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The Role of Social Housing in the 'Care' and 'Control' of Tenants with Mental Health Problems

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Social housing is at the intersection of two policy agendas, namely anti-social behaviour and community care. This means that tenants with mental ill-health might at once be defined as vulnerable and in need of support to enable them to live independently, but simultaneously their behaviour may be viewed as a threat to the safety of others serving to legitimatise disciplinary and punitive forms of intervention on the grounds of 'difference'. This paper focuses on the role of housing professionals in the management of cases of ASB involving people with mental ill-health. It argues that housing practitioners are not adequately equipped to make judgements on the culpability of 'perpetrators' who have mental ill-health and ensure their response is appropriate. This raises questions about the training housing officers recieve, and more broadly, whether the competing policy aims of community care and ASB can be reconciled.

Introduction

'Community care' in the UK broadly refers to the care of individuals (who fall into one of the national 'priority groups') within their own homes as an alternative to institutional or long-stay residential care (Gleeson, 1997; Morris, 1993). This paper is concerned with one of those priority groups, namely individuals who experience mental health problems[1] and who live in social rented housing. The key issue examined here concerns the housing management duty to regulate the 'anti-social', and the implications this agenda has for tenants of social housing suffering from mental ill-health. The paper also considers what the ASB agenda might mean for care in the community policy more broadly.

Although care in the community has been a policy objective since the 1960s, it was the 1990 National Health Service and Community Care (NHSCC) Act which transformed health and social care provision in Britain, including mental health services. Living in a home of one's own or a 'homely' setting in the community was a key objective of the Act and it provided resources to enable this. The Act therefore marked a key stage in the process of deinstitutionalisation and necessitated a substantial reduction in long-stay psychiatric and acute hospital facilities. Together with the progressive residualisation of social housing (Murie, 1997), this has brought with it a disproportionate concentration of individuals with mental ill-health living in social housing. Recent estimates suggest that those with mental health conditions make up around 9 per cent of applicants accepted by local housing authorities in England under homelessness legislation on grounds of priority need. Of these, a high proportion experience what is described as 'severe and enduring' mental health problems (Cobb, 2006). This is, however, likely to be a conservative estimation since these figures do not include those who have undiagnosed

conditions or young people and children with mental health problems living in social housing. Suffice to say however, that social housing organisations play a significant role in the provision of care in the community. Notwithstanding this, the role of housing in community care has always been and remains both marginalised and ill-defined due to a range of organisational, strategic and cultural barriers (Bochel and Bochel, 2001; Franklin, 1998). Adding to this inherent ambiguity is social landlords' role as regulators of tenant's conduct, in particular, the management of those deemed to be 'anti-social'. The emergence of the anti-social behaviour (ASB) agenda and its accompanying legal framework has given rise to fears that people suffering from mental illness may be wrongly targeted not only due to the disproportionate concentration of those with mental ill-health in social housing (Cobb, 2006), but because the all-embracing nature of the policy discourse means that there are few parameters to that which can be labelled 'anti-social'. As such, challenging, obsessive or ritualistic behaviour associated with a person's impairment (which might well be essentially harmless) may be perceived as threatening or alarming and therefore qualify as 'anti-social' (Macdonald, 2006). In this way aspects of 'difference' can potentially become problematised and may legitimatise disciplinary and punitive forms of intervention.

Social housing is therefore at the intersection of two agendas in which tenants with mental ill-health might at once be defined as vulnerable and in need of support to enable them to live independently, but simultaneously treated with suspicion and their behaviour viewed as a threat to the safety of others. This paper focuses on the role of housing professionals and the ways in which front line officers operationalise ASB agendas with regard to people with mental ill-health. In so doing, the paper draws on the findings from a critical review of disabled people's experiences of ASB in social housing conducted for the Disability Rights Commission (DRC) (Hunter *et al.*, 2007a). The paper begins with a brief overview of the role of social housing in, firstly, community care and, secondly, the management of ASB. It then goes on to review emerging evidence of the impact of ASB measures on those with mental health problems. The fourth section of the paper draws on primary data to explore the challenges and barriers housing professionals face when dealing with cases of ASB that involve an individual with a mental health problem. The paper concludes that, on the whole, housing practitioners are not adequately equipped to make judgements on the culpability of 'perpetrators' of ASB who have a mental health problem and ensure their response is an appropriate one. This raises urgent questions not only about the impact of ASB measures on disabled people and the training housing officers receive but, more broadly, whether the competing policy aims of community care and ASB, and housing professionals' duties in relation to these, can be reconciled.

