Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Costs and Benefits of the Supporting People Programme

Dadansoddi ar gyfer Polisi

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Analysis for Policy

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1.0 Introduction

The Supporting People programme seeks to enable vulnerable people to gain and retain independence by remaining in their own home. Through an integrated policy and funding framework, the programme aims to deliver high quality and strategically planned housing-related services which are cost-effective and reliable, complementing existing care services.

Launched on 1st April 2003, the programme marked a change in the way in which supported housing and related services are organised, delivered and funded. The situation prior to this could be described as ad hoc, with little or no strategic planning and little needs-led provision or integration of services. Supporting People was developed to change this situation through the:

- development of specific policy objectives and aims around supported housing. This has included a fundamental objective that supported housing should promote, maintain and improve the independence of specifically targeted client groups through, for example, the use of short-term services and the development of 'floating support';
- the development of a coherent framework for the planning and commissioning of services at the local level; and
- a shift in funding of services from demand-driven funding via housing benefit to cash-limited funding via grant allocations to local authorities.

While the programme is a UK-wide programme, there are differences in these elements and implementation of the programme for each of the constituent countries of the UK. The Welsh Assembly Government, for example, prefers a commissioning approach based more on collaboration and partnership than the competitive market-place espoused in England.[1] In addition, in Wales the funding of Supporting People service is divided between central government funding and local government funding. In England the programme is funded through grants from the Department for Communities and Local Government (DCLG, formerly ODPM) to Administering Authorities (the local authority given oversight over the local programme).

There are two funding streams in Wales:

1. The Supporting People Grant (SPG) is administered by local authorities and is used to fund chargeable support services. SPG services relate primarily to long-term support provision, and generally cater for older people, people with learning disabilities, and people with mental health problems.
2. The Supporting People Revenue Grant (SPRG) is administered by Assembly Government directly to Accredited Support Providers, and is used to fund non-chargeable support services, and generally relates to shorter term support provision.

The way the two funding streams are split is shown in section 4.0 below.

1 Because in England the commissioning of services is done locally, in practice different Administering Authorities may make different choices about the extent to which they cultivate partnerships or competition.

The key aims of Supporting People include:

- to promote independence for clients and improve their quality of life; and
- to save other public service costs by:
    - enabling people to live in their own home rather than more costly alternatives, such as residential care or homelessness services; and
    - preventing crises that may lead to tenancy breakdowns and associated downstream costs for public services to help people out of these crises.

Supporting People links to a number of other Assembly Government policy areas. These include *Making the Connections* which involves service users in the development and design of services which are focused on vulnerable people who are among the most difficult to engage in Wales. *Fulfilled Lives, Supportive Communities,* the draft new strategy for social services in Wales (currently under consultation) makes reference to the value of maintaining independence and earlier stage engagement, supporting people in ways that enable them to remain in their own homes and retain responsibility for their own future. The *National Service Framework* (NSF) for older people highlights early intervention to maintain independence and stresses the value of challenging dependency. The *Strategy for Older People in Wales* registers the maintenance of independence as an aim and the *Mental Health strategy* and *NSF for Mental Health* speaks of the value of social inclusion. Supporting People also has links to *Tackling Domestic Abuse: the all Wales national strategy*, and *The National Homelessness Strategy*. Supporting People services also contribute to strategies at a local level such as *Community Safety Strategies* and *Health, Social Care and Wellbeing* Strategies.

A key question facing the Assembly Government is what is the value of Supporting People? Supporting People services can help prevent or defer more costly support services, such as residential or nursing home support, hospitalisation, or use of temporary accommodation. Evidence as to the extent of this impact will have practical implications for the Supporting People strategy, as well as guide local authorities on how they should use their Supporting People grant to realise these financial benefits.

Given the size of the Supporting People budget, and its recent beginning, the Assembly Government has commissioned this study. It aims to quantify the benefits, primarily those to the public purse, of the Supporting People programme in Wales.

2.0 Methodology

This study follows on from the Benefits Realisation of the Supporting People Programme study conducted for England (ODPM, 2004), which was also undertaken by Matrix. Both the English 2004 study and this study for the Assembly Government combined desk-based literature reviews, stakeholder consultation and economic modelling. No primary data collection was undertaken. This study used the English study by building on the literature review, stakeholder consultation and modelling and attempted to address some of its key limitations. An advisory panel of three academics based in Wales was formed to inform the project.

2.1 Literature review

The English study identified and reviewed existing evidence on the benefits of housing related support across all the client groups. This was not undertaken as a systematic review due to time limitations, but information was collected through a call for evidence, internet searches and by following up references. The information collected was critically assessed according to several criteria including timeliness, relevance, scale and methodology. The literature review found that although there is a body of qualitative research that identifies the types of benefits which are reported, or expected from Supporting People services, as yet there had not been any large scale evaluations of housing related support for any client groups and there was no information on the level of impact that these services have on the behaviour and experiences of those receiving them. This study found that this situation remains largely the same. This study built on the existing literature review and also included findings from another call for evidence from English Administering Authorities. Where assumptions for the model were based on evidence from the literature review, the relevance of this evidence for the new study was assessed by:

- Checking if the research had been updated since the 2004 study; and
- Identifying the client base on which the research was based and assessing if it is applicable to Wales (for example, checking whether the study was based on an ethnic profile that was not appropriate for Wales).

2.2 Validation of impact estimates

The English study developed a series of working assumptions on the level of impact of Supporting People in consultation with central government departments in England. These assumptions formed the basis of the assumptions that were validated as part of this study. A list of these assumptions is in section 4.0 below. A questionnaire was developed allowing stakeholders to comment on these assumptions which was sent to:

- Supporting People leads from all 22 local authorities in Wales;
- members of the All Wales Criminal Justice Group (mainly made up of probation officers); and,
- provider representatives (through Cymorth Cymru).

Interviews were also conducted with key stakeholders from two social services departments (Powys and Torfaen). This process of validation is further discussed in section 4.0.

2.3 Modelling impact

Matrix has modelled the potential benefits of Supporting People services to a selection of client groups over the period of one year and has assumed that all benefits occur within a year of the services being provided to the individuals. In general, such studies are complex and there are a number of difficulties in relation to the quality of the evidence base and the data requirements of the modelling. The paucity of evidence on the level of impact of the benefits of Supporting People services led Matrix to develop many working assumptions to complete the modelling. For these reasons, the findings presented in this report will change as the evidence base grows, modelling methods are further developed and the assumptions are refined.

