Haringey’s Housing
Related Support
Needs Assessment
2012
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1. Introduction

The Housing Related Support (HRS) Commissioning Plan 2012 – 2015 is an evidenced based document that sets out our intentions for the programme for the next three years.

It is important that we have considered all the relevant needs information that we can obtain in order to help inform our priorities. As the programme covers a wide range of client groups (or sectors) this does amount to a considerable quantity of information from a wide range of primary and secondary sources.

These sources include:
- Demographic data from national and local sources
- Information from the recent Council wide joint strategic needs assessments (JSNA)
- National and local research data
- Reviews of our services
- Wide ranging consultation with providers, stakeholders and service users

This HRS needs assessment has been completed in advance of the publication of Haringey's JSNA. This document will be reviewed as and when the JSNA is updated.

This body of collected information is too large to include within the Commissioning Plan so we have only included the highlights for each sector within it. The remainder of the information is contained within this Housing Related Support Needs Assessment. This needs assessment should be read as an accompanying document for those who wish to have more information that the commissioning plan gives.

2. Housing Related Support trends

National data on HRS ceased to be collected after March 2011. The chart below shows the national number entering services at that date. Of the 230,000 entering services, some 60,000 were categorised as single homeless with support needs. The national categorisation is broadly in line with the categories used in Haringey, but for ease and because some of our services are more generic we use the following broader categories:-

- Black and Minority Ethnic (BME) Groups and Refugees
- Domestic Violence
- Generic Floating Support (Families and Single Homeless)
- Learning Disabilities
- Mental Health
- Offender and Substance Misuse
- Older people
- Physical Disabilities, Sensory Impairment and HIV
- Young People
Graph 2-1

2.1. National Client Record data (St Andrews Annual Report 2009/10)

Up until the end of 2011/12, all providers, with the exception of the older people sector, had to submit client record data for each of their service users including information such as the presenting needs and outcomes. This data was collated and analysed at a national, regional and local level. Although there is no longer an obligation to complete returns, Haringey, like many other local authorities will continue the requirement for providers to collect and submit the data.

The latest analysis Client Record data (St Andrews Annual Report 2009/10) is based on analysis from records 239,366 from clients entering services between 1st April 2009 and 31st March 2010 and includes comparisons with Client Record data from 200/04 onwards.

The report states that:-

Service provision has remained relatively constant over time, with voluntary organisations accounting for the largest share, followed by Registered providers and housing authorities.

Since 2003/04 clients have most commonly accessed three service types; floating support, support housing and direct access hostels. The pattern of access has however changed with floating support accessed more commonly and a decrease in the proportion of clients accessing direct access hostels.
Single homeless, women at risk of domestic violence, mental health problems, young people at risk, people with generic needs and homeless families make up 70% of all clients. There has been a decrease trend in the proportion of clients with drug problems since 2003/04.

Over the past 7 years the most common age range for clients has been 18-24 years.

The proportion of clients who were accepted as statutorily homeless and owed a main homelessness duty has steadily decreased over time.

The most common types of accommodation clients occupied prior to accessing services include: general needs local authority tenancy (decreasing trend), living with family, private sector tenancy (increasing trend), Registered Provider tenancy (increasing trend), living with friends and sleeping rough (decreasing trend).

For outcomes for short term services (up to 2 years), the two most identified needs were the same for 2008/09 and 2009/10, maximising income and achieving more choice and control. The third most frequently identified need for 2009/10 was securing settled accommodation, which was a new indicator (introduced in 2009/10). Possibly due to effects of the recession, a decline was observed in the clients who had received support in obtaining paid work, being in paid work on exiting the service or who had participated in paid work whilst in receipt of the service.

The proportion of clients identified as needing support to participate in training and education and the proportion who went on to achieve this outcome had remained the same, although there was a slight increase in the proportion who achieved qualifications in the previous year. Increases were seen in the proportions of outcomes relating to the staying safe and three of the four outcomes of being healthy.

For long term services, the most frequently identified needs remained the same as for previous years, namely maximising income, physical health and aids and adaptations.
2.2. Housing Related Support Trends in Haringey

Graph 2-2

Presenting needs across five main themes over the last 4 years are shown in the graph above. The data indicates that the most prevalent need (maximising income 65-77%) has remained consistent since 2008. The second most frequent need in 2010-2011 (introduced as an indicator in 2009/10) was securing settled accommodation at 54 and 59% in the last 2 years), and External Contacts (49 and 47% in years 4 and 5) was the third.

While the type of presenting needs have not changed considerably over time, there has been an increase in the numbers of clients requiring support to maximise income, maintain and secure accommodation and with assisted technology.
The following charts show that in 86% (18 of the 21) of the outcomes the proportion of clients with their needs met, increased in year 5 compared with the previous year and for the last 3 years performance has either remained stable or improved year on year in 12 of the outcomes.

Effectiveness in all years across the types of need being met, varied considerably, the highest proportion of needs met was within the ‘maximising income’ need (at between 83 and 90%) and the lowest being for support to enter paid work (at between 26 and 47% across the two outcomes for that need).

![Graph 2-3](image-url)
LBH, HRS Needs Met (Outcomes 3, 4 and 5)

Graph 2-4

LBH HRS providers, Income, Debt and paid Work Outcomes

Graph 2-5
Graph 2-6

LBH HRS providers - Health outcomes

Graph 2-7
Graph 2-8

LBH HRS Providers Statutory Orders, Harm and Risk

Graph 2-9

LBH HRS Providers - Outcomes
2.3. Client profile and performance

In the year 5 returns the number of HRS clients who were considered statutorily homeless and owed a duty was 38 (5% of all clients) with the largest number coming from the ‘people at risk of domestic violence group’. Overall however providers considered that 160, 20% of all clients were homeless, this included people that were not statutorily homeless and those who were but the local authority did not have a duty to house.

Graph 2-10

Of the 816 clients 50% were between the ages of 32 and 52, 15% between 53 and 59 years and 4% were over 60 years. Just under a third were 32 or younger, 0.6% of these were 16 or 17 years of age.
The returns also show that across the primary presenting need, the mental health problems are more prevalent in 46-52 year old clients, and that physical or sensory disability and alcohol problems are more common in the 53-59 year olds age range. Leaving Care, single homelessness and young people at risk are also more frequent among clients under the age of 24 years of age. It should however be noted that not all providers are obliged to submit returns therefore there will be an under representation for some age ranges and certainly for older people’s housing providers.
Of the clients presenting a HRS need between April and Dec 2011 (Yr5), 28% were white, this is a lower proportion compared with Haringey as a whole. The next two highest groups were people of black origin (27%) compared with 16% of all Haringey residents and 22% were from the white other group (12% of Haringey’s population according to ONS Mid year estimates).

Graph 2-13

The chart below shows the outcomes for Haringey HRS providers for national indicators NI141 (achieving independent living) and 142 (maintaining independent living) over in 2010 and 2011 and confirms consistent performance over this period.

Graph 2-14
Since 2007/08 Haringey’s Housing Related Support Services have assisted almost 7,000 vulnerable people. The data over the last five years indicates that services supported a higher number of clients in 2008/09 and 2010/11. The steep drop in year five is not a complete representation as in year five data was only collected until December, rather than the end of March in other years.

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Frequency</th>
<th>Frequency %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 (2007-8)</td>
<td>981</td>
<td>14%</td>
</tr>
<tr>
<td>Year 2 (2008-9)</td>
<td>1751</td>
<td>26%</td>
</tr>
<tr>
<td>Year 3 (2009-10)</td>
<td>1520</td>
<td>22%</td>
</tr>
<tr>
<td>Year 4 (2010-11)</td>
<td>1825</td>
<td>27%</td>
</tr>
<tr>
<td>Year 5 (Apr - Dec 2011)</td>
<td>783</td>
<td>11%</td>
</tr>
<tr>
<td>Total:</td>
<td>6860</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2-1

3. Our Community

We have divided the needs information below into the sector by which we categorise our services. This division is not precise and there is some overlap between sectors.

3.1. BME and Refugees

We currently provide services for the following groups in Haringey:

- Cypriot & Elderly Disabled Group
- Cypriot Community Centre
- Embrace UK Community Support Centre
- Haringey Chinese Community Centre
- Haringey Somali Community & Cultural Centre
- Kurdish Advice Centre
- Kurdish Community Centre
- Turkish Cypriot Women’s Project
- PEEC Family Centre (Polish)

Since the inception of Supporting People (SP) in 2003 there have been some changes to profile of BME groups in Haringey. Since the accession of eastern European countries into the EU there has been an increase in the numbers of migrants from these countries.

The needs information for this section of the Commissioning Plan has mainly come from two sources:
1. The Borough Profile Demographic Data, Haringey Council 2011

As well as focussing on housing, this study also captured information on the support people require.
Borough Profile

Ethnicity

48.7% of the Haringey population are non-white British. This is higher than the London figure of 40.5%.

The table below shows the ethnic breakdown of Haringey compared to London.

The Population Estimates by Ethnic Group were first published, as experimental statistics, in 2006 and are now available for areas in England and Wales for each year from 2001 to 2009. The experimental statistics status of the estimates indicates that they have not yet reached the standards required for National Statistics, and each release has been accompanied by supporting information noting possible sources of error in the estimates.

<table>
<thead>
<tr>
<th>2009 Mid Year Ethnicity Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Ethnic Groups</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Asian or Asian British</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Black or Black British</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Table 3-1 Source: 2009 Experimental Ethnicity Mid Year Estimates, ONS
As can be seen from this table, Haringey has a higher percentage of Irish, Other White, Black Caribbean and Black African population compared to the rest of London.

Migration

In 2009/2010, ONS states that 4,950 people moved to Haringey from overseas. This is 21.9 per 1000 of the population (13th highest rate in London).

In the same period 4,644 people left Haringey to live overseas. This is 20.6 per 1000 of the population (10th highest rate in London).

Table 3-2  Source: 2005-2010 Mid Year Estimates, ONS

National Insurance Registrations (NINo) Allocations to Adult Overseas Nationals entering the UK

Between 2002 and 2011 91,250 people registered for national insurance in Haringey, whose previous address was overseas.
The chart below shows the yearly breakdown.

![Total NINO registrations in Haringey](chart.png)

Graph 3-2  Source: 2002-2011 Department of Work and Pensions (DWP)

Poland, Hungary and Bulgaria are the top three countries where people who have registered for national insurance over the last 3 years in Haringey have come from.

Below is a table showing the top 20 countries since 2008.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>3130</td>
<td>1840</td>
<td>1270</td>
</tr>
<tr>
<td>Hungary</td>
<td>970</td>
<td>730</td>
<td>1110</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>860</td>
<td>640</td>
<td>1060</td>
</tr>
<tr>
<td>Romania</td>
<td>860</td>
<td>620</td>
<td>1020</td>
</tr>
<tr>
<td>Italy</td>
<td>790</td>
<td>590</td>
<td>770</td>
</tr>
<tr>
<td>France</td>
<td>580</td>
<td>470</td>
<td>650</td>
</tr>
<tr>
<td>Spain</td>
<td>510</td>
<td>430</td>
<td>800</td>
</tr>
<tr>
<td>Turkey</td>
<td>410</td>
<td>360</td>
<td>490</td>
</tr>
<tr>
<td>Brazil</td>
<td>320</td>
<td>310</td>
<td>360</td>
</tr>
<tr>
<td>Australia</td>
<td>280</td>
<td>280</td>
<td>290</td>
</tr>
<tr>
<td>Portugal</td>
<td>260</td>
<td>230</td>
<td>270</td>
</tr>
<tr>
<td>Nigeria</td>
<td>250</td>
<td>220</td>
<td>240</td>
</tr>
<tr>
<td>Germany</td>
<td>220</td>
<td>180</td>
<td>220</td>
</tr>
<tr>
<td>Rep of Lithuania</td>
<td>220</td>
<td>180</td>
<td>220</td>
</tr>
<tr>
<td>India</td>
<td>190</td>
<td>180</td>
<td>210</td>
</tr>
<tr>
<td>Colombia</td>
<td>180</td>
<td>160</td>
<td>200</td>
</tr>
<tr>
<td>Slovakia</td>
<td>170</td>
<td>150</td>
<td>190</td>
</tr>
<tr>
<td>Rep of Ireland</td>
<td>160</td>
<td>150</td>
<td>180</td>
</tr>
<tr>
<td>China Peoples</td>
<td>150</td>
<td>120</td>
<td>170</td>
</tr>
<tr>
<td>South Africa</td>
<td>140</td>
<td>120</td>
<td>150</td>
</tr>
</tbody>
</table>

Total 13270 Total 10030 Total 12810

Table 3-3  Source: 2008-2011 Department of Work and Pensions (DWP)

North London sub-Region black and Minority Ethnic Housing Study 2007- 09

In November 2007, the Joint Black & Minority Ethnic RSL and Borough Group of the North London Sub-Region, commissioned research into the housing needs and aspirations of black and minority ethnic people living in North London. Building on
existing data the commission was intended to create detailed, ward level maps of where different communities had settled and how these patterns had changed over time.

Many of the data sources underpinning the research do not distinguish between first, second or subsequent generations of people from different communities in North London and no attempt is made in the research to try to differentiate between generations.

*What the community mapping shows*

The research drew on many sources of data including Census, CORE lettings, school rolls, social housing bidding information and housing development data. The information has been used to create an atlas of North London showing the residential distribution of local community groups.

This atlas has revealed patterns of settlement at a ward by ward level for the many different communities who make up the population of the sub-region. The results show that communities tend to settle and then stay in fairly tightly bracketed areas with little mobility either within boroughs or across the sub-region. Pockets of immigration can be found in affluent areas and areas of deprivation, but more often than not immigrant communities are housed in the poorest areas. This pattern of settlement does not match the distribution of social housing in the sub-region. This has led to the creation of certain migration hot-spots.

**Summary findings from the mapping:**
- Many communities have a tight geographical focus
- Settlement is often constrained by artificial geography (i.e. borough boundaries)
- Mobility is limited
- Those most reliant on social housing are most tightly focused and least mobile
- Areas of existing deprivation disproportionately absorb immigration
- New house building has added to existing social housing densities

*Reasons for settlement*

Most people have come for work. This is true of communities like the Irish, Greek and Turkish Cypriots and Chinese who arrived in the 1960s as well as Bangladeshis, Biafrans in the 1970s and more recent migrants like Poles and other eastern Europeans.

If people do not come for work then the reason is for safety. Recent immigration is characterised by people seeking asylum, starting in the 1980s with Vietnamese and into the 1990s with wars in the Balkans and in Somalia, Ethiopia and Eritrea along with the recent war in Iraq and other places in the Middle East and North Africa.