Methodological note

The DRC evidence review (Hunter *et al.*, 2007a) comprised four key strands: a critical review of the literature; a content analysis of ASB policies and procedures at both a national and local level; an online survey sent to a total of 315 (general and specialist) social housing providers across England, Scotland and Wales, to which 77 responded; and three focus groups with housing providers, disabled people and carers.

Much of the analysis below draws on data collected from nine focus group participants, including housing practitioners responsible for the development of ASB

strategies, policies and procedures across both local authorities and RSLs, and a representative of a consultancy service providing ASB-related disability awareness training to social landlords. Not all the issues raised in discussion could be explored fully and the participants were not representative of all housing providers. Thus, the findings presented here are preliminary and cannot be generalised to all housing organisations. The paper is therefore primarily intended to be exploratory and aims to open up some highly important and under-researched issues for debate and more comprehensive exploration.

The policy context

Housing and community care

While a major concern of deinstitutionalisation policy has always been the issue of where people live, in its earlier phases (the 1960s and 1970s) housing had only a relatively peripheral and 'functional' importance (Bochel and Bochel, 2001; Franklin, 1998; Allen, 1997). During this period, 'community care' largely took the form of 'special needs' accommodation (Morris, 1993). Throughout the late 1980s and 1990s however, awareness increased about the major role that the 'housing dimension' played in community care beyond a sole concern with the 'bricks and mortar' of dwelling units (Bochel and Bochel, 2001; Franklin, 1998; Means, 1996). Over this period, government rhetoric shifted towards an emphasis on the desirability of people remaining in their 'own home', rather than having to move to new or 'special needs' accommodation.[2]

Financial imperatives provided the primary incentive for the Thatcher government to act on community care (Carr, 2005; Allen, 1997; Morris, 1993), with the Audit Commission (1986) highlighting the ever-increasing drain that long-term residential care (mainly of old people) was having on the social security budget (rising from £10 million in 1970 to over £1,000 million in 1989). At that time, social security regulations had created a 'perverse incentive' for local authorities and the NHS to encourage patients to make private arrangements funded by social security (Lewis and Glennerster, 1996). The Audit Commission's proposals were eventually incorporated into the NHSCC Act and this marked a key stage in the process of deinstitutionalisation. The legislation transformed the financial and delivery framework by allocating the lead role in community care processes to local authority social services departments (SSDs). These were tasked with, firstly, assessing whether an individual's need would be best met through residential or community-based services and, secondly, purchasing the services deemed appropriate. With this, the budget for those requiring residential care was transferred from social security to SSDs (Lewis and Glennerster, 1996; Morris, 1993). This shift required agencies at the centre of community care to take more account of the housing needs of those coming within their remit and led to an increasing interest in the idea of 'supported living' (Morris, 1993) aimed at enabling mental health service users to live in 'homes of their own' with the provision of flexible, individualised support wherever they might be (Bostock, 2004).

Although the NHSCC Act defined living in a home of one's own as a key objective in successful community care, it was criticised for failing to address how this should be achieved (Franklin, 1998). Indeed, there exists no mandatory requirement for housing organisations to be incorporated into joint planning. Since then, there has been a broad consensus that progress with regard to the housing dimension of community care has

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been slow and uneven, and remains, in many respects, disappointing and lacking in vision (Bochel and Bochel, 2001; Social Exclusion Unit, 2004).

This relative inertia with regard to the housing dimension of community care has taken place within a wider context of what some claim is a 'failure' of care in the community to provide humane and effective maintenance in community settings of particular groups, in particular those with mental health problems leading to a reappraisal of confinement as a model of care (Moon, 2000). Central to this perception has been a discourse about the protection of the public from the potential risks posed by (possibly violent) mental health service users.

Social housing and anti-social behaviour

Social housing has always been a key player in the government's high profile campaign to address ASB. Indeed, the political impetus for the focus on ASB in the 1990s was intrinsically connected to housing management and calls from social landlords for stronger powers to use against 'troublesome' tenants (Burney, 1999). Although ASB policy documents and the more recent 'Respect' agenda vigorously assert that ASB is a non-tenure specific issue and a problem for all of society, there has been a continuing inference, partly backed up with statistics, that ASB is a problem particular to social housing estates (Respect Task Force, 2006; Home Office, 2003). It is presented as a plaguing, degenerative and urgent problem that must be tackled in order to control crime and regenerate the most deprived neighbourhoods. The anti-social tenant is consequently viewed as a risk, not only to the quality of life of individual residents, but the reputation of entire estates or neighbourhoods such that they will become, or remain, 'difficult-to-let' affecting the viability of housing organisations themselves (Cobb, 2006).

