Mental health and housing: making the links in policy, research and practice

This article documents policy developments at local and national level in England that reflect a growing recognition of the role of housing and the built environment in promoting and maintaining mental health. It first considers the evidence for the housing disadvantage experienced by people with moderate and severe mental health problems and the negative impact of poor housing and neighbourhood circumstances on mental health. It goes on to explore the expansion in housing-related support and housing-based solutions in the 1990s, and the revived ambition to integrate housing with community care and community cohesion initiatives. It concludes by describing the work of the NIMHE housing reference group in co-ordinating policy guidance, promoting positive practice in communication and co-operation between housing and mental health services, and conducting research to fill gaps in current understanding.

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POLICY

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The Victorians, like the Romans before them, understood that the best way to improve the health of the general population was through sanitation and environmental health. Today, in the 21st century, the worst of the Victorian slums are cleared and streets are clean. But mental health is now rivalling physical health as a cause of public and policy concern (Layard, 2004). Depression is projected by the World Health Organisation (WHO, 2001) to become the leading cause of disability and the second leading contributor to the global burden of disease by the year 2020. In the UK, depression and anxiety have overtaken musculo-skeletal problems such as back pain as the most common reason for new claims for long-term sickness benefits (Henderson *et al*, 2005), and mental health problems are estimated to be costing society as a whole some £77 billion per annum – of which dedicated health and social care services account for only one sixth (Social Exclusion Unit, 2004). What, then, is the new public health agenda in UK mental health policy, and what is the role of housing and the built environment in promoting improved mental health?

At first sight, it seems simple. Housing cannot be regarded as incidental to community care. Good quality, safe and suitable accommodation is one of the cornerstones of well-being, and for many people access to decent housing can be the key to a better quality of life, positive relationships with immediate neighbours, independence and an accepted 'place' in the local community. People with mental health difficulties are no different in this respect from anyone else in society. Alongside financial security, constructive activity and a welcoming family or social circle, good housing, with the appropriate support to help manage the ordinary tasks of living, is one of the topmost priorities of mental health service users (Meltzer *et al*, 2002; Rankin, 2005) and their carers. Yet there is strong evidence to suggest that people who use mental health services are also at a distinct disadvantage in the housing market. The known facts are as follows:

- people with mental health problems are twice as likely as other respondents to report discontent with their accommodation, and four times as likely to believe that their accommodation makes their health problems worse (Meltzer *et al*, 2002)
- people with mental health problems are significantly under-represented in owner-occupier housing – generally the most socially valued and secure housing in the UK (Meltzer *et al*, 2002)
- mental health problems are high on the list of risk factors for tenancy breakdown (Slade *et al*, 1999); housing-related problems, in turn, are among the most

common triggers for admission or re-admission to psychiatric care[1]

- recent reports identify a shortage of suitable accommodation – of supported accommodation in particular – as a major factor in delayed discharge from hospital (or 'bed blocking') (Greater London Authority, 2003)
- many studies indicate a very high prevalence of mental health problems and in particular of serious mental health disorders among homeless people (eg. Bines, 1994; Gill, 1996; Odell & Commander, 2000; Timms & Balázs, 1997)
- there are consistently higher concentrations of people with mental health problems in inner city areas (Kai *et al*, 2000; Macpherson *et al*, 2003), where poor housing – including overcrowding, multi-occupancy and a dependence on high-rise accommodation – is known to exacerbate other mental health difficulties (Commander *et al*, 1997; Ellaway *et al*, 2000; Hanrahan *et al*, 2001; Latkin & Curry, 2003). High-rise accommodation in particular is often identified by users – and particularly by carers – as unsuitable, yet pressure on housing stock means that often this is all that is available
- younger adults, particularly in rural areas, will often 'sofa surf', stay with friends, or remain in the family home because they cannot find suitable accommodation nearby (Taylor *et al*, 2005). This hidden homelessness can give rise to additional stress for both parties and inhibit the young person's progress to independence.