Migration settlement is unplanned and haphazard. Some is due to the presence of labour hungry industries, for example, Bangladeshis working in textiles in east London. In other cases it is more organic and first settlers establish a node around which other members of the community then grow when they arrive in the UK.
The management of arrivals in the UK seems haphazard with many being left to find their own way to housing and support.

In the 1950s, 1960s and early 1970s new communities settled in the private rented sector. More recent communities have tended to settle in the public sector. This pattern accounts for the increasing polarisation of new settlement into a few areas of the sub-region.

Some newcomers from the A8 accession countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia) have been specifically excluded from access to public housing.

Help, advice and support

The study found that:
1. Little structured help appeared to be available to many of the groups who were interviewed.
2. The greatest source of help is from within communities but this is often provided by non-experts who do not know the system or what is available.
3. Communities that have been the most self-reliant have tended to fare better in terms of employment, education and housing. Those that have relied on social housing providers have fared less well.
4. A knowledge of English appears to be a significant determinant of how successful a community ultimately is.
5. Some communities feel strongly that they prefer a community organisation to act on their behalf because of poor experiences with the public sector.

Mapping

The population: who & where

This section presents the findings of the research broken down by specific ethnic group. Most sources of available data use or have used the standard categories employed in the 2001 census and are used primarily to report findings in this research also.

As stated earlier the 2001 census classifications are fairly broad and do not identify ethnic groups of importance in the North London context. For example, the large Somali population in the sub-region cannot be isolated from the data relating all people from Africa under the black African classification. Therefore, where appropriate, additional classifications have been used in this section.

For this section of the Needs Assessment we have used only the maps of BME groups where there are significant numbers in Haringey
A large Kurdish pupil population in Tottenham and Harringay constitutes over 50% of the total Asian Other pupil population in those areas, along with a smaller but significant Vietnamese group.
**White Other**

To a greater extent than most, the White Other population is the most problematic to analyse through the various sources of available data chiefly because so many different communities are captured by this broad classification.

The 2001 census records 196,104 people from a White Other background making it the second most populous group after White British people in the sub-region. The map of the sub-region shows higher densities stretching along the Westminster and Camden borders with a further higher density zone in eastern Haringey and Enfield. Broadly an even representation of this group can be found in most wards in the sub-region.

**Other White households Census 2001**

*Map 3-7*

Bearing these considerations in mind, the data shows that the specific groups that make up the White Other classification are by and large, characterised by small pockets of high population densities. The overall picture of a widely and evenly dispersed White Other population appears to be simply an agglomeration of many smaller tightly geographically focused communities.

The PLASC data of ethnicity of school pupils helps us to identify BME groups on a ward basis. Again we have included the relevant maps to identify White Other groups.
Albanian & Kosovan pupils PLASC 2007

Map 3-8

Turkish pupils PLASC 2007

Map 3-9
Map 3-10

Turkish Cypriot pupils PLASC 2007

Map 3-11

Greek Cypriot pupils PLASC 2007
3.2. Domestic Violence

The information below on domestic violence is taken from Haringey’s Joint Strategic Needs Assessment 2012.

Haringey’s Domestic and Gender Based Violence Strategy, developed in 2008, runs through to 2012. During its lifespan, there have been a number of changes which have had an impact on the way we need to deliver services now and in the future. In order to reflect those changes, and to ensure that we are realistically able to deliver on our commitments across the borough, Haringey’s strategic partners have scrutinised and revised the Domestic and Gender Based Violence Strategy delivery plan for 2011/12. We have adopted the four priorities set out in the Home Office’s action plan with a Call to End Violence Against Women and Girls (VAWG) published in March 2011. These are:

- Preventing violence
- Provision of services
- Partnership working
- Justice outcomes and risk reduction

From the end of 2012, the strategic approach to DGBV will be incorporated into the Community Safety Strategy, and a separate, more detailed delivery plan will map the priorities and the actions to be taken to tackle DGBV in the borough.

Cost of domestic violence

Domestic violence in England\(^1\) costs £5.5bn a year, and London has some of the highest costs at £590.5m. According to the Trust for London and the Henry Smith Charity, the estimated cost of domestic and gender based violence in Haringey every year is:

- £27.6 million. This includes the cost of physical and mental health care, criminal justice, social services, housing and refuges, civil legal services and lost economic output.
- In addition, the human and emotional cost is estimated to be £47.6 million.

These costs are likely to be an underestimate since they do not include domestic violence by family members who are not intimate partners.

Risk factors for becoming the victim of domestic violence include:

- being female
- long-term illness or disability (women and men with a long-term illness or disability were almost twice as likely to experience domestic violence as others)
- use of any drug in the last year
- marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- age (women in younger age groups, in particular in those aged 16–24 years are at greatest risk)
- alcohol consumption
- frequent visitor to a nightclub (Home Office 2011)

\(^1\) Trust for London 2011
• pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth (Harrykissoon et al. 2002)
• being in a lesbian, gay or bisexual relationship (Home Office 2010a).

Women are more likely than men to experience all forms of intimate violence, but the risk will vary among different groups of women. For example, younger women are more likely to be victims than older women. Some forms of violence against women are more likely to be experienced by particular sub groups of the population than others, e.g. Black and Minority Ethnic and Refugee (BMER) women are more likely to experience female genital mutilation (FGM) and forced marriage and so called honour based violence. There are no significant differences in domestic violence between urban and rural areas.

The level of need in the population

Getting a comprehensive picture of the extent of domestic violence remains a challenge. This is often (although not always) a hidden crime. Haringey depends largely on the British Crime Survey (BCS) for data as most agencies do not collect domestic violence this information. The key agencies for reliable local data are the police, our domestic violence advice and support centre, Hearthstone; children’s and adults safeguarding; housing; and the domestic violence voluntary sector. These sources are utilised in the commissioning and development of new services.

**Home Office Statistical Bulletin, January 2011**

Haringey has a population of approximately 73,000 women and 79,600 men aged 15 to 59.

Domestic violence
• 29% of women aged 16-59 in England and Wales have experienced domestic violence, compared with 16% of men. This means that, potentially, 21,170 women in Haringey have experienced domestic violence since they were 16 compared with 12,736 men.
• According to interviews undertaken for the 2010/11 British Crime Survey self-completion module, 7% of women aged 16 to 59 were victims of domestic abuse in the past year compared with 5% of men. For the past year in Haringey, this equates to approximately 5,110 women and 3,980 men.

Sexual offences:
• 20% of women in England and Wales had experienced any sexual assaults (including attempts) since the age of 16. For those who had been victims of serious sexual assault since they were 16, the most common perpetrator was a partner or ex-partner (54%). 36% experiencing serious sexual assault thought that the offender was under the influence of alcohol and 9% thought the offender was under the influence of drugs at the time of the incident. 11% of those who had been victims of serious sexual assault in the last year had reported the abuse to the police, a similar level of reporting to that found in 2007/08.
• Around 2% of women and less than 1% of men had experienced some form of sexual assault (including attempts) in the last year. The majority of these are accounted for by less serious sexual assaults. Prevalence of serious sexual
assault is lower than other forms of intimate violence (0.4% of women and 0.1% of men).

Stalking and non-sexual partner abuse:
- 19% of women in England and Wales had experienced stalking since the age of 16. The most common perpetrator was a partner or ex-partner (39%). The most common of the range of incidents that make up stalking was being sent unwanted letters, emails, text messages or cards that were either obscene or threatening (50%). Others were receiving a number of obscene, threatening, nuisance or silent phone calls (35%), having property deliberately interfered with or damaged (21%), being followed around and watched (17%) and having someone wait or loiter outside the respondent's home or workplace (14%).
- 23% of women and 11% of men said that non-sexual partner abuse was the most commonly experience of the separate types of intimate violence they had experienced since the age of 16.
- In the past year, non-sexual partner abuse and stalking were the most common of the separate types of intimate violence, with 5% of women and 3% of men reporting having experienced non-sexual partner abuse and 4% of women and 3% of men reporting having experienced stalking.

Domestic homicide:
- Since 1995, approximately 45% of all female murder victims aged 16 or over in England and Wales were killed by their partner or ex-partner; 8% of murders of men are by partners or ex-partners. In 2009/10 there were 94 such offences (accounting for 54% of all female homicides). Twelve per cent of male murder victims have been killed by their partner or ex-partner since 1995. In 2009/10 that figure reduced to 5% (21 offences) (Home Office 2011; Thompson 2010). On average two women are murdered by their current or former partner each week.
- 76% of women who were murdered by their current or former partner, were stalked by their attacker in the 12 months preceding the murder. This figure rises to 86% for attempted murder. Some 50% of stalkers are ex-intimates

Police call outs for domestic and gender based violence
Victims of domestic violence are less likely than victims of other forms of violence to report their experiences to the authorities because of beliefs that their abuse is not a matter for police involvement, their experiences too trivial, or from fear of reprisal. It is therefore generally acknowledged that there is significant under-reporting of domestic abuse by victims. This means that figures, including those supplied by the Metropolitan Police, should be regarded as indicative only. In 2010/11, the Metropolitan Police recorded 1,269 victims of domestic violence in Haringey.

Domestic violence and pregnancy, babies, children and young people
- Domestic violence is more likely to begin or escalate during pregnancy. More than 30% of cases of domestic violence start during pregnancy. Domestic violence has been identified as a prime cause of miscarriage or still-birth. It is estimated that approximately 23% of women visiting Hearthstone are pregnant.
- At least 750,000 children and young people are estimated to be exposed to domestic violence every year in England (DH 2002). Approximately 75% of those living in households where domestic violence occurs are exposed to actual incidents (Royal College of Psychiatrists 2004). Many will be traumatised by what
they witness – whether it is the violence itself or the emotional and physical
effects the behaviour has on someone in the household (DH 2009). Domestic
violence is also associated with an increased risk of abuse, deaths and serious
injury for children and young people (DH 2009).

**Domestic violence and child protection**

- Neglect, abuse and domestic violence are other factors impacting on children’s
wellbeing. The *Local Safeguarding Children Board’s annual report 2010* highlights
the impact of domestic violence and the need to ensure a widespread
understanding of the risk indicators peculiar to domestic violence and the impact
that living with violence has on children. This includes the violence that takes
place in teenage relationships.

- Domestic violence rates are seven times higher in the deprived parts of east
Haringey than the level in the west of the borough. It constitutes 30% of all
violent crime in Haringey which is high when compared to other London
boroughs.

- Following an *unannounced inspection* of Haringey’s Child Protection services in
October 2011, Ofsted praised a great deal of Haringey’s children’s safeguarding
work. One of the points requiring further consideration is around the protocols and
assessment tools that are currently used to assess risks to victims of domestic
abuse. Ofsted’s view is that these do not properly consider the differing needs of
young people who are direct victims. Consequently, they do not always receive a
service that meets their needs.

- At 30 September 2011, 151 families (290 children) were subject to a child
protection plan. Thirty of these 151 families (19.9%) (55 children), were subject to
a child protection plan and, at the point of referral, domestic violence was
identified as a presenting need.

- A random snapshot of child protection conference presenting issues between 14
October and 8 November 2011 shows that domestic violence is the leading
primary concern factor by a good margin. It is rated as the presenting issue for
around 20% of the children subject to child protection plans.

- Data for the first two quarters of 2011/12 shows that:
  - Of the 1,209 referrals received, 348 (28.8%) identified domestic violence as a
    presenting need
  - 122 of the 348 referrals have had a previous referral, of which 67 were within
    the last 12 months
  - Of the 67 previous referrals, 12 children had a previous referral in which
domestic violence was identified as a presenting need in the same period April
to September 2011
  - Of the 348 where domestic violence was given as the reason for the referral,
27 were aged between 13 and 18 years of age (this accounted for 7.8% of the
total number of 348 referrals citing domestic violence). Almost half of these
were referred by the police, and 15% by their school or the education
department. The referrals were fairly evenly spread across the borough,
although very slightly higher in the wards of Northumberland Park, White Hart
Lane and Woodside
  - The highest number of child referrals identifying domestic violence as a
presenting need between April and September 2011 were in Tottenham Hale
ward (42), 12% of the 348 referrals in this category. The number of referrals is
significantly more than the next highest wards of Tottenham Green (29) (8.3%) and Northumberland Park (28) (8%)

- The majority of child referrals identifying domestic violence as a presenting need were in the 0-4 age group (58%), followed by the 5-10 age group (18%), and unborns (12%). However, research studies indicate that in maternity services the practice of routine enquiry or screening for partner violence can increase the detection rate of domestic violence. Pregnancy is thought to be of particular significance in many domestic violence trajectories. Research evidence suggests that domestic violence may either start or escalate during pregnancy, and also that domestic violence may get worse during the postpartum

- Over 60% (210) of child referrals with domestic violence as a presenting need were made by the police in the period April to September 2011. In the same period, the police made 31% of child referrals overall (384). No referrals with domestic violence as a presenting need were received from community paediatrics, nursery/children’s centres, school nurses, consultants, mental health in-patients, prisons, youth offending, courts or MPs

- According to Haringey MARAC reporting data for 2010/11 saw a 6.4% rise in the number of cases discussed compared with 2009/10, and a 37% rise in the number of children in the households. However, 6.6% of the cases discussed were repeat cases, compared with 14.4% in 2009/10

**Domestic violence, mental ill health, alcohol and substances**

- Research indicates that mental health service users are at higher risk of domestic violence than the general population. However, most domestic violence remains undetected by mental health services internationally. Consideration may need to given to how we link people who use our mental health services and families suffering domestic violence into effective support, in cases where either the domestic violence survivor or the perpetrator has mental health needs

- There is a gap in local performance data relating to perpetrators and mental ill health. Data is taken from Safeguarding Adults; this focuses on the service user group and the primary recorded need would be the requirement for a mental health service. This means that other issues (i.e. possibly a perpetrator of domestic violence) are not reflected without trawling through individual records. In the first two quarters of 2011/12, four individuals were identified by Safeguarding Adults as having mental health needs who also suffered either physical or emotional abuse where their partner was the main perpetrator (there were no recorded incidents of sexual abuse in this same time period). This equates to 8.16% of all alerts involving an alleged victim with a mental health need (49); and 1.54% of the total number of alerts (259)

- Research shows that about half of all women being treated for mental illness will have experienced domestic violence. In 2011, 11.6% of Hearthstone clients had a mental illness while only 11% claimed that the perpetrator had mental health issues

**Alcohol:**

- Women who experience domestic violence are 15 times more likely to abuse alcohol. Approximately 45% of perpetrators of domestic violence are under the influence of alcohol. In 2010/11, 29% of people using Hearthstone stated that the perpetrator had issues with alcohol
Drugs:
- Domestic violence survivors are nine times more likely to abuse drugs.
- In 2010/11, 32% of people using Hearthstone's services said the perpetrator had issues with drugs.