In defining the problem of ASB, housing policy discourse draws sharp distinctions between different types of people and their behaviour, which turns target populations into dangerous and threatening individuals and agents of moral decline. Emotive images have been used to portray perpetrators who are described as a 'yobbish minority', 'neighbours from hell', 'drunken hooligans' (Nixon and Parr, 2006) and presented as feckless individuals who are unconcerned for others:

> At the heart of antisocial behaviour is a lack of respect for others—the simple belief that one can get away with whatever one can get away with. (Blunkett, 2003)

The cause of the problem is located with the individual and a key consequence of this construction of the anti-social individual is a refusal to absolve perpetrators from blame for their conduct on grounds of their own difficult circumstances, such as mental ill-health (Cobb, 2006; Hunter and Nixon, 2009) Cobb (2006) suggests that this kind of political sloganeering has the potential to stigmatise those with mental health problems through their elision with the archetype of the anti-social 'yob'.

In this context, an ever-increasing range of legal tools aimed at shaping the conduct of social tenants have been introduced (Hunter, 2006). Most tenants of social landlords in the UK have security under either the Housing Act 1985, the Housing Act 1988 or the Housing (Scotland) Act 2001. All these statutory regimes make provision for tenants to be evicted in certain prescribed circumstances relating to instances of ASB. The relevant Acts also make provision for tenants to be demoted to a lesser form of security as an alternative

to eviction. In England and Wales social landlords have also been given specific injunction powers to order both tenants and, in certain circumstances, non-tenants to cease to behave in an anti-social manner. In addition, they may also seek to have a power of arrest and/or an exclusion order attached to the injunction.

Perhaps the most controversial legal measure has been the anti-social behaviour order (ASBO), introduced in England, Wales and Scotland by the Crime and Disorder Act 1998. Effective for a minimum of two years, ASBOs place tailor-made prohibitions on named individuals and can ban anyone of ten years (12 in Scotland) and over from carrying out specific acts or entering certain geographical areas. Although a civil charge, breach of an order is a criminal offence. Since 2002, the power to apply for an ASBO has been extended in England and Wales to Registered Social Landlords (RSLs), and from 2007, ALMOs and Tenant Management Organisations were given the power to apply. In Scotland the relevant provisions are contained in the Antisocial Behaviour etc. (Scotland) Act 2004. This Act extended the power to apply for ASBOs to RSLs.

This raft of legal tools can have serious consequences for those with mental ill-health, not least the increased vulnerability to social exclusion that they are likely to suffer through eviction and the loss of a stable tenancy. Although the use of legal remedies against tenants who are disabled is constrained by the Disability Discrimination Act 1995 (DDA), ss.22–24, the Court of Appeal decision in *Manchester City Council* v. *Romano* [2004] EWCA Civ 834; [2004] H.L.R. 47 made it relatively easy for landlords to justify discriminatory treatment (Hunter *et al.*, 2008; Cobb, 2006). In a recent non-ASB case *Malcolm* v. *Lewisham*, the House of Lords further downgraded the potential of the DDA as a defence to legal proceedings (Horton, 2008). Although the Act is intended therefore to be protective, its powers have effectively been defused by social landlords. Thus, the law, which does not give positive rights to community care, also does not protect housing rights either against the armoury of the landlord to deal with ASB. As Hunter (2006) has pointed out, for those landlords who wish to exercise them, ASB powers have provided social landlords with tools of social control that are both extensive and powerful.

Disciplining difference?

