovery cycle is summarised in Box 3.2 below. Details in relation to floating supports used in the UK can be found in Appendix 1 (see also Cotter, Silke and Browne, 2010).

Box 3.2

Summary of accommodation-related supports required at different stages of recovery

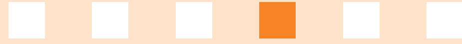
Discharge	Initial Settlement	Living Independently
Housing information and advice services	Support in daily living (cooking, budgeting and managing resources)	Peer support/self-help
		Tenancy sustainment
Assistance accessing housing	Advocacy and on-going support	Training and employment
Family support		Community integration
Resettlement		
Developing capacity and independent living skills		

3.4 Conclusion

This section has drawn on international comparative studies and Irish studies to examine the housing and support needs of people with mental health disabilities. In relation to housing needs, the available research points towards the importance of individualised living units, ideally not clustered in large projects, with consumer choice, stable, affordable and of good quality. Housing arrangements that combine support for everyday living, with quality accommodation and a suitable social environment, are most likely to maximise independent living. Research regarding the importance of family supports was also reported.

The next section reports on the findings from stakeholder interviews undertaken as part of this research.

SECTION FOUR



Stakeholder Interviews

4.1 Introduction

The terms of reference for this report stated that the research would be undertaken by means of qualitative interviews with representatives of the following groups:

- People with mental health disabilities and groups representing their interests
- Carers
- Other service providers (e.g. voluntary, local authority or HSE)

As the research was exploratory in nature, interviews were conducted using a themed interview guide which varied depending on the situation. Interviewees were selected based on consultations with members of the research steering group and other stakeholders using a snowballing technique. This section discusses themes that emerged from these interviews.

In total 30 interviews were undertaken and, as can be seen from Table 4.1 below, these varied to include local authority and HSE staff, service users/tenants, advocates, service managers/outreach workers, psychiatrists, psychologists, occupational therapists and community nurses. The tenants interviewed had both medium- and low-support needs (based on the nature of their tenancy, self-reporting, service provider assessment) and were selected using convenience sampling on the basis of their willingness to participate and ability to engage with the researcher. It was not possible to include interviewees who were home-owners due to problems accessing such a sample.

The interviews were based on a semi-structured topic guide which varied depending on the interview. For service users it focused on housing histories, daily activities and use of services; for service providers it focused more on issues such as referrals, funding, tenancy sustainment, inter-agency co-operation, obstacles facing mental health service users and issues such as anti-social behaviour.

Table 4.1

Profile of Stakeholders Interviewed	
4 advocates	3 urban, 1 rural. Advocates were based in non-statutory agencies or provided by CIB
6 service managers/outreach workers	2 rural, 4 urban (all from voluntary housing projects)
2 psychiatrists	1 rural consultant, 1 urban outpatient service
2 clinical psychologists	2 urban
2 occupational therapists	1 urban, 1 rural
2 community nurses	1 urban, 1 rural
1 rehabilitation manager	Urban non-statutory support service
10 tenants/service users	3 rural, 7 urban Voluntary housing (supportive) 4 Part V apartment units (voluntary) 2 Living alone with rent allowance 2 Living with parents 2
2 local authority staff members and HSE staff member	Rural town

The resources available, including the relatively short time available to undertake fieldwork, the lack of previous Irish empirical work in this area and the lack of a comprehensive dataset from which to sample, led to the use of this method. The limitation of this approach is that the findings cannot be considered as statistically representative.

The interview information collected will now be discussed under the following headings:

- Diversity of need
- Housing options/issues
- Supports required
- Discharge from institutional care
- Inter-agency co-operation

4.2 Diversity of Need

Medical professionals and support staff all emphasised the need to focus on recovery and the central role accommodation plays in the individual rehabilitation of service users. Recovery was loosely defined as the development of psychological and social well-being. Many respondents described mental ill-health as an 'invisible disability', as the side-effects which can impinge on their housing status are often difficult to recognise. Categorising levels of need is problematic, particularly when considering the variety of symptoms, factors and conditions which contribute to an individual's well-being and support requirements. The area of diagnosis emerged as a significant issue in the interviews. There is a distinction between mental health patients and those without a diagnosis but in some cases an individual may not have a diagnosis – and hence will not be receiving services from within the system – but will be suffering from the symptoms that threaten his/her residency/tenure. In addition, respondents noted that identifying a package of supports for an individual can be difficult in the absence of a diagnosis.

Psychiatric diagnoses were classified as neurotic (e.g. depression or anxiety), psychotic (e.g. schizophrenia or bi-polar disorder), substance abuse or personality disorders. An individual's condition can worsen considerably in periods where he/she has stopped taking medication or is combining it with alcohol and/or drugs abuse (referred to as a 'dual diagnosis').

Needs were classified as medical, social and personal and were differentiated in categories of care and support. *A Vision for Change* clearly outlined a strategy for the creation of multi-disciplinary Community Mental Health Teams (CMHTs) across various catchment areas, and services varied in accordance with staff numbers and financial resources. In broad terms, the service users' medical needs are catered for in a variety of ways in accordance with living options and the mental health services they use, i.e. if they are 'in the system' or outside of it. In many cases, respondents reported experiences of 'revolving door' patients who repeatedly entered and left institutions as a result of inadequate accommodation and supports to cater for the episodic nature of their conditions.

Respondents emphasised the need for flexibility with regard to service provision so that they can be tailored towards individuals' changing needs. A particular area of concern in some cases – specifically in highly populated urban areas – was the role of a key worker. Staff reported instances where individuals fell between services and catchment areas, initially leaving their accommodation, 'couch-surfing' and moving between temporary accommodations, and eventually disappearing for a period of time before re-emerging in a worsened condition. In these situations, it was suggested, an individual could take responsibility for the accommodation element of the service user's care plan (case management) and step-in when complications or ambiguities in relation to responsibilities and catchment areas arise.

Respondents also noted that need is significantly affected by the individual's place and accommodation history in the life cycle.

For example, younger individuals – who had spent considerable periods in institutional care – require training in areas of independent living such as cooking, cleaning and budgeting. These 'life skills' are diminished by long periods living in institutions, and respondents reported that this can have a knock-on effect on confidence and motivation. In areas with fully staffed rehabilitation teams, these skills can be taught and tested by occupational therapists while in other areas training in such capacities is undertaken by support workers or in community day centres. In addition, staff from a secondary service reported that age and gender had a significant effect on housing status, with most service users aged 18-30 living with their families and single males less likely to acquire local authority social housing.

4.3 Housing Options/Issues

Respondents all regarded type of accommodation, quality of accommodation and security of tenure as central to their recovery plans. Service users reported a worsening in their conditions and periods of mental ill-health provoked by unsuitable living arrangements. In some cases where no suitable accommodation was available, patients remained in acute wards, which proved detrimental to their recovery. Other respondents reported sharing rooms in emergency accommodation where noise prevented them from sleeping at night. Many temporary hostels also require residents to leave during the day-time. This can be unsuitable for many individuals on strong medication, in need of a place to sleep during the day.

The living situations of persons with a mental health disability vary significantly. These include family home, living with parents or relatives, private rented accommodation, temporary hostel, HSE accommodation, local authority social housing or housing association housing. The latter categories include supported accommodation[15] which varies in accordance with the tenant's condition and resources in the area.

15 Supported accommodation is used to describe services that include comprehensive residential supervision, training and other assistance in a small group home.

In some instances housing and homeless lists do not reflect the extent of need as they do not reflect situations where individuals are living with their families and the arrangement is detrimental to both parties, and there are people who should be on these lists, but are not. Respondents felt that local authority housing lists operated on a points system which tends to favour families and does not prioritise single men under the age of 35.

Some support staff reported that local authority housing/homeless staff 'don't have mental health on their agenda' and have little understanding of the issues that can affect people who suffer from mental ill-health in situations where a tenancy may be under threat. Confidentiality was seen as an issue in these instances. In the absence of information on the diagnosis or condition of an individual, outreach workers/development officers have difficulty in making allowances for specific circumstances. In addition, housing authorities have a responsibility towards all their tenants and could be left in a situation where they may have to evict someone who is causing problems for other tenants/families. One suggestion was the provision of an outreach worker specific to mental health. The local authority interviewed had well-established communication channels with the local mental health services and as a result, data sharing and flexibility was evident with the intent of ensuring the best outcome for the individual.

The most important accommodation factors reported were safety, comfort, affordability, stability and privacy. Many of these are affected by the individual's environment and personal resources but they are reported in a broad sense below.

4.3.1 Safety

Service users reported living in unstable emergency accommodation or rented property which they felt had a negative impact on their mental health conditions. People with mental health disabilities can be particularly vulnerable to anti-social behaviour.

Psychologists reported writing letters to local authority housing staff on behalf of service users whose conditions had worsened as a result of what they considered to be unsafe and unstable accommodation. Local authority houses in areas of cumulative disadvantage with a large young population are particularly unsuitable. The stigma attached to mental illness has in some reported cases led to the targeting of particular individuals for low-grade harassment. Examples of such harassment included loud noise, throwing objects at windows and repeated ringing of doorbells. Such interruptions can have a profoundly negative effect on individuals who are prone to delusional behaviour or spells of acute paranoia or anxiety.

4.3.2 Comfort

Single unit residences in an area with good access to services and public transport are seen as the 'gold standard' for single people with mental health disabilities living in the community. For independent living options, such residences could be an apartment or a house, preferably with separate living spaces. Interviewees reported that this ideal is not always possible to achieve due to lack of availability of units or sites to construct suitable units, or the individual's mental health condition. The following factors would contribute to an ideal community residence scenario conducive to recovery.