To determine benefits of the Supporting People programme, it is important to understand at the outset what would happen if Supporting People funding were not available. We have assumed that *Supporting People funded services would not be picked up by other sources of funding if the Supporting People programme was stopped.* Hence, our approach compares the current Supporting People programme against the situation where Supporting People funds are not distributed in any form to local governments or the services. If this assumption is not made, one can imagine a situation where the Supporting People funds are alternatively redistributed through other local or central government funding streams to reach the same services and clients (although in practice this is very unlikely). If this is what the current Supporting People programme is compared against, the benefits of the programme would be zero. The programme would simply be a way of distributing funds to services, rather than ensuring those services are delivered.

A worked example of how impacts are modelled is shown below. There is variation in the way that each impact is modelled depending on the available data and many are dependent of a series of calculations. The example below is a relatively simple example, but shows the logical structure of the approach.

Reduction in admissions for mental health			**Comments**
A	Number of people with MH problems receiving Supporting People	2,693	Service user data collected from Local authorities and SPRG supply maps.
B	Percentage of people receiving Supporting People who are admitted for MH treatment	25.00%	A conservative assumption based on consultation.
C	Number of admissions for mental health expected for Supporting People	673	25% of the total number of service users. (B x A)
D	Reduction in mental health admittances due to Supporting People	25.00%	Impact assumption based on consultation.
E	Reduction in number of admissions	168	25% of expected number of admissions (D x C).
F	Cost of serious mental health episode	£6,000	Gathered from secondary data.

	Total cost saved from reductions in admissions for mental health	£1,009,973	Cost of serious mental health episode (F) x Reduction in number of admissions (E).

Figure 1: Worked example of model

2.4 Key limitations

Beyond the lack of a strong evidence base on which to form assumptions of the impact of Supporting People, this study has a number of key limitations:

- This study does not take into account variations in the intensity and type of support offered to service users;
- Quality of programme implementation could not be incorporated into the models;
- This study does not postulate alternative services that may be implemented in the absence of Supporting People;
- This study only includes savings made within a single year; and
- This model does not include benefits where there is insufficient data to allow inclusion in the models, or where benefits have not been valued by previous research.

Given these limitations the study has adopted a conservative approach to estimating the impact of Supporting People. As discussed further in section 4.0, stakeholders reported higher impact levels than the ones chosen for the model, but the lower estimates were used to minimise the effect of the methodological limitations.

This study focuses on nine client groups. These groups were chosen because of the availability of data for the models, particularly on the usage and associated costs of public services by particular client groups.

The following client groups are included in this study:

- Women seeking refuge from domestic violence
- People with learning disabilities
- People with mental health problems
- People with alcohol dependency
- People with drug problems
- Young single homeless and young people leaving care
- Ex-offenders
- Homeless or potentially homeless people
- Older People

The following client groups are excluded from the study.

- People with chronic illness including AIDS/HIV and related conditions
- Vulnerable single parents
- Refugees
- People with a physical disability who require support

Along with these excluded client groups, alarms, community care and certain other types of Supporting People funding are excluded as well. A large portion of the total Supporting People spend could not be assigned to a client group due to the way that data is coded for SPRG funding. In total, 83.3 per cent of the total spend is included (The total spend is £128,493,616).

3.0 Costs and service user levels

Data were collected on the costs and numbers of service users during the financial year 2005-2006, and the model contains 83.3 per cent of the total Supporting People spend. For SPG funded services, a data request was made to the 22 local authorities. They returned data on the numbers of service users and costs associated with services primarily aimed at particular client groups. Local authorities were asked to assign funding and service users to the client group definitions used by this study, based on the Assembly Government's own eligible client group criteria ('E numbers') as well as Older People (see figure 5 below for list of client groups). For SPRG funded services, data was extracted from the supply map in each local authority's Supporting People Operational Plan, and Assembly Government systems.

For the some of the SPRG and SPG data, the total number of actual service users was not available. For SPG funded services there two local authorities that could only provide the number of units. For SPRG funded services this applied to less than 2 per cent of total funding. In this situation, an overall cost per service user for a particular client group was calculated from the data returned from the other local authorities, and the number of service users was derived for the areas where only household units were known. In this sense the overall figures are an estimate rather than actual figures.

For the SPRG data, where a service is assigned to multiple client groups, the funding for that service has been divided equally across all the client groups.

A service user is defined as an initial contact with a service i.e. the total number of individuals who have had contact with a service during the year.

	Client group	SPRG data	SPRG Service users	Spend per service user
e1	Women seeking refuge from domestic violence	£8,054,015	2536	£3,175
e2	People with learning disabilities	£1,268,419	423	£2,995
e3	People with mental health problems	£6,901,909	1602	£4,307
e4	People with alcohol dependency	£2,989,216	844	£3,540
e5	People with drug problems	£3,312,579	655	£5,055
e8	Young single homeless and young people leaving care	£7,174,215	2247	£3,193
e9	Ex-offenders	£3,657,203	868	£4,214
e10	Homeless or potentially homeless people	£11,520,963	8284	£1,390
	Older People	£229,315	67	£3,422
	Totals	£45,107,833	17527	£2,574

Figure 2: SPRG costs and service users (2005-06)

	Client group	SPG costs	SPG service users	Spend per service user
e1	Women seeking refuge from domestic violence	£186,749	349	£535
e2	People with learning disabilities	£35,958,980	2277	£15,792
e3	People with mental health problems	£7,911,443	1091	£7,251
e4	People with alcohol dependency	£635,524	150	£4,236
e5	People with drug problems	£427,947	139	£3,078
e8	Young single homeless and young people leaving care	£189,888	154	£1,233
e9	Ex-offenders	£30,824	68	£453
e10	Homeless or potentially homeless people	£2,407,417	752	£3,201
	Older People	£14,235,239	22199	£641
	Total	£61,984,011	27179	£2,281

Figure 3: SPG costs and service users (2005-06)

	Client group	Total costs	Total service users	Spend per service user
e1	Women seeking refuge from domestic violence	£8,240,764	2885	£2,856
e2	People with learning disabilities	£37,227,400	2700	£13,787
e3	People with mental health problems	£14,813,352	2693	£5,500
e4	People with alcohol dependency	£3,624,741	994	£3,646
e5	People with drug problems	£3,740,526	794	£4,710
e8	Young single homeless and young people leaving care	£7,364,103	2401	£3,067
e9	Ex-offenders	£3,688,027	936	£3,940
e10	Homeless or potentially homeless people	£13,928,379	9036	£1,541
	Older People	£14,464,554	22266	£649
	Total	£107,091,845	44706	£2,395

Figure 4: Combined costs and service users (2005-06)

Although these data are informative, it is not possible to draw conclusions about the efficiency or value of the different funding streams without significant further work. These figures do not show differences in service design and the different needs that these services may be catering for. The overall split between the two funding streams for cost and service users included in this model is shown in charts below.