There is currently no firm evidence (because it is currently not collected centrally) on the extent to which ASB control measures disproportionately affect those with mental ill-health. However, anecdotal evidence suggests that those with mental health problems (and learning difficulties) are more likely to be recipients of ASB control mechanisms, giving rise to fears that these measures are not being used to regulate harmful behaviour but discipline difference. This has led to extensive criticism from a number of sources, including children's charities, think-tanks and civil liberties groups. The National Association of Probation Officers (NAPO) (2005) for instance collected a number of case studies which point to a potential misuse of ASBOs, 13 of which related to cases involving children and young people with neurological disorders, including attention deficit hyperactivity disorder (ADHD), Asperger Syndrome (AS) and autism. One case included a 15-year-old boy whom the court knew to be suffering from Asperger's Syndrome and who was ordered not to look into his neighbours' gardens. Another boy, also 15, with Tourette's Syndrome was ordered not to swear in public (Hewitt, 2007; Macdonald, 2006). In 2005, the British Institute for Brain Injured Children (BIBIC) (2007) launched the Ain't Misbehavin' campaign, which, following a survey of all youth offending

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teams and ASB officers, revealed that 5 per cent of ASBOs reported by ASB officers and 37 per cent reported by YOTs between April 2004 and April 2005 were issued to children under 17 who had a diagnosed mental health disorder or an accepted learning difficulty.[3] Similarly, a survey of ASB files of social landlords by Hunter *et al.* (2000) revealed that there was evidence of mental ill-health in 18 per cent of cases.

Three separate evaluations of Family Intervention Projects (FIPs)[4] (Dillane, 2001; Jones *et al.*, 2005, 2006; Nixon *et al.*, 2006a, 2006b) have provided evidence about the characteristics and support needs of adults and children referred to FIPs. The findings from these studies are remarkably similar in their reporting of high levels of mental health problems among those referred. Nixon *et al.* (2006) found that depression affected 59 per cent of adults, while adults in a further 20 per cent of families suffered from other mental health problems, such as schizophrenia, personality disorders and obsessive-compulsive disorder (OCD). The study also reported that children in 19 per cent of families were also affected by depression or other mental health problems, while young people or children in a further 18 per cent of families were affected by ADHD. In Stephen and Squires' (2003, 2005) evaluation of the work of the community safety team in East Brighton New Deal for Communities, which sought to elicit families' feelings about their experience of the ABC process, mental health problems were said to 'dominate' participants' accounts. The authors professed to be being 'continuously disturbed' by the number of young people subject to Acceptable Behaviour Contracts (ABCs) with mental health problems or personality disorder problems and learning difficulties for which some were receiving psychological/psychiatric support.

The contradictory roles of the housing provider: care or control?

The link between the use of ASB measures and the propensity for 'perpetrators' to have a mental health problem was corroborated by housing staff interviewed as part of the review for the DRC. Focus group participants recounted several ASB cases that involved people with mental health problems and learning difficulties, including ADHD, Asperger Syndrome, schizophrenia, autism, brain injuries and OCD.

Drawing on qualitative data collected from housing professionals and findings from the survey of social landlords, this section focuses on the response of housing officers to those with, or suspected as having, mental health problems who present behaviour interpreted by others as 'anti-social'.

Confusion, fear and anxiety

Attempts to identify the extent to which an individual's conduct is caused by their impairment is fraught with uncertainty (Cobb, 2006) and housing professionals, normally lacking a background or training in medico-welfare professions, reported the complexities they face in attempting to determine whether 'problem' behaviour might be a symptom or manifestation of a mental health condition. This was compounded by the challenge of not being able to recognise the symptoms of mental illness/learning difficulties, not knowing when and how to ask somebody whether or not they are disabled and associated with that, a fear of making inappropriate assumptions and/or offending that person with the use of inappropriate language/terminology. Likewise, housing officers were very reluctant to ask people to undergo psychological assessments. Reflecting popular fears

and anxieties concerning the behavioural attributes of those with mental health problems and widespread perceptions about the 'failure of community care' (Gleeson, 1997; Moon, 2000), participants also described how they or their colleagues found dealing with cases involving mental impairment 'stressful' and sometimes 'frightening' since behaviour that is erratic and alarming, and sometimes violent, can feel intimidating. Drawing on what we know about how those with mental health problems are disadvantaged in the criminal justice system (Hunter *et al.*, 2007a), it is reasonable to assume that a similar lack of knowledge and negative perceptions about mental impairment could be leading to inappropriate housing management responses in ASB cases. During the focus group, housing officers admitted that in a context where there is extreme pressure to meet expectations around ASB, compounded by the large case loads housing officers commonly carry, the impact of an individual's impairment may not be given due regard. This was particularly felt to be the case where the accused has what were described as 'low-level mental health problems', as opposed to those with assessed community care needs. This echoes findings from other research that has highlighted housing officers' lack of capacity to pursue complex ASB cases effectively within the pressures of other elements of their function and remit. Flint *et al.* (2007) found widespread frustration amongst front line staff about the lack of time available to conduct thorough investigations, the length of time cases took to be resolved and the difficulties in addressing holistically underlying causes.