The business of maintaining a home – coping with household finances and bills; dealing with the complexities of the benefits system; organising basic repairs and upkeep; sustaining relationships with neighbours, and with the landlord or housing agency staff – can be demanding at times for all of us. But these aspects and responsibilities of ordinary living may be that much harder for people who are also struggling with mental or emotional difficulties, the sedative or other side effects of medication, and the misunderstanding and stigma that all too often accompany and exacerbate mental ill health.

Poor housing and poor mental health

Meanwhile, there is growing evidence that poor housing in itself may contribute to poorer mental health, independent of and in addition to any socio-demographic characteristics such as class, gender, age and ethnicity with which disadvantage is associated (Ellaway & Macintyre, 2004). Poor housing appears to act as a multiplier of other disadvantage. Since inequality is itself associated with stress and poor health (Wilkinson, 2005), any identifiable factor that steepens the gradient of the vicious cycles of deprivation and exclusion has to be taken seriously as a significant public health issue.

Several studies indicate that priority rehousing on mental health grounds (in comparison with physical disability) is particularly effective at relieving distress (Blackman *et al*, 2003; Elton & Packer, 1986), suggesting that mental health difficulties may be particularly responsive to poor housing and to an improvement in housing circumstances. Some studies indicate significant benefits for residents from neighbourhood renewal initiatives in reducing individual ill health, including in particular mental health (Dalgard & Tambs, 1997; Levental & Brooks-Gunn, 2003) – although other studies (eg. Allen, 2000) caution that the disruption from housing renovation may have an adverse effect, particularly where sitting tenants have little control over the building works programme.

It is still, nevertheless, not fully understood what exactly it is about housing that is good or bad for mental health. The impact of poor housing – whatever that may in practice mean – on the mental health of the nation as a whole has yet to be systematically studied, let alone costed, and in particular the crucial role of community – for good or ill – needs further exploration. There are, in fact, some grounds for believing that it is the social environment, in tandem with and to some extent stemming from the physical design or condition of the housing stock, that has the greatest impact on emotional well-being.

The most comprehensive review of the literature when it was published, and still the most rigorous examination of the arguments, is David Halpern's study into the links between mental health and housing, Mental Health and the Built Environment (Halpern, 1995). Halpern traces the evidence for a complex chain of causal links to identify the impact of the built environment on common mental health problems (ie. anxiety and depression). His analysis of the methodological pitfalls of research into mental health and housing, although now ten years old, remains probably the most comprehensive statement on the subject in print. His conclusion was clear: there is an independent effect of the built environment on mental health, but the effect is multi-factorial, and the impact of each factor may operate only at the margins, and may be contained or triggered by other aspects. Previous studies, which tended to lack precision in identifying the nature of the problem, the cohort to be studied, and/or the range or complexity of factors, may have

[1] There are few systematic studies on the social – rather than medical – triggers for admission. A recent informal survey of care management staff in one mental health trust suggested that perhaps 50% of their caseload had continuing problems with appropriate accommodation. For the other 50%, actually finding appropriate accommodation for clients was the primary preoccupation of the workers.

understated this cumulative impact. But this is in part because these effects seem to be mitigated or exacerbated principally through architecture's impact in creating a supportive or disabling social environment, while what we would now call social capital emerges as the crucial mediator.

Halpern's primary concern throughout his book is with the primary causes of mental ill health, and with the need to go beyond mere statistical association in order to identify with greater confidence the direction of causes and effects. Being concerned with primary causes, he does not perhaps give sufficient attention to the factors that may aggravate or perpetuate already established ill health. But he devotes considerable time to the factors that do promote health and/or resilience, such as neighbourly behaviour or social cohesion. In doing so, he goes some way towards identifying what may predispose and sensitise certain residents both to material and social environmental stressors. The people most socially marginalised (or, we would now say, most excluded) are shown to be the most vulnerable to impact. A failure to appreciate the greater sensitivity of some residents may have led to an under-recognition here of the importance both of housing and neighbourhood features, and of the factors making for better community integration.