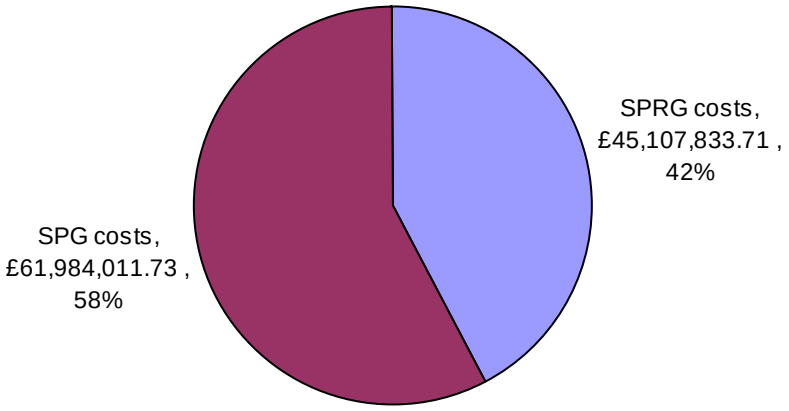

Figure 5: Costs by funding stream (2005-06)

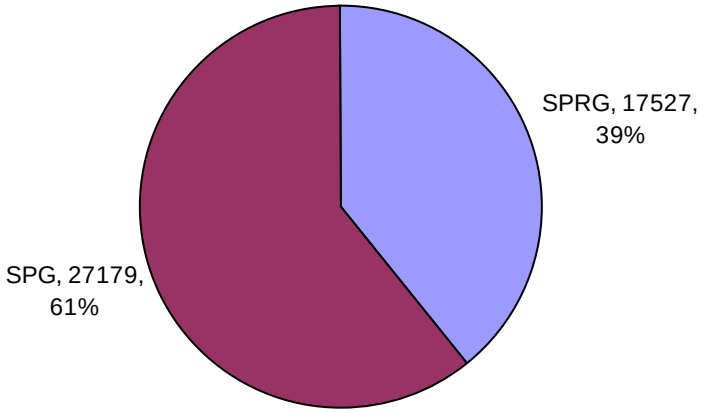

Figure 6: Numbers of service users (2005-06)

4.0 Impacts

The tables below list the impacts that form the basis of the models. Matrix undertook a stakeholder consultation exercise. Participants were invited to comment on the impacts and suggest their own estimates. Five per cent has been used as a default level where there is no obvious logic or reliable evidence to suggest otherwise. Stakeholders found it difficult to comment on the figures (which were largely based on the previous study). This was mainly due to a lack of empirical evidence to support challenges to the initial assumptions. However those stakeholders that did return questionnaires, in every case estimated higher impact levels than those in the model. By this measure, the impact estimates in the model can be considered conservative.

The tables below show the impact level used in the actual model, the mean (i.e. the average) and the maximum responses from stakeholders.

4.1 Women seeking refuge from domestic violence

Area of Impact	Impact	Model	Mean	Max
Physical Health	Reduction in A&E attendances due to reduced experience of violence	80%	80%	80%
	Reduced number of violence related GP visits per woman/child due to Supporting People	80%	80%	80%
	Reduced number of GP visits (general health) due to Supporting People	10%	17%	30%
	Impact of Supporting People on outpatient attendances of women/children	5%	18%	30%
Mental Health	Reduction in community mental health contacts for those experiencing DV	5%	18%	30%
	Reduction in admissions for serious mental health episodes for women/children	25%	25%	25%
Crime	Reduction of risk of sexual assault once the victim accesses Supporting People accommodation and support	80%	80%	80%
	Reduced risk of murder once accessing Supporting People accommodation and support, given that in 19% of cases the violence carries on	80%	80%	80%
Homelessness	Percentage of people prevented from becoming homeless though receiving Supporting People	50%	50%	50%
	Impact of Supporting People on reducing likelihood of tenancy failure	50%	50%	50%

Figure 7: Impacts for women seeking refuge from domestic violence

The initial impact estimates for this client group were already relatively high, due to a better evidence base for the assumptions. Where the default five per cent was used, in the reduction in outpatient attendances and community mental health contacts, stakeholders felt that the actual impact would be higher.

4.2 People with learning disabilities

Area of impact	Impact	Model	Mean	Max
Physical health	Reduction in admission rate for population receiving Supporting People	5%	24%	30%
	Reduction in A&E attendances	5%	25%	30%
	Reduction in length of stay (general admissions)	50%	26%	50%
	Reduction in use of GP for those with learning disabilities	5%	23%	30%
	Reduction in outpatient attendances of those with learning disabilities	5%	17%	30%
Mental Health	Reduction in length of stay (mental health admissions)	50%	50%	50%
	Reduction in mental health admittances due to Supporting People	5%	14%	30%
	Reduction in community mental health contacts for population receiving Supporting People	5%	11%	20%
Crime	Reduction in burglaries due to advice from Supporting People services	5%	38%	75%
	Reduction in violent crime through advice on personal safety from Supporting People services	5%	38%	75%
Homelessness	Percentage of people with LD prevented from becoming homeless though receiving Supporting People	5%	38%	75%
Social Care	Percentage of Supporting People population who would receive non-statutory social services interventions (home care – 2 hours per week)	20%	35%	80%
Residential Care	Percentage of Supporting People population that would require residential care if Supporting People was removed.	50%	-	-
	Percentage of Supporting People population that would require respite adult placement if Supporting People was removed.	24%	-	
	Percentage of Supporting People population that would require permanent adult placement if Supporting People was removed.	6%	-	-

Figure 8: Impacts for people with learning disabilities

Where the model varies from the default level most is for shortened length of stay for both mental and physical health related issues, and the need for residential care. This is due to Supporting People supporting service users in a way that enables them to be discharged from hospital. The need for residential care and adult placement if Supporting People services were removed (and no new types of services were put in place) equates to a very high cost. This impact was added to the model after the impact questionnaire was sent out. Assembly Government Health and Social Care representatives as well as representatives from two social services departments were consulted to set the levels.