Depression and suicide:
- Domestic violence survivors are five times more likely to attempt suicide. In 2011, 72% of those visiting Hearthstone described themselves as depressed or suicidal.

Childhood sexual abuse:
- According to PANSI (Project Adult Needs and Service Information), the number of people aged 18-64 in Haringey predicted to be survivors of childhood sexual abuse is likely to be 18,275 in 2015, rising to 18,650 in 2030. So by 2030, it is estimated that there will be a 4.3% rise from the 2010 figure of 17,875. For women, this is a 4.4% increase over the same period (12,240 in 2010 to 12,784 in 2030), and for men, a rise of 4% (5,635 in 2010 to 5,866 in 2030). Research shows that both male and female victims of abuse have significantly higher rates of psychiatric problems than the general population. Studies demonstrate an association between child sexual abuse and a subsequent increase in rates of childhood and adult mental disorders.

Men and domestic violence:
- National and local research on men indicates that 50% of men who identify as victims may be perpetrators and so best practice is to screen men to ensure that they are genuine victims, this helps to avoid child protection issues and other problems with housing, civil and criminal law.
- Men at high risk of domestic violence may include gay and bi men, transgender men, men at risk of Forced Marriage and Honour Based Violence. Disabled men may also be at greater risk than other men.

Housing and domestic violence:
- In 2010, there were 17 housing moves in total, four of which were as a result of domestic violence (three in N17 and one in N22). Three of these four moves were through management transfers within the borough.
- In the year January to October 2011, the number of housing moves currently stands at 23, eight of which were as a result of domestic violence (one in N15, five in N17 and two in N22). Seven of the eight moves were through management transfers within the borough.
- In the case of families fleeing domestic violence who are subject to immigration control and have no recourse to public funds, we make sure they are placed in appropriate accommodation. This can be a refuge; however, some of these will not take families with no access to benefits. An alternative is to place them in private accommodation which involves paying for accommodation with all bills included and providing a weekly subsistence. We are currently supporting nine cases, involving a total of 20 children.
In 2010/11, Hearthstone, Haringey’s multi-agency domestic violence advice and support centre, received 466 visits. This included 443 clients, 18 of whom were seen twice, plus five visits from unnamed people:

- The average age of clients was 34.4 years, and 96% of all clients were female
- 110 of these clients have attended Hearthstone more than once since April 2009, and 13 have attended more than twice
- 77% described the abuse as “physical”, 42% said the current incident had resulted in injury, and 34% said that the perpetrator had been known to use a weapon or an object to hurt them
- 90% described the abuse as “verbal”, 25% as “sexual”; 76% as “mental”; 76% as “financial”; 53% as “emotional/honour based violence”.
- 91% of visitors did not record an answer about disability and it is not therefore possible to provide an accurate figure
- 21% were pregnant or had a baby aged 18 months or younger; additionally, 26% of respondents said there was a conflict over child contact
- 70% of visitors had at least one child living in the household, compared with 24% who had none
- 48% of victims said the perpetrator had never been in trouble with the police and did not have a criminal history
- Over 50% described the abuse as happening more often; 55% said it had got worse over time
- 26% said the perpetrator had issues with alcohol; 29% cited drugs; only 11% claimed that the perpetrator had mental health issues. Research indicates that mental health service users are at higher risk of domestic violence than the general population. However, most domestic violence remains undetected by mental health services internationally. Consideration may need to given to how we link people who use our mental health services and families suffering domestic violence into effective support, in cases where either the domestic violence survivor or the perpetrator has mental health needs
- In 41% of cases, the abuser was an ex-partner and in 29% the husband, with 58% stating they were either separated from the perpetrator, or had tried to separate in the last year.
- 30% of victims said there were financial problems, for example, they were dependent on the perpetrator for money
- 57% said the perpetrator tried to control everything and was excessively jealous
- White British (75), Black (70) and Black African (61) were the highest recorded numbers by ethnicity, while the lowest numbers were Pakistani/UK Pakistani (3), White Greek Cypriot (3), Mixed Asian and White (2), Mixed Black African/White (2), Other Black (2), Chinese (1), East African Asian (2).
- In 14 cases, information on ethnicity was not provided
- 99% of victims did not provide a response to the question of whether they had any personal issues with drugs
- 57% did not provide a response to the question of what they were afraid of (for example, further injury or violence). If those who did respond, 23% said they were afraid of further injury to themselves, and 0.6% were afraid their child may suffer further injury; 14% were afraid of further violence to themselves, and 0.9% were afraid of further violence against their child
The number of visits to Hearthstone in 2010/11 showed a slight reduction on 2009/10 figures, but in the six months to the end of September 2011, the trend was on the rise again, with 252 visits, peaking with 57 visits in June 2011. Of these 252 visits, 26% (66) were referrals from the police, 17% (42) from Haringey social services, and 15% (38) self-referrals or referrals by friends.

**Projected service use in 3-5 years and 5-10 years**

While there was a general decline in the numbers of domestic violence in England and Wales since 2005/06 (according to the British Crime Survey), numbers did increase substantially once again in 2010/11.

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</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>292</td>
<td>534</td>
<td>989</td>
<td>814</td>
<td>626</td>
<td>506</td>
<td>402</td>
<td>358</td>
<td>407</td>
<td>343</td>
<td>293</td>
<td>289</td>
<td>392</td>
</tr>
</tbody>
</table>

*Table 3-4 Domestic violence (British Crime Survey 2010/11) (numbers in 000s)*

**Research** from Women’s Aid estimates that domestic violence:

- accounts for 16% of all violent crime (source: Crime in England & Wales 2004/05)
- has more repeat victims than any other type of crime (on average there have been 35 assaults before a victim calls the police). Repeat victimisation accounted for 73% of domestic violence. Just under one-half (44%) of those interviewed were victimised more than once and nearly one-quarter (24%) were victimised three or more times
- is reported to the police at a rate of one incident every minute
- costs the country in excess of £23bn per year, of which £3bn falls to public services
- claims the lives of two women each week and 30 men per year
- is the largest cause of morbidity worldwide in women aged 19-44, greater than war, cancer or motor vehicle accidents
- affects one in four women and one in six men in their lifetime, with women at greater risk of repeat victimisation, serious injury and fear.
- is among the 576,000 violent crimes witnessed by children aged 10 to 15 (around two-thirds of the total number of 878,000 crimes witnessed by children)

### 3.3. Generic Floating Support – families and single homeless

We know from Government statistical returns that since 2006, households with dependant children have been the largest priority need group, and have accounted for around 58% of all cases accepted as homeless by local authorities nationally each year. Pregnancy also accounts for around 11% of accepted households and one person households (vulnerable single applicants) account for around 25% of cases. Lone female parents make up on average almost half of all applicants.
Graph 3-3

In Haringey (2010/11) 55% households were accepted because of dependant children and 4% due to pregnancy. Half of households with children were lone parent households, compared with 13.6% of Haringey’s residents.

Being asked to leave by family or friends is prevalent across the country, including Haringey at around a third of all cases and loss of private rented accommodation was also similar (15% nationally and 17% in Haringey).

L.B. Haringey - Accepted households, priority need (%)

Graph 3-4
39% of cases were single person households, with single females accounting for 19% and males accounted for 20% of all accepted homeless applications in 2010/11, 3% higher compared with the profile of all Haringey residents.

![L.B. Haringey, Accepted households, household type, 2010/11](chart)

**Chart 3-1**

Between October 2010 and September 2011, 25% of single male applicants were made homeless because they were asked to leave family or friends accommodation (25%). There is a similar picture among all applicants. However a significant proportion (16%), were homeless following discharge from hospital and 13% following a successful Asylum application\(^2\). Single males, homeless following discharge from prison, leaving care and eviction from the private rented sector each accounted for 7% of accepted applicants. Almost half (48%) had mental or physical health issues. 27% were vulnerable for some other reason and 21% were either 16 or 17 years old (10%) when they applied or had formerly been in care (11%).

This however only tells part of the story.

A national study by Crisis (2008/09)\(^3\) highlighted further at risk groups some of which include; 464 rough sleepers, 22,755 stays in direct access emergency beds, 28,118 stays in supported accommodation (for homeless people not in priority need), 33,165 people in receipt of asylum support, more than 270,000 people living under threat of eviction, 665,000 people living in overcrowded housing and 5,987,000 people living in unfit housing.

The study also identified that the profile of single homeless people continues to change, Two out of four people using housing support services for single homeless

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\(^2\) Accommodation provided by the National Asylum Support Service ended when asylum was granted

\(^3\) A review of single homelessness in the UK 2000-2010 – York University
people were women and central and eastern European migrants are appearing among the population of rough sleepers, in significant numbers in central London.

On average there are two or three reasons why people may find themselves sleeping rough.

The most common reason cited for the first episode of rough sleeping is relationship breakdown, either with parents or partners (Greeve, 1990). However, the underlying reasons can often be economic, social or personal (Shelter, 2007), as identified in the table below.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship breakdown</td>
<td>41%</td>
</tr>
<tr>
<td>Drug problems</td>
<td>31%</td>
</tr>
<tr>
<td>Asked to leave family home</td>
<td>28%</td>
</tr>
<tr>
<td>Alcohol problems</td>
<td>28%</td>
</tr>
<tr>
<td>Leaving prison</td>
<td>25%</td>
</tr>
<tr>
<td>Lost jobs</td>
<td>21%</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>15%</td>
</tr>
<tr>
<td>Bereavement</td>
<td>15%</td>
</tr>
</tbody>
</table>

Respondents were able to tick more than one
(Source: Shelter, 2007)

Table 3-5 Factors contributing to sleeping rough

For some vulnerable groups rough sleeping is triggered by leaving an institutional background such as hospital, prison or care.

Migration has also become a factor, particularly for individuals from Central and Eastern Europe with no recourse to public funds.

Rough sleeping is the most harmful form of homelessness, and although the majority of new rough sleepers spend one night on the street, those that remain are at risk of developing complex issues which can significantly affect their life chances.

Homelessness leads to poor physical health and mental wellbeing. Rough sleepers tend to experience a greater range of significant physical and mental health problems, whilst those who live in temporary accommodation are more likely to experience depression, relationship problems, suicide attempts and alcohol and drug misuse (Rees, 2009).

Between 2001/01 and 2007/08 just under three quarters of rough sleepers had some support need – 40% suffered from alcohol related problems, 35% had drug related problems and 34% had a mental health support need (Broadway, 2009).

Rough Sleeping in Haringey is a concern. On the night of the 2008, Multi-agency rough sleepers count, 10 people were found sleeping out in the streets of Haringey. The count returned in 2009/10 is not thought to be reflective, given severe weather conditions on the night of the count.
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</tr>
</thead>
<tbody>
<tr>
<td>(Actual)</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>3</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 3-6

A rough sleeper’s counts only provide a snap shot, a better indication of the numbers of rough sleepers is from contacts recorded by outreach teams and published in the CHAIN\(^4\) report. Data for 2010/11 shows that 54 people were seen bedded down during this period; of those 46 were seen once, 8 were seen twice.

Of the 66 people who were contacted by outreach services and/or arrived in or departed from accommodation in the period, 55 were male and 11 were female. British nationals were most highly represented among this group (27) and there were 20 A8\(^5\) or A2\(^6\) nationals.

This is an increase of 18 A8 or A2 nationals since 2008/09. There were 14 between the ages of 18-25, 27 between 26-35, 23 between 46-55 and 2 over 55.

There are however concerns that the known number of A2 and A8 nationals is not a true representation of the prevalence of rough sleeping among this group.

Many of the 66 rough sleepers seen bedded down had one or more support needs related to drug, alcohol or mental health problems. This figure is increasing year on year. The report also identified the institutional history of people showing that 3 had been in care, 5 had been in prison. This compares well with numbers in 2008/09 where 8 had been in care, 14 in prison and 5 in the armed forces.

Joint working since 2008, with the Department for Community and Local Government, Outreach services and other partner agencies, has provided targeted solutions for rough sleepers in the borough and a comprehensive approach to tackling rough sleeping through the Rough Sleeping strategy.

The development of the Move-on Strategy also seeks to ensure that the annual availability of short term supported housing is increased for those who need it and that no one remains in short term supported housing for longer than they need. The Commissioning Plan will assist in implementing the action plan of the Move-on strategy.

Homelessness Prevention features heavily in local authorities’ approach to tackling homelessness. The Council’s draft Homelessness Strategy 2012-14 builds on the preventative partnership approach to tackling homelessness introduced by the Councils Homelessness Strategy 2008-2011. This strategy transformed the Council’s approach preventing and alleviating homelessness through a series of themed multi-agency delivery groups and the creation of the Housing Advice and Options services.

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\(^{4}\) Combined Homeless and Information Network  
\(^{5}\) Slovenia, Slovakia, Hungary, Lithuania, Latvia, Poland, Czech Republic & Estonia  
\(^{6}\) Bulgaria & Romania
The numbers of households in temporary accommodation have also significantly reduced over the last 3 years. At the end of December 2011, there were 2,991 households in TA, 1,961 fewer compared with July 2008 (4952).

Graph 3-5
Despite the reducing numbers in temporary accommodation, we recognise that the most vulnerable households may require housing related support while in temporary accommodation.

The Council’s approach to preventing homelessness has proved successful over recent years. Since 2008 more than three thousand households have been helped to either remain in their accommodation or relocate by the housing advice and options service.

3.4. Learning Disabilities

The term Learning Disability covers a spectrum of needs and whilst some people may present with similar issues there are differences. For this Commissioning Plan we have followed the same approach as contained within Haringey Learning Disability Partnership Learning Disabilities (HDLP) Commissioning Framework 2010/11. The information below is taken from this framework but we have also added a separate section on Autism, taken from Haringey’s draft Strategic Needs Assessment on Autistic Spectrum Condition 2011.