This book should remain indispensable for all those wishing to understand the impact of housing design in fostering or restricting a sense of community, and gives food for thought for community care planners seeking to understand and respond in the longer term to the housing needs of all those with mental ill health. For more recent studies, Halpern's book and its conclusions are complemented by recent Medical Research Council research findings from a large area UK study (Ellaway & Macintyre, 2004) that demonstrate convincing evidence for an independent effect of poor housing on mental health. We also see Halpern's identification of community well-being as the key to individual mental ill health recapitulated in the chapter on neighbourhood, community and mental health in Rogers and Pilgrim's analysis of the links between mental health and inequality (Rogers & Pilgrim, 2003), which also cites more recent studies that tend to the same conclusion.

What all these more epidemiologically-oriented studies do not address, however, is the impact of the built environment and its key mediators – social capital and community – on those already most at risk. Yet there is, in fact, increasing evidence suggesting that the impact of unsuitable housing – including both homelessness and temporary and insecure housing – is most severe on the most vulnerable: the young and those with major mental health problems, for whom the effects may be further compounded by being misconstrued as a symptom of their illness, rather than a response to their housing situation (Halpern, 1995; Rogers & Pilgrim, 2003). Meanwhile, a ground breaking study (Harkness *et al*, 2004) from the US has suggested that not only the neighbourhood but also immediate housing circumstances, and the nature of the housing stock, do matter to those with severe and enduring mental health problems.

In a retrospective study of a housing refurbishment and relocation programme, in circumstances as close as natural experiments can get to a random controlled trial, and with a total of 670 individuals with chronic mental illness – a large sample by comparison with most such studies – certain kinds of housing stock seemed to function better than others in preventing readmissions and reducing demand for casework care interventions. Interestingly, this study also tends to confirm the 'group density effect' hypothesis – identified in Halpern's earlier work (Halpern, 1993), and in other subsequent studies (Neeleman *et al*, 2001) – which suggests that, in relation to the axis of mental health, there may be an optimal population density for the number of individuals in any socially marginalised group in an area. Too few, it is suggested, creates isolation; too many creates a ghetto, and accentuates residential sorting and social exclusion.

The implications of this finding for housing policy will need careful thought. But most striking are the US researchers' attempts to calculate the costs and savings in healthcare interventions that seem to stem from improved housing. Their conclusion – that 'the mental health care cost savings associated with these favourable [housing] features far outweigh the costs of developing and maintaining properties with them' – would alone justify an attempt to replicate this study in the rather different UK housing context.

The national policy framework

Before the founding of the NHS in 1948 and the re-construction programme that followed World War II, housing was the responsibility of the then Department of Health (Malpass, 2000). Given the importance of housing as an aspect of preventive and public health, let alone as an aspect of community care, the NHS was somewhat slow to recognise the need to work with housing services as a key partner in the welfare sector. It could certainly be argued that the prevailing philosophy of the 1980s and 1990s, which stressed the need for state-funded agencies to prioritise their 'core business' in order to become more business-like, militated against recognition of the links and common ground between disparate agencies' responsibilities and concerns.

Nevertheless, in 1999 the government published the National Service Framework (NSF) for Mental Health (Department of Health, 1999), which called for more inter-agency planning and the development of a continuum of accommodation for mental health service users. This continuum should include staffed and supported housing, long-stay secure accommodation,

crisis and refuge places, service user-run sanctuaries, family placement and respite services, and supported living options, including individual tenancies and shared living with flexible support. Since the 1990s, and particularly in the first few years of the 21st century, there has been a significant increase (Audit Commission, 2005; Matrix Research & Consultancy, 2004) in the number of people with mental health problems (including those with drug and alcohol problems) living in supported accommodation projects (ie. in specialist or 'special needs' accommodation that provides practical and emotional support as well as housing).

Nevertheless, the great majority of people with mental health problems, even with severe mental health problems, are living in their own homes – and wish to continue to do so. Recent years have therefore also seen growth and development of 'floating' support that is provided to vulnerable individuals in their own homes to enable them to maintain their independent tenancy. In many cases, access to this support has enabled them to take on independent living in the first place (ODPM, 2005a). While these new housing-related support services have grown significantly, development across the English regions has often been unco-ordinated, and remains patchy. Some areas have seen a real expansion in both the capacity and the quality of housing support for those with mental health, drug or alcohol problems; others have seen relatively little. There is certainly still much work to be done to ensure nationwide availability of these alternatives to conventional mental health interventions.

Launched the same year as the NSF for mental health, the Supporting People (SP) programme suggests recognition of the value of the new housing-related support model, but also the need for better integration with other agencies and programmes. It set out to identify needs and co-ordinate funding for all such supported housing services for all client groups in each locality. Perhaps curiously, the SP consultation papers (Department of Social Security, 1998), published in the same year, made reference to the NSF for mental health, but the NSF itself, despite calling for the development of a range of supported housing services, made no reference to SP. The early years of SP have been bedevilled by uncertainties over the programme's funding, erratic and unplanned local coverage, and broad definitions of eligibility that were intended to provide seamless coverage but have instead produced confusion, overlap and border wars over who funds what in the cold climate of budget cuts. This may well have made it particularly hard to keep sight of the bigger picture – a better recognition of the role and contribution of housing in community care and community safety.

There is however a new and more confident tone emerging from the Office of the Deputy Prime Minister (ODPM) over the value and future of the programme. In November 2005 a consultation paper was released (ODPM, 2005b) for a new national strategy that intends to clarify many of the more complex issues around inter-agency involvement in the development of new services, and to help re-establish SP as one of the key government initiatives for ensuring better integrated care and support for the most vulnerable. We are now seeing across England attempts, co-ordinated through the Supporting People programme, to obtain an overview of supported housing services for all vulnerable adults. For the first time, therefore, all the necessary information to identify housing support needs and their role in the matrix of community care will be gathered in one place. With this overview comes the opportunity, through more integrated and flexible funding, to re-shape the pattern of services, moving away from more institutional, congregated models of care and support towards more effective packages of housing-related support and housing-based solutions that are based in ordinary housing.

Engaging with housing services

However valuable the role of housing support services may be – and we must bear in mind that there are still some parts of England with no dedicated mental health housing support services at all – we must appreciate that, ultimately, the task of identifying suitable housing, signing up tenants and managing the stock, repairs, arrears and neighbour disputes is likely to remain with the housing services themselves. Yet housing services employees may not feel confident of their ability to recognise mental health problems underlying tenancy difficulties, or know how to respond appropriately. Housing staff report feeling under-informed on mental health issues, on the organisation and function of mental health services, and on how to identify and respond to concerns that may require specialist professional intervention (ie. when and whom to call when a tenant is unwell) (Chartered Institute of Housing, 2003; Sharples *et al*, 2002). The National Institute for Mental Health for England (NIMHE) has recognised this gap and has commissioned a study on the views and experiences of social housing staff (in both local authority and housing associations) who encounter mental health issues in the course of their work. One key finding of this study (NIMHE, 2005) is that the majority of mainstream or general needs social housing staff interviewed saw themselves as providing a significant, valuable, but often un-sung role in social inclusion practice with the most vulnerable. They were very willing to continue in this role, but argued that there needs to be better inter-agency co-operation and more co-ordinated support from mental health services. The study interim report observes:

> 'There are certainly significant differences in the professional cultures and formal responsibilities of

> housing and mental health services, which can lead to communication difficulties – particularly over information-sharing and confidentiality – which will need to be overcome. But housing workers also had many positive suggestions for confidence and competence building measures to improve communications and joint working.' (NIMHE, 2005)

The study suggests that even quite basic mental health awareness training can give confidence to housing staff, and so help to build bridges between agencies and between housing staff and tenants. Some housing services are now attempting to ascertain all new tenants' support needs – not to exclude the more vulnerable, but in order to be able to bring in support services as needed, and to have details of contact key workers should problems arise. In addition, initiatives such as appointing discharge co-ordinators and mental health link workers in housing services, establishing communication channels between local agencies, with clarified protocols around confidentiality, and introducing mechanisms to flag up causes of concern such as mounting arrears through benefit claims lapses can do a great deal to prevent problems overwhelming an individual who is struggling to cope. The study sheds considerable light on the institutional processes and inter-agency blind spots that may contribute unwittingly to disadvantaging the more vulnerable. At the time of writing, the study report and its many recommendations for improved inter-agency communication (from the very simple and practical to calls for quite wide policy-level shifts) are entering the final triangulation stage of feedback, corroboration and amendment in discussion with housing and mental health services in the localities where the study was conducted.[2]