4.3 People with mental health problems

Area of Impact	Impact	Model	Mean	Max

Area of Impact	Impact	Model	Mean	Max
Physical health	Reduction in admission rate to hospital for population receiving Supporting People	5%	22%	30%
	Reduction on length of stay (general admissions) for population receiving Supporting People	5%	29%	50%
	Reduction in A&E attendances	5%	22%	30%
	Reduction in number of GP visits for population receiving Supporting People	20%	18%	20%
Mental health	Reduction in number of counselling visits for population receiving Supporting People	20%	18%	20%
	Reduction in community mental health contacts for population with MH problems receiving Supporting People	10%	11%	15%
	Reduction in mental health admittances due to Supporting People	25%	29%	35%
	Reduction on length of stay (MH specialty admissions) for population receiving Supporting People	5%	10%	15%
Crime	Reduction of burglaries due to advice from Supporting People services	5%	18%	30%
	Reduction in violent crime through advice on personal safety from Supporting People services	5%	18%	30%
Homelessness	Percentage of people with MH problems prevented from becoming homeless though receiving Supporting People	50%	63%	100%
Social services	Percentage of Supporting People population who would receive non-statutory social services interventions	5%	20%	40%
Residential care	Percentage of people with MH problems currently receiving high level of Supporting People support whose dependency levels would rise as a result of not receiving Supporting People services	15%	25%	40%
	Percentage of people with MH problems currently receiving medium level of Supporting People support whose dependency levels would rise as a result of not receiving Supporting People services	10%	19%	30%
	Percentage of people with MH problems currently receiving low level of Supporting People support whose dependency problems would rise as a result of not receiving Supporting People services	5%	27%	50%

Figure 9: Impacts for people with mental health problems

Some stakeholders suggested that the attendance at certain health services would increase as a result of Supporting People, due to the stability that Supporting People can provide and the chaotic nature of this client group. However on average the suggested change to the assumption (18% instead of 20%) was small so the original assumption was kept. One response suggested that homelessness among this group of service users could be eliminated through Supporting People, but a more conservative assumption was felt to be only 50%.

4.4 People with Alcohol problems

Area of impact	Impact	Model

Area of impact	Impact	Model
Physical Health	Reduction in A&E attendances due to reduced experience of violence	5%
	Reduction in hospital admissions due to Supporting People	5%
	Reduced number GP visits due to Supporting People	5%
	% prevented from becoming people with alcohol dependency due to Supporting People allowing their treatment to be successful	5%
	Impact of Supporting People on outpatient attendances of people with alcohol dependency	5%
Mental Health	Reduction in serious mental health episodes due to Supporting People	5%
	Reduction in outpatient mental health visits due to Supporting People	5%
Homelessness	Percentage of people prevented from becoming homeless though receiving Supporting People	25%
	Impact of Supporting People on reducing likelihood of tenancy failure	25%

Figure 10: Impacts for people with alcohol problems

This client group was added part way through the process. It had not been included in the English study but was added to this study due to its strategic importance to the Supporting People programme in Wales. Therefore it was not included in the consultation process. There is a paucity of data on the number of people with alcohol problems who use public services so the modelling was more limited than for other client groups.

4.5 People with Drug problems

Area of Impact	Impact	Model	Mean	Max
Physical Health	Reduction in A&E attendances due to reduced experience of violence	5%	19%	30%
	Reduction in hospital admissions due to Supporting People	5%	22%	30%
	Reduced number GP visits due to Supporting People	5%	21%	30%
	Percentage of people prevented from becoming problem drug users due to Supporting People allowing their treatment to be successful	5%	29%	70%
	Impact of Supporting People on outpatient attendances of people with drug problems	5%	21%	30%
Mental Health	Reduction in serious mental health episodes due to Supporting People	5%	19%	30%
	Reduction in outpatient mental health visits due to Supporting People	5%	19%	30%
Crime	Reduced percentage drug arrests due to Supporting People	5%	21%	30%
	Reduced number of arrests for acquisitive crimes due to Supporting People	5%	21%	30%

Area of Impact	Impact	Model	Mean	Max
	Reduced number of nights in police custody due to Supporting People	5%	21%	30%
	Reduced number of court appearances	5%	21%	30%
	Reduced percentage days in prison due to Supporting People	5%	20%	30%
Homelessness	Percentage of people prevented from becoming homeless though receiving Supporting People	25%	42%	65%
	Impact of Supporting People on reducing likelihood of tenancy failure	25%	43%	65%

Figure 11: Impacts for people with drug problems

The largest variance between the modelled impact and the suggested impact from the consultation was for the percentage of people prevented from becoming problem drug users, suggesting that this is an area for further research. In order to remain conservative in the estimates for the model, the default impact level (5%) was kept.

4.6 Young single homeless and children leaving care

Area of impact	Impact	Model	Mean	Max
Physical Health	Reduction in hospital admission rate	30%	37%	40%
	Reduction in A&E attendances	30%	38%	45%
	Impact on length of stay in hospital	30%	33%	40%
	Impact of Supporting People on outpatient attendances of single homeless	30%	33%	40%
Mental health	Reduction in mental health admittances due to Supporting People	30%	40%	50%
	Reduction in community mental health contacts for single homeless receiving Supporting People	30%	33%	40%
Crime	Reduction in re-offending due to having stable housing	5%	23%	30%
	Reduction of burglaries due to advice from Supporting People services	30%	50%	90%
	Reduction in violent crime through advice on personal safety from Supporting People services	30%	33%	40%
Homelessness	Reduction in tenancy failures from settled accommodation	80%	65%	80%
	Percentage of people helped to move into permanent accommodation by the support provided by Supporting People	30%	55%	90%
	Percentage of people who are in temporary housing who would otherwise be sleeping rough	30%	35%	50%
Drug and Alcohol use	Reduction in problem drug use for those receiving Supporting People in permanent accommodation.	30%	50%	100%
	Reduction in problem drug use for those receiving Supporting People in temporary accommodation	30%	60%	100%

Area of impact	Impact	Model	Mean	Max
	Reduction in problem alcohol use for those receiving Supporting People in permanent accommodation.	30%	53%	100%
	Reduction in problem alcohol use for those receiving Supporting People in temporary accommodation	30%	40%	50%

Figure 12: Impacts for young single homeless and children leaving care

The fact that most of this client group is in carefully managed accommodation such as foyers, with planned objectives for service users, affected the way that stakeholders estimated the impact of Supporting People services. Where the suggested impacts were 100 per cent, it was felt that this did not take into account service users who dropped out of Supporting People services.

4.7 Ex-offenders

Area of Impact	Impact	Model	Mean	Max
Physical health	Reduction in admission rate to hospital for population receiving Supporting People	5%	18%	30%
	Reduction in A&E attendances	5%	19%	30%
	Percentage of people prevented from becoming problem drug users due to Supporting People allowing their treatment to be successful	5%	18%	30%
	Percentage of people prevented from becoming problem users of alcohol due to Supporting People allowing their treatment to be successful	5%	18%	30%
	Impact of Supporting People on outpatient attendances of those at risk of offending	5%	17%	30%
Mental health	Reduction in community mental health contacts for population receiving Supporting People	5%	17%	30%
	Reduction in mental health admittances for serious episodes due to Supporting People	5%	18%	25%
Crime	Reduction in re-offending due to having stable housing	5%	21%	30%
Homelessness	Percentage of people prevented from becoming homeless though receiving Supporting People	33%	48%	60%
	Impact of Supporting People on reducing likelihood of tenancy failure	50%	54%	65%
Social Services	Impact of Supporting People on allowing mothers to access stable housing and regain custody of children	5%	15%	30%

Figure 13: Impacts for ex-offenders

Stable housing is an important risk factor in offending, although it is only one of many criminogenic factors that contribute to re-offending. Therefore the default estimates were kept for the effect of Supporting People on re-offending.