Lack of training

Contributing to the anxiety expressed by housing officers was a broad lack of understanding of disability and community care legislation, policy and practice. In the DRC survey of social landlords, 70 per cent claimed to provide housing officers who deal with ASB with some type of disability awareness training (Hunter *et al.*, 2007a). Although this appears encouraging and indicates that a majority of social landlords provide training to staff, the contents and utility of this training must be considered. Again, drawing on what we know about the police, research by Mencap (1997) suggested that of 35 per cent of police forces which offer initial awareness training that focuses specifically on people with an intellectual disability, only 26 per cent of respondents thought that this training was good. Importantly, nearly three quarters (71 per cent) thought that the training they had received had not helped them in dealing with people with learning disabilities. Discussion in the focus group carried out with housing officers, highlighted that similar problems may be endemic in housing as participants pointed to inadequate training around disability issues for housing staff together with lack of direction and guidance from central government such that housing officers had little understanding of the requirements of the DDA and its implications for their work.[5] This lack of training and awareness was contrasted to that provided over recent years around race equality policy frameworks, and was described by one participant as a 'massive hole': 'it's a new issue … disability is only just coming on to the radar'. Indeed, although mental health is generally referred to in national guidance on how housing providers should deal with cases of ASB, there is very little detail as to how agencies should address ASB where the perpetrator (or victim) is disabled (e.g. ODPM, 2004; Housing Corporation, 2004). Guidance is consistent in so far as it advises on the requirement to comply with the DDA, but also gives very little assistance on how this should be achieved. Only the

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ASBO Guidance in Scotland (Scottish Executive, 2004) and the more recent Home Office Guidance on ASBOs (2006) recognise with more than a passing reference that there are particular issues about disability and perpetrators of ASB. The guide states that:

> Local authorities have a duty under the NHS and Community Care Act 1990 to assess any person who may be in need of community care services. If there is any evidence to suggest that the person against whom the order is being sought may be suffering from drug, alcohol or mental health problems or an autistic spectrum disorder, the necessary support should be provided by social services or other support agencies. (2006: 21)

However, even this does not amount to detailed guidance on how to assess and respond to perpetrators who experience mental ill-health.

Unequal partners in care

The problems housing practitioners encounter when dealing with alleged perpetrators who have a mental health problem were also driven by what was perceived as an absence of effective partnership working and a 'failure of community care' whereby those with mental health problems were deemed to be 'falling through the net'. A view was expressed that that formal care agencies concentrate primarily on those with high levels of need, leaving social housing organisations to support those (a much larger group) without formal community care assessments. Yet it is only through negotiation with medico-welfare professionals enabled by effective inter-agency partnership that housing officers can hope to engage in a meaningful assessment of blame in cases of ASB (Cobb, 2006). Housing staff explained, however, that they are not seen as 'equal partners in care' and, as a consequence, find it difficult to carry out their 'caring' and 'welfare support tasks' since they are often not able to build effective working relations with other agencies and therefore access appropriate support for perpetrators (or victims) of ASB with mental ill-health. This is in contrast to housing's established position in multi-agency ASB management arrangements. Indeed, participants described having to 'squeeze' themselves into care planning meetings and only being formally invited in 'extreme cases', for instance where an eviction may be imminent. Some even suggested that in a context where care services are under-resourced, ASB measures can be sometimes the only way to access support for alleged perpetrators. This perhaps reflects the well-documented tensions between housing and social care services regarding their respective roles and responsibilities in addressing problems of ASB (Flint *et al.*, 2007; Nixon *et al.*, 2006b). Possibly indicative of this, only half (52 per cent) of all social landlords surveyed claimed to carry out full assessments of the support needs of disabled people (including those with mental health problems) accused of ASB, with 34 per cent stating that housing officers did not have access to staff with appropriate expertise when dealing with a case that involved a disabled person (Hunter *et al.*, 2007a). This means of course that 66 per cent of survey respondents did state that housing officers have access to staff with appropriate expertise, with respondents listing a range of professions which they work with, including dedicated assessment officers/teams, community psychiatric nurses, child psychologists, social workers etc. While these findings appear encouraging, on the basis of the focus group discussion, this indication of proactive and widespread partnership working might not reflect the reality 'on the ground' in all housing organisations.

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What role for housing?

Focus group participants were fully committed to the ASB agenda and their role therein to protect their tenants. This is not to say, however, that they advanced simplistic understandings of the 'irresponsible' 'anti-social' subject. Housing officers recognised the complexities involved in assessing culpability and the need to ensure they do not discriminate against 'perpetrators' who have (or might have) an impairment. As such, participants acknowledged the need for further guidance and training in this area. Notwithstanding this, they also emphasised the need for a debate on the extent to which housing officers can be expected to be active and knowledgeable agents in a number of (at least potentially) conflicting policy arenas, and they expressed frustration at the extent to which they are increasingly being asked to become 'experts in all roles'. Members of the focus group therefore questioned what the correct and appropriate level of training is for housing staff around issues of mental health. Housing scholars have drawn attention to this issue before, and the way in which housing management has always lacked a clear definition of its role and has contradictory pressures placed on it such that practitioners are ambivalent about the extent to which their organisation should take on responsibilities relating to ASB or community care (Flint, 2006; Saugeres, 2000; Franklin, 2000). However, discussion in the focus group suggested that housing has a much firmer footing in the former policy agenda. Following a raft of training and guidance driven locally and by central government, supported by a relatively clear legal framework, housing officers' confidence to deal with ASB is something that has increased dramatically over the course of the last decade. Thus, while housing officers generally see ASB as a core function of housing and estate management, and a key element of generic housing officers' roles (Flint *et al.*, 2007), they are less assured of their responsibilities in relation to community care. This perhaps illustrates how the clarity of competing legal frames reflect and/or lead the predominance of the ASB agenda over that of community care.

Conclusion

The debate about housing's role in community care has been ongoing since the inception of deinstitutionalisation (Audit Commission, 1989). The rise in the ASB agenda has given the debate a new urgency, bringing to the fore the competing rights of: (a) those with mental ill-health to receive community care and security in housing and (b) the landlord to tackle ASB. This provides a fundamental challenge to housing professionals as the vulnerabilities suffered by tenants with mental health problems which place them 'at risk' are juxtaposed with the threat they may pose to the safety of others.

On the one hand, those with mental ill-health are often deemed to be psychologically and behaviourally 'unacceptable' (Moon, 2000). They are often treated with suspicion and regarded as 'out of place' (Cresswell, 1996) and their behaviour perceived as a threat to the safety of others', as alarming or 'anti-social'. In turn, this may legitimise the use of punitive ASB control measures. On the other hand, those same individuals *may* pose 'risks' to the wider community that warrant intervention, possibly under ASB legislation (Cobb, 2006). Notwithstanding this, the employment of a regulatory mechanism on somebody with a mental health problem can have harmful exclusionary effects that might serve to exacerbate both their exclusion and their disorder (Cobb, 2006). The individual's needs might therefore be better met through community care systems and management.

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However, the extent to which social landlords should, and are actually able to, assume responsibilities for managing the competing agendas of community *care* and community *control* remains unresolved (Flint, 2006). The evidence presented here has drawn attention to how the knowledge, skills and professional development needs of those responsible for enacting ASB prevention policies circumscribes their ability to assess effectively 'need' and 'risk'. Moreover, the lack of coordination between the major ASB and community care agencies fuels a disarticulation of housing and community care policies. This suggests a need for policy makers and practitioners to give greater priority and provide more resources to ensure that front line officers are equipped to administer ASB interventions with equity and prevent them being used to discipline difference. However, it also raises a more substantive issue about the appropriateness of mainstream tenancies for housing some individuals and the levels of support that are available to them (Flint *et al.*, 2007).

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Notes

1 Learning disabilities are also referred to in the paper as the latter is sometimes confused with mental illness – although the two are very different – but also because people with learning disabilities often experience mental health problems.

2 These 'community care' reforms were compatible with some of the rhetoric of the independent living movement promoted by a growing disability movement, although in conflict with much of its practice (Morris, 1993)

3 The disparity in the figures returned from the two professional groups is clearly quite pronounced and raises important questions about disability awareness and how the two organisations monitor for disability.

4 Family Intervention Projects (FIPs) provide families who are homeless or at risk of eviction as a result of ASB with intensive 'support' to address the often multiple and complex needs of which ASB is often a manifestation.

5 The DDA defines disability (Part I) as 'a physical or mental impairment, which has a substantial and long-term adverse effect on [the] ability to carry out normal day-to-day activities'

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