Mental Health in All Housing Policies

Use this as a cross-cutting checklist whenever you write or review policies (allocations, arrears, ASB, repairs, retrofit, complaints, tenancy management, etc.).

1. Home standards, security of tenure and "not losing your home"

HAVE WE:

- Clearly defined what "decent, safe, warm" means for us, including damp, mould and cold?
- Set clear timescales and responsibilities for fixing serious defects?
- Built in **protections for people admitted to hospital or in acute mental distress,** so they don't lose their tenancy by default?
- Minimised avoidable moves, especially for people with poor mental health or children?

If not, what needs changing so the policy reduces stress rather than adds to it?

2. Repairs, compliance and retrofit

DOES THE POLICY:

- Offer **genuine appointment options** (time windows, alternative days) rather than one imposed time?
- Make it easy to say "I can't do that time" without threat or shame?
- Spell out how staff/contractors should behave in people's homes (ID, respect, how many people, what to do if someone is distressed)?
- Set out a **different pathway** for residents known to have significant mental health needs (e.g. pre-visits, a single point of contact, fewer visits bundled together)?
- Treat repeated "no access" as a **signal to understand what's going on,** not an automatic enforcement trigger?

Are we measuring waste (no access, repeats, cancellations) and asking what it tells us about people's ability to cope with our process?

3. Choice, agency and co-production

- In this policy, where do residents get to choose? (Appointment slots, communication channel, order of works, payment options, etc.)
- Is there at least **one meaningful decision** residents can make, rather than everything being fixed?
- Has this policy been co-designed or tested with residents, including people with lived experience of poor mental health?
- Do we show people how their input has changed anything?

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4. Trauma-informed practice

- Assume that some residents will have experienced trauma, without requiring them to disclose it?
- Avoid default use of threats and legal language as a first step?
- Build in safety, trust, collaboration and choice wherever possible?
- Make it clear what staff should do if they see signs of trauma or distress (and when to escalate)?

Have front-line teams had practical training on how to understand trauma and to apply this policy in a trauma-informed way?

5. Communication standards

For all letters, emails, texts, portal messages and scripts linked to this policy:

ARE WE:

- Using **plain, everyday English** and explaining why something is happening?
- **Saying clearly what options the resident has,** including what will happen next if no response is received, so people are not left uncertain or anxious about the process.
- **Avoiding language that shames, blames or intimidates,** particularly as a first step, while still being honest and transparent about statutory duties, safety requirements and potential consequences where these genuinely apply.
- Giving realistic timescales rather than over-promising?
- Being explicit about what *we* will do, not just what *they* must do?

Do we have a rule of thumb that we do what we say we will and if something slips (e.g. missed appointment), we own it, apologise and explain?

6. Information about needs and adjustments

DOES THIS POLICY:

- Explain how staff should record mental health–related needs or adjustments in a respectful way, with consent?
- Spell out how that information is *used* – e.g. flags on the system that alter letters, appointment types, or escalation routes?
- Avoid unnecessary retelling of traumatic histories by residents?

Are we checking that what we record is changing how we behave, not just filling in fields?

7. Working with health and other partners

WHERE RELEVANT, DOES THIS POLICY:

- Include agreed referral routes to mental health services, support organisations, advice agencies?
- Reflect any **data-sharing agreements** that allow safe alerts (e.g. admission/discharge triggers for welfare checks)?
- Clarify how housing staff can seek advice from health colleagues, and vice versa?

Is there scope to pilot embedded roles (e.g. mental health practitioners linked to a housing patch, or a housing worker in a community mental health team) and reference them here?

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8. Staff wellbeing and capability

DOES THE POLICY:

- Seek to minimise risk factors for mental health at work for our people, and protect as much as possible from mental distress?
- Recognise the emotional impact on staff of dealing with distress, crisis or conflict?
- Build in realistic workloads, time for relationship building where needed, and supervision routes?
- Identify training required (e.g. mental health awareness, suicide awareness, trauma-informed practice, domestic abuse, safeguarding)?

Are the people delivering this policy supported to do it well, not just told to "get on with it"?

9. Measurement and review

FOR THIS POLICY, HAVE WE:

- Defined what "good" looks like in a way that includes **resident experience** (not just volumes and timescales)?
- Identified a few simple measures that pick up mental health impacts – e.g.:
    - "No access" rates and reasons
    - Repeat contact / failure demand
    - Escalations and complaints with mental health as a factor
    - Resident feedback on feeling safe, listened to and in control
- Agreed how often we will review the policy with residents and staff, not just at audit time?

10. Community, belonging and ontological safety

DOES THIS POLICY:

- Help people feel settled, not constantly "on the move"?
- Avoid unnecessary relocation, especially for people with established support networks?
- Consider furniture poverty and the ability to make a house feel like a home?
- Connect to wider work on safe, inclusive communal spaces and neighbour relations?

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