4.8 Homeless or potentially homeless

Area of Impact	Impact	Model	Mean	Max
Physical Health	Reduction in hospital admission rate	30%	33%	40%
	Reduction in A&E attendances	30%	33%	40%
	Impact of Supporting People on outpatient attendances on homeless	30%	30%	30%
	Reduction in GP visits due to Supporting People	30%	30%	30%
Mental Health	Reduction in community mental health contacts for homeless people receiving Supporting People	30%	30%	30%
	Reduction in admissions for mental health reasons for adults	30%	33%	40%
Crime	Reduction of burglaries due to advice from Supporting People services	30%	33%	40%
	Reduction in violent crime through advice on personal safety from Supporting People services	30%	37%	40%
	Reduction in re-offending due to having stable housing	5%	26%	30%
Homelessness	Impact of Supporting People on tenancy failures of families from permanent accommodation	50%	50%	50%
	Percentage of families helped to move into permanent accommodation by the support provided by Supporting People	50%	50%	50%
Drug and Alcohol use	Impact of Supporting People in permanent accommodation on problem drug use	30%	37%	50%
	Impact of Supporting People in temporary accommodation on problem drug use	30%	37%	50%
	Impact of Supporting People in settled accommodation on problem alcohol use	30%	30%	30%
	Impact of Supporting People in temporary accommodation on problem drug use	30%	30%	30%

Figure 14: Impacts for the homeless and potentially homeless

The particular relevance of Supporting People services for this client group is reflected in the relatively high impact estimates. Stakeholders mainly agreed with these estimates. The default estimate for reduction in re-offending reflects the lack of data about the profile of service users within this client group i.e. the proportion of service users who have been offenders is unclear.

4.9 Older people

Area of Impact	Impact	Model	Mean	Max
Physical Health	Reduction in district nursing contacts for older people population receiving Supporting People	5%	15%	15%
	Reduction in physiotherapist initial contacts for older people population receiving Supporting People	5%	5%	5%
	Reduction in occupational therapist initial contacts for older people population receiving Supporting People	5%	8%	10%

Area of Impact	Impact	Model	Mean	Max
	Reduction in admission rate to hospital for older people population receiving Supporting People	5%	30%	50%
	Reduction in falls for older people population receiving Supporting People	5%	22%	30%
	Reduction in length of stay in hospital for non-mental health episodes for older people population receiving Supporting People	5%	15%	20%
	Reduced number of GP visits per older person receiving Supporting People services	5%	15%	20%
	Reduction in outpatient attendances for population receiving Supporting People	5%	11%	20%
Mental Health	Reduction in community mental health contacts for older people population receiving Supporting People	5%	12%	20%
	Reduction in mental health admittances for older people population receiving Supporting People	5%	17%	25%
	Reduction in length of stay due to mental health episodes in hospital for older people population receiving Supporting People	5%	22%	40%
Crime	Reduction of burglaries for older people population receiving Supporting People	5%	38%	70%
	Reduction in violent crime through advice on personal safety for older people population receiving Supporting People	5%	38%	70%
Homelessness	Reduction in total (i.e. not just older people) homelessness due to older people population receiving Supporting People	1%	33%	65%
Social services	Reduction in older people population receiving non-statutory social services interventions due to Supporting People	20%	30%	40%
Residential care	Percentage of older people currently in very sheltered housing whose dependency levels would rise as a result of not receiving Supporting People services	5%	44%	100%
	Percentage of older people currently in sheltered housing whose dependency levels would rise as a result of not receiving Supporting People services	5%	54%	100%
	Percentage of older people currently receiving floating support whose dependency levels would rise as a result of not receiving Supporting People services	5%	49%	100%

Figure 15: Impacts for older people

The large variance between the modelled assumption and stakeholder estimates in the reduction in homelessness may reflect a misunderstanding in the basis of the estimate, which looks at total homelessness rather than homelessness for older people. This was necessary due to a lack of data on the how many homeless people are also older people. Stakeholders

suggested that the need for residential care would be much higher for this client group. Although this was a plausible argument, there was no further evidence to support this change so the default levels were retained.

5.0 Findings and conclusions

Based on the approach and data described in the preceding sections, the modelled benefits of the Supporting People programme in Wales, categorised by client group are shown in figure 20 below.

	Client group	Spend	Quantifiable savings	Net benefit
e1	Women seeking refuge from domestic violence	£8,240,763	£56,187,110	£47,946,346
e2	People with learning disabilities	£37,227,399	£40,569,794	£3,342,394
e3	People with mental health problems	£14,813,351	£10,874,989	-£3,938,362
e4	People with alcohol dependency	£3,624,740	£1,414,946	-£2,209,794
e5	Problem drug users	£3,740,525	£1,427,886	-£2,312,639
e8	Young single homeless and young people leaving care	£7,364,103	£4,965,955	-£2,398,148
e9	Ex-offenders	£3,688,027	£3,568,315	-£119,712
e10	Homeless or potentially homeless people	£13,928,379	£31,024,855	£17,096,475
	Older People	£14,464,553	£30,030,539	£15,565,985
	Totals	£107,091,845	£180,064,389	£72,972,545

Figure 16: Overall findings by client group

It is important to stress that negative figures constitute client groups for which the *quantifiable* savings are lower than the spend. Given the limitations in what can be quantified it should not be inferred that these services are poor value. It simply means that the methodology is limited in that area which could be for a number of reasons e.g. secondary data is limited for a particular client group or benefits mainly accrue to the individual, rather than the public purse.

Based on the costs and service users included within this model, and given the limitations of this approach, we have calculated a £180,064,389 saving to the public purse from the Supporting People programme in Wales. This is a net financial benefit of £72,972,545, which is equivalent to a saving of £1.68 for every £1 spent.

5.1 Findings by client group

The models were developed on a client group by client group basis. The following sections summarise the findings, disaggregated by impact. These sections also summarise some of the perceived benefits of Supporting People that could not be quantified for the model.

5.1.1 Women seeking refuge from domestic violence

The modelled net benefits (savings minus spend) for this client group are £47,946,346. Figure 21 below shows that avoiding costs to the criminal justice system and NHS of severe incidents of domestic violence constitute the vast majority of savings due to Supporting People for this client group. The hypothesis behind the model, supported by qualitative data, is that Supporting People helps reduce the level of crime suffered by women and children experiencing domestic violence, by ensuring they maintain stable housing, providing emotional support and training in life skills, developing a social network and through ensuring that people's mental and physical health is maintained. This model also assumes on the basis of evidence that the percentage of women experiencing violence who have children aged under 16 in the household is 72 per cent[2], and 40 per cent[3] of these children will also suffer domestic violence. The value of savings are calculated for children as well as their mothers.

