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Homeless Link response to New Horizons -Towards a shared vision for mental health

Homeless Link welcomes the opportunity to respond to this consultation. Homeless Link is the national membership organisation for agencies working with people who are homeless. The services provided by our members range from local authority housing services, housing associations, day centres, outreach services, residential care homes, hostels, supported housing, floating support through to employment, training and education.

As Homelessness agencies caring for people with complex mental health problems is at the heart of what we do.

- Homeless Link's 2008 National Survey of Needs of Provision shows that a third of clients in homelessness services experience poor mental health, with this rising to 43% of day centre clients.
- Around a third of rough sleepers in London are recognised as having mental health problems.
- The Seeds of Exclusion research from The Salvation Army revealed that more than a third of homeless clients surveyed nationally had attempted suicide at least once, with around six out of ten having paranoid personality disorders.
- Crisis figures show similar findings of homeless people suffering disproportionately from mental health problems.
- St Mungo's research points to this being the tip of the iceberg if significant psychological disorders are also taken into account.

In this context our overall comment in relation to New Horizons is that we really welcome it as a strategy. If the guiding principles are put into practice it will move mental health services on; put increased emphasis on prevention and understanding where mental health problems start; will result in developing the sort of services that people want led by their needs; and combat inequalities. However there is a major omission as the strategy does not sufficiently address issues for homeless people.

- **Lack of access to mental health services for people who are homeless is an issue that the homeless sector has been struggling with for many years. This strategy makes reference to offenders, substance misusers, looked after children, people with personality disorder, young people who have experienced violence and abuse. In addition to mental health problems the other issue many of these groups have in common is their homelessness. It is well evidenced that**

as a group homeless people face the additional burden of difficult access to services.

- **Recognition of the connection between mental ill health and homelessness is a major gap in this document and we would like to the strategy include a commitment for better mental health services that specifically recognises the needs of homeless people.**

Responses to the Consultation Questions
We have not responded to all the questions but have prioritised those that are of most relevance to homeless agencies and people who are homeless.

Q1. What do you think are the three most important changes for mental health and mental health care in the next 10 years? And why?

1. A designated budget for complex needs linked to joint commissioning and joint outcomes and some assurance that when guidelines are issued they are mainstreamed into practice.

The majority of the homeless population who experience mental health problems also have substance dependence problems. Part of the complex picture is the use of alcohol and drugs to obliterate painful pasts and to self medicate in the absence of mental health treatment. Despite the issuing of guidelines on dual diagnosis and on personality disorder not being a diagnosis of exclusion, there is a gap between guidelines and practice. The experience of practitioners is that drug and alcohol services persist in being the poor relation of mainstream mental health services and that there continues to be very little joint working across mental health and addiction services. The approach of staged services where people are expected to detox and become abstinent before their mental health is treated is ineffective, addiction is a mental health problem and needs to be treated concurrently.

We are concerned that the current approach is one where services seem to be able to pick and choose who they can work with. As a result, people with more complex issues can be left outside statutory services and often in the care of the homeless sector, which can lead to a deepening of people's problems and their social exclusion. The experience of our member agencies is that non-engagement with services is often used as a reason to close the case by statutory services. Non engagement should be taken as a sign of deep social exclusion and should mean that different ways are found to approach the issue until the individual becomes engaged.

We would like to see a service from which you are neither excluded because your symptoms are not severe enough, nor because they are too severe, nor because they are combined with other issues such as substance misuse or challenging behaviour. We recognise that different approaches are more effective with different problems and that the same service is not going to work for everybody but where people's problems are complex and join up, services need to join up to address them.

2. Universally accessible non clinical services that achieve positive outcomes for people with low level mental health problems.

Supporting People currently funds much of the work that could be called preventative, e.g. housing related support that enables people to keep their tenancies across sheltered and supported housing; engaging, containing and providing stability for vulnerable people; building a trusting relationship with people that are chaotic and outside statutory services. The homeless sector and Supporting People funded services have lots of experience of working with complex needs and people who make multiple use of services, offering resettlement and floating support and encouraging independent living skills. We also have experience of

providing the sort of activities that address social inclusion: day centres; befriending; meaningful activity; physical recreation; and enjoying outdoor space.