Table 3-7, below, shows the projected learning disability baseline estimates in Haringey for 2009–2020 (Source PANSI & POPPI). This projection shows that the overall number of people with learning disabilities is not expected to significantly increase. However, the change within the age groups is significant. Broadly, the numbers of young people with learning disability going through transition are declining but there are significant increases in the number of people with learning disabilities living beyond age 45. At a time of significant increase in the elderly population in general, this is likely to put added pressure on resources.
### Table 3-7
Haringey (Age Group 18 to 85 and over for period 2009-2020) projected learning disability baseline estimate (Source: PANSI & POPPI)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-24 predicted to have a learning disability</td>
<td>583</td>
<td>514</td>
<td>484</td>
</tr>
<tr>
<td>People aged 25-34 predicted to have a learning disability</td>
<td>1,223</td>
<td>1,240</td>
<td>1,233</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have a learning disability</td>
<td>1,008</td>
<td>992</td>
<td>1,012</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have a learning disability</td>
<td>648</td>
<td>739</td>
<td>746</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have a learning disability</td>
<td>393</td>
<td>428</td>
<td>503</td>
</tr>
<tr>
<td>People aged 65-74 predicted to have a learning disability</td>
<td>249</td>
<td>249</td>
<td>266</td>
</tr>
<tr>
<td>People aged 75-84 predicted to have a learning disability</td>
<td>138</td>
<td>150</td>
<td>145</td>
</tr>
<tr>
<td>People aged 85 and over predicted to have a learning disability</td>
<td>43</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total Population aged 18-85 and over predicted to have a learning disability</strong></td>
<td><strong>4,283</strong></td>
<td><strong>4,358</strong></td>
<td><strong>4,443</strong></td>
</tr>
</tbody>
</table>

### Table 3-8
Table 3-8 below, shows the predicted number of people with Down’s syndrome, by age group 18-65 and over, in Haringey for the period 2009-2020. Source PANSI & POPPI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-24 predicted to have Down’s syndrome</td>
<td>13</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>People aged 25-34 predicted to have Down’s syndrome</td>
<td>31</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have Down’s syndrome</td>
<td>26</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have Down’s syndrome</td>
<td>18</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have Down’s syndrome</td>
<td>11</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>People aged 65 and over predicted to have Down’s syndrome</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Population aged 18-65 and over predicted to have Down’s syndrome</strong></td>
<td><strong>99</strong></td>
<td><strong>101</strong></td>
<td><strong>103</strong></td>
</tr>
</tbody>
</table>

### Table 3-9
Table 3-9 below, shows the number of people predicted to have a severe learning disability, aged 18-64, and likely to be in receipt of services in Haringey for the period 2009-2020. Source PANSI.
Table 3-9

Table 3-9 shows the predicted number of people with a moderate or severe learning disability, aged 65-85 and over, in Haringey for the period 2009-2020. Source POPPI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-24 predicted to have a severe learning disability</td>
<td>44</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>People aged 25-34 predicted to have a severe learning disability</td>
<td>66</td>
<td>71</td>
<td>73</td>
</tr>
<tr>
<td>People aged 35-44 predicted to have a severe learning disability</td>
<td>68</td>
<td>67</td>
<td>69</td>
</tr>
<tr>
<td>People aged 45-54 predicted to have a severe learning disability</td>
<td>33</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>People aged 55-64 predicted to have a severe learning disability</td>
<td>20</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total Population aged 18-64 predicted to have a severe learning disability</strong></td>
<td><strong>231</strong></td>
<td><strong>236</strong></td>
<td><strong>242</strong></td>
</tr>
</tbody>
</table>

Table 3-10

Table 3-10 shows the predicted number of people with a moderate or severe learning disability, aged 65-85 and over, in Haringey for the period 2009-2020. Source POPPI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65-74 predicted to have a moderate or severe learning disability</td>
<td>40</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>People aged 75-84 predicted to have a moderate or severe learning disability</td>
<td>15</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>People aged 85 and over predicted to have a moderate or severe learning disability</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total population aged 65 and over predicted to have a moderate or severe learning disability</strong></td>
<td><strong>59</strong></td>
<td><strong>61</strong></td>
<td><strong>63</strong></td>
</tr>
</tbody>
</table>

Table 3-11

Table 3-11 shows the predicted number of people with a learning disability living with a parent, aged 18-64, in Haringey for the period (2009-2020). Source PANSI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-24 living with a parent</td>
<td>87</td>
<td>77</td>
<td>73</td>
</tr>
<tr>
<td>People aged 25-34 living with a parent</td>
<td>122</td>
<td>130</td>
<td>135</td>
</tr>
<tr>
<td>People aged 35-44 living with a parent</td>
<td>99</td>
<td>98</td>
<td>100</td>
</tr>
<tr>
<td>People aged 45-54 living with a parent</td>
<td>35</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>People aged 55-64 living with a parent</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total Population aged 18-64</strong></td>
<td><strong>350</strong></td>
<td><strong>353</strong></td>
<td><strong>357</strong></td>
</tr>
</tbody>
</table>
Table 3-12 below, shows the number of people aged 45-54, 55-64, and 65 and over predicted to have Down’s syndrome and dementia in Haringey for the period 2009-2020. Source PANSI & POPPI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year:2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 45-64 predicted to have Down’s syndrome and dementia</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>People aged 45-64 predicted to have Down’s syndrome and dementia</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People aged 65 and over predicted to have Down’s syndrome and dementia</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3-12

Table 3-13 below, shows the number of people aged 18-64 with a learning disability predicted to be helped to live at home, and those supported by social care in care homes 2009-2020. Source PANSI.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Year: 2009</th>
<th>Year: 2015</th>
<th>Year: 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 18-64 with a learning disability helped to live at home</td>
<td>356</td>
<td>363</td>
<td>368</td>
</tr>
<tr>
<td>People aged 18-64 with a learning disability supported by social care in care homes</td>
<td>161</td>
<td>164</td>
<td>167</td>
</tr>
</tbody>
</table>

Table 3-13

**Service provision and current demand for services**

Currently there are a total of 1265 adults in Haringey known to HLDP of which 580 are receiving learning disabilities services, leaving 685 who potentially require a lower level of support that HRS typically provides.

Table 3-14, Table 3-15 and Table 3-16 below, shows the current service users receiving services from the HLDP presented here in terms of the services used, ethnicity and gender breakdown.

Some people receive more than one service. Other people are not in receipt of a service but are an ‘open’ case.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of people receiving this service</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house residential care</td>
<td>9</td>
</tr>
<tr>
<td>Independent sector residential care</td>
<td>189</td>
</tr>
<tr>
<td>Nursing care</td>
<td>8</td>
</tr>
<tr>
<td>NHS residential care (e.g. ‘Edwards Drive’)</td>
<td>0</td>
</tr>
<tr>
<td>Independent hospital</td>
<td>4</td>
</tr>
<tr>
<td>Supported living</td>
<td>50</td>
</tr>
<tr>
<td>Domiciliary support at home</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Number of people receiving this service</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>In-house day services - Day opportunities</td>
<td>64</td>
</tr>
<tr>
<td>(Breakdown according to: ‘High support’; ‘Complex behavioural needs’; ‘Moderate needs’)</td>
<td></td>
</tr>
<tr>
<td>Independent sector day services</td>
<td>117</td>
</tr>
<tr>
<td>NHS Campus</td>
<td>0</td>
</tr>
<tr>
<td>Respite care placements</td>
<td>35</td>
</tr>
<tr>
<td>Adult Placement Scheme</td>
<td>28</td>
</tr>
<tr>
<td>Supported employment</td>
<td>27</td>
</tr>
<tr>
<td>‘Mainstream’ employment (with or without support)</td>
<td>27</td>
</tr>
</tbody>
</table>

Table 3-14 – No. of people receiving a service

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>40</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>148</td>
</tr>
<tr>
<td>Mixed</td>
<td>13</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>35</td>
</tr>
<tr>
<td>White</td>
<td>341</td>
</tr>
<tr>
<td>not recorded</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>580</strong></td>
</tr>
</tbody>
</table>

Table 3-15 – Breakdown of service users (current) by ethnicity

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>243</td>
</tr>
<tr>
<td>Male</td>
<td>334</td>
</tr>
<tr>
<td>not recorded</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 3-16 - Breakdown of service users (current) by gender

Commissioning priorities from the Haringey Learning Disability Partnership, Learning Disabilities (HDLP) Commissioning Framework 2010/11 that are relevant to this Commissioning Plan:

During 2010-11 the HDLP supported the development of more comprehensive integrated commissioning, in line with the principles of Valuing People Now and with the transformation of adult services evolving from the roll out of personalisation, a number of current services and service initiatives will be reviewed. In addition the JSNA will provide more robust data on current and future demand.

**HDLP Priorities**

1. Develop robust support to Providers to manage the impact of transforming social care and ‘outcome’ based services;
2. Review of Housing Options within Haringey Housing ‘moving on’ strategy, to develop a number of options such as:
   a. Shared ownership scheme;
   b. Additional capacity for independent living;
c. Commissioning of supported living housing options, and floating support outreach services, to support people living in the community;

3. Review service needs of people living at home with older carers;
4. Review services provided to young people during transition and planning process
5. Develop ‘in borough’ autistic specific provision - both day opportunities and housing.

3.4.1. Autism

The National Autistic society defines autism as a lifelong developmental disability that affects how a person communicates with, and relates to, other people and the world around them. It is a spectrum condition, which means that, while all people with autism share certain areas of difficulty, their condition will affect them in different ways. Asperger's syndrome is a form of autism.

People with an Autistic Spectrum Condition (ASC) experience difficulties in three main areas, these are sometimes known as the ‘triad of impairments’. They are:

- difficulty with social communication;
- difficulty with social interaction and
- difficulty with social imagination

Who has autism?

The National Autistic Society estimates that there are over half a million people in the UK with autism – that is around 1 in 100 people. It is a lifelong condition: children with autism grow up to become adults with autism. It affects people from all cultures and backgrounds. More men than women have autism. Based on a population of 230,000 in Haringey an estimated number of children and adults with autism is 2,300. However, prevalence data for Haringey, based on Projecting Adult Needs and Information System (PANSI)\(^7\) shows that the current number of people with autism spectrum conditions in Haringey is estimated to be 1602. It is estimated that this will number will increase to 1721 by 2030. This is less than the 1% projection for the population.

Housing issues

The Borough Investment Plan provides a long term coherent plan for determining investment. The Plan which covers the period 2011 to 2014 states that: ‘Haringey is experiencing growing need for housing related support services for people with varied needs. On average there are over twenty young people with learning disability and a further eight people with autism that are in need of support. In addition there are an equivalent number of vulnerable people who are need of independent living arrangements.’

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\(^7\) Projecting Adults Needs and Service Information (PANSI) provides forecasts based on 2001 census of the numbers, characteristics, needs of adults aged 18-64 in their locality. POPPI (Projecting Older People Population Information) is equivalent for people aged 65 and over.
Further work is currently being undertaken with specific providers both in voluntary sector and private market to develop specific supported living schemes designed according to the needs of the people with autism in Haringey.

Furthermore it needs to be acknowledged with the changing financial environment, some of the plans are currently under review.

Consultation from the National Strategy on Autism acknowledges the benefits of comparatively low levels of support for enabling adults with autism to live independently and have real choice and control over where and how they live. For people with higher needs it is recommended that long-term planning is undertaken with specific groups of people and their families.

3.5. Mental Health

Housing problems and homelessness along with other key factors are known to increase the risk of mental illness namely; deprivation, employment, age, ethnicity, drugs and alcohol, crime and some groups (refugees and asylum seekers) are more likely to have a mental health diagnosis. 1 in 4 patients come from a BME group.

- In 2010/11 around 7% of homeless applicants nationally were accepted as being in ‘priority need’ due to a mental illness. In Haringey mental illness was the reason for priority in twice as many cases (14%) in 2009/10 and 11% in 2010/11.

- 7% of homeless applicants were homeless following discharge from an institution, 34% of these were homeless on discharge from hospital.

- Haringey has high levels of deprivation, particularly in the east of the borough and it is estimated that more than half (55%) of Haringey’s 228,000 residents come from BME backgrounds.

- In the UK at least 1 in 4 people will experience a mental health issue at some point in their life and 1 in 6 adults has a mental health issue at any one time.

- The draft JSNA identifies that in 2010 in Haringey there were 15,275 people in the 16-74 age group, registered with a GP with a ‘common mental health’ diagnosis (mainly anxiety or depression), although it is estimated that only half seek help from primary health care. Women are more likely to be diagnosed with this issue.

- The prevalence of depression in Haringey is quite low compared with North Central London but similar to the rest of London.

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8 Haringey Mental Health Needs Assessment 2010.
9 Draft Joint Strategic Needs Assessment
10 McManus et al 2009 as referenced in the Cross Party Working Group paper on mental health.
Graph 3-6 Source NHS Information Centre

The JSNA also states that Haringey has a particularly high level of severe mental illness concentrated in the east of the borough (74%) and it has the 3rd highest rate of psychotic disorder in London (3230 patients are registered). This is related to high ethnic diversity (severe mental illness is more common in BME communities) and high levels of deprivation as well as factors such as relatively cheaper housing.

<table>
<thead>
<tr>
<th>Percentage of people that had an inpatient spell that included a period of detainment under the Mental Health Act (1983) (2008/09)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
</tr>
<tr>
<td>Camden</td>
</tr>
<tr>
<td>Enfield</td>
</tr>
<tr>
<td>Haringey</td>
</tr>
<tr>
<td>Islington</td>
</tr>
<tr>
<td>London average</td>
</tr>
</tbody>
</table>

Table 3-17

- In 2009 46% of people who had an inpatient spell that included a period of detainment under the Mental Health Act of 1983. This was an 8% increase from the previous year.

- Black or black British ethnic groups account for 20% of Haringey's population, but represent 46% of all admissions for schizophrenia and 39% of all admissions for bipolar disorder/mania.

- Mental health and physical health issues are inextricably linked. People with mental illness are more likely to suffer from chronic diseases as to a greater extent have adverse lifestyle risk behaviours such as smoking, poor diet, lack of physical activity and non-compliance with self management regimes (as referenced in the draft JSNA). Around 1 in 3 with heart failure and diabetes
and 1 in 5 people with coronary heart disease and chronic pain will experience depression.

- 78% of the suicides in Haringey were amongst men (NCHOD) and the life expectancy of patients with mental health who also misuse drugs is reduced for a number of reasons including accidental overdose, blood-born viruses, suicide and accidents. Direct drug-related deaths due to overdose are mostly found in young male opiate users aged 20-40 years and often associated with concurrent alcohol intake.\(^{11}\)

**Provision**

There are 40 independent residential care homes for people with mental health issues (including forensic) in Haringey. Across all the care homes, there is a total capacity of 245 beds across the borough. Haringey Council funds people in 104 of these placements. It can be noted that the majority of care homes that work with mental health in Haringey are in the east of the borough.