Area of Impact	Impact	Total
Physical health	Severe incidents of DV	£25,363,007
	Minor incidents of DV	£148,944
	Murder	£651
	Sexual assaults	£141,253
	Admissions (general)	£240,453
	Outpatient attendance	£78,203
	GP visits (violence)	£215,881
	GP visits (general)	£365,136
Mental Health	Community contacts	£14,279
	Serious episodes	£153,068
Crime	Sexual assault	£31,881
	Minor DV incidents	£438,071
	Severe DV incidents	£20,151,309
	Murder	£1,070,103
Homelessness	Decreased use of emergency accommodation	£4,348,383
	Tenancy failure	£568,805
	Social costs of homelessness	£2,857,675

Figure 17: Savings due to Supporting People for women seeking refuge from domestic violence

The model for this client group is very sensitive to the high impact estimates (see Section 5.1) due to the high costs associated with severe incidents of domestic violence.

There are a range of benefits to this client group, to which a monetary value cannot be ascribed. These un-costed benefits include:

[2] ODPM (2002) The Provision of Accommodation and Support for Households Experiencing Domestic Violence in England.

[3] Walby S (2004) The cost of Domestic Violence.

- improved quality of life for the individual and children through greater independence;
- decreased vulnerability;
- improved health;
- greater choice of options on where and how to live;
- greater stability to enable women and children to plan for the future, and children to gain education;
- reduced fear; and
- increased involvement in the community (benefiting both the individual and society).

5.1.2 People with learning disabilities

The modelled net benefits (savings minus spend) for this client group are £3,342,394. The literature identifies a number of different benefits that can accrue from the provision of housing related support. The evidence for people with learning disabilities was qualitatively based and many of the benefits could not be modelled. While this has also been the case for other client groups, it was particularly marked for people with learning disabilities. The main examples of un-costed types of benefits identified for this group are an improved quality of life for the individual and their families. The largest quantifiable impact has been on the use of residential care and adult placement services.

Area of impact	Impact	Total
Physical health	Admissions	£250,764
	A&E attendances	£19,654
	Length of stay	£2,382,263
	Ambulance journeys	£13,430
	GP visits	£17,012
	Outpatient attendances	£11,893
Mental Health	Length of stay	£1,253,304
	Mental health admittances	£9,178
	Community contacts	£5,312
Crime	Burglaries	£7,920
	Violent crime	£1,567
Homelessness	Prevention of homelessness	£596,116
Social Care	Non-statutory social services interventions	£674,023
Residential care	Residential care	£32,437,394
	Adult placement – respite	£1,393,738
	Adult placement – permanent	£1,496,219

Figure 18: Savings due to Supporting People for people with learning disabilities

The fact that many of the potential benefits identified in the literature cannot be quantified, or given a meaningful economic value, combined with the high unit cost of support, means that the benefits that we have been able to model have a small economic value compared to the total cost of providing Supporting People services to people with learning disabilities.

A significant potential saving that has been modelled relates to reduced length of stay. Qualitative evidence suggests that housing related support can impact positively on health by reducing delayed discharge and unnecessary long stays in hospital through services provided through Supporting People such as the supervision and monitoring of health, developing life skills and providing emotional support and advice.

5.1.3 People with mental health problems

The modelled net benefits (savings minus spend) for this client group are -£3,938,362. The main elements of the savings due to Supporting People for this client group are: avoiding serious mental health episodes (mainly by making it more likely that treatment is adhered to); avoiding take up of residential care; and avoiding tenancy failure and homelessness.

Area of Impact	Impact	Total
Physical health	Admission rate	£23,837
	Length of stay	£22,645
	A&E attendances	£7,840
	Ambulance journeys	£5,357
	GP visits	£138,739
Mental health	Community contacts	£325,963
	Mental health admittances	£1,009,973
	Length of stay	£145,441
Crime	Burglaries	£12,342
	Violent crime	£1,563
Homelessness	Prevention of homelessness	£1,067,070
	Tenancy failure	£1,311,079
Social services	Non-statutory social services interventions	£168,059
Residential care	High level of Supporting People support	£5,553,394
	Medium level of Supporting People support	£626,320
	Low level of Supporting People support	£455,359

Figure 19: Savings due to Supporting People for people with mental health problems

Benefits not included in the model include:

- improved quality of life for the individual including greater independence;
- improved health;
- greater choice of options on where and how to live;
- lessened dependence on relatives and carers;
- prevention of further mental health problems and fewer suicides;
- reduced burden of care for carers (leading to improved quality of life); and
- easier access to appropriate services.

5.1.4 People with alcohol dependency

The modelled net benefits (savings minus spend) for this client group are -£2,209,794. There is limited evidence for the usage of public services by people with alcohol problems (where they are not picked up in the other models) so some impacts have not been modelled. This is mainly due to the difficulty in disaggregating people with alcohol dependency from other people using public services. Therefore this model is limited in scope compared to the other models in this study.

Area of Impact	Impact	Total
Physical Health	A&E attendances	£2,894
	Ambulance journeys	£1,977
	Hospital admissions	£18,687
	Successful treatment	£47,537
Mental Health	Serious episodes	£3,379
Homelessness	Prevention of homelessness	£492,400
	Decreased use of emergency accommodation	£750,058
	Tenancy failure	£98,009

Figure 20: Savings due to Supporting People for people with alcohol dependency

There are also likely to be more benefits for people with alcohol dependency than could be quantified for the model. It is envisaged that these would be similar to those felt by people with drug problems, as set out in the next section.

5.1.5 People with Drug problems

The modelled net benefits (savings minus spend) for this client group are -£2,312,639. The largest savings are related to tenancy and homelessness, as well as cost related to reduced offending by this client group. There is a large body of recent research establishing the link between crime and class A drug use, and this has enabled detailed modelling of the effects of reducing drug use on offending.

Area of Impact	Impact	Total
Physical Health	A&E attendances	£2,312
	Ambulance journeys	£1,579
	Hospital admissions	£14,928
	GP visits	£3,478
	Successful treatment	£24,112
	Outpatient attendances	£6,995
Mental Health	Serious mental health episodes	£2,699
	Outpatient visits	£2,007
Social care	Looked after children	£2,673
Crime	Drug arrests	£43,142
	Arrests for acquisitive crimes	£137,135
	Nights in police custody	£3,289

	Court appearances	£41,371
	Days in prison	£71,379
Homelessness	Prevention of homelessness	£393,334
	Decreased use of emergency accommodation	£599,155
	Tenancy failure	£78,291

Figure 21: Savings due to Supporting People for people with drug problems

Over and above the benefits to which a monetary value has been ascribed in this study, there was strong evidence in the literature of positive benefits for this client group that could not yet be quantified or valued. These include:

- improved quality of life;
- decreased anti-social behaviour;
- improved prospects for employment;
- increased likelihood of completing treatment programmes; and
- decreased suicide rates.