We welcome the holistic emphasis in the strategy and the approach of promoting well being. It is vital with Supporting People money no longer being ring fenced and going into the area based grant that these types of functions are not lost and that the experience of voluntary and community sector agencies in providing them is valued and drawn upon. Currently these are not seen as 'mental health services' but the experience in our sector is that this type of accessible service which promotes social interaction, encourages engagement and interest and boosts self worth can be the key to giving some people stability and meaning in their lives. '*No one left out*', the strategy to end rough sleeping by 2012, commits 'government departments to support and extend positive activities for homeless people'. We would like to see this commitment reflected in the mental health strategy.

3**. A recovery oriented approach built into commissioning.**
This fits with the direction of the strategy and with the personalisation agenda but in the experience of our members is far from the reality of services. This means valuing the strengths people bring to their recovery, recovery working from the inside out and a move from people being passive recipients of professional interventions to a respect for a self directed approach to defining and moving towards recovery. This is well articulated in the strategy already but there is a need for more direction about what will make this a reality.

If this approach is to become standard in mental health services it will mean moving more services out of clinical environments and challenging the power of the consultant, developing more mental health services that are user led and located in the voluntary and community sector and building recovery outcomes into commissioning. It will mean an emphasis on developing alternatives to admission to psychiatric hospital when a crisis is experienced, and employing more people in services who have experience of mental health difficulties.

Q2. Do you support the twin themes of public mental health/prevention and mental health service development? Please explain your views, giving examples if possible.

Homeless Link endorses the twin approach of mental health prevention and mental health service development. We are well aware that a high proportion of rough sleepers and homeless hostel residents are those recovering from traumatic childhoods of physical, emotional or sexual abuse and that a far better approach would be to offer the best mental health treatment and support to those who need it the most before they end up homeless. We appreciate the three tiered approach described in the strategy:

- reducing risk factors in the whole population;
- targeting those most at risk;
- promoting recovery and better outcomes for those with mental health problems.

There is recognition in the strategy that the right interventions in childhood would make between a quarter and a half of adult mental health problems preventable.

The UK has consistently poor performance on international rankings of child well being and indices of social dysfunction. Evidence from Europe shows that this is an issue that goes far wider than mental health services. We advocate an approach that averts social problems from arising and creates more cohesive communities and which supports overall wellbeing. This should include investment for universal childcare provision and paid parental leave; children's services that take a 'whole child approach' and that focus on the psychological and social aspects of children's lives including positive feelings, social connectedness and capabilities.

A particular issue our members are concerned about is the way in which our society demonises young people, does not create safe places for them to congregate and then blames them for being on the streets. Transitions to adulthood are a difficult time and there is little support on offer. We appreciate the emphasis in the document on early years, parenting

skills and developing emotional and social skills, however, we feel there needs to be more emphasis on universal services for adolescents not just those who are in CAMHS services. Where young people have been taken into care there should be mandatory psychological assessment and access to support for the child and for foster carers. We recognise that these issues cross government departments and are much wider than can be addressed in a mental health strategy alone but we would like to see the Department of Health taking a strong lead on investment in creating the social conditions that promote wellbeing.

In relation to people in treatment for mental health services our members feel there is a need to build in much better support during transitions. People who are admitted into psychiatric services get inadequate support on discharge and not enough support is put into preventing readmissions. For our client group, access to appropriate housing and support and to the type of activities that promote inclusion, referred to earlier, are key to maintaining stability. All too often people are discharged to the same situation they were admitted from. The experience of members is that contrary to a preventative service there are high thresholds set for accessing mental health services and in many cases getting a service is delayed until an individual is in crisis. These issues are addressed in the strategy but will need specific resources allocated if early intervention is to become a reality.

Q3. Are the guiding values described in section 1 the right ones? Please explain your view giving examples, if possible.

The guiding principles as described in section 1 are all principles that Homeless Link would endorse and lay the foundation for a welcome 10 year strategy. However the omission of homelessness needs to be addressed.

Equality, justice and human rights and the emphasis on social inclusion are issues we would put high on the agenda, as is the importance of tackling the stigma that people with mental health problems face in their daily lives. Shifting the emphasis to the person's own definition of recovery, recognizing the importance of hope and moving towards a service that fits around the individual rather than people fitting into the service offered are all sound principles. An emphasis on prevention and early intervention are key to a society where well being and quality of life and social connectedness are valued. However the omission in the document of addressing the needs of homeless people, when mental health problems are very often one of the triggers on the road to homelessness, reflects a lack of understanding of the reality of social exclusion in people's lives.