We are, therefore, despite the obstacles, beginning to see ordinary housing services concerning themselves not just with the bricks-and-mortar issues of allocating accommodation and arranging repairs. They are also starting to play a part in identifying the support needs of vulnerable people to help them maintain their tenancies, and in arranging support workers or referral to specialist support agencies, as a part of their basic housing management tasks.

Strategic commissioning

There have, meanwhile, been major changes in the social housing world, and in the structures and policy context of the role and responsibilities of local authorities. Where previously local authorities were major, if impoverished, housing providers, recent government guidance encourages them to distinguish more clearly their role as landlord and owner of housing stock from their statutory and strategic roles (ie. in assessing homelessness and vulnerability, analysing overall housing needs and identifying local priorities for development). All authorities have been required to assess their options for management of their housing stock. Many have opted to contract out housing services, either to a voluntary sector body (LSVT) or to an arms-length organisation (ALMO) that will manage the stock on their behalf; many more are in the process of doing so. This leaves the authority free to concentrate on its strategic role, and many are now looking to the voluntary sector, and indeed to a more collaborative relationship with the private sector (Leather *et al*, 2001), to fulfill those statutory responsibilities they still have to house the most vulnerable (Audit Commission, 2002). This structural shift is now introducing to housing departments the commissioning or purchaser/provider split that we have seen developing in health and in social care since the 1990s, and which we also see in Supporting People. It will mean that housing services, at least in some of their organisational structures and processes, will come into closer alignment with other welfare services provided by the state.

It is perhaps too soon to say what developments in housing stock, or in housing management, we might wish to see in order to address the public health angle in housing. NIMHE's At Home? study (2005) is already giving rise to a wide range of recommendations for improved inter-agency communication, but these will need to be customised to the particular circumstances in each local area; what may be best achievable practice in one area may not be realistically achievable or appropriate at all in another. Hence a lively exchange of examples of success is more fruitful than any normative hierarchy of 'best' practices. One NIMHE initiative that is being actively discussed involves the creation of a web-based practice exchange network that would encourage and facilitate the sharing of positive practice between agencies, and between localities and regions.

Just as there is a need for more focused etiological and epidemiological research on causal chains linking mental health and housing, there is a clear need for research on the efficacy of new practices in inter-agency co-operation. Fakhoury *et al* (2002) and Quilgars (2000) argue the need for more research on housing support services. The need for evaluative research on positive practice in mental health and general needs housing management is equally pressing. Perhaps clarity on future developments in practice will only emerge when local agencies begin talking to each other about how best to work together to meet local needs. But we can see that the necessary structures at locality level are in the process of coming together, and we may hope to find health and local authority commissioners exploring and learning together what they might now be able to achieve.

[2] The full report At home? should be available for download from the NIMHE website (www.nimhe.org.uk) and/or that of the RJA practice (www.rjaconsultancy.org.uk) in February 2006.

NIMHE and the Housing Reference Group

As regards national policy guidance, the Social Exclusion Unit report on mental health (Social Exclusion Unit, 2004), published in June 2004, marked an important step in the long march towards joined-up government. If social inclusion is to mean that all individuals, regardless of any perceived 'differentness' (Harrison with Davis, 2001; Sayce, 2000) or disadvantage in life, are able to feel at home in the world and have a sense of belonging in their local community, then the most important place to feel at home is at home. The SEU report noted that access to decent homes is part of 'getting the basics right'. It called for examples of best practice in preventing and managing rent arrears, and endorsed the idea of mainstreaming mental health awareness training for all housing management staff. It indicated an intention to explore the operation of allocations policies, in order to assess the extent to which the needs of those whose mental health problems make them more vulnerable are catered for by current systems.

Following publication of the SEU report, NIMHE inherited the task of co-ordinating implementation of its recommendations. A series of fact sheets appeared in September 2004 (ODPM, 2004) as the culmination of the SEU's work. The one specific to housing pointed to a wide range of practical issues to be tackled through inter-agency work. The fact sheets built on more detailed representations to the ODPM/SEU over the previous year from advice and campaigning bodies such as Mind, Citizens Advice and Shelter, and on preparatory work undertaken and commissioned by NIMHE itself through 2003-04 (Johnson, 2004; NIMHE, 2004). This bringing together of agencies and interested parties led in February 2005 to the creation of the NIMHE Housing Reference Group (HRG): a national inter-agency representative body charged with advising and overseeing work on both the SEU's immediate action points and its wider vision.

The HRG seeks to bring together at national level representatives of all the key stakeholder groups, and to work with a range of affiliated organisations to encourage and facilitate more joined up policy guidance. That is a very broad and ambitious agenda for an amalgam of agencies that have no history of working together, and it may be too soon to say what this new body will be able to achieve. It is, for example, not clear whether the HRG will have its own funds to pump-prime or match-fund new initiatives, or whether it will simply seek to influence priorities and support applications to other funding sources (and so be dependent on other agencies' processes and timescales). The group must therefore first tackle at national level all the problems of fragmented vision and responsibility and lack of coterminosity that have bedevilled inter-agency work at locality level.

Meanwhile, change continues. NIMHE itself, having forged this creative inter-agency partnership, was itself merged in early 2005 with several other agencies in the health and social care betterment business to become part of the new, integrated Care Services Improvement Partnership (CSIP). Since many of the issues in mental health, housing and social inclusion apply to vulnerable adults in general, not just to those with severe and enduring mental health problems, the hope is that this partnership will strengthen rather than dilute the effort. It is certainly the case that, while inter-agency communication deficits and lack of strategic co-ordination do seem particularly pronounced in relation to mental health services, many wider issues of housing disadvantage apply to vulnerable and excluded groups more broadly.

Certainly, if joined-up government is to become a reality, one manifestation of that more integrated vision will be a better recognition of the role that housing plays in the matrix of community care. A more appropriate approach to housing should, indeed, be a textbook illustration of the general point made in the SEU's report: 'Mental health problems require more than a medical solution; they require a positive response on the part of society to accommodate people's individual needs and to promote mental well-being' (SEU, 2004). It does appear that the importance of housing in mental health – and mental health in housing – is now being recognised. Housing is emerging as one of the key – and also one of the most complex – areas for development in social inclusion practice. Achieving a better co-ordination of housing and mental health services will involve recognising and encouraging integrated practice in the operation of frontline services; in local inter-agency commissioning; in regional strategic planning; and in national policy and guidance and monitoring.

There is plenty for the HRG to do. There is the proposal for the practice exchange network and website. The HRG is also supporting the creation of a housing and mental heath research group within the UK Mental Health Research Network (the recently formed network that provides the infrastructure to support the development of large-scale research relating to mental health) to bring together evaluative research (good practice, efficacy and cost-effectiveness of improved practice) and etiological (cause and effect) studies, identifying in each case key gaps in our understanding. This initiative should tie in well with, and help carry forward, work currently being undertaken by the Sainsbury Centre for Mental Health on behalf of the NHS Service Delivery & Organisation (SDO) research and development programme to consult with stakeholders about their future research priorities in mental health to better reflect the concerns of service users and carers. Housing is already emerging here as a major issue. In relation to the large questions that ought to shape thinking about housing and mental health over the next few years, it is salutary to reflect on NIMHE's own statement (NIMHE, 2005):

'It is clear that any mental health service that is focused upon personal recovery and social inclusion must learn to address the housing needs of its clients. Equally, any housing agency that is focused upon individual and community well-being must recognise the mental health needs of tenants. Any strategy for neighbourhood renewal which neglects the most vulnerable and the most challenging is bound to fail. All three sectors must learn to see people with mental health needs, first and foremost, as citizens.' ✪

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