These benefits arise for, and are valued by, the individual drug user, their families and the wider community. There is considerable qualitative evidence of the positive effect that housing related support can have on the often chaotic life of drug users, and how these benefits also relate to successful outcomes in relation to associated health and social care provision such as drug treatment services.

5.1.6 Young single homeless and children leaving care

The modelled net benefits (savings minus spend) for this client group are -£2,398,148. The largest modelled savings come from costs related to homelessness and re-offending.

Area of impact	**Impact**	**Total**
Physical Health	Hospital admissions	£22,560
	A&E attendances	£10,483
	Ambulance journeys	£4,775
	Outpatient attendances	£10,572
	Drug treatment	£136,386
	Alcohol treatment	£66,543
Mental health	Mental health admittances	£269,259
	Community contacts	£7,870
Homelessness	Tenancy failures	£1,028,291
	Move into permanent accommodation	£1,453,565
	People who are in temporary housing who would otherwise be sleeping rough	£184,949
Crime	Re-offending	£1,468,837
	Burglaries	£104,054
	Violent crime	£106,985

	Violent crime against rough sleepers	£90,819

Figure 22: Savings due to Supporting People for young single homeless and children leaving care

The benefits that could not be quantified for this model are expected to be particularly significant for this client group. In particular, the fact that this study only attempts to quantify benefits felt in a single year means that the long term benefits of a supported and stable transition to adulthood for this vulnerable group are not quantified. These could include marked changes in achievement over the course of an entire life. Such benefits could include:

- improved quality of life for the individual including greater independence;
- decreased vulnerability;
- improved health;
- greater choice of options on where and how to live;
- greater stability allowing people to deal with other issues in their lives, such as substance abuse, unemployment, mental health problems, offending and behavioural problems;
- decreased fear of crime;
- easier access to appropriate services; and,
- improved involvement in the community benefiting both the individual and society.

5.1.7 Ex-offenders

The modelled net benefits (savings minus spend) for this client group are -£119,712. The largest modelled savings come from costs related to homelessness and re-offending.

Area of Impact	Impact	Total
Physical health	Admission rate	£14,072
	A&E attendances	£2,179
	Ambulance journeys	£1,489
	Outpatient attendances	£4,121
	Alcohol treatment	£15,750
	Drug treatment	£7,297
Mental health	Community mental health contacts	£1,227
	Serious mental health episodes	£3,180
Crime	Reduction in re-offending	£1,908,699
Homelessness	Prevention of homelessness	£611,785
	Tenancy failure	£55,351
	Decreased use of emergency accommodation	£931,914
Social Services	Custody of children	£11,244

Figure 23: Savings due to Supporting People for ex-offenders.

There has been research showing a link between stable accommodation and rates of recidivism, however this is not yet able to show a causal link, or the level of impact. We have

therefore assumed the impact of Supporting People services on offending rates to be a reduction of five per cent. Crime reduction is also an area where some work is being done to value benefits to the individual such as human costs. In this model, the values of the hypothesised reduced offending are sourced from a review of evidence by the Social Exclusion Unit and only include exchequer benefits (i.e. benefits to the criminal justice system through reduced police time, for example).[4] It is likely that if these human costs of crime were modelled in their entirety, the crime reduction benefits would be higher than estimated in this study.

The literature provided strong evidence of a number of benefits that could not be quantified or valued and therefore, could not be modelled. These are largely related to the benefits to the individual service user or the community where they live and include:

- improved quality of life for the individual through more flexible housing support;
- improved health;
- greater housing stability allowing people at risk of offending to deal with other issues in their life such as alcohol and drug dependency problems;
- acquiring basic life-skills that have been lost after being institutionalised;
- easier access to appropriate services; and
- reduced fear of crime in the community.

5.1.8 Homeless or potentially homeless

The modelled net benefits (savings minus spend) for this client group are £17,096,475. The largest benefits relate to homelessness and re-offending.

Area of Impact	Impact	Total
Physical Health	Hospital admission rate	£2,038,141
	A&E attendances	£591,901
	Ambulance journeys	£269,644
	Outpatient attendances	£955,145
	Alcohol treatment	£644,101
	Drug treatment	£1,600,547
Mental Health	Community contacts	£261,399
	Admissions	£1,013,540
Crime	Burglaries	£198,770
	Violent crime	£137,915
	Violent crime (rough sleepers)	£702,452
	Re-offending	£5,528,975
Homelessness	Prevention of homelessness	£6,936,717
	Rough sleeping	£4,077,481

[4] Social Exclusion Unit (2002) *Reducing Reoffending.*

	Decreased use of emergency accommodation	£5,775,022
Social Services	Custody of children	£293,098

Figure 24: Savings due to Supporting People for homeless or potentially homeless people

There is evidence that the provision of housing related support can prevent both new and repeat homelessness. This is a complicated relationship and there is little evidence around the levels at which this occurs. There are also issues about the type and duration of services that must be considered.

Data in Wales do not disaggregate single homeless people from homeless families in way that enabled separate modelling. This model focuses on the savings associated with single homeless people.

The monetary benefit of the potential reductions in crime are the next largest impact as calculated by the model. This includes the potential benefits arising from reductions in the level of crime committed against as well as by single homeless people.

In addition to the costed benefits set out above, there are a wide range of other potential or expected benefits to this client group that were identified in the literature. These include:

- improved quality of life for the individual including greater independence;
- decreased vulnerability;
- improved health;
- greater choice of options on where and how to live;
- greater stability allowing single homeless people to deal with other issues in their lives, such as substance abuse, unemployment, mental health problems, offending and behavioural problems;
- decreased fear of crime;
- easier access to appropriate services; and,
- improved involvement in the community benefiting both the individual and society.

5.1.9 Older people

The modelled net benefits (savings minus spend) for this client group are £15,565,985. The most significant saving is the reduced need for residential care because of Supporting People. The model makes the conservative assumption that 5% of older people receiving Supporting People services would need to go into residential care if not for Supporting People.

Area of Impact	Impact	Total
Physical Health	District nursing	£109,880
	Physiotherapist	£49,108
	Occupational therapist	£6,757
	Admission rate	£1,140,140
	Falls	£106,827
	Length of stay	£1,083,133

	GP visits	£177,710
	Outpatient attendances	£162,118
Mental Health	Community contacts	£7,583
	Mental health admissions	£56,965
	Length of stay	£2,933,299
Crime	Burglaries	£36,420
	Violent crime	£38,220
Homelessness	Prevention of homelessness	£2,952,372
Social services	Non-statutory social services interventions	£1,389,398
Residential care	Dependency levels (very sheltered housing)	£303,266
	Dependency levels (sheltered housing)	£16,902,185
	Dependency levels(floating support)	£2,575,150

Figure 25: Savings due to Supporting People for older people

Not all of this cost would be borne by the public sector as funding for residential care is means tested and may be partly paid by the clients themselves. It has not been possible to proportion these costed benefits between exchequer and non-exchequer benefits. However, majority of these costs would fall to the public purse.

It is further assumed that without housing related support, the remaining 95 per cent would be able to live independently, however, their need for health and social care services would increase as a result.

A number of other benefits of housing related support that were strongly evidenced in the literature could not be modelled. These are largely related to the benefits to the individual or their carer, or the community in which they live, and include:

- improved quality of life for the individual including greater independence;
- improved health;
- greater choice of options on where and how to live;
- lessened dependence on relatives and carers;
- reduced burden of care for carers;
- increased participation in the community by older people and decreased isolation;
- decreased fear of crime; and,
- easier access to appropriate services.

5.2 Conclusions

The total financial benefits as a result of Supporting People modelled in this study are £180,064,389. This is equivalent to £1.68 for every £1 spent. It is important to reiterate that the value of the benefits of the Supporting People programme are at this stage calculated based on a series of assumptions. The calculations in the models are likely to change as research around the programme is undertaken. Evidence on the value of un-costed benefits – largely benefits to

the individual services user, their families and wider communities – is also likely to improve over time. This study is based on over 130 separate impact assumptions. Each one of those impacts could be evaluated separately and this study highlights the need to do further research into the impact of Supporting People.

For the nine client groups studied, the evidence base suggests that there are benefits of Supporting People services that accrue to the individual in receipt of housing related support, their families and wider communities as well as to the public purse. While some of these potential benefits are fairly amenable to measurement and valuation (for example the resources devoted to dealing with longer hospital stays), others are more difficult (for example the value to the individual of improved health). These un-costed benefits may be very important to the individual, their families and to society as a whole and need to be considered alongside those which have been modelled when considering public expenditure investment decisions. The modelled savings to the public purse were grouped into thematic areas, and the findings for each thematic area are shown in figure 30 below.

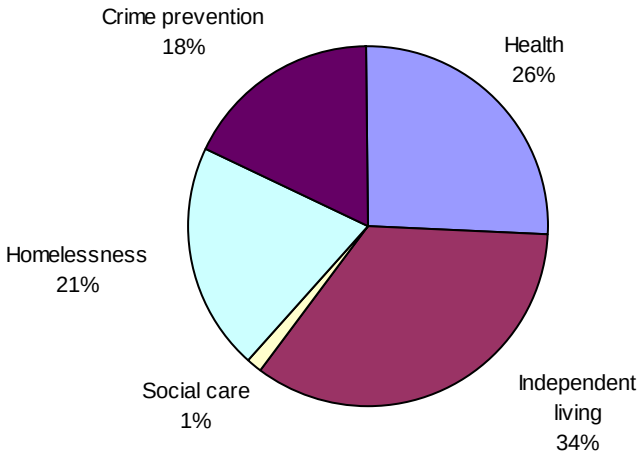

Figure 26: Modelled savings by thematic area

Health

The total modelled financial benefits of Supporting People classified within this thematic area are £46,281,801. Health benefits account for 26 per cent of the total calculated savings. This covers savings in relation to the need for health services as a result of improved or maintained health status or appropriate access to services. The potential savings modelled include: admissions to hospital; length of stay and delayed discharge from hospital; mental health services; visits to A&E; access to primary care services; and use of treatment services (for example, drug treatment services). The health benefits that have been modelled accrue to the exchequer. There is ongoing research in relation to the monetary value of un-costed health benefits in terms of the impact of improved health on the individual.

Independent living

The total modelled financial benefits of Supporting People classified within this thematic area are £61,743,028. The costed benefits of independent living account for 34 per cent of the total value of benefits as calculated by this study. This covers benefits in relation to choice and range

of appropriate accommodation options. The costed benefits in terms of independent living cover the level of residential or nursing home care that would be required if Supporting People did not exist. Independent living is an area where there are also considerable un-costed benefits (such as the benefit of choice for individuals) however, little research has been done to attempt to ascribe a monetary value to these. Some of these costed benefits may accrue to the individual rather than the public exchequer but at this stage it is not possible to separate these out, though they represent a small proportion of the savings.

Social care

The total modelled financial benefits of Supporting People classified within this thematic area are £2,538,498. The value of benefits in relation to social care account for 1.4 per cent of the total value of benefits. This covers the benefits in relation to reduced need for social care services including personal domiciliary care and services for looked after children. However, as set out above, the impact of reduced demand for more intensive types of support (including residential care) has been included under independent living.

Homelessness

The total modelled financial benefits of Supporting People classified within this thematic area are £37,167,832. These benefits account for just under 21 percent of the total value of benefits. This covers benefits in relation to securing and maintaining stable housing. Benefits modelled include the cost of tenancy failures to local authorities, the use of temporary accommodation and the benefits from avoiding homelessness and rough sleeping.

Crime

The total modelled financial benefits of Supporting People classified within this thematic area are £32,333,226. The value of benefits in relation to crime account for just over 18 per cent of the total value of benefits. This covers both benefits from reduced offending by some client groups (people with drug problems and ex-offenders), and reduced risk of Supporting People clients being victims of crime. The models cost the reduction in need for criminal justice system services and the other costs associated with crime. In the models for older people and for women escaping domestic violence, the social costs of crime (i.e. non exchequer costs) have also been calculated, but they represent a small proportion of the total savings.

General benefits of Supporting People

There are a number of un-costed benefits that are common across the eight client groups included in this study, and which have not been valued. These include:

- improved quality of life for the individual including greater independence;
- improved health;
- lessened dependence on relatives and carers;
- independent living, including a greater choice for individuals around accommodation, lifestyle and the provision of skills to enable this choice;
- increased ability to participate in the community. This covers a number of areas including reduced isolation or social exclusion, and greater stability for people with chaotic lives;
- decreased fear of crime; and,
- easier access to appropriate services.

It should be noted that the potential savings which have been valued in the model relate to a one year period. For some clients, Supporting People services can have a potential lifetime effect. For example, low level intervention services for older people may postpone health deterioration and compress the period of morbidity which arises as part of the ageing process. Similarly for offenders and substance users, early intervention may have a lasting impact on re-offending and problematic substance misuse. Supporting People may also be having important impacts on the children of service users, providing an improved environment for nurturing children and improving the health of parents. These potential longer term benefits have not been explicitly incorporated within the work undertaken to date.