Haringey has a number of supported living providers, working with people with mental health issues, including those funded through the Housing Related Support Programme. It typically provides the service user with their own flat or shared housing within a warden controlled scheme. Schemes vary in terms of the level of support provided to cater for a wide ranging level of user need. Including Housing Related Support funded schemes (188 places), there are 13 main providers of supported living, offering around 285 places.

**Unmet Need and Service Gaps**

The Joint Mental Health and Well-being Strategy for Adults (2010-13) has identified that there is an absence of strong enough community based services, supporting people living in their own homes.

Recommendations from draft JSNA that relate to homelessness and the Housing Related Support Commissioning Plan include:-

- To support independent living
- To address common mental health problems among adults especially in the east of the borough
- To support people with severe and enduring mental health needs
- To endorse joint working between Adult and Housing Services with Planning and Enforcement to work towards ensuring the right level of residential care and supported living capacity is available within the borough
- To endorse market development approach for improving the range and quality of provision

The HRS service review on the council’s Vulnerable Adults Team indicated that they have difficulty placing people with a higher level of mental health need in supported accommodation.

\(^{11}\) As referenced in the draft JSNA
3.6. Offender and Substance Misuse

3.6.1. Alcohol

The JSNA for this sector identifies that in Haringey, as in the rest of England, hospital admission rates due to alcohol are rising rapidly as more and more people are drinking to excess.

Alcohol misuse is associated with a number of health-related problems including: cancers, liver disease, alcohol poisoning, accidental injuries, road traffic accidents, violence, and premature death. The Department of Health has estimated that the annual cost to the National Health Service for alcohol-related hospital admissions, A&E attendances and primary care was around £2.7 billion in England in 2006/07 (Alcohol Concern, 2011). In Haringey the Alcohol Specific Mortality rate for men is higher than both London and England average.

The impact of alcohol is wide reaching encompassing alcohol related health harms and injuries as well as significant social impacts including alcohol related crime and violence, teenage pregnancy, loss of workplace productivity and homelessness (DoH 2007).

Locally and nationally, alcohol is associated with domestic violence and other violent crime, as well as anti-social behaviour such as street drinking. Parental drinking is also a factor in a number of cases focused on the protection of children.

The key issues that have been identified include:-

- Alcohol related hospital admissions in Haringey have doubled between 2002 and 2011
- In Haringey the Alcohol Specific and alcohol Attributable mortality for males is higher than both London and England averages
- The corresponding rates for women are higher than the London average Local Alcohol Profiles for England (Local Alcohol Profiles for London (LAPE), 2011)
- Male deaths from Chronic Liver Disease are higher than both London and England averages. The corresponding female figure is higher than the London average (LAPE, 2011)
- There is a visible street drinking population that consists of ‘traditional’ street drinkers along with individuals from Eastern European countries
- There are higher alcohol related ambulance call outs in the more deprived east of the borough
- The number of under-eighteen year olds admitted to hospital with alcohol specific conditions between 2007/08 to 2009/10 was 53. This is low in comparison to other areas such as Liverpool (n = 384) (LAPE, 2011)
• Synthetic estimates of crimes relating to alcohol show that all alcohol recorded crime and violent crime attributable to alcohol in Haringey has decreased slightly between 2006/07 and 2010/11 (LAPE, 2011)

• Synthetic estimates of sexual crimes attributable to alcohol have increased slightly between 2006/07 and 2010/11 (LAPE, 2011). Given the underreporting of sexual crimes; it is probable that this figure is actually higher

• The National Social Marketing Centre estimates that the annual societal cost of alcohol misuse in England is £55.1 billion, including almost £3 billion costs to public health services and care services. In Haringey, £819,077 was allocated for alcohol services in 09/10. This was funded from a number of grants from LB Haringey and NHS Haringey

• Men are more likely to drink heavily than women. 38% of men and 16% of women consume more alcohol than is recommended (DoH, 2004, ANARP Project)

• The most deprived fifth of the UK population suffer two to three times greater loss of life attributable to alcohol; three to five times higher death rates due to alcohol specific causes and two to five times more admissions to hospital because of alcohol than wealthy areas (DoH, 2009). This is a pattern that is recognisable in Haringey with the majority of alcohol-related and alcohol-specific hospital admissions coming from the East of the borough

  o Males are more at risk than females; due to higher rates of liver disease, alcohol related admissions and alcohol related mortality

  o Men from the Irish community seem particularly vulnerable in relation to alcohol related problems in Haringey

• North West Public Health Observatory (NWPHO) synthetic estimates suggest that 19.02% of the local population are drinking at increasing risk and 4.79% are drinking at high risk within Haringey (NWPHO, 2011). However, only a small percentage of this population will go onto become dependent drinkers and require specialist alcohol treatment

• NATMS data indicates that 576 adults were accessing specialist alcohol treatment services (430 currently in treatment) during November 2011 in Haringey (NDTMS, 2011). However, alcohol data has only been collected since 2009 and local intelligence tells us this figure is an underestimate

• National and local trends of alcohol related hospital admissions suggest the upward trend in alcohol related admissions will continue meaning the need is likely to increase, at least in the short to medium term.
The following charts are based on data from the North West Public Health Observatory tables:

### Table 3-18

<table>
<thead>
<tr>
<th>ID</th>
<th>Indicator</th>
<th>Measure (a)</th>
<th>National Rank (b)</th>
<th>Regional Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Months of life lost - males</td>
<td>10.0</td>
<td>221</td>
<td>8.1</td>
</tr>
<tr>
<td>2</td>
<td>Months of life lost - females</td>
<td>4.0</td>
<td>170</td>
<td>3.4</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol-specific mortality - males</td>
<td>13.3</td>
<td>297</td>
<td>10.4</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol-specific mortality - females</td>
<td>4.3</td>
<td>110</td>
<td>3.9</td>
</tr>
<tr>
<td>5</td>
<td>Mortality from chronic liver disease - males</td>
<td>17.4</td>
<td>251</td>
<td>13.3</td>
</tr>
<tr>
<td>6</td>
<td>Mortality from chronic liver disease - females</td>
<td>6.8</td>
<td>198</td>
<td>6.0</td>
</tr>
<tr>
<td>7</td>
<td>Alcohol-attributable mortality - males</td>
<td>40.1</td>
<td>279</td>
<td>33.4</td>
</tr>
<tr>
<td>8</td>
<td>Alcohol-attributable mortality - females</td>
<td>13.0</td>
<td>144</td>
<td>12.5</td>
</tr>
<tr>
<td>9</td>
<td>Alcohol-specific hospital admission - under 15s</td>
<td>36.2</td>
<td>78</td>
<td>36.1</td>
</tr>
<tr>
<td>10</td>
<td>Alcohol-specific hospital admission - males</td>
<td>447.5</td>
<td>225</td>
<td>409.6</td>
</tr>
<tr>
<td>11</td>
<td>Alcohol-specific hospital admission - females</td>
<td>164.2</td>
<td>197</td>
<td>155.4</td>
</tr>
<tr>
<td>12</td>
<td>Alcohol-attributable hospital admission - males</td>
<td>1,550.4</td>
<td>246</td>
<td>1,423.1</td>
</tr>
<tr>
<td>13</td>
<td>Alcohol-attributable hospital admission - females</td>
<td>672.5</td>
<td>346</td>
<td>743.2</td>
</tr>
<tr>
<td>14</td>
<td>Admission episodes for alcohol-attributable conditions (previously NHS)</td>
<td>1,040.0</td>
<td>245</td>
<td>1,084.4</td>
</tr>
<tr>
<td>15</td>
<td>Alcohol-related recorded crimes</td>
<td>12.9</td>
<td>326</td>
<td>11.7</td>
</tr>
<tr>
<td>16</td>
<td>Alcohol-related violent crimes</td>
<td>8.0</td>
<td>259</td>
<td>7.9</td>
</tr>
<tr>
<td>17</td>
<td>Alcohol-related sexual intercourse</td>
<td>0.2</td>
<td>303</td>
<td>0.2</td>
</tr>
<tr>
<td>18</td>
<td>Claimants of incapacity benefits - working age</td>
<td>109.2</td>
<td>225</td>
<td>105.0</td>
</tr>
<tr>
<td>19</td>
<td>Mortality from land transport accidents</td>
<td>1.4</td>
<td>184</td>
<td>1.0</td>
</tr>
<tr>
<td>20</td>
<td>Abstainers synthetic estimate</td>
<td>30.7</td>
<td>8</td>
<td>24.5</td>
</tr>
<tr>
<td>21</td>
<td>Lower Risk drinking (% of drinkers only) synthetic estimate</td>
<td>78.2</td>
<td>77</td>
<td>81</td>
</tr>
<tr>
<td>22</td>
<td>Increasing Risk drinking (% of drinkers only) synthetic estimate</td>
<td>90.0</td>
<td>95</td>
<td>20.9</td>
</tr>
<tr>
<td>23</td>
<td>Higher Risk drinking (% of drinkers only) synthetic estimate</td>
<td>4.8</td>
<td>66</td>
<td>10.0</td>
</tr>
<tr>
<td>24</td>
<td>Binge drinking (synthetic estimate)</td>
<td>15.5</td>
<td>78</td>
<td>14.3</td>
</tr>
<tr>
<td>25</td>
<td>Employees in bars - % of all employees</td>
<td>1.6</td>
<td>75</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### Graph 3-7

**Rate of Alcohol Related Admissions, per 100,000 population**

- Enfield
- Haringey
- Islington
- Barnet
- Camden
- Westminster
Alcohol Prevalence
18-75's in contact with structured alcohol treatment
2009/10

Graph 3-8

Claimants of IB/SDA whose main medical reason is alcoholism:
(Aug 2010)

Graph 3-9
3.6.2. Substance Misuse

The JSNA states that Haringey has high levels of problematic drug use. The latest prevalence estimate of crack cocaine and opiate users in Haringey is 2424. The rate
of 14.96 per 1000 population is higher than in London and England, 9.45 and 8.93 respectively (Hay et al, 2009). Those most vulnerable to problematic drug use, are more likely to live in deprived areas, suffer from mental ill health, live in poor housing and be involved in other criminal activity (National Treatment Agency :2010).

Drug misuse not only impacts on the individual drug user but is also a key cause of societal harm, including crime, poverty and family breakdown.

The profile of clients in drug treatment in Haringey mirrors other patterns of deprivation. The majority of people in drug treatment are from the east of the borough, are unemployed and without a permanent place to live. Around a quarter enter drug treatment via the criminal justice system; a similar proportion has mild or severe mental health issues. Injecting drug users are particularly susceptible to contracting blood borne viruses – including hepatitis B and C and HIV (Health Protection Agency, 2009).

In terms of drug misuse the JSNA highlights that:-

- Haringey has higher rates of problematic drug use than the London and England averages.
- A significant majority of the drug treatment population use crack cocaine (75%; 1812) with opiate use at slightly lower level (1736).
- Combined use of crack and opiates is common.
- Reported numbers of those tested for Blood Borne Viruses and being vaccinated for hepatitis B in structured drug treatment remain low
- Haringey is classed as Band C by the Health Protection Agency (high band) for numbers of drug users infected with hepatitis C
- Haringey is rated in the top quartile in the country for crack cocaine and opiate users leaving treatment free of drug dependence

Data from Haringey adult drug treatment services in 2010-11 indicates that this population has a wide range of social problems:

- Significant housing problems with just under one third (31%; 188)
- 12 per cent (74) being homeless (no fixed abode)
- A little over quarter came to treatment via criminal justice system (26%; 169)
- Nearly a quarter (24%; 151) were identified with dual diagnosis, a term which is used to describe co-existing mental health and substance misuse problems.
- Only 15 percent (90) had any paid work in the last four weeks prior to their treatment start date

The latest prevalence estimate of crack cocaine and opiate users in Haringey is 2424. The associated confidence intervals are 2,220 - 2,714. The estimate includes age’s 15-64. The prevalence rate of 14.96 per 1000 population is higher than in

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13 Source: Treatment Outcome Tool baseline report 2010-11
14 2009-10 estimates by the University of Glasgow. The associated confidence intervals are 2,220, 2,714. The estimate includes ages 15-64.
London and England (9.45 and 8.93 respectively, see Graph 3-12). A significant majority use crack cocaine (75%; 1812) with opiate use at slightly lower level (1736). Combined use of crack and opiates is however common.

Graph 3-12 Source: University of Glasgow prevalence estimates
- The prevalence estimates for Haringey have decreased since the first study in 2004-5 but due to changes in methodology, yearly trend information is not reliable
- The prevalence of young opiate and crack users aged 15-24 per 1000 population is lower than those aged 25-35 (12.35 and 17.38 respectively, see Table 3-19) but higher than regional and national averages (8.51 and 6.87 respectively). Previous local needs assessments have shown that young adult population seeking drug treatment are more likely to use cannabis.

2010/11

<table>
<thead>
<tr>
<th>PDUss (All Ages)</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Treatments Journeys</td>
<td>52</td>
<td>90</td>
<td>135</td>
<td>174</td>
<td>207</td>
<td>248</td>
<td>267</td>
<td>331</td>
<td>360</td>
<td>389</td>
<td>418</td>
<td>443</td>
</tr>
<tr>
<td>Retained Over 12 Weeks</td>
<td>39</td>
<td>69</td>
<td>107</td>
<td>141</td>
<td>169</td>
<td>201</td>
<td>234</td>
<td>271</td>
<td>296</td>
<td>320</td>
<td>343</td>
<td>360</td>
</tr>
<tr>
<td>Completed Treatments</td>
<td>*</td>
<td>*</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>10</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Percent In Effective Treatment</td>
<td>*</td>
<td>*</td>
<td>83%</td>
<td>84%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

All Drugs (18+)

<table>
<thead>
<tr>
<th>PDUss (All Ages)</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Treatments Journeys</td>
<td>65</td>
<td>117</td>
<td>178</td>
<td>237</td>
<td>280</td>
<td>348</td>
<td>401</td>
<td>459</td>
<td>500</td>
<td>546</td>
<td>594</td>
<td>640</td>
</tr>
<tr>
<td>Retained Over 12 Weeks</td>
<td>47</td>
<td>86</td>
<td>136</td>
<td>187</td>
<td>224</td>
<td>278</td>
<td>320</td>
<td>367</td>
<td>399</td>
<td>438</td>
<td>474</td>
<td>509</td>
</tr>
<tr>
<td>Completed Treatments</td>
<td>*</td>
<td>7</td>
<td>12</td>
<td>13</td>
<td>15</td>
<td>21</td>
<td>24</td>
<td>24</td>
<td>28</td>
<td>29</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Percent In Effective Treatment</td>
<td>*</td>
<td>79%</td>
<td>83%</td>
<td>84%</td>
<td>85%</td>
<td>86%</td>
<td>86%</td>
<td>85%</td>
<td>85%</td>
<td>86%</td>
<td>85%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Table 3-19
- Haringey residents who seek treatment are likely to come from the more deprived, diverse and densely populated east: the highest concentration of 2009-10 drug treatment population were found to be residing in areas around
Seven Sisters, Bruce Grove and Northumberland Park. Accordingly, the main drug services are based around those areas (See Map 3-12).

Figure 3: Index map of drug treatment population in 2009-10 by super output area (n=89115)

Map 3-12 Source: National Drug Treatment Monitoring System (NDTMS) - analysis by Haringey Council Business Intelligence

- Women consistently make up a quarter of the drug treatment population (see figure 5 in the projection section), which is on par with national and regional average
- Almost one third (30%, 187) of new clients in 2010-11 were born outside of the United Kingdom
- The largest group of all clients in treatment in 2010-11 were White British (35%; 473) followed by Black Caribbean and Other White (14%; 191 and 18%; 246 respectively). These two groups were over represented in treatment compared to overall Haringey population.

Figure 4: Ethnicity breakdown of adult clients in treatment in Haringey 2010-11

15 The analysis includes only known values hence the sample is smaller than the total number in treatment in 2009-10. It includes Haringey residents in drug treatment in 2009-10 aged 18 who had their full postcode recorded, representing 66% of the total treatment population. It was not possible to retrieve this data from CRI and residential agencies outside the borough. The representative ness of the sample was tested: there were no differences of more than 3% percentage points in the demographic profiles between the sample and the total treatment population.

16 The index map shows a score for each of the boroughs 144 Lower Super Output Areas (LSOA). An index value of 100 indicates a score that is proportionate to the borough average rate (3.95 clients per thousand residents [891 known clients/225,529 residents] based on ONS MYE 2009 population figs). The client rate for each LSOA is calculated: (no of clients/LSOA residents) x 1000 and then the rate is divided by the overall borough rate and multiplied by 100 to create the index score i.e. (LSO rate/borough rate) x 100. A score exceeding 100 indicates that an area is above average. Thematic mapping requires class ranges for each area (or LSOA) - absolute numbers do not work - so the borough average is represented as a range defined as 20% less than 3.95 to 20% greater than 3.95. This translates to an index class range for the borough average of 80 – 120.
<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>473</td>
<td>35%</td>
</tr>
<tr>
<td>White Irish</td>
<td>64</td>
<td>5%</td>
</tr>
<tr>
<td>Other White</td>
<td>246</td>
<td>18%</td>
</tr>
<tr>
<td>White &amp; Black Caribbean</td>
<td>37</td>
<td>3%</td>
</tr>
<tr>
<td>White &amp; Black African</td>
<td>13</td>
<td>1%</td>
</tr>
<tr>
<td>White &amp; Asian</td>
<td>*</td>
<td>1%</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>21</td>
<td>2%</td>
</tr>
<tr>
<td>Indian</td>
<td>*</td>
<td>1%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>*</td>
<td>0%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>18</td>
<td>1%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>28</td>
<td>2%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>191</td>
<td>14%</td>
</tr>
<tr>
<td>African</td>
<td>74</td>
<td>5%</td>
</tr>
<tr>
<td>Other Black</td>
<td>72</td>
<td>5%</td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>45</td>
<td>3%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>21</td>
<td>2%</td>
</tr>
<tr>
<td>Missing ethnicity code</td>
<td>26</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 3-20  Source: National Drug Treatment Monitoring System – Quarter 4 Adult Partnership report. * Data suppressed for data protection

The JSNA recommends that the wider determinants of health inequalities in this group such as access to housing and employment, should continue to be tackled, by working with colleagues elsewhere within the council and through national government initiatives such as the Work Programme, HRS programme and locally commissioned education, training and support services.

### 3.6.3. Offenders

The needs information for this sector has been supplied by the London Probation Service.

The chart below identifies the percentage of offenders by ward. The wards with the highest level of offending are in the east of the borough.
Violence against the person is the offence with the highest prevalence across the North London Sub Region. All types of offences have a similar prevalence rate in each borough.
As can be seen in the chart below, the number of men committing offences is far higher than women.

Graph 3-14

The tables below details the Demographic, Accommodation, Drug and Alcohol misuse caseload profiles of Haringey Local Delivery Unit which is part of the London Probation Trust, taken on the 20th February 2012.

This table shows that on 20.02.2012 303 people required accommodation. This does not necessarily mean they need HRS.

<table>
<thead>
<tr>
<th>Criminogenic Need Data</th>
<th>Total Haringey Caseload</th>
<th>Accommodation Needs</th>
<th>Drug Misuse</th>
<th>Alcohol Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Accommodation</td>
<td>303</td>
<td>22%</td>
<td>303</td>
<td>100%</td>
</tr>
<tr>
<td>Education, Training, Employability</td>
<td>379</td>
<td>28%</td>
<td>132</td>
<td>44%</td>
</tr>
<tr>
<td>Financial Management and Income</td>
<td>575</td>
<td>43%</td>
<td>180</td>
<td>59%</td>
</tr>
<tr>
<td>Relationships</td>
<td>477</td>
<td>35%</td>
<td>198</td>
<td>65%</td>
</tr>
<tr>
<td>Lifestyle and Associates</td>
<td>814</td>
<td>60%</td>
<td>253</td>
<td>83%</td>
</tr>
<tr>
<td>Drug Misuse</td>
<td>415</td>
<td>31%</td>
<td>146</td>
<td>48%</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>292</td>
<td>22%</td>
<td>105</td>
<td>35%</td>
</tr>
<tr>
<td>Emotional Well-Being</td>
<td>385</td>
<td>29%</td>
<td>153</td>
<td>50%</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>978</td>
<td>72%</td>
<td>299</td>
<td>99%</td>
</tr>
<tr>
<td>Attitudes</td>
<td>680</td>
<td>50%</td>
<td>234</td>
<td>77%</td>
</tr>
</tbody>
</table>

Table 3-21
### Table 3-22

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Haringey Caseload</th>
<th>Accommodation Needs</th>
<th>Drug Misuse</th>
<th>Alcohol Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>392</td>
<td>81</td>
<td>109</td>
<td>72</td>
</tr>
<tr>
<td>25-34</td>
<td>444</td>
<td>108</td>
<td>157</td>
<td>101</td>
</tr>
<tr>
<td>35-44</td>
<td>288</td>
<td>65</td>
<td>91</td>
<td>75</td>
</tr>
<tr>
<td>45-54</td>
<td>167</td>
<td>39</td>
<td>49</td>
<td>34</td>
</tr>
<tr>
<td>55-64</td>
<td>41</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>65+</td>
<td>18</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1350</td>
<td>303</td>
<td>415</td>
<td>292</td>
</tr>
</tbody>
</table>

### Table 3-23

The majority of people needing accommodation are from the Black or Black British-Caribbean community.

### Table 3-24
### Table 3-25

The majority of offences that relate to an accommodation need is 28.7% followed by robbery at 13.9%.

### Table 3-26

55.4% have medium need and 33% have high needs, a total of 88.7%.

#### 3.7. Older People

An ageing society is one of the great challenges for housing. National Government over the past decade has identified this as an area where significant changes need to be made, not only in the actual buildings but in challenging society’s perceptions of what housing for older people should mean. There are strong links between older age, housing and health and we recognise the interdependence of these.

### Age and gender

In 2001, there were 48,295 people aged 50+ in Haringey which is approximately 22% of the total population. 45% (21,841) were male and 55% (26,454) were female (2001 Census).

In 2009 it was estimated that there were 21,200 people aged 65+ which is approximately 9.4% of the total population (2009 Mid Year Population Estimates).
These numbers are similar to our neighbouring boroughs of Camden, Hackney, Islington and Newham. As with the rest of London the population over 65 declined slightly between 2001 and 2007 as a proportion of the total population.

Projections for 2026 show there is a projected overall increase to 24,200 aged 65 and over. By the same year, the number of residents aged 10-39 is projected to fall by 3.4% while the number of those aged 40-69 years will grow by 22.4%

In 2026 the wards with the highest number of residents of retirement age will be Alexandra, Bounds Green, St Ann’s and White Hart Lane.

By 2030 the overall number of people aged 65 and over will increase by 6,700 and of these, 1,300 will be 85+. It is this older age group that typically requires more support and care than younger age groups.
Map 3-14  Total number of retirement age population 2026, Haringey wards

Ethnicity

In 2007 the majority of older people were white (67%), which is close to the 65.6% across all ages. This ranks Haringey as the fifth most diverse borough in the country. Based on Greater London Authority population projections, by 2026 BME groups will account for 36% of our population. In actual numbers of people, the biggest increase will be Black African and Chinese residents.

The next table details the breakdown by age and ethnicity of our older people in Haringey.
Table 3-27 People aged 65 and over by age and ethnic group, year 2007\textsuperscript{17}

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>People aged 65-74</th>
<th>People aged 75-84</th>
<th>People aged 85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (this includes British, Irish and Other White)</td>
<td>8,279</td>
<td>5,372</td>
<td>2,145</td>
</tr>
<tr>
<td>Mixed Ethnicity (this includes White and Black Caribbean; White and Black African; White and Asian; and Other Mixed)</td>
<td>236</td>
<td>101</td>
<td>21</td>
</tr>
<tr>
<td>Asian or Asian British (this includes Indian; Pakistani; Bangladeshi; and Other Asian or Asian British)</td>
<td>853</td>
<td>330</td>
<td>59</td>
</tr>
<tr>
<td>Black or Black British (this includes Black Caribbean; Black African; and Other Black or Black British)</td>
<td>2,184</td>
<td>876</td>
<td>124</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
<td>262</td>
<td>94</td>
<td>11</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11,814</td>
<td>6,774</td>
<td>2,361</td>
</tr>
</tbody>
</table>

Tenure

The 2001 Census showed that 58% of people aged over 50 in Haringey were owner-occupiers. 73% of residents in Muswell Hill and 78% in Alexandra wards owned their own homes whilst only 38% in White Hart Lane and 40% in Northumberland Park do.

\textsuperscript{17} Figures are taken from Office for National Statistics (ONS) Table PEEGC163, Ethnic group of adults by custom age bandings, mid-2007. This table is a commissioned table from the Population Estimates by Ethnic Group. The Estimates, released in April 2009, are experimental statistics. This means that they have not yet been shown to meet the quality criteria for National Statistics, but are being published to involve users in the development of the methodology and to help build quality at an early stage.
The graphs above clearly show that there are greater numbers of owner occupiers in the younger age groups (61% people aged 55-64, 58% people aged 65-74 compared with 41% for people aged 85+). However we know that these figures are not evenly spread across the Borough. The requirements of the increasing numbers of home owners need to be reflected in the priorities of this strategy.

It is anticipated that the 2011 Census will show a further increase in the number of older people owning their own homes in Haringey. We know from the Older People's Housing Strategy that many older people do not want to move into rented and therefore the demand for this type of accommodation is likely to decrease further over the coming years.

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18 Office for National Statistics 2001 Census
The health of our older people

Health significantly affects lives of older people and has a major impact on a person’s ability to continue to live fulfilled lives within their communities. Appropriate housing and location, with or without care and support, plays a key role in enabling people to live independently.

Life expectancy is rising generally, in line with national trends, but we remain below the national average for male life expectancy. Men in the west will live, on average, 6.5 years longer than those in the east\(^19\) (Fortis Green 78.2 years and Tottenham Green 71.3 years).

Women’s life expectancy is above the national average; while the east/west is divide is less apparent, the gap between the highest and lowest life expectancy has widened (Stroud Green, 86.5 years and White Hart Lane and Tottenham Hale, 76.8 years).

Data from the General Household Survey, carried out in 2004 indicated that by 2008, 6,947 people over 65 would be living alone. Of these, 4518 would have a limiting long term illness\(^20\).

The number of people living alone is projected to rise to 9,096 by 2025, and of this number, those living alone with a limiting long-term illness is predicted to increase to 5,521 over the same period.

**Current Housing for Older People**

We know from Haringey’s Older People’s Housing Strategy that there is an over provision of sheltered housing when compared with other authorities. We currently have 2106 units of sheltered and Community Good Neighbour (low level floating support schemes)

<table>
<thead>
<tr>
<th></th>
<th>Number of units</th>
<th>Units per 1000 people aged 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haringey (inc sheltered and Community Good Neighbour)</td>
<td>2106</td>
<td>107</td>
</tr>
<tr>
<td>Hackney</td>
<td>1731</td>
<td>80</td>
</tr>
<tr>
<td>Westminster</td>
<td>2069</td>
<td>64</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>1032</td>
<td>55</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>1298</td>
<td>46</td>
</tr>
<tr>
<td>Barnet</td>
<td>1638</td>
<td>37</td>
</tr>
<tr>
<td>Redbridge</td>
<td>1362</td>
<td>34</td>
</tr>
<tr>
<td>Enfield</td>
<td>1350</td>
<td>29</td>
</tr>
<tr>
<td>London (average)</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>England (average)</td>
<td></td>
<td>68</td>
</tr>
</tbody>
</table>

**Table 3-28**

\(^19\) Haringey Borough Profile 2010

\(^20\) (Figures are taken from Office for National Statistics (ONS) Table C0839, Age (65 and over in 5 year age groups) and Limiting long-term illness (LLTI) by household size, a commissioned table from ONS using information from the 2001 census. Numbers have been calculated by applying percentages to projected population figure)
Demand for supported housing

In December 2010 there were only 381 applicants on Haringey’s Supported Housing Register and, of these 229 (55%) are seeking sheltered housing. A quarter of applicants are awaiting a review to confirm that they are still interested in sheltered housing.

During 2010/11, a total of 203 units of supported housing (council and housing association homes) became available for letting. Of these 28 (14%) were in Community Good Neighbour schemes and 175 (86%) were in rented sheltered housing schemes.

Haringey’s previous housing allocations policies resulted in some older people moving into sheltered housing when they could have successfully remained in their own homes with appropriate support. The shortage of accommodation in community Good Neighbour schemes also encouraged applicants to consider sheltered housing as a housing option when they either had minimal or no support needs. For many it was a way of avoiding a long wait for general needs housing.

Extra Care Housing

Haringey has a limited supply of extra care housing for older people compared with other boroughs. This type of housing offers the opportunity for independent living for longer as most care can be delivered in this setting, reducing the need to move into residential or nursing care. There is currently 40 units in a scheme in the east of the Borough which opened in 2011. A further 40 unit scheme is planned to open in 2012, again in the east and Haringey Council is planning to redevelop a site of a sheltered housing scheme in Tottenham as extra care housing. This will have approximately 45 units.

There is no housing related support funding for these schemes although as in sheltered it will be delivered.

Home improvement agency

Metropolitan Care and Repair service was established in 1991 as a working partnership between Haringey Council and Metropolitan Housing Partnership. It supports mainly vulnerable people, including older people (98% of its clients) and those with disabilities who live in the private sector. The service usually helps people on low incomes to get disabled adaptations and essential repairs to their homes. The service is funded by Haringey’s Supporting People plus raising money from other sources.

Metropolitan Care and Repair also provide:

- Technical building service
- Anti-burglary support service incorporating home security
- Hospital homelink
- External handyperson scheme
- Care and repair in the garden
- Emergency shopping service
• Energy efficiency and central heating projects
• Free advocacy and support including welfare benefit advice
• Fall prevention
• Protecting people from ‘cowboy’ builders
• Helping people to apply for grants

Assisted technology

The use of assisted technology can greatly enhance independence and give security both to the older person and their families. The term assisted technology includes community alarms, which are familiar, to less known uses such as movement detectors, tracking devices and medication reminders. The growing use of technology will help us care for people with dementia and increased frailty in their own homes whether rented or owned

3.8. Physical disabilities, sensory impairment and HIV

Percentage spend per sector benchmarked against similar boroughs

In March 2010, nationally, there were 56,400 people registered as deaf and 156,500 people registered as hard of hearing. 88,500 people were registered as blind or partially sighted and of these, 25,300 (29%) were recorded as having impairment as their additional disability.\(^{21}\)

In March 2010, London had 25,290 people registered as deaf or hard of hearing. Haringey had the fourth lowest number among the London boroughs.\(^{22}\)

Census data (2001) shows that the prevalence of limiting long-term illness in Haringey is similar to the rest of London and slightly lower than in England as a whole.

<table>
<thead>
<tr>
<th>Table 2-4: Limiting long-term illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people (persons)</td>
</tr>
<tr>
<td>Count</td>
</tr>
<tr>
<td>People with a limiting long-term illness (persons)</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>People of working age with a limiting long-term illness (persons)</td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>

Source: Census 2001

Table 3-29

\(^{21}\) National Statistics – People registered Deaf or Hard of Hearing Year ending 31 March 2010 in England
\(^{22}\) NHS.uk
Haringey’s profile guide identifies that in January 2008 the numbers of people receiving a community based service to support them with physical disabilities or sensory impairment was higher in the east of the borough, with the highest concentrations in Noel Park, Bounds Green, Bruce Grove and Northumberland Park.

In 2011 there were 8,225 Incapacity Benefit and Severe Disablement Allowance (IB & SDA) claimants in Haringey, representing 5% of the working age population. This claim rate is the same as England, but significantly higher than the London rate (3.9%). The majority are long term claimants with 79% having received this for five or more years (compared with 78% in London and 76% in England)

The highest proportions of claimants are from Northumberland Park, White Hart Lane, Tottenham Green, Noel Park, Tottenham Hale and West Green, with claims rates of 7-8%.

In May 2011, there were 10,855 claimants in Haringey in receipt of Disability Living Allowance, with 34% having received this for 5 or more years. The highest proportions of claimants are from Bruce Grove, Noel Park, Northumberland Park, Tottenham Green and Woodside Wards, all each representing 7% of all claims.
Housing Related Support data demonstrates that the people who use the HRS services for physical disabilities, HIV and sensory impairment have a number of equalities protected characteristics:

- 74% of the people who use the services for physical disabilities, HIV and sensory impairment have a form of disability.
- All service users are between the ages of 18 and 69 years. The majority (73%) of service users are between 32 and 59 years.
- Table 3-30 provides data on the gender of service users compared with the borough profile. The data shows that women are under marginally under represented.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Physical Sensory Services</th>
<th>Disabilities, HIV &amp; Impairment</th>
<th>Haringey Profile*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>54%</td>
<td></td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>46%</td>
<td></td>
<td>49%</td>
</tr>
</tbody>
</table>

Table 3-30  Gender of users of HRS services for physical disabilities, HIV and sensory impairment
*Breakdown by gender for whole of Haringey population (ONS Mid-year Estimates 2009).

- Table 3-31 below provides data on the ethnicity of service users of services for physical disabilities, HIV and sensory impairment.
  - The data clearly shows that White Other and Black or Black British groups (both Black African and Black Caribbean) are significantly over represented.
<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Physical Disabilities, HIV &amp; Sensory Impairment Services</th>
<th>Haringey Borough Profile*</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>51%</td>
<td>65%</td>
</tr>
<tr>
<td>White British</td>
<td>26%</td>
<td>48%</td>
</tr>
<tr>
<td>White Irish</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Other White</td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>Mixed</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Indian</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>36%</td>
<td>19%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>African</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>Other Black</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Chinese or Other Ethnic Group</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 3-31 Breakdown of ethnicity of service users of Housing Related Support services for physical disabilities, HIV and sensory impairment, compared with whole borough figures.

* Haringey whole borough population figures are from ONS 2005.

3.9. Young People

The last decade has seen a number of policy and statutory changes aimed at preventing youth homelessness through intervention, support and a joined up approach.

The previous Government’s Homelessness Strategy\(^{23}\), published in March 2005. It recognised the wide range of reasons why young people become homeless and focused on preventing homelessness through early identification and intervention; support for those living in temporary accommodation and effective management of the transition between temporary and settled accommodation to ensure continued access to services.

\(^{23}\) Sustainable Communities: settled homes; changing lives
In 2006, the Secretary of State announced a package of measures to prevent and tackle youth homelessness including a commitment to eradicate the use of bed and breakfast accommodation for 16/17 years (except in an emergency) and through the national Youth Homelessness Scheme, establish supported lodgings, accommodation and advice and mediation services for young people who can no longer stay in the family home\textsuperscript{24}.

Changes in the statutory framework also expanded the priority need categories to include 16/17 year olds and 18-20 year olds who had been a relevant child. A new code of guidance also recommended mediation for conflict resolution and to prevent homelessness where appropriate.

The Council’s Homelessness Strategy 2008-2011 was a multi-agency approach to tackling homelessness and contained nine strategic priorities. Strategic priority two: Invest in early intervention, set out the commitment to “Develop and promote a range of services and interventions for young people (including mediation, supported lodgings and mentoring) to prevent homelessness and sustain tenancies” and contained number of specific actions including:-

- Undertake research to understand the needs of homeless young people and the reasons why they become homeless, research should include an analysis of ethnicity, worklessness, teenage pregnancy, educational attainment and family support networks
- Undertake research to identify good practice
- Evaluate each of the services and interventions, based on their success on preventing homelessness and sustaining young people’s tenancies

The following information is drawn from internal data and national research. It provides an overview of the issues faced by young homeless people and explores some tested interventions.

- It is estimated that 1 out of 100 young people in the UK aged 16-24 experience some form of homelessness annually\textsuperscript{25}.
- From 2008-2010 16% of the total number of households that approached Haringey Council were 16-21 (200 in 08/09 and 121 in 09/10)\textsuperscript{26}.
- In February 2012 there were 1,468 16-24 year olds living in temporary accommodation, 433 of these, (365 female and 68 male) were the main homeless applicant (15% of all applicants).
- The top five reasons for the homelessness of female applicants in TA aged 16-24 years include:-
  - Homeless from family or friends accommodation (58%)
  - Other (8%)
  - Evicted – private landlords (6%)
  - Leaving care (5%)
  - Emergency or referral from the National Asylum Support Service (NASS)

\textsuperscript{24} Tackling youth homelessness (policy briefing 18)\textsuperscript{25} Youth Homelessness in the UK – a decade of progress? – Joseph Rowntree Foundation (2008)\textsuperscript{26} Data from Haringey Council’s Housing Management System
The top five reasons for homelessness for male applicants in TA aged 16-24 years include:
- Homelessness from family or friends accommodation (47%)
- Leaving Care (11%)
- Emergency (10%)
- 16/17 years of age (8%)
- Discharge from prison (6%)

Nationally, on average 39% of all homeless application acceptances\(^27\) had main applicants aged 16-24.

A study by the Joseph Rowntree Foundation\(^28\) found that young women are more likely to be accepted as statutorily homeless.

In 2010, broadly speaking the housing issues experienced by young people are mirrored across all age ranges. Overall there are more than 1200 households that became homeless from family/friends accommodation.

**Reasons for Approach- (TA Residents- 2010)**

Graph 3-15

Homelessness Triggers

A study by the Joseph Rowntree Foundation (JRF), “Youth Homelessness in the UK- a decade of progress?” is a comprehensive evaluation of the measures taken to address youth

\(^27\) Table 781- homeless households accepted by local authorities, by age of applicant, Communities and local government
homelessness over the last ten years. This study reviews all previous research and statistical analysis, provides detailed case studies and a national consultation exercise.

The main findings of this study confirm a number of points that have been broadly accepted by housing and care professionals and are listed below:-

Young homeless people are likely to have:

- Experienced family disruption (because of parental separation or divorce and/or the arrival of a step parent);
- Witnessed or experienced violence within the home;
- Had difficulty getting on with parents;
- Lived in a family that experienced financial difficulties;
- Run away from home;
- Spent time in care;
- Been involved in crime or anti-social behaviour;
- Had their education severely disrupted (e.g. been suspended or excluded from school)

Additionally the JRF study highlights that conflict within the home may predate the young person leaving home by many years and that relationship breakdown (typically with parents or step parents) is the major trigger for homelessness. This is consistent with the local picture. It is also stated that Homelessness compounds other traumas and experiences resulting in a negative impact on the young person's mental health and wellbeing.

A further study in 2008/09 found that 58% of young people seen by Centrepoint reported that they had to leave home because of arguments, relationship breakdown or had been told to leave. This study also highlighted that with extra strain caused by lower standards of living, the problem of youth homelessness due to relationship breakdown is likely to intensify.

Teenage parents

In February 2012 there were 33 female applicants in TA aged 16-24 who were expecting a child. 4 were 16-18 years of age, 9 were aged 19-20 years of age, 6 were 21-22 years of age and 14 were 23-24 years of age.

\[\text{Number of pregnant women 16-24 years in TA - February 2012}\]

29 Family life: the significance of family to homeless young people - Centrepoint
Local data provided by the Children and Young People’s Service indicates that the majority of teenage (18 years and under) conceptions and terminations are to residents in the east of Haringey.

Map of Conceptions in 2010 leading to a termination (n=70)

Map 3-16  Map of Conceptions in 2010 leading to a termination (n=70)

Map 3-17  Map of Conceptions in 2010 leading to a birth (n=7)

Ethnicity

There are three ethnic groups that represent 46% of all the young people that approached and are now in temporary accommodation. People who self identified as Black African, Black Caribbean and White British, represented 16%, 17% and 13% of all young people.
Not in Education, Employment or Training (NEET)

- Nationally in Q1 2010, 10%\(^\text{30}\) of 16-18 year olds were not in education, employment or training (NEET). The average number (Nov’08-Jan’10) for London was 5.3%.

- Locally, data shows that, in November 2010 there were 6.5%\(^\text{31}\) of 16-18 years olds that were NEET in the borough of Haringey\(^\text{32}\). With Noel Park (10.4%), Tottenham Hale (9.9%) and White Hart Lane Wards (8.7%) having the highest number of NEET’s.

Chart 3-6

The concentration of NEETs appears similar to the concentration of TA. The JRF study confirms that a sense of people’s life being on hold while in temporary accommodation and that there is a greater risk of disruption to education, training and

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\(^{30}\) Education.gov.uk DSCF: NEET Statistics – Quarterly Brief- May 2010

\(^{31}\) A detailed breakdown for each ward for November 2010 can be found in appendix 1

\(^{32}\) Places.communities.gov.uk
employment\textsuperscript{33}. This is supported by a CLG report which confirms that a third of children have to change schools as a result of homelessness.

A survey conducted by Shelter\textsuperscript{34} found that children missed an average of 55 school days due to the disruption of moves into and between temporary accommodation and that the top three reasons listed were Transport problems (33%), No school places/unable to get a school place (22%), and having to move (20%).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{map3-18.png}
\caption{Map 3-18}
\end{figure}

Educational attainment in Haringey as a whole was below the national and London average in 2009, with attainment in the east of the borough being lower than in the west.

Preventing Youth homelessness

A number of approaches in preventing homelessness which may alleviate youth homelessness have been advocated over recent years. The Joseph Rowntree Foundation study (JRF, 2008) called for early intervention, but recognised that this must not be linked exclusively to homelessness prevention. Recommendations included training for staff to recognise when a young person may be having problems at home (including schools and GP’s) and for homelessness issues to be taught in schools. Support for parents at an early stage was also considered beneficial in addressing issues before they escalate.

\textsuperscript{34} Living in Limbo – Survey of Homeless households living in temporary accommodation (2004)
The following information provides an overview of the main schemes that have been promoted and where available any analysis of their effectiveness. Generally speaking there is however a lack of information relating to the long term effectiveness of interventions.

**Mediation Schemes**

As demonstrated earlier, people asked to leave the homes of parents, other relatives or friends account for a significant proportion of all homelessness acceptances. Mediation is considered good practice in preventing homelessness and can be one way of reconciling families. It has also however been recognised that the mediation process is not appropriate in all cases (when for example a young person is at risk).

Mediation UK defined the mediation process within Shelter’s 2004 Good Practice Guide as a “process for resolving disagreements in which an impartial third party (the mediator) helps people in dispute to find a mutually acceptable resolution”.

Research and guidance (JRF and National Youth Homelessness Scheme), show that in addition to preventing homelessness mediation can deliver wider benefits. These include; helping a young people stay in education, training or employment, reducing re-offending and anti-social behaviour and having long-term positive effects on the parenting skills of parents. Similar crises can then be avoided with younger siblings, if mediation can be provided at an early stage. This is supported in research (Mediation and Homelessness, 2001, Lemos and Crane), who state that “…it may produce other benefits, principally in the sustaining and strengthening of social networks.” Centrepoint conclude in their study – Family life: The significance of family to homeless young people that, “mediation should not solely be linked to homelessness approaches, more should be done to involve extended family”

Shelter state that the main aims/outcomes of successful mediation should be:-

- The young person and their family resolve their difficulties, leading to the young person either returning home or remaining at home
- The young person and their family resolve their difficulties, but that instead of the young person returning to the family home, they will live with other family or friends
- The young person and their family resolve their difficulties, and the young person returns home with the aim of a planned move to alternative accommodation
- The young person and their family resolve their difficulties, but decide that the young person cannot return home, even temporarily. The family agrees to support the young person in living independently.

In 2008-2010 mediation prevented homelessness in 6% of homelessness cases nationally, with trained mediators used in just under 7,000 cases. The JRF study highlighted that mediation schemes had varying degrees of success in terms of preventing homelessness, between 38 and 96 per cent in different local authorities (Association of Local Government, 2005). This could be attributed to a number of factors surrounding the configuration, aims and methods of referral.

While some schemes evaluated in the JRF study were provided by independent organisations, others where based within the local authority housing departments. Many

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36 Shelter, Mediation for Young Homeless People – A good practice guide (2004)
were tightly integrated with housing options interviews, resulting in a feeling that the process was purely to gate keep and to avoid the provision of temporary accommodation. Some schemes relied on the willingness of parties to take part in the process, others did not.

Shelter’s Good Practice guide highlights a series of issues which can result in mediation not working. These include:-

- if people feel coerced to take part,
- if they have no wish for a future relationship,
- if people feel unsafe or threatened
- if the mediator has a vested interest in the outcome.

One local authority however felt that arranging mediation in person increased uptake of mediation. Another believed changing their approach from “do you think mediation could help” to “would you like to see a mediator”\(^{38}\), made take up more likely.

It is clear from the information available that practitioners believe mediation should be delivered by dedicated trained workers (as housing officers are seen as negotiators rather than mediators) and participants should be willing (rather than compelled) to engage in the process. Early referral is also recommended. In one case study, referrals at housing options stage was believed to minimise expectations of young people in terms of obtaining social housing, however case law is clear that a homeless application should not be delayed by a referral to mediation\(^{39}\) and that the homelessness application and assessment process should be independent of any mediation.

There is also a consensus that success should be measured against positive outcomes for young people (including “strengthening social networks which can increase resilience against homelessness and enhance wellbeing, quality of life and social capital”\(^{40}\)), not only enabling the young person to return or remain at home\(^{31}\).

Despite some reservations relating to the monitoring of the long term effectiveness of mediation schemes, it has been stated that schemes of this nature are “highly cost effective. That is, their operating costs are probably well below the consequent saving in relation to temporary accommodation expenditure”\(^{42}\)

**Educational Programmes**

Taught within schools (as part of Personal, Social and Health Education (PSHE) and citizenship) and youth work programmes, there is agreement that educational programs can:-

- increase awareness of the harsh realities of homelessness and the availability of social housing,
- challenge stereotypes,
- educate young people on the range of options and help available,
- emphasise responsibilities in regard to housing,
- teach conflict resolution skills.

\(^{38}\) Evaluating Homelessness Prevention, CLG, 2007  
\(^{40}\) Evaluating Homelessness Prevention, CLG, 2007  
\(^{41}\) Shelter – Mediation for Young People – A good practice guide (2004)  
\(^{42}\) Evaluating Homelessness Prevention, CLG, 2007
Despite little evidence relating to the long-term outcomes of educational programmes (in homelessness trends), there is confidence that overall outcomes would be positive.

An evaluation into a scheme run in Birmingham\textsuperscript{43} identified that “…a number of pupils might have been experiencing the risk factors that can cause homelessness” and that “…many of the students were unclear about the housing provision available for a young person if they ever became homeless”. This scheme’s sessions are supported by a peer educator – a young person who has previously been homeless and young people are able to access advice and support following the sessions. Peer educators are also able to complete a further training programme and become peer mentors. The study has also shown that peer trainers and mentors’ future aspirations were focused on continuing to support young people, with 28% wishing to enter formal youth work or social work.

A pie chart showing what pupils throughout Birmingham schools learnt from a peer educator during a STaMP session

- Be prepared before you leave home (32%)
- Who you can go to for help and advice (15%)
- Why people become homeless (8%)
- The consequences of leaving home at a young age (17%)
- The typical stereotype of a homeless person is not always right (13%)
- Appreciate what you have (10%)
- No answer (5%)

Chart 3-7

Post session evaluation questionnaires demonstrated that young people had a greater awareness of the reasons, stereotypes associated with homelessness as well as being better prepared in the event that they became homeless.

It was also evident that young people’s expectations in relation to what housing options were available had been addressed, with only 12% stating that they thought they would live in council housing.

\textsuperscript{43} Is Prevention an effective way of tackling youth homelessness, Case study: How effective is St Basil’s School Training and mentoring Project at preventing youth homelessness in Birmingham? (2005) – An Independent Review
A pie chart showing where forty school pupils attending Birmingham schools think they could live if they were to leave home, excluding friends/family, and pre STaMP session.

Chart 3-8

Crucially, the majority of the young people (90%) understood where they could access help if they needed it in the future.

A pie chart showing where forty school pupils attending Birmingham schools would go for help and advice if they needed anywhere to stay, excluding friends/family, and post STaMP session.

Chart 3-9

Short films and teaching packs (“The Prodigals” (Lambeth Council) and “Behind closed doors” (Alone in London)) are available for use in schools and some local authorities have provided links to the films on their web sites. The Alone in London pack has been identified as the preferred tool for use in Haringey Schools and is currently being promoted for inclusion in the PSHA programme, through the Children Young People and Families Delivery Group. It has been proposed that the sessions will be supported by a Housing Adviser.

Another approach adopted in Brent, involved a series of road shows. Delivered in partnership with Brent Homeless User Group, Connexions and the London Borough of Brent, road shows were delivered by three facilitators and include workshops focused on presenting information (reality based case study) about homelessness, to young people aged 14-15. Feedback from young people after the road show found that 96% of young people found the information useful or very useful. It has also been reported that since the road show Brent
has seen a 44% reduction in applications from 16/17 year olds and this is believed to be largely attributable to this work.

Supported Lodgings

The Supported Lodgings model is based on a trained host providing accommodation and support for a young person for a period of between 8 weeks to 2 years. The host receives payment covering both rent and support. Vigorous vetting (including medical and CRB checks), training, support and monitoring procedures of and for hosts is believed to ensure a successful placement and to ensure that the young person’s transition into independence is well managed (JRF study).

Although it has been stated that this approach has received mixed reviews from young people\textsuperscript{45}, a London scheme run by the YMCA (Lambeth & Southwark) launched in 2007 has reported success. Unfortunately, despite positive testimonials and continuing to support 20 young people, this scheme is likely to end in 2010/2011 due to spending cuts.

Private Sector affordability

A further study by the Joseph Rowntree foundation\textsuperscript{46} identified that the chaotic pathways which generally apply in youth homelessness are exacerbated by the lack of affordable accommodation. In addition, single room rate (for the under 25’s) recipients are more likely to struggle to meet a shortfall between rent and benefits. This compounded with landlords being reluctant to enter into agreements with housing benefit claimants and buying in to the stereotype that young people may be less reliable tenants; means that young people are less able to compete to secure this type of accommodation. Some local authorities have introduced schemes to facilitate flat sharing (Flatmates, Cyrenians, West Lothian), deposit guarantee scheme and access to credit unions to counter this issue. Up until now rent guarantee/bond schemes have been relatively successful in facilitating access to the private sector. In 2008 and 2009 around 37% of homelessness was prevented nationally through these\textsuperscript{47}. However with the proposed welfare reforms, which include expanding the single room rate to all under 35’s, a reduction of housing benefit by 10% after a year of unemployment and a reduced cap on the rents payable, the private sector may become a less accessible and affordable option, with some parts of London being totally out of the reach of benefits claimants. Locally authorities are currently developing strategies to mitigate the impacts of these changes and to ensure that existing links with providers of private sector rented accommodation are maintained and developed further.

Foyers

The Foyer Federation\textsuperscript{48} identifies that there are over 140 Foyers nationwide (120 accredited) that provide integrated learning and accommodation, helping around 10,000 young people per year. The Foyer approach is focused on helping disadvantaged young people aged 16-25 who are homeless or in housing need, to achieve the transition from dependence to independence through personal development and education, training and employment.

\textsuperscript{44} NHYS website – Andy Ludlow award application - 2007
\textsuperscript{45} Youth Homelessness in the UK – A decade of progress?, JRF, 2008
\textsuperscript{46} Housing Choices and issues for young people in the UK, JRF; 2008
\textsuperscript{47} CLG - Homelessness Prevention and Relief, England 2008/09 and 2009/10 - Experimental Statistics
\textsuperscript{48} Coming of Age, 18 years, 18 stories (2010) The Foyer Federation
opportunities. In terms of costs, a study by Cambridge University (Launch pad for life) states..

Comparisons with the Housing Benefit and Supporting People costs of other supported housing schemes suggest that on average foyers are not particularly expensive. Their average bed space rental costs and their average resident support costs are similar to the average for supported housing.

Joint working and Commissioning – Accommodation and Support pathways

Joint commissioning of accommodation and support for young people aged 16-25 is being promoted as an effective way of addressing some common problems such as ‘compressed’ transitions for young people leaving care, minimal choice and control for young people, placement breakdown and developing a clear pathway of housing and support services. A number of benefits cited include:-

- efficiencies coupled with better experiences and outcomes for young people by bridging the gap between children’s services, (adult) housing and housing support services,
- better links with wraparound services by designing them into the system,
- pooled commissioning and procurement expertise including approaches to quality and standards
- advantages of increased scale, for example reducing procurement costs, aligning services, increasing influence on markets 49.

A good practice model launched in Oxfordshire aiming to:

- prevent young people becoming homeless,
- ensure high standards of accommodation and support,
- provide a range of accommodation options to meet diverse needs,
- improve value for money,

saw 20% savings in delivering services, while maintaining the level of provision in the county.
All new contracts were clearly focused on the outcomes for young people and partnerships strengthened across the CHYPFD, the Supporting People partnerships and the housing departments 50. Oxfordshire’s model is shown below.

49 Joining up the commissioning of accommodation and support for young people aged 16-25 (Dec 2010)- Commissioning Support Programme
50 Strategic Commissioning of housing for vulnerable young people in Oxfordshire (case study) – Commissioning Support Programme
A review of three programmes conducted by Newcastle University found that while a multi-agency approach has progressed significantly since the implementation of the integrated policy framework a number of elements can contribute to more effective multi-agency working. These principles can be applied in a broader sense in relation to the prevention of homelessness and are:

1. The provision of training that involves the joint sharing of knowledge and a joint understanding of the different professions and role which can contribute to multi-agency responses
2. The commitment and buy-in of managers and practitioners at all levels to the benefits of multi-agency working and a willingness on the part of professionals to find sufficient time to attend panel meetings and TAC’s (team around child).
3. Organisational structures that facilitate co-working, joint commissioning and the pooling of budgets
4. Shared understanding among agencies and practitioners of the aims and objectives of new initiatives and their contribution to targeted services for vulnerable young people
5. The lack of professional and agency territorialism and a mutual respect for the different roles played by practitioners in the statutory, voluntary and private sectors and the contributions they make to integrated service delivery
6. A commitment to information sharing and the development of protocols which overcome concerns about confidentiality and the protection of vulnerable people
7. Clear distinctions between the roles of key worker and lead profession and an understanding that the LP role embodies a set of functions
8. The appointment of lead professionals who are trained for and supported in their pivotal role as the single point of contact for young people and their families and as co-ordinators of appropriate packages of support which meet each young person’s specific needs and circumstances

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51 The Budget-Holding Lead Professional Pilots, The targeted Youth Support Pathfinders and Youth Inclusion and Support Panels
52 Intervening to improve outcomes for vulnerable young people a review of the evidence – Newcastle University (Jan 2011)
The review also found evidence to indicate that “co-located teams are able to achieve quicker responses, easier and faster access to information and caseload transparency and a collegial learning environment.”

Teenage parent supported housing pilot

Seven grant funded pilot projects have been evaluated\(^{53}\). These focused on a range of issues including; increasing access to the private rented sector, ETT opportunities, high support accommodation, low and high level floating support. Preliminary findings were that of nearly 500 referrals only 47 young people did not take up services and at the time of the study 88% of young people were still being supported. Of those no longer being supported 53% completed their programme and 29% (17 TP’s) had disengaged. In a telephone survey, young people identified assistance with accommodation as one of the most useful elements of the support they had received, as well as one of the two main priorities for making a difference to their lives in the future (41% had moved since starting the pilot).

Early experience suggests that some types of support were more easily understood and readily taken up and that take up was influenced by the location of services. Co-location of services for young people appeared to work best. There was also a consensus that the pilots have led to improvement to inter-agency working at a local level.

The pilots are funded to March 2011 and a full evaluation will be available in summer 2011.

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\(^{53}\) Teenage parent supported housing pilot evaluation – Centre of Housing Policy, University of York (Oct 2010)
### Appendix 1

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>16</th>
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<th>18</th>
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<th>Percentage</th>
<th>Rank</th>
</tr>
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<tbody>
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<td>10</td>
<td>12</td>
<td>30</td>
<td>10.4%</td>
<td>1</td>
</tr>
<tr>
<td>Tottenham Hale</td>
<td>3</td>
<td>9</td>
<td>13</td>
<td>25</td>
<td>8.7%</td>
<td>2</td>
</tr>
<tr>
<td>White Hart Lane</td>
<td>5</td>
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<td>10</td>
<td>25</td>
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</tr>
<tr>
<td>Northumberland Park</td>
<td>5</td>
<td>8</td>
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</tr>
<tr>
<td>Tottenham Green</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>21</td>
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</tr>
<tr>
<td>St Ann's</td>
<td>3</td>
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<td>7</td>
<td>20</td>
<td>6.9%</td>
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</tr>
<tr>
<td>West Green</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>20</td>
<td>6.9%</td>
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</tr>
<tr>
<td>Bounds Green</td>
<td>3</td>
<td>8</td>
<td>8</td>
<td>19</td>
<td>6.6%</td>
<td>8</td>
</tr>
<tr>
<td>Bruce Grove</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>18</td>
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</tr>
<tr>
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<td>8</td>
<td>3</td>
<td>13</td>
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</tr>
<tr>
<td>Hornsey</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>12</td>
<td>4.2%</td>
<td>11</td>
</tr>
<tr>
<td>Harbingay</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>3.8%</td>
<td>12</td>
</tr>
<tr>
<td>Seven Sisters</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>11</td>
<td>3.8%</td>
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</tr>
<tr>
<td>Crook End</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>3.1%</td>
<td>14</td>
</tr>
<tr>
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<td>5</td>
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<td>15</td>
</tr>
<tr>
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<tr>
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<tr>
<td>Woodside</td>
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<tr>
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