The property should:

- Be bright and of a high decorative standard
- Be located in a 'settled' or mature community
- Provide a quiet and restful environment
- Be capable of providing space and privacy to the tenant
- Be close to public transport services
- Be convenient to shopping, church and other community services
- Be readily accessible to health services
- Provide access to fresh air and greenery

Interviewees also reported that a high proportion of mental health service users are smokers and this should be considered

and facilitated in the context of residency. Interviewees whose residences enabled them to easily access community day centres or training/educational facilities reported significantly higher levels of comfort and satisfaction. In many cases the tenants received their daily meals at these locations. While it was acknowledged that resources and tenant suitability may inhibit the individual's chances of securing a residence with all of these features, it was hoped that the residence would at least avoid an exacerbation of his/her mental condition. Features that should be avoided were reported as follows:

- Locations in estates with a young population
- A corner site
- Sites deep in an estate necessitating passage through it
- Locations isolated from the community
- Locations too close to sport and recreation areas (noise irritation)
- Residences too close to main roads with heavy traffic (noise irritation)

The attitude of neighbours was reported to have an impact on locating suitable accommodation for service users in the community. The issues of stigma and fear characterise attitudes towards mental health and successful examples identified in this project put considerable effort into enhancing awareness of mental health issues in the community. In addition to the specific features and areas of good practice identified above, respondents emphasised the necessity of a range of high-quality housing options appropriate to different needs and circumstances (permanent or transitional). These options included shared housing and group housing. Transitional housing/step-down units are used to prepare individuals for independent living.

Ideally, in order to provide a continuum of security and familiarity, the graduation to more independent living would not always involve a physical move on behalf of the resident. However, obviously this is not possible in all circumstances.

4.3.3 Affordability and Stability

Many interviewees emphasised the necessity for security of tenure in the context of recovery from mental illness. Staff reported that in most cases this factor is as important as the individual's medication. In addition, security of tenure enables individuals to take up part-time employment, which in many cases represents an important part of the recovery plan. It was reported that without secure housing people with mental health disabilities may become homeless, and without sufficient access to proper mental health care this could aggravate the problem for both themselves and homeless services.

Many single respondents felt that the current rent supplement only enabled them to afford low-grade accommodation. In many cases respondents reported that landlords refused to accept rent supplement tenants, which significantly lessened their options. In many cases, low-standard accommodation was accompanied by bad practice from landlords such as failing to deal with repairs and maintenance.[16] The local authority reported that community welfare officers (CWOs) could be flexible in making resources available to ensure that the individual could access better quality accommodation. This was enabled through communication between the various stakeholders making the CWOs aware of the potential problems for individuals with mental health disabilities living in low-grade accommodation.

As outlined in Section 1 above, a separate research project is assessing the potential of the private rented sector to accommodate people with disabilities.

16 See Fennell et al (2010) for the role of the private rented sector in accommodating people with disabilities.

4.4 Supports Required

Interviewees stressed the need for supports to be tailored in a manner that tied them into the rehabilitation continuum. The episodic nature of mental illness necessitated that such supports should be flexible and responsive to periods where symptoms of mental ill-health emerge. Support workers reported that *A Vision for Change* had provided a clear framework for the community-based care of service users. The interviews revealed a wide variety of circumstances where support would be required and these are broadly defined as follows:

- People who are at risk of homelessness through eviction or abandonment of property
- People who have lost their tenancies, or have had to leave their homes, and may be in a crisis situation requiring emergency accommodation
- People leaving institutional care such as hospitals or prison
- People living in temporary accommodation who require assistance and support to obtain and establish themselves in longer-term accommodation
- People living in long-term, owner-occupied, local authority or private rented housing who require supports to maintain their independence and tenancies
- People who have 'fallen between stools' and are not categorised as having either one form of disability or another
- People who are not managing their medication

Respondents emphasised the need to delineate clearly between housing-related and medically-related supports. In some cases resource limitations have blurred the line between the sources of such supports. For example, support staff in one area reported a greater need for home help provision. This is usually provided by health services but in some cases was provided by housing support workers.

Many of the supports can be provided by floating support services[17] which assist people with low-level mental health needs. In many cases, these services can help people to maintain their living situations without needing to access specialist or high-level care and mental health services. The following areas of support were identified by respondents:

4.4.1 Resettlement and Household Maintenance Supports

This can include individuals setting up a home and putting bills in their names, organising security deposits and furnishing the residence. Maintenance can include areas such as gardening. Resettlement support services are person-centred and focus on elements that contribute towards a possible transition to independent living.

4.4.2 Developing Domestic and Practical Skills

These skills, referred to as ‘independent living skills’, included cooking and cleaning. Individual competencies can vary significantly in accordance with the individual’s position on the life cycle and history of care within mental health services. Interviewees reported that these are generally provided as part of resettlement services.

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17 Floating supports are defined as support services not tied to accommodation so that they can follow the individual as he/she moves, or can ‘float’ to someone else when no longer needed.

4.4.3 Managing Finances

In addition to accessing benefits many individuals need assistance in budgeting. In some cases, individuals also require assistance in setting up bank accounts. The Money Advice and Budgeting Services (MABS) provide such a service in addition to the community welfare officer. Specific conditions, such as bi-polar disorder, can make people particularly vulnerable with regard to managing finances. Respondents reported incidences of loan sharks operating in specific areas and targeting individuals with mental health issues.

4.4.4 Advocacy and Advice (including Tenancy Sustainment Services)

Information and advocacy services were identified as key supports for mental health service users living in the community. Advocacy training workshops provided participants with necessary housing advice and information and information on their rights as tenants. Individual advocates represented individuals who cannot cope in particular situations, for example if they are the victims of anti-social behaviour in their living situations.

Tenancy sustainment services help individuals to tackle specific difficulties that threaten their tenure such as rent arrears. Respondents also reported that advocates provide a useful link between services by supplying individuals with addresses and contact details and in some cases helping them to gain access to other services.

4.4.5 Personal Safety and Security Support

As previously noted, tenants in particular areas have been victims of anti-social behaviour which can have a demonstrably negative impact on their quality of life. Respondents reported instances where support providers organised meetings with community Gardaí or community safety forums.

4.4.6 Emotional Support and Advice

Support staff reported that confidence and motivation can be significantly damaged by periods of mental ill-health. These seriously diminish the individual's quality of life and can consequentially have a knock-on effect on his/her tenancy. Respondents reported that regular visits by support staff played an important role in these areas. Having someone available to call in a stressful situation provided a good source of comfort. In this research, social supports were generally provided by housing support workers or volunteers in local 'befriending' systems.

4.4.7 Peer Supports

Peer support was reported as a particularly valuable resource for service users. The experience of discussing concerns or problems with people who may have gone through similar difficulties was reported to be extremely beneficial and enabled individuals to highlight common concerns. Such supports, which are provided through voluntary groups or in community group settings, also provide a valuable social network.

4.4.8 Training/Education/Employment Support Services

The resource of a daily occupation was reported as a particularly important part of the individual's recovery plan. Vocational outlets helped to build confidence and increase motivation. Respondents acknowledged that employment may not be a realistic option in many cases but the availability of such options provided a strong source of empowerment.

The above are classified as non-medical supports; in many cases individuals may require additional services to operate in tandem with accommodation-related supports. Support staff identified the following cases as indicative of the need for mental health or other specialist services or a supported housing setting:

- People with drug and alcohol problems
- People with highly volatile or offending behaviour
- People with a history of disruption or experience of exploitation
- People who are reluctant to engage with services
- People displaying signs of significant social disability

4.5 Discharge from Institutional Care

The subject of discharge protocols for those leaving institutional care was reported and researchers identified the need for an established system to prevent patterns of deprivation or homelessness as a result of poor case management or systems failure. Support staff identified information provision as a crucial service that can be provided at discharge. This includes providing a list of telephone numbers, addresses and contacts for appropriate services including those listed above. Medical professionals interviewed for this research reported that no patients are released into homelessness. Difficulties have emerged when individuals move from emergency or transitional accommodation to staying with friends or 'couch surfing'. The Camberwell Assessment of Need is a clinical assessment of an individual's competencies and capacities for living independently. This test is used by many hospital-based clinical teams in Ireland, and focuses on the following:

- Accommodation
- Food
- Looking after the home
- Self-care
- Daytime activities
- Physical health
- Psychotic symptoms
- Information on condition and treatment
- Psychological distress
- Safety to self
- Safety to others
- Alcohol
- Drugs
- Company
- Intimate relationships
- Sexual expression
- Childcare
- Basic education
- Telephone
- Transport
- Money
- Benefits

4.6 Inter-agency Co-operation

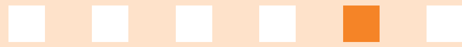
Co-operation between mental health and services related to housing support services varied in accordance with the geographical areas and the staff involved. This reflected the length of time the local support groups (or mental health and housing associations) had been in operation, the population density of the catchment area and the resources of the local mental health services and housing services. It also reflected the extent to which mental health and ancillary services had evolved from the traditional model to the community-care based model. In some reported cases, floating support workers could call local community psychiatric nurses (CPNs) when they felt that an individual was displaying signs of entering a period of mental ill-health. Intervention, it was reported, is crucial at this early stage to prevent a possible worst-case scenario that would involve hospitalisation. Difficulties were identified when individuals required hospitalisation and refused support.

Co-operation is most evident at the referral stage where social workers and housing managers discuss support needs and an individual's suitability for a particular residence. In the case of high- and medium-support residences, the care staff are provided by the HSE and the housing association look after maintenance issues on behalf of the local authority. The funding in this type of arrangement is provided by the Capital Assistance Scheme (construction) and the HSE Section 39 (Health Act 2004) funding while rent is paid from disability benefits and rent allowances. Another example is the Homeless Forum, which was formalised as a result of the Government's *Homelessness: An Integrated Strategy* (2000). Interviewees highlighted that these forums are a useful outlet for discussing needs, gaps and services in the locality. Inter-agency housing forums, involving members of the mental health care teams, particularly social workers and local authority housing staff, have been successfully piloted in some areas but require the participation of senior local authority housing staff.

Another example of inter-agency co-operation in this research was the relationships between housing associations. In some cases the housing needs of individuals with mental health disabilities were not being met and properties were constructed and provided by voluntary housing associations with no background or expertise in mental health. In these circumstances, floating support is provided by specialist agencies/housing associations through HSE funding streams. The discretionary nature of such funding was reported as an area of concern.

Based on these initial interviews, examples of current practice were selected, and a snowballing technique was used to examine case studies. These are outlined in the next section of the report.

SECTION FIVE



Case Studies

5.1 Introduction

To help inform the development of the National Housing Strategy for People with a Disability it was decided to document some current practices in this area in Ireland. Case studies discussed in this section were selected on the recommendation of various stakeholders consulted before and during the interview stage of the research. As formal evaluations are lacking, however, the case studies are presented to illustrate how service providers have responded to issues raised in the previous sections such as: permanency of tenancy, floating support services, individualised support plans, community projects to break down stigma associated with mental health, advice and advocacy services and approaches to de-institutionalisation and the recovery plan. These are all issues that will need to be considered in the National Housing Strategy for People with a Disability.

5.2 Case Study 1 – HAIL Housing

The Housing Association for Integrated Living (HAIL) is a voluntary housing association with 173 dwelling units in the greater Dublin area. The Association provides accommodation for families and individuals with a range of housing needs, but primarily for those with mental health disabilities who require additional support to live independently in the community.

HAIL was established as a result of an initiative by members of St Brendan's Mental Health Association and others following the preparation of their report, *Let's Look at Housing* (1986). This report identified the housing needs of single, socially vulnerable persons, some of whom had been patients in hospital or other institutions and often have difficulty coping on their own, or at least need start-up help to integrate into the community. Since then, HAIL has both purchased and built homes in all four Dublin local authorities, and more recently in Celbridge, Co. Kildare, for people with mental health disabilities.

HAIL properties are purchased through the Capital Funding Scheme provided by the DEHLG and drawn down through the relevant local authorities. The Association's Strategic Plan 2009-2011 has identified the objective of increasing its stock by 30 per cent over that period.

All of the properties have own-door access and are dispersed throughout larger housing developments. Where HAIL is given a site from the local authority to build on, this site also includes general needs housing in order to avoid ghettoising those with additional support needs. Prospective HAIL tenants must be on the homeless or housing local authority waiting list for the area. This has been identified by staff as a difficulty. They believe that many others, not on local authority housing lists, who may be living at home with elderly parents or other family members, may require such housing in the future. The Strategic Plan notes that in the organisation's administration areas in 2007 there were over 350 individuals in need of the type of supported housing on offer through HAIL.

HAIL takes referrals from the psychiatric services, from the local Community Mental Health Team and from homeless and transitional services. Many HAIL residents use the Burton Hall Day Centre service at Cluain Mhuire (St John of Gods) in south Dublin, and HAIL staff have made a series of presentations on their services and upcoming housing there.

The 2007 Report of the Inspector of Mental Health Services praised the Cluain Mhuire (St John of Gods) community-based service in South County Dublin for its practice of developing links with community providers and made particular reference to housing. HAIL was credited by HSE staff interviewed for this research as adopting a holistic and targeted approach to housing.

Prospective tenants fill out an application form which is subsequently completed by a referral agency. The agency fills in background information on the person such as the length of time that he/she is in the service, his/her preparations for independent living and the person's particular competencies. The referral agency is asked for a commitment to the continued mental health of the person and to take responsibility for his/her hospitalisation or accommodation during episodes of ill-health or serious relapse. HAIL also requests applicants to nominate a 'sponsor' – a family member or personal friend – as an extra support in some circumstances. In a number of instances this role is undertaken by an advocate from the Citizens' Information Board or the Irish Advocacy Network. Tenants are requested to attend an interview with a three-person panel consisting of the service manager, the project support worker and their social worker. Respondents who had histories of mental illness and chronic anxiety reported a sense of comfort with the interview process.

A permanent tenancy is a core component of the HAIL policy and as a consequence the organisation only operates a waiting list when a new property has come on stream. Successful applicants are given a pre-tenancy preparation which varies in accordance with their position on the life-cycle. In the case of younger applicants, who have had little experience of living alone, this can include independent living skills such as cooking and cleaning. The settling period usually takes between 6-18 months and can be intensive.

Tenants are facilitated to link with the community welfare officer to access financial entitlements to purchase equipment and furniture for their new property. They are assisted to establish budgeting arrangements for paying rent, utility bills and household management. Rent can be supplemented by the rent allowance available from the community welfare officer, depending on individual circumstances.

HAIL employs three settlement/support workers who each have a caseload of 25-30 people in their respective operational areas of Ballymun and Raheny, Clondalkin/Stepaside and Tallaght/North Inner City. In one particular area HAIL has entered into an agreement with Clúid housing association to provide floating support on a two-year basis on apartments obtained through Part V agreements. This service is partly funded by the Homeless Agency and the Health Service Executive. The low-support services are available during office hours in tandem with a 24-hour emergency maintenance service and a duty social worker.

Support workers are not medically trained and the service does not seek to replace mainstream clinical services but to maintain a strong line of communication with duty community psychiatric nurses. This line of communication is vital in cases where symptoms of deterioration – such as a decline in physical appearance or a failure to maintain property or put out bins – are noticeable and service users may be relapsing. The episodic nature of many mental health issues mean tenants link more intensively into the service at some times than others.

Tenants are introduced to their new communities and pointed towards the key services they will need to maintain their tenancies, e.g. banks, shops, libraries, post offices and Money Advice and Budgeting Services (MABS). The latter can be utilised in situations where the tenant has fallen into arrears and his/her tenancy is under threat. Tenants are also encouraged to link into appropriate community education, therapeutic and employment opportunities. These vary significantly in accordance with the location of the properties and the age of the tenants. The support workers' roles are person-centred and in some instances their regular social visits were reported as making a strong and positive contribution to maintaining tenants' mental health.

During their regular visits support staff carry out reviews with tenants to establish their current needs, prioritise them and develop action plans with the tenant to address them. Anti-social behaviour was reported as a problem in particular areas. The HAIL support team responded to concerns expressed by tenants by organising a community safety meeting which was attended by local community Gardaí.

Strengths

- HAIL's permanent tenancies and care plans make allowances for the episodic nature of mental illness. Such issues can make tenancies particularly vulnerable in the private rented sector.
- Strong links with local authority housing officers, homeless services (including homeless forums) and local community mental health services help tenants to link-in with specific services necessary to ensure their continuum of recovery and in some cases enable a possible transition to independent living. Links to community education and employment initiatives are particularly important in this area.
- Floating support arrangements with other voluntary housing associations provide an example of how the British model (see Appendix 1) could be employed in an Irish context where support services could be separated from both housing and health services.
- Properties are integrated in developments with general needs and privately owned housing. This reduces the risk of ghettoising the tenants and reduces the stigma associated with mental illness.

Limitations

- HAIL boasts a strong record of maintaining tenancies and this is a combined result of settlement/support services and careful selection of tenants. The latter – while necessary for the smooth running of services – results in the exclusion of particular individuals whose support needs or behavioural problems prohibit them from availing of such services.

5.3 Case Study 2 – Cork Mental Health and Housing Association

In 2006 the Cork Mental Health Association split into the Cork Mental Health Foundation and the Cork Mental Health and Housing Association. The latter works on building and managing a series of social housing projects in a variety of areas in the county while the former aims to promote positive mental health, support people with mental health disabilities and create awareness and understanding. Both organisations are voluntary and the Foundation creates the groundwork for the smooth running of the Housing Association. This is achieved through presentations, as requested, to community, voluntary and statutory groups in the area of mental health promotion. The organisation also works on education programmes in local post-primary schools.

Mental Health Services in Cork operate in four HSE South catchment areas: North Lee, North Cork, South Lee and West Cork. Cork Mental Health and Housing Association lease properties from the HSE and Cork City and County Councils and build units through funding from the DEHLG's capital funding schemes. The organisation provides large residences, which are staffed by the HSE, smaller houses supporting between two and four tenants and single apartments for independent living. They currently operate over 30 properties throughout the city and county catering for almost 200 residents. There is a further development in Bantry and the organisation is seeking to purchase houses in the Togher/Ballyphehane and Midleton areas.

When the needs of people with mental health disabilities are identified in co-operation with statutory and voluntary organisations in the area, the association applies for CAS/CLSS funding in conjunction with the local authorities. Developments are then progressed taking into consideration the resource implications for the association. Access to accommodation is generally facilitated by the referral from the local community health nurse. Applicants must be on the housing list to qualify for a place in a residence. The location and design of the development is taken into account prior to construction or acquisition. The importance of these factors was illustrated where two tenancies broke down as a result of noise and low-grade harassment which diminished the residents' quality of life.

North Cork is an example of the positive changes in mental health service provision which has taken place since *Planning for the Future* (1984). Three long-stay wards have been closed since 1999 and residents have been resettled into community residences. The 14-bed residences in Kanturk and Mallow provide high-support care for people who have histories of being 'revolving door' patients. A quality of life study (Holley and Reilly, 2004) conducted on one of the residences – renamed 'Glenview' for anonymity purposes – identified a series of factors of importance in the planning of such care. These were summarised under the following themes: preparation for the move; leisure activities; social contact; work/occupation; independence/autonomy and physical environment. Of these areas, preparation for the move was seen as the most important part of the process after selection of patients for discharge to a group home. The report recommends that the information gathering and accommodating phase of the move takes place at an individual and group level so that each person has the opportunity of getting to know the feelings of others and discuss them in a safe setting.

The high-support residential units were envisaged as step-down facilities where, in scenarios where all components fit together, residents could make a transition to independent housing association, local authority or private rented accommodation. In some cases, however, where tenants had stayed in the residences for a long period of time, there could be a reluctance to move. This reflected the age variety in the residence which ranged from 28 to 70. As the majority of residents are smokers this was taken into consideration and specific rooms were provided.

In the context of community supports and integration, the Volunteer Befriending project, which was piloted in the Togher/ Ballyphehane area, has provided a potential example of good practice. The service aims to foster independence and self-empowerment and reduce social isolation for residents/tenants. Volunteers are given comprehensive training in mental health awareness, confidentiality and listening skills. The befriending relationship operates under a structured, time-limited framework which aims to help the person to widen his/her social network and make informed independent choices. This service operates through the Cork Mental Health Foundation, which is funded by charitable donations.

The organisation has put a considerable emphasis on allaying fears – characterised by a fear or misunderstanding of the varying degrees of mental ill-health – in the wider community ahead of residents moving into a new development. However, while some community concerns regarding child safety were noted at the early stages of the project, staff report strong relations with the local community exemplified by the large attendance of members of the wider community at a recent anniversary ceremony. Medical professionals commented that the community cohesion in the smaller, rural settings is particularly evident if a local mental health service user has not been seen for a period of time. This contrasts to urban settings where service users have slipped between catchment areas into homelessness.

Cork Mental Health and Housing Association is affiliated with the Irish Council for Social Housing and receives its funding through rents from their properties. For local authority owned houses an agreement is reached where security of tenure is guaranteed. The tenants' incomes are assessed by welfare staff from the local authority and two-thirds of the agreed rent is given to Cork Mental Health. The latter subsequently take responsibility for decorations and minor structural repairs while major defects are dealt with by the Council. Minimum rents have risen as part of overall attempts to professionalise the service further, with profits contributing towards future building projects. Similar arrangements are in operation with Clúid and Respond housing associations.

Strengths

- Established links between Cork Mental Health Housing and HSE services provides clear delineation between housing maintenance, support and medical responsibilities. A well-resourced rehabilitation team and step-down facilities with a dedicated funding stream strengthens chances of individual recovery.
- Mental health awareness campaigns in the community help to break down the stigma traditionally associated with mental illness and enable a smooth transition into the community for service users. The befriending system also provides an illustrative example of the social supports that can be provided through informal arrangements.

Limitations

- The acquisition of suitable sites is a regular challenge for the Association. Single units for independent living have been identified by Cork Mental Health and HSE staff as the most suitable environments for the recovery of many patients with low-support needs, but such provisions are costly.

5.4 Case Study 3 – Slí Eile Housing

Slí Eile Housing Association Ltd in Dromina in North Cork (HSE North Cork) is a registered company limited by guarantee with charitable status. It is an approved body for capital funding from the DEHLG and is a registered company with a Service Level Agreement with the HSE. There are currently five tenants in the Slí Eile house and all have a history of multiple admissions to psychiatric units.

The Association aims to help such 'revolving door' patients make the transition to independent living through the concept of community living with the necessary supports. Tenants have meetings with members of the Community Mental Health team every three months, while support workers work through plans in an attempt to both anticipate and prevent a crisis. Three house meetings take place every week to discuss issues relevant to tenancies and sustaining the house.

An important aspect of Slí Eile's work is its all-inclusive approach: families, professionals and the tenants themselves. In addition to their weekly rent, tenants contribute a nominal fee towards a 'house kitty'. As a rehabilitative residence, it is envisaged that it will be possible to provide skills-training opportunities, both in house and externally in partnership with CMHTs, FÁS, VEC, NTDI and Teagasc. Staff reported initiatives such as links with local businesses and a pilot project involving home-baking and deliveries to provide real work experience for residents.

The therapeutic environment of the residence was enhanced with the employment of a Strategic Development Officer in January 2007. This enabled the tenants and staff to focus on recovery and was signified later when residents stopped referring to staff as 'nurses'. An internal progress report noted that the impact of institutionalisation needed to be taken into account when assessing a tenant's progress. This involved 'small steps' towards confidence, engagement and independence. Areas of responsibility where progress had been made were identified and included household tasks, use of mobile phones, using banking services and saving money for holidays.

A progress report (Sapouna, 2007) assessed the target group and referral procedures for the residence. It was noted that a number of issues needed to be factored in when selecting tenants who would benefit from and be of benefit to the project. The report recommended that further attention should be paid to ensuring that the group was neither too homogenous to prevent them from supporting each other nor too diverse which may result in an unstable environment. An extension of the trial period to allow prospective tenants to get a fuller picture of the project's recovery vision and expectations for them was also recommended.

The tenants' contact with the local community has increased since moving to the Slí Eile house. Members of the Slí Eile Board, which comprises a diverse group of people with experience of all aspects of mental illness, have spoken of the importance of community support but note that a clear line is necessary between community involvement and consultation with local community members. This issue arose in the context of opposition Slí Eile has faced in the past from members of the local community. Board members argue that an over-emphasis on consultation and information may undermine the aim of the project, which is to provide a normal home environment.

Strengths

- Slí Eile offers an innovative example of practice in housing and recovery for a particularly vulnerable group ('revolving door' patients). The project considers contemporary theory on rehabilitation and recovery and attempts to create a sustainable community environment for residents by utilising local resources.

Limitations

- The project has required a lot of time, money and effort to become established and could be difficult to replicate on a larger scale in the context of the housing strategy.

5.5 Case Study 4 – Wexford Mental Health Association

Wexford mental health services are illustrative of the changes that have taken place since *A Vision for Change*. The 2007 Report of the Inspector of Mental Health Services highlighted the four-year rehabilitation plan developed by the Wexford mental health services rehabilitation team as an example of a good practice initiative. The service has also prepared a five-year plan indicating its intended implementation of the *A Vision for Change* recommendations. The multi-disciplinary team meet on a monthly basis at St Senan's Hospital in Enniscorthy to discuss the progress of their business plan. The head office of the Wexford Mental Health Association is located on the same premises. The Association provides a bridge between mental health professionals and the community in developing and maintaining community residences, training facilities and mental health education programmes. The provision of accommodation in the community is one of its central aims.

Wexford Mental Health Association has been involved in providing accommodation in the community since 1978 and currently operates 21 family-type houses in Wexford, New Ross, Enniscorthy and Gorey. There are 100 ex-residents of St Senan's Hospital living in these high-, medium- and low-support residences. St Senan's Hospital currently operates acute and long-stay wards for psychiatric patients.

The residences are owned by the HSE, the local authority and voluntary housing associations. The Association first assumed responsibility for properties when doctors' houses surrounding the hospital were vacated. Wexford Mental Health Association works in conjunction with the HSE and has traditionally been staffed on a voluntary basis by local mental health service employees. The rehabilitation team meet with the local authority three or four times per year to discuss the needs of clients on their list as part of their operational plan.

There are currently 20 service users who have made the transition to independent living in local authority or private rented housing and still receive outreach support. Applications for such housing are made by HSE staff with the service user. A 12-bed high-support unit, funded under the Capital Assistance Scheme, is currently in the pipeline. This proposed residence will act as a step-down unit for discharged patients and will contain a rehabilitation centre. The centre will be used to teach skills required to make a possible transition towards independence.

Strengths

- A variety of residences and a full rehabilitation team have enabled service users to make the transition to independent living.
- A good relationship with the local authorities has enabled the construction of purpose-built projects with good access to day care centre and health facilities.
- The transfer of HSE residences to voluntary associations is an example of good practice in inter-agency co-operation.

Limitations

- The catchment area contains comparatively few low-support units, hindering the transition of some patients, while others are not ready to move on.
- A study of the HSE community residences concluded that such homes risked re-creating the environments of hospitals or mini-institutions and thus may hinder the independence or recovery process of inhabitants (HRB, 2007).

- Wexford Mental Health Association relies on fundraising to carry out work that in other areas would fall under the HSE remit. Staff reported that this unique and informal arrangement may create an awkward position in the future if the Association does not have the funds or volunteers to carry out these responsibilities.

5.6 Case Study 5 – Sophia Housing

Sophia Housing provides accommodation for single, homeless people with support needs, including those with mental health disabilities. The Association was launched in 2001 and is affiliated to the Irish Council for Social Housing and the Disability Federation of Ireland. Sophia operates transitional and long-term supported properties in Dublin and Cork in collaboration with local authorities and housing associations. The association's model has four strands: housing, support services, training and collaboration.

Prospective tenants complete application and referral forms. The referral form provides a good example of the information required prior to establishing a tenancy with someone who has a mental health disability. This is generally completed by a social worker. The form deals with the applicant's accommodation history and, if the person has moved frequently in the previous five years, asks for the underlying reason for his/her changing living arrangements. A section on the applicant's health and medical history requests the referral agency to be as 'forthcoming as you can'. In the case of health professionals, confidentiality has been identified as an obstacle in dealing with housing officers from local authorities where they feel the service user is experiencing a period of mental ill-health.

On the subject of psychiatric illness, the form requests information on history and current status but also asks whether the applicant is in touch with a support agency connected to his/her illness. This agency can fall outside the health service parameters – affiliation with a psychiatric unit is requested separately – and offers a good example of connectivity with support agencies that may offer additional support in maintaining future tenancies. A detailed section on patterns of behaviour enables Sophia to establish a care or support plan for the prospective tenant during erratic periods. The 'Coping and Social' skills section identifies the following areas of support:

- Confidence and personal development
- Home care and management
- Establishing routines in the home
- Diet, nutrition and health care
- Budgeting
- Other

The level of support required in each of these categories is identified and a series of additional questions on maintenance and financial issues pinpoint areas that contribute to the tenant's plan. A budgeting service is provided. Sophia's project in Dublin City links with the Clubhouse service run by Eve Limited (FÁS). This service offers social programmes to facilitate integration in the community.

The association's first property – from which it operates its administrative offices – is a former convent and now contains 50 apartments and a crèche and parenting centre. The tenancies in these properties have been funded under the Rental Accommodation Scheme since 2007. The design has proven favourable to the therapeutic functions of Sophia by enabling reception staff to passively monitor comings and goings of tenants and report indications of mental ill-health. Rent is also paid in cash on a weekly basis by single tenants to facilitate a regular meeting. Staff note appearance, demeanour and eating habits as symptoms of a decline in mental health. For demeanour, staff report irrational anxiety and poor motivation levels as key signs. On the latter, support staff perform daily checks on particular tenants, placing an emphasis on encouragement.

Strengths

- A high level of personalised support is carefully planned out at the application stage for the tenancy.
- Innovative design enables support staff to passively monitor the progress of tenants.

Limitations

- Sophia combines tenants with mental health disabilities with general needs clients from a variety of backgrounds. While the support services are carefully planned the places available for mental health patients are therefore limited.

5.7 Case Study 6 – Monaghan County Council and St Davnet's Hospital

Cavan/Monaghan mental health services (HSE Dublin North East) were mentioned in both the 2007 and 2008 Mental Health Commission's annual reports as providing significant home based services: ... *the home base treatment team had been effective in reducing admissions to hospitals and enabling people with acute illness to be treated at home.* (MHC, 2007:102)

In 2008 the Mental Health Commission's annual report reiterated that services in this area were significantly home based but raised the issue of staff vacancies as problematic for provision of multidisciplinary care.

Therefore, Monaghan was selected as a local authority case study as independent living was clearly established, despite human resource constraints (2007-2008) within HSE services. St Davnet's Hospital is a mental health services hospital in Monaghan with two long-stay wards, one admission unit and home-base treatment, rehabilitation and psychiatry of later life teams. This case study is based on information collected from the clinical coordinator for St Davnet's Hospital and from a social worker and a senior executive for housing from Monaghan County Council. As with the other case studies, it is not a formal evaluation.

Monaghan County Council reported an excellent working relationship with mental health services in St Davnet's Hospital, and this relationship frequently extends to include other service providers and stakeholders. At its core, these services and relationships were considered to work well due to early planning and anticipating requirements, as well as allowing person-centred care to guide service provision.

When an individual is due to be given a discharge date from St Davnet's and a housing need is identified, Monaghan County Council is notified and the local authority social worker will visit the individual to discuss his/her needs. The hospital draws up a care plan, with the patient present, in agreement with other service providers (e.g. local authority, community-based support providers). A holistic approach is taken where the individual's proximity to family members, the local town, education and work are considered. From the local authority perspective, the intent is to ensure that a successful tenancy ensues, and therefore the individual's housing need is considered in the context of supports being available (this would include, for example, providing a second bedroom for a carer) and placement where a person would not experience harassment by other tenants. More often other tenants can be very helpful, acting to identify problems with a person who has experienced mental illness and communicating this through community groups and residents' associations – this was considered invaluable by the local authority and the mental health team as it was felt that early identification could prevent major problems for the individual at a later date.

Not everyone on the housing list with mental health disabilities will be accessing housing from the hospital. The local authority identifies people on the housing waiting list with medical certificates. Their application form includes consent for the local authority to contact medical services. The following three questions govern these enquiries:

- What services are working with the person?
- Is the person capable of independent living?
- Where is the most suitable place to house this person?

It was reported that particular care is taken when a person is moving into the private rented sector with rent supplement, to ensure that the accommodation is suitable and of a reasonable standard. This was considered important from a sustainability point of view. Particular attention was given to the role of rent collectors. It was reported that their regular contact with tenants provides an early warning system if problems should arise that might require the intervention of the local mental health team. In this way, problems are identified at an early stage and could be tackled before becoming more entrenched. Early identification of rent arrears was also considered important in preventing the situation escalating and the need for evictions. However, it was thought that the general move to deduction at source could mean that this passive support will eventually be eliminated.

Monaghan has a Homeless Forum that includes stakeholders such as domestic violence services, the St Vincent de Paul Society, and probation services. Protocols for housing homeless people include identification of a medical problem; services are contacted to find out what is needed and what has worked or has not worked in the past for this individual. The data-sharing that occurs is based on a need-to-know basis; the entire case history is not disclosed. Contractually all stakeholders are bound by confidentiality and data-sharing is not considered problematic where the individual has given consent.

The local authority reported the following challenges:

- It is often the accommodation provider for difficult cases, for example those undiagnosed or not availing of services, but who displayed behavioural problems in the community and have limited accommodation options.
- Staff vacancies cannot be filled.
- There is a lack of data in relation to the level of disability at a local level.
- There are difficulties in moving those in receipt of rent supplement to RAS where the original accommodation is not suitable, and relocating the individual could be disruptive.

Monaghan County Council is embarking on a large project to review its entire waiting list to ensure that all needs are known and identified early on. In addition, the County Council intends to make presentations to the St Davnet's staff on forthcoming housing options. These have previously been helpful to the hospital staff.

Strengths

- Monaghan County Council and St Davnet's have established good communication links and appear to have similar end-goals and ideas on how to achieve these. In other words, both service providers appear consumer-orientated, with the intent of providing long-term solutions that are best served through co-operation at the early stages of planning. These relationships are well-established, and are maintained even when staff move on.

Limitations

- There are resource constraints, for example not filling vacant posts. It can be difficult to identify and access individuals who have not been in contact with mental health services, but their housing and support needs may require such a response.

5.8 Community Support Services

The following examples provide an illustration of how services, independent of health or housing services, can complement or enhance service users' capacity to live independently. In addition to the examples below, the Gateway Mental Health Project and Rathmines Pembroke Community Partnership have recently commenced a self-advocacy skills-training course for people with personal experience of mental health disabilities. The course aims to increase users' knowledge of their rights and improve their ability to assert them. Housing rights and entitlements in the social housing and private rented sectors form part of the programme.

5.8.1 Case Study 7 – City Gate Accommodation Services

City Gate is a corollary of St John of God Housing Association. It was funded through the Capital Assistance Scheme and was set up primarily to address the needs of clients of St John of God services to access affordable and long-term accommodation. City Gate provides housing support to St John of God patients in homeless services, the private rented sector, privately owned property and local authority or housing association properties, with the objective of facilitating independent living.

All clients – aside from those in privately owned accommodation – must be registered on the local authority housing list, be willing to pay their own bills and take responsibility for their own cooking and cleaning and apply for rent allowance. Clients receive one visit per week from City Gate services and an emergency service operates in the evening and on weekends.

City Gate clients have mild/borderline intellectual disability or mental health disabilities. Support packages are negotiated with clients on an individual basis. The pre-tenancy course has been in operation since 2005 and covers the following areas:

- Being a good neighbour
- Bills
- Living skills
- Health and safety
- Tenancy agreements (a tenancy handbook has been in operation since 2006)
- The importance of working and having a social life

City Gate staff attend the bi-monthly Dun Laoghaire-Rathdown County Council (DLRCC) Homeless Forum with HSE staff, local authority housing and welfare staff, vocational committees and representatives from local housing associations. Staff report weekly contact with DLRCC staff and emphasise the importance of building relations with local authority counterparts. Currently the organisation hopes to pilot a six-week course – in collaboration with the VEC and Homeless Unit – in independent living skills with a focus on applications and subsequent paperwork. Staff reported that tenancies in the private rented sector have been problematic for many clients due to their instability, by comparison with local authority housing, and spells of anxiety have occurred approaching the end of lease agreements.

5.8.2 Case Study 8 – The Basin Club/Shine (formerly Schizophrenia Ireland)

The Basin Club was opened in 2002 following a period of consultation with stakeholders living and working in the Dublin North City area. The centre was developed as an alternative to the rehabilitative training services model in operation in Ireland and is based on an empowerment model. The model was furthered with the establishment of a second resource centre, The Basement Resource Centre, in Cork City in 2006. Participation in the centre is voluntary and each member is a key stakeholder. Weekly meetings are held for the purposes of discussion and decision-making and members are asked to bring suggestions or issues regarding any aspect of the activities, policies or procedures of the service.

The overall intention of the model is to support each member to build the insights, understanding and capacity associated with recovery and mental illness. The involvement of the peer group in this is considered to be of paramount importance. The Basin Club is open six days per week and provision of impartial information and advocacy – including housing support and guidance – is a key activity. The Basin Club operates as a drop-in centre during office hours and is accredited by FETAC as a means of developing and certifying skills and competencies necessary for further development. Networking with the local community services and supports is seen as a priority. Members report the club as their 'community' but live in a variety of areas and housing situations including family homes, HSE residences, hostels, local authority social houses and housing association properties.

The Basin Club operates on the principles of recovery and believes that the concepts of greater personal responsibility and self-determination are implicit in this process. This progression is life-long and rehabilitation services are responsive and flexible to support the individual's personal recovery. The structure of the service is divided into three main areas:

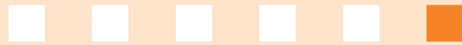
- Operational units (for day-to-day running and administration)
- Health education and wellness (activities intended to foster recovery)
- Supports and groups (peer support and activity aspects including accommodation)

Individual wellness recovery action plans (WRAPS) are put in place by service users with a mentor when needs have been identified and they have accessed the relevant information. Members and staff report that the club's strength lies in its empowering approach which is aided by its non-affiliation with mainstream services.

5.9 Conclusion

These case studies describe some current practice in relation to meeting the accommodation needs of people with mental health disabilities. They are not formal evaluations of the services. Common threads which come from the case studies are the need to respond to individual needs and to have inclusive approaches, the importance of smooth transfers from one setting to another and of security of quality accommodation. The importance of positive social relations has been stressed in some of the case studies and this links well with many of the principles of sustainable communities – that sustainable communities are inclusive places where people want to live and where equality of opportunity is promoted. The next section of the report focuses on how this information can inform the development of the National Housing Strategy for People with a Disability.

SECTION SIX



Conclusion and Recommendations

6.1 Introduction

This report has adopted a three-pronged approach to inform the National Housing Strategy for People with a Disability; with a particular mandate in the area of accommodation and support needs for individuals with mental health disabilities.

Firstly, the report considered the policy context and research evidence in this regard. The international experience and consumer preferences, the recovery approach, links to the homelessness sector, housing and supports were discussed.

Secondly, this report provided information on stakeholders' experiences of the housing and support needs for people with mental health disabilities. The gaps between policy and practice were highlighted. Though not exhaustive, this research provides an introduction to some of the concerns at grassroots level in Ireland at present.

Finally, this report considered case studies of current practice – again, though not definitive, these case studies should provide examples of current approaches. They were selected in consultation with key stakeholders as examples of what is considered to be working well. The purpose of the case studies was not to formally evaluate these projects but to describe the approaches used and to document some of the challenges faced in providing accommodation and associated supports for people with mental health disabilities.

The Housing Needs Assessment 2008 (see Cotter, Silke and Browne, 2010) provides some information on the demographics of Ireland's population with disabilities and in housing need; but this is limited. The categories are not broken down by disability type, and people who are in housing need may not always be represented on this list. For example, adults living in their family home may not be included, although they may have a housing need based on the recovery principles. The recommendations presented here follow the central assertion in relation to housing as outlined in *A Vision for Change* (2006): local authorities must fulfil their obligations to provide housing to people in their area who require it. *Happy Living Here* (HRB, 2007) also emphasises this, and pinpoints low- and some medium-support residents who could be housed by local authorities.

Delivering Homes, Sustaining Communities (2007) recommends the establishment and maintenance of sustainable communities that are inclusive. Recovery principles aim to make people with mental health disabilities increasingly independent. Keeping these foci as central, these recommendations follow the principles of sustainable communities as well as the recovery approach; using these models could enable people with mental illness to take an active role in improving their lives and feel empowered within their communities through acceptance and interaction. These principles will be considered under the following headings: person-centred support; centrality of housing needs and preferences; choice in independent living, responsiveness to population needs, separation of housing and support; inter-agency collaboration and co-ordination; advocacy; long-term perspective of housing and support needs and dedicated funding streams.

6.2 Support Principles

Person-Centred Support

Person-centred services should aim to plan and implement housing and support around the person's identified needs and preferences. This process is underpinned by assertive outreach and time to nurture and build a relationship between the individuals and support workers. This was illustrated by the HAIL model in this research, in which tenants received intensive support during the initial settlement and when the person may be experiencing particular difficulty and stress. Consistency in service providers is also vital in this area to enable a smooth continuum of care for the service user and ensure that the necessary mechanisms are in place to prevent a crisis. This is particularly relevant in situations where clinical intervention is required. Documentation and testing of good practice should also be prioritised.

Centrality of Individual's Housing Needs and Preferences

One of the central features of sustainable communities is that they are places where people want to live. Those with mental health disabilities interviewed as part of this research all stressed the importance of their living situation (including location and level of supports provided) – the living situation that they are most happy with is likely to be most sustainable to them over time. In this context, wherever possible, personal preference should be taken into account in responding to identified needs.

Choice for Independent Living

Facilitating choices in independent living applies a developmental approach to skills, decision-making, financial management and community participation. It has the expectation of widening the individual's choices for independent living by maximising his/her abilities. Mental health disabilities have been shown to negatively impact an individual's confidence and motivation and this may threaten the person's ability to make decisions or feel empowered. In these situations, access to information, advocacy (of the person's choosing) and advice services in community settings would provide crucial supports to those who wish to gain greater independence.

Responsiveness to Population Needs

Service and system-wide approaches should be sensitive and responsive to the needs of differing population groups. This would include people across the life cycle with mental health disabilities as well as people with different co-morbidities (e.g. dual diagnosis) and different criminal justice histories.

Service users who have spent long periods living in institutions may prefer to live permanently in a supported environment. For others, these supported settings could be transitional step-down units where they acquire the necessary skills and confidence to move on to independent living. There are also other people with mental health disabilities who could follow the 'housing first' approach where the housing unit is established first and necessary supports provided. Others may not require any particular assistance and are already living independently. Deciding on the most appropriate response will depend on a person-centred needs assessment and consulting with the person about his/her preferences.

Separation of Housing and Support

This report highlights particular examples of current practice in housing and support services in Ireland. These combinations of permanent tenancy and individualised supports greatly enhance the prospects of maintaining a residency. Separation of these functions by independent organisations or by separate functions within one organisation aims to minimise conflict and ensure integrity of landlord and support functions.

Fennell et al (2010) looked at the potential role of the private rented sector in fulfilling accommodation needs. The findings indicated that while the sector can offer choice, quick access and cost-effective accommodation, one of the problems identified with the sector for people with disabilities was tenancy sustainment. The report recommended developing more person-centred supports for those moving to or living in private rented accommodation in order to help with sourcing accommodation, adjusting to independent living and providing supports for landlords, for instance. This might take the form of tenant liaison officers or advocacy services.

Inter-agency Collaboration and Co-ordination

Inter-agency collaboration and co-ordination aims to focus the service on the needs of the person rather than the organisational boundaries. This report gives examples of therapeutic and sustainable environments provided by specialised housing associations. The major advantage of these arrangements, in the context of inter-agency co-operation, is the continuing communication between support workers and mental health staff. Through experience and training, support staff are conscious of symptoms that may indicate a decline in the tenant/service user's mental condition and subsequently contact the appropriate clinical staff. Referral information – within the limits of data protection and confidentiality – facilitates such an arrangement.

Advocacy

Under the Citizens Information Act 2007 the Citizens Information Board has a mandate to provide advocacy targeted at people with disabilities. Advocacy aims to address discrimination, social exclusion and stigma experienced by people with mental illness in their homes and communities. It moves beyond direct housing and support services to advocating and building inclusiveness in mainstream services, community networks and civil society. Contemporary best practice in mental health service provision is characterised by the recovery model, and suitable accommodation is seen as both a lynchpin and a target of this overall continuum. This research, while not representative, indicates that the availability of such services varies significantly in accordance with resources and population densities within particular catchment areas. Interviews with service users indicated that information on service availability and entitlements can represent a considerable obstacle preventing independent living.

Assuming that sufficient advocacy services are in place, service providers should then ensure that every possible effort is made to encourage the service user to avail of them. The Basin Club provides a useful template for this aim. Peer support enables service users to identify common obstacles and empower them to take an active role in overcoming problems. Advocacy courses – provided in community resource centre settings with the collaboration of the Irish Advocacy Network – have been piloted successfully and should be expanded throughout the country. These courses provide information on service availability and the application process and legal tenancy rights.

Long-Term Perspective of Housing and Support Needs

A long-term perspective on housing and support aims to achieve continuity through tenancy sustainment. It contrasts with a short-term focus on a current housing crisis, which compromises the goals of housing and support policy. A long-term perspective aims to nurture and strengthen family, peer, community and natural supports. These support requirements are likely to vary over time as a person's circumstances change.

Dedicated Funding Streams

The Homeless Agency's *Evaluation of Homeless Services* (Brooke et al, 2008) highlighted the need for a defined funding scheme for all short-term and long-term housing support services. The authors pointed to savings accrued from the provision of more cost-effective long-term accommodation to former long-term occupants of private emergency accommodation. Short-term supports such as resettlement and tenancy sustainment are funded under Section 10 of the Housing Act 1988. The authors estimated that the unit cost of providing this housing support is approximately €4,000 per annum per client (in the current economic context, lower costs may be achievable and this should be kept under review through competitive tendering). This estimate is based on a caseload of approximately 20 service users requiring different levels of support. Support services for housing associations catering for clients with mental health disabilities are provided through HSE Section 39 funding. This research, with examples of existing good practice, has illustrated that adjunct outreach and resettlement services are an essential part of initiating and maintaining independent living arrangements.

Appendix 1 contains some additional information on models of practice from Australia and the UK which may further inform the development of the National Housing Strategy for People with Disabilities.

6.3 Recommendations

Housing Need

- The current housing needs assessment carried out by local authorities does not provide information on the specific housing needs of those with mental health disabilities. Local authorities should review their measurement of housing need to ensure that they have sufficient information available for planning and service delivery for this group. DEHLG could take the lead in this, providing specific guidance to local authorities.
- The interviews undertaken for this research revealed the difficulties people suffering from mental health disabilities may encounter when attempting to access social housing. Local authorities' homeless or housing lists are updated every six months and those not registered will no longer be considered in need of housing. In many cases advocates reported individuals failing to respond to correspondence from local authority housing staff due to mental illness or letters being sent to old addresses. Allowances should be made in such circumstances. One consideration is for their cases to be automatically renewed at the end of each six-month period.
- The services available to prospective tenants, as well as the different forms of housing that could be on offer (e.g. voluntary housing) could be publicised by local authorities – possibly through the housing advice centres advocated in *Delivering Homes, Sustaining Communities*.

- The housing needs of single people with mental health disabilities have not always been adequately prioritised by local authorities in the past. The National Housing Strategy for People with a Disability should prioritise the further development of policies and services to address this group. This could include developing good practice on identifying and responding to the housing needs of single people, the incorporation of these needs in local authority Housing Action Plans, the role of the voluntary and co-operative housing sectors, and drawing on the range of housing responses to address the housing needs of this group.

Provision

- As recommended in *A Vision for Change*, mental health services should work in liaison with local authorities to ensure housing is provided for people with mental health disabilities who require it. The provision of social housing is the responsibility of the local authority. Furthermore, as recommended in the Homeless Agency's *Evaluation of Homeless Services* (Brooke et al, 2008) a dedicated funding stream is needed for the provision of supported housing for homeless people whose non-housing needs are such that they are unable or find it difficult to sustain a tenancy in mainstream housing (some of whom will have mental health disabilities).
- People with a mental health disability are particularly vulnerable to anti-social behaviour. In some cases such events can lead to aggravation of their symptoms. These special needs should be taken into consideration when allocating social housing and best practice should be further developed and tested in this area. Design of housing and accommodation can also help to prevent anti-social behaviour by maximising the amount of defensive space and the potential for natural surveillance (see Norris, 2003).

- The Rental Accommodation Scheme or similar long-term lease schemes should be expanded where possible to meet the long-term accommodation requirements of service users who could be vulnerable to the tenure restrictions of private rented accommodation. As this research has shown, security of tenure could have positive quality of life impacts for those with mental health disabilities.
- The obligations on private landlords in relation to standards have been enhanced since the 2004 Residential Tenancies Act and, most recently, through the Technical Guidance Document (standards for Private Rented Accommodation, 2008). Local authorities should make the best possible effort to enforce these standards and ensure that people with mental health disabilities do not have their condition exacerbated by low-grade accommodation and/or poor landlord practice.

Management Issues

- Respondents in this research expressed concern that patterns of staff turnover within local authorities can result in new housing staff being unfamiliar with the symptoms associated with mental ill-health. Generic training should be provided where possible, by representatives from service user or stakeholder groups (such as Mental Health Ireland) to familiarise staff with patterns of behaviour that may indicate a mental health disability.

- The principle of inter-agency co-operation emerged as a strong theme in this research. A good model for such co-operation would involve mental health staff and local authority housing staff meeting on a regular basis (i.e. monthly) to discuss developments and housing requirements. Such meetings would require the involvement of senior housing officials from the local authorities, relevant members of the multi-disciplinary team and stakeholders or advocates. The Homeless Agency care and case management programme (see Cotter, Silke and Browne, 2010 for details) could be a good model.
- Housing support should be formally acknowledged as a housing service that is an integral element of mainstream housing provision for people with mental health disabilities. Box 2.4 above outlines the recent development of housing supports for homeless households, which provides an example of a possible way forward. Greater clarity on funding and responsibility for the types of supports that those with mental health disabilities may require over time is needed between the Department of Health and Children and the Department of the Environment, Heritage and Local Government. Some supports are likely to be provided by local authorities and others by the HSE but they should follow the support principles outlined in 6.2 above.
- Previous research has highlighted potential difficulties around discharge planning (HRB, 2006). The development of appropriate and effective discharge protocols should be included as an action under the new Strategy, together with the development of the evidence base regarding best practice in this area.

- The important role that advocacy can play has been identified, for example given its statutory footing, but variation in access to the service has been reported. There are many ways in which people can access these services – community resource centres, Citizens Information Disability advocates or tenancy sustainment services, for example. It is important that these services are funded to provide more universal access and that service providers are trained to recognise the special needs that people with a mental health disability may have.
- The *Homeless Agency's Evaluation of Homeless Services* (Brooke et al, 2008) recommends that all emergency accommodation services should operate a key worker system. A similar system should be established as part of the mental health multi-disciplinary team. The key worker in this situation would establish a long-term accommodation plan for the service user at the time of discharge from hospital. Protocols should then be put in place to ensure that a specific person is sharing responsibility with the individual if things go wrong. The resettlement workers provided by housing associations provide a possible template for this service.
- Community awareness programmes, such as befriending systems, community centre meetings or school presentations should be actively promoted and funded to raise awareness and tackle the stigma associated with mental health. Local authorities should participate in these initiatives as part of the broader policy aim of making communities more sustainable.

Improve the Evidence Base

- International literature identifies supported housing as best practice for people with mental health disabilities. The transferability of international research to the domestic situation, however, is problematic (see Cotter, Silke and Browne, 2010). An Irish evidence base needs to be established, as well as methods for measuring the effectiveness of different housing settings and supports. Building the evidence base regarding who does what, what works well and in what circumstances and with what cost should be an important feature of the National Housing Strategy for People with a Disability.

Appendix 1

Mental Health and Accommodation – examples from other countries

The original terms of reference for this study did not include an international literature review. However, the following information from Australia and the UK was collected while undertaking background research for the study and is presented here for general information. A more detailed examination of international practice would provide a more empirical basis for commentary on good practice.

Case Study: Housing Accommodation and Support Initiative, NSW, Australia

The Housing Accommodation and Support Initiative (HASI) is an innovative tri-partisan programme, funded by the Centre for Mental Health, between non-government supported accommodation organisations, the Office of Community Housing, and Area Mental Health Services in New South Wales Australia.

The Initiative was established to provide high-level accommodation support for people with a mental illness. It reduces the pressure on hospital beds and increases independence and privacy for low-income people with mental health problems by providing additional accommodation and support in the community. In the past, supported accommodation for people with high-level or complex needs was mostly provided in group home settings.

HASI has a focus on securing individual housing that is linked to a range of co-ordinated support services. This model separates the functions of landlord, disability support and mental health care. The main emphasis of the HASI programme is to bring people home – free from psychiatric institutions, homelessness or out-of-area placements. A key component is voluntary participation in the programme. HASI is linked with other acute and non-acute inpatient initiatives of the Centre for Mental Health and also complements a number of other supported housing projects being undertaken by the Department of Housing to assist people with complex needs.

NSW Health provides recurrent funding for clinical mental health services, the Richmond Fellowship of NSW (RFNSW); Neami and New Horizons (three NGOs) provide the accommodation support services (psychosocial rehabilitation interventions that include domestic, emotional and community support);[18] and the Department of Housing provides properties for supported housing of individuals on low incomes. The Area Health Service, the housing provider and NGO enter into a service level agreement that describes the services to be provided by each of the partners.

18 Assistance may target: activities of daily living, including domestic chores such as shopping, cooking and cleaning; personal care tasks such as showering and taking medication as prescribed; health care, including identification of general and mental health treatment and rehabilitation needs as well as seeking assistance when required; and income support issues such as the identification of a source of income, the maintenance of budget, and the payment of rent. RFNSW provides up to 16-hour support per day and provides a 24-hour non-clinical phone support. RFNSW makes arrangements for an appropriate response to be made which may include the assistance of the 24-hour non-mental health crisis service, the 24-hour translating and interpreting service of the Community Relations Commission or NSW Health, or the Area Health Services 24-hour mental health crisis service.

HASI aims to assist people with a mental illness and high levels of psychiatric disability who:

- Are residing in a hospital bed because it has been difficult to access high levels of accommodation support
- Are homeless, at risk of homelessness or inappropriately housed. This can include clients whose current housing is at risk due to an inability to access support
- Have the ability and desire to live in the community
- Are unlikely to be able to maintain a mainstream tenancy agreement.

Accommodation support services will accept referrals for clients who are:

- 16 to 65 years of age
- Diagnosed with a mental disorder
- Experiencing moderate to severe levels of psychiatric disability
- Capable of benefiting from the provision of disability support services
- Capable of informed consent to participate in the programme

The local Area Health Service, the housing provider and the NGOs have formally established an Advisory Committee and a Selection Committee that monitor and review the referral process and identify eligibility of referrals in accordance with the terms of reference. The selection committee reviews all allocations and placements.

Source: www.rfnsw.org.au

Evaluation

The Housing and Accommodation Support Initiative has been evaluated:

Morris, A., Muir K., Dadich, A., Abello, D. and Bleasdale, M. (2005) *Housing and Accommodation Support Initiative Report 1* Social Policy Research Centre and Disability Studies Research Institute, report commissioned by the NSW Department of Housing and NSW Health

See also: Muir, K., Fisher, K.R., Dadich, A. and Abello, D. (2008) 'Challenging the exclusion of people with mental illness: the Mental Health Housing and Accommodation Support Initiative (HASI)' *Australian Journal of Social Issues* 43(2):271-90

This evaluation is longitudinal using a mixed-method approach, and is focused on outcome – evaluating if HASI supported people with high levels of psychiatric disability to improve housing, mental health and community participation. The evaluation found the HASI model to be an overwhelming success. There was an 81 per cent reduction in the average number of hospitalised days per person per year. A brief summary of initial outcomes shows that:

- There was an improvement in community participation levels – 72.2 per cent of clients had made new friends and 65.6 per cent were participating in social and community activities.
- Eighty-five per cent had successfully maintained their tenancies.
- Sixty-nine per cent of the area mental health services case managers reported an improvement in their clients' mental health.
- Over 50 per cent reported improvement in their cooking, shopping and budgeting skills, along with improved diet and use of public transport.

Relevant analysis:

- Effective governance was key to successful outcomes.
- Relationships between the three partners were positive. However, some tensions were detected around the style of support provided, training, response times and clients with dual diagnosis.
- Support provided by the NGOs worked best when coupled with social interaction, enabling a rapport to develop between service provider and client. Long-term interaction provided the best relationships. Without this, clients expressed unhappiness with the supervisory nature of support.
- It was found that separate homes, unit or townhouse complexes worked best. Stand-alone housing could be problematic due to garden maintenance; this was addressed through subsidising gardeners. Small clusters of clients often worked well as a support basis for each other. However, one unsuited client could disrupt this equilibrium.
- Within the evaluation, stakeholders debated the appropriateness of clustered housing – is it stigmatising, negating the aim of independent, integrated, community living? Or, beneficial in fostering social relations between tenants – but only in a maximum grouping of four properties with carefully selected tenants.
- It was sometimes difficult, but attempts were made to match clients to housing that was accessible to social networks, services and resources. In almost all cases this was possible. A limitation of HASI was the prohibition of shared tenancies. Clients wanted to share with people they had meaningful relationships with, not acquaintances/strangers.
- Eighty-five per cent of clients attributed their tenancy stability to the HASI programme; housing providers were equally satisfied with the work of the NGOs and mental health services. In addition, the Centrepay[19] system, enabling prompt rent payments, was also cited as contributing towards tenancy sustainment.

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19 Centrepay (a Centrelink service) provides customers with a voluntary option to pay their bills by having regular, manageable amounts deducted from their Centrelink payments and paid directly to their Centrepay organisations (utility companies etc.) as part or full payment for services.

Two further evaluations of HASI are forthcoming. However, Muir et al (2008) reveal that in these later evaluations, although the 'honeymoon' period was over and there was some slippage, overall the HASI model appeared to still be working well.

Muir et al (2008:286) state that:

At the core of the model is stable housing in the community. Success in this outcome is associated with finding housing suitable for the person's needs and providing early responsive housing support to prevent tenancy breakdown. Factors including personal preferences, social connections, access to community opportunities, compatibility in the neighbourhood and flexibility to relocate when needs change or the housing proves to be unsuitable. Co-ordination between the housing, accommodation support and mental health partners is also instrumental to the success of the model. … The strength of the HASI model is that it acknowledges the integral nature of ongoing partnerships between the three service partners and commits sufficient resources to facilitating its success.

New South Wales' Department of Health has produced two inter-agency action plans. The most recent of these – the *Inter-agency Action Plan for Better Mental Health: Second Yearly Progress Report* (April 2008) – makes a commitment to enable people with a mental health illness to have stable housing by linking them to other avenues of support. This document does not discuss housing only; instead the remit is wide and makes an interesting read in terms of how advanced NSW is in integrating and communicating across departments.

For example, the NSW *Health Discharge Planning Policy for Adult Inpatient Mental Health Services* (January 2008) provides for a standardised approach to all facets of clinical care concerning discharge and the transition between inpatient treatment settings, as well as from the hospital to the community.

Simple measures such as ‘My Health Record’ patient books are intended to enable people with chronic mental health problems to keep track of their treatment and support information. Common privacy policies and referral protocols are integral to ensuring that hospital and community supports share common information to best serve the client. With regard to further education and employment opportunities, the flexibility and communication between various state and voluntary agencies has proven to have success with people with complicated histories.

HASI resource manual

The HASI resource manual (available on www.health.nsw.gov.au) outlines the structure of the collaboration by HASI partners, and also provides information for service providers on selecting clients, negotiating consent, dispute resolution, contingency strategies, relative needs assessment. These are not dealt with here due to space limitations and a summary would not do full justice to these guidelines. However, the following gives an overview to the way inter-agency co-operation and collaboration between partners is working in this case study.

Management

The HASI Advisory Committee oversees HASI and has representatives from sponsor and partner agencies as well as other key organisations. The Committee’s role is to oversee implementation and provide direction as well as support monitoring and evaluation. Since 2006 the Committee also hosts quarterly practice forums. These bring stakeholders together to share information and workshop issues.

HASI has a three-tier management and co-ordination structure involving sponsor agencies (NSW Health and the Department of Housing), partner agencies (Office of Community Housing, Centre for Mental Health, Area Health Services, community housing providers, NGOs), and local HASI providers (local area health services, housing provider, accommodation support provider).

When a client is accepted into HASI, these steps are followed, where appropriate:[20]

- The accommodation support provider liaises with the client to identify his/her accommodation needs
- A support contract is drawn up containing details of the support services to be provided by the accommodation support provider
- The mental health care plan should be finalised – this includes details of the clinical services to be provided by the local mental health provider and the client's recovery plan
- The residential tenancy agreement should be signed by the housing provider and client – this contains details of the terms and conditions of the tenancy
- The individual support plan should be finalised – this consolidates the key contacts and service information related to the support contract, mental health care plan and the tenancy agreement

When these are in place and the client can move into his/her new home, the following services comprise the HASI system. This is reproduced here where relevant to inter-agency co-operation.

Support Coordinator

The support coordinator is an individual (typically from the accommodation support provider) responsible for coordinating the care and support provided to a client. This person may also be responsible for client advocacy. The support coordinator is responsible for:

- Coordinating services to be received by the client

20 All of these may be unnecessary where the client is under the lower support HASI programme and already has accommodation.

- Negotiating individual support plans between the three key providers (housing, mental health, accommodation support)
- Monitoring changes in the client's situation, and being the client's first contact point when a problem is encountered
- Participating in joint reviews of the mental health care plan
- Passing on feedback regarding services

Accommodation Support Provider

The accommodation support provider conducts a thorough assessment of need that is translated into a support contract prepared with the client and documents the specific services to be provided. The accommodation support provider is entrusted to provide comprehensive, client-centred, strengths-based assessment, care planning and intervention which addresses the range of needs consumers may have, to include:

- Self-maintenance needs (e.g. home management)
- Productivity needs (e.g. education)
- Leisure needs
- The implications of cultural and linguistic diversity and of disabilities other than mental health problems, such as physical disabilities
- An after-hours call service providing emergency support to clients in non-clinical, non-mental health matters

Aside from these duties, delivered daily, the accommodation support provider must also frequently liaise with other service providers and keep abreast of referral options.

Mental Health Services Provider

The local mental health provider has responsibility to:

- Clinically assess the client
  - Complete a psychosocial history of the client (mental health outcomes and assessment tool) and consult with the client, family members and other support people nominated by the client about this assessment data
  - Liaise with other service providers
  - Develop a care plan
- Provide treatment and rehabilitation
- Provide crisis intervention

The mental health care coordinator is the direct service provider and must respond to new developments and constantly review the rehabilitation process with the client and other parties to negotiate changes to care components. It is necessary to liaise not only with the HASI partners, but also with the hospital should the client be admitted.

The mental health outcomes and assessment tool (MH-OAT), mentioned above, is the core document underpinning the client's care co-ordination. The MH-OAT care plan is a four-page module designed to identify appropriate levels and types of service for the client. It contains an outline of the current situation, the goals to improve the situation and indicators of improvement, the strategies for achieving goals, key personnel responsible for implementing strategies, as well as strategies for managing risks and relapse prevention. Each client is also given a mental health consumer recovery plan; this is developed by the client with the accommodation support worker and mental health worker. It contains identification of strengths, contact details of nominated support people, and potential stressors.

Housing Services

These differ for high-support and low-support HASI. In the case of high-support HASI, the housing provider is required to source and allocate suitably designed and located accommodation for the HASI client. Property will be selected based on individual need and in consultation with the accommodation support provider. This tenancy is managed in accordance with relevant legislation (Residential Tenancies Act (RTA)). The properties are also maintained and repaired (as per RTA), rent is collected and all payments and arrears are monitored. For lower-support HASI, the housing service provider assists in tenancy sustainment and in all respects acts as a benevolent landlord.

Individual Service Plans

The accommodation support provider is charged with responsibility for this document and ensuring that all parties have current copies of it. The document defines what each client will receive and how services will be delivered, and is regularly reviewed. It also contains key contacts for the client, and has all other related HASI documents attached (e.g. tenancy agreement, mental health care plan, support contract). The document is a shared document negotiated between all the parties and signed by all the local HASI providers as well as the client. It enables all three providers to define their roles in relation to each other as well as the client. It brings the partnership from a service to an operational level. Each plan defines specific commitments to the client such as:

- Identification of the support coordinator
- The nature or range of services to be provided
- The average number of hours, or range of hours, to be provided by the accommodation support provider
- Lists of contact people and contact details relevant to the client's housing, clinical care and support

- A signed client agreement form that:
  - Acknowledges his/her participation in finalising the service plan
  - Commits to meeting with the support coordinator on a regular basis
  - Where required and appropriate, authorises the three local HASI providers to discuss the client's progress, particularly in circumstances where their accommodation, health or well-being is being jeopardised or where services need to change

Case Study: UK

The UK model operates with independent sector providers. The National Health Service and Community Care Act 1990 states that it is a duty for local authorities to assess whether people need social care or support. If patients are deemed to require community services, these must be provided by law regardless of resources. This new legislation resulted in a greater involvement of non-statutory agencies in care arrangements. It also enabled registered social landlords to provide a large amount of the affordable housing to people with mental health problems. These may take responsibility for the housing management while entering into an agreement with a support agency to provide care services or they may hand over responsibility of both to the voluntary agency.

The 'Supporting People' initiative commenced in 2003 with the intention of providing related support to vulnerable tenants and households. The programme is a partnership between the Care Trust, the local authority and the National Probation Service who – together with providers from voluntary, charitable, statutory and private sectors, users and carers – act as the key commissioning body agencies. These services can take different forms including: community-based advice centres (mediation and dispute resolution, form-filling and benefit entitlement); visiting people at risk of homelessness and drop-in centre support to combat isolation.

In conjunction with this initiative, the Office of the Deputy Prime Minister (2005) published a guide to accommodation and support options for people with mental health problems. The guide lists the following range of specifically housing related support needs:

- Tenancy sustainment services to enable them to stay in their accommodation as soon as their initial mental health needs have been identified
- Support with independent living skills such as how to obtain furniture and setting up payment of household bills
- Assistance with domestic skills such as cooking, shopping or how to deal with practical aspects of living independently
- Assistance in managing finances
- Advocacy to ensure they are receiving their full entitlements and help to gain services including mental health services
- Support to establish social networks and activities or to re-establish old friendships, social and family networks (ODPM, 2005:4)

The above services can be administered by floating support services and can be delivered over short or longer periods. This can take the form of crisis prevention or resettlement into a new home after a period in an institution or supported housing. The report notes that this service can be provided by either generic support agencies or those focusing exclusively on mental health.

The support services dedicated to overcoming crises tend to focus on one particular issue that can threaten a tenancy. This can include the following issues:

- Engagement with people struggling to cope who are in danger of eviction
- Engagement with people who have been abandoned and risk re-admission to hospital for causes related to their mental health difficulties
- Assistance with a particular personal issue that is reaching a crisis point

The resettlement floating support services offer intensive support on a time-limited basis focused on helping someone settle into independent living for the first time in a new area. The intensity of the support would gradually reduce after the initial period of resettlement. The report also notes that such services may not be suitable for some people:

- People with highly volatile behaviour
- People who have both mental health problems and a major drug or alcohol problem (a dual diagnosis)
- People with a history of disruption or experience of exploitation
- People with low self-esteem who are not prepared for living independently, particularly if the service does not offer regular emotional or social support
- People who have lived in institutions who often prefer supported housing, either in the long term or as a step towards having their own home
(ODPM, 2005:9)

A review of low intensity support services in Britain (Quilgars, 2000) revealed a number of substantively important messages including: how the way in which a service is delivered (timing, attitudes of staff) influences the likelihood of a tenancy being successful; users consistently valued the support of a worker or volunteer, often in preference to more formal networks and activities; and there was limited success in increasing users' social networks and activities (cited in Anderson and Wynne, 2004).

UK: Service Example

Mental health services are delivered on a decentralised basis in the UK and floating support services vary in accordance with the local area. An example of such a service is provided by Julian Housing, which has operated in Norfolk since 1990 as a partnership with Supporting People, Norfolk Social Services, Norfolk Primary Care Trusts and almost every major housing provider in the county. Julian Housing does not own any properties and serves roughly 1,500 people, 85 per cent of who are in their own homes (JHS, 2009). Referrals are accepted through Continuing Support, mental health teams and housing providers. In addition to their active outreach support services and supported housing partnerships, Julian Housing also operates a Housing Link Worker Service. Through this service one or two link workers are attached to each psychiatric acute ward in Norfolk. The workers link up with clients early in admission to help prevent a lengthy stay in acute hospital. Link workers can work with people for up to four weeks after discharge on matters to do with their housing support needs. Clients have been referred to the service for the following reasons:

- Homelessness
- In the process of being evicted
- Want to move from current accommodation
- Relationship breakdown or bereavement impacting on housing
- Currently living with family, but wants to live independently
- Does not want to return to existing accommodation but wants to live independently
- Benefit and debt difficulties impacting on housing stability
- Problems in managing current tenancy
- Other housing related issues such as problems with utilities, repairs and furniture

Source: www.julianhousing.org

Under the UK's 'Supporting People' initiative, floating supports have been researched in terms of their effectiveness (Civis Consulting Research, April 2008). Floating supports are defined as support services not tied to accommodation so that they can follow the individual as he/she moves, or can 'float' to someone else when no longer needed. Within this research, floating supports are identified as being cost-effective for the following reasons:

- They can reduce rent arrears
- They can prevent tenancy breakdown and resulting costs
- They can reduce costs of hospital admissions and facilitate timely discharge
- They can reduce re-offending rates and address anti-social behaviour

Aside from being cost effective, authorities stated that floating supports could be closely aligned with their strategic aims, and could enable provision of more services to more people which happens to be more cost effective due to flexibility and streamlining. Floating supports can also help create sustainable communities and promote social cohesion.

This research gives an estimate of an average hourly rate of STG£22.46 for all floating support services (median STG£19.78). However, Appendix 3 is very useful in supplying further information on floating support costs by client group and region. These variations demonstrate how these costs cannot be crudely transferred into an Irish context for comparative purposes, but can provide us with a rough guide.

www.spkweb.org.uk
provides the costs of ‘Supporting People’ by service type.

http://www.sitra.org.uk/fileadmin/sitra_user/2009/benchmarking/Support_Benchmarking_web.pdf
demonstrates costs from around the UK and Northern Ireland.

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