The principles are sound but our concern is that there needs to be some more teeth behind it to actually change services. There are strong statements on equalities and diversity but we would like to feel more confident that they will be put into action. In our experience documents with examples of good practice don't do enough to persuade commissioners to reconfigure services.

Q4. What should the Government do to promote more personalised services for people with mental health problems and their families? It would be helpful to hear about both what works in your area, and, if appropriate, what does not and what could be done in the future.

- **Jointly commissioned and jointly delivered services**
- **Investment in social capital and social connectedness through universal and preventative services**

As stated already, jointly commissioned and jointly delivered dual diagnosis services or services for complex needs client groups would be a good start. One example given by a member agency was of a service in Oldham for young people jointly commissioned by the

PCT, Supporting People, the DAT and the Youth Offending Service. Because all agencies were jointly taking responsibility they were able to address the complexity of need.
We were interested recently to hear about a supported housing project provided by Look Ahead for people with severe and enduring mental health problems. They are piloting a personalisation approach. This had involved looking at the core essential costs and staffing of keeping the project stable. They froze a vacant post and with the revenue developed a budget of £40 a week per resident for them to spend on things that improved their quality of life. They had also flexible time for support staff factored into the rota to accompany residents in activities that they wanted to do. It is an interesting example of how personalisation can be applied while retaining a stable living and support base.

One of the issues that is crucial if personalisation is to work is to invest in building social capital. It cannot be assumed that the 'community 'is a benign place, particularly for people with mental health and substance misuse issues, learning difficulties and more particularly if they have been homeless. Assumptions need to be challenged that there is 'a community' for people who are socially excluded and work needs to go into building that community. The five healthy habits: 'Connect', 'Be active', 'Take notice', 'Keep learning', and 'Give' are sound and helpful but make an assumption that the basics in life are in place. That you do not feel excluded from libraries, museums, your local community centre, adult education classes, local allotments or even the countryside. Our experience in the homeless sector is that access to physical activity and learning and creativity and voluntary work, appreciation of the arts and of green spaces and growing things, have all been enormously important for people who are homeless, but that they need resources and support in order to make use of them.

Preventative and universal services are one of the keys to building social connectedness and social capital but there needs to be a specific pot of money for preventative universal services, without it money will always go to acute services for people in substantial need.

Q7. In your view, where are the current gaps in research evidence supporting the development of New Horizons?

There is a lack of a knowledge base on the numbers and needs of people with complex needs, mental health problems, personality disorders, learning difficulties, substance dependence, offending history, and homelessness who are out of contact with statutory services. This becomes a reason not to prioritise them in Public Service Agreements because it is difficult to monitor progress. This gap needs to be addressed and this group prioritised.

There is a need for information on the cost effectiveness of non- clinical universal services accessible to people with mental health problems referred to earlier in the document. Our experience is that access to structured meaningful activities across the spectrum of physical activities, creative arts, growing things, and trips out to green spaces enhances physical and mental well being for people who are socially excluded. However it is very difficult to access funding for this type of work and a robust evidence base is needed.

There is a lack of effective interventions with people who have experienced damage and trauma in their early lives, which is later expressed in complex needs and challenging behaviour.
'No one left out' the strategy to end rough sleeping by 2012 committed the Department of Health alongside Communities and Local Government to explore the extent to which childhood trauma is a factor in the lives of people with the most complex and chaotic lives, and to identify effective interventions. It also makes a commitment to consideration of how more training and support can be provided for hostel workers to promote their understanding and capacity to address this issue. We would like to see reference to this commitment in this strategy.

Q9. How can we promote joint working between local authorities, the NHS and others to make New Horizons effective in your local area?

In our experience the encouragement of joint commissioning across mental health, adult social care and supporting people is an important mechanism. The approach of funding and delivering care and support in silos is the antithesis to the holistic approach advocated in the strategy and encourages services to defend budgets and create barriers about who they can and cannot offer a service to. *No one left out*, the strategy to end rough sleeping, commits Communities and Local Government (CLG) along with the Department of Health (DH), to gathering data to strengthen the case for better planned and integrated services. It also commits the CLG, DH, Home Office and criminal justice agencies to work together to promote better integration between health, drug treatment, criminal justice and housing. We would like to see these commitments reflected in the mental health strategy to ensure that joining up at a government level filters down to a local area level. The duty to produce Joint Strategic Needs Assessments and to make them inclusive of the most marginalised and seldom heard is one mechanism by which local authorities and health can be encouraged to pull together evidence on the needs of homeless people and people with complex needs.

We would also like to see investment in voluntary and community organisations which can deliver universal and open access services. The voluntary and community sector have the expertise in the provision of universal services. In particular the homeless sector has experience in providing open access services. Traditionally homelessness agencies have provided a service to people excluded from statutory services and we have learned from that experience that if you have the flexibility to get services right for the most marginalised and most chaotic, you can get them right for everybody.

An example is the Mental Health Support Team (MHST) in Nottingham. They are part of the HLG, a voluntary sector provider for homeless people, the MHST view mental health in its widest sense and recognise the impact that homelessness has on an individual's self esteem, motivation and coping skills. They carry out assessments, advocate for homeless people to help them access a range of services, offer ongoing support to homeless people who find it difficult to access mainstream services and provide a key working system for some individuals who remain socially excluded. The team undertake community care assessments on behalf of Adult Social Care (ASC) for homeless people who require residential or home care services. Their assessments are accepted by ASC because they know that they are familiar with the client group and are more able to do a realistic assessment and have a better understanding of their needs than a team social worker.

Q10. What do you think are the most important steps that the Government can take to reduce the inequalities that affect our mental health? And why?

We would like to see a commitment in the strategy to be working with other government departments to end rough sleeping among people with mental health problems by 2012 and to put in place accountability in Primary Care Trusts (PCTs) for homeless people with mental health problems. We would also like to see explicit commitments to address inequalities in access to mental health services and in particular psychological therapies for people with complex needs, people with a diagnosis of personality disorder and older people.

In relation to inequalities it is a shocking indictment that some of the people with the most complex and entrenched mental health problems end up sleeping on the streets without access to high quality mental health services. Tackling this problem effectively will equip practitioners with the tools to address other socially excluded groups. The strategy mentions that personality disorders are common among people in the criminal justice system, affecting 50 to 70 per cent of prisoners, research evidence shows that this percentage is very similar in

the homeless sector, yet the homeless sector is not mentioned. The strategy states that looked-after children are at five to six times increased risk of developing mental health problems, on average 14% of residents in homeless hostels have a history of being in care.

The document notes the high incidence of a diagnosis of psychosis among African Caribbean communities; this inequality has been known about for many years and yet persists. It is also well known that older people's mental health services are a Cinderella service and that people over 65 with depression and anxiety and other functional mental health problems receive a very poor service compared to working age adults. In the homeless sector we have evidence of the multiple needs of older people, with around 60% experiencing mental health problems, either depression and anxiety. or problems of a severe and enduring nature, often combined with substance dependence, poor physical health and other issues. It is imperative that these overt inequalities be addressed if we are to achieve a mental health service that can make claims that 'all individuals will be treated with respect in an inclusive society, whatever their age, background or circumstances.'

A recent example of a programme that does not enhance qualities is the huge amount of resources that have gone into the Improving Access to Psychological Therapies (IAPT) programme. We welcome the fact that there is an increased emphasis on access to psychological therapies but the fact that it is only accessible to working age adults and cannot be accessed by any one with a drug or alcohol problem means that older people and those with complex needs are discriminated against. In order to address inequalities there needs to be a commitment to expand access to psychological therapies to all client groups. We recognise there will need to be different models to offer such a service to people with complex needs, dual diagnosis, a diagnosis of personality disorder and older people but a commitment to reducing inequalities makes this an imperative.

Q11. How best can we improve a) the transition from child and adolescent mental health services to adult services, and b) the interface between services for younger and older adults? What works well in your local area?

The experience of our members is that the fact that CAMHS stops at 18 years old is difficult and damaging at a time when people need continuity of support in the transition to adulthood. There was a suggestion that CAMHS services should continue to the age of 25 years but there needs to be an awareness that this would involve safeguarding issues as treating young women in the same space as 25 year old men could pose difficulties.

Q12. In your view, what more should the Government do to combat stigma?

Addressing the stigma that people with mental health problems experience is an issue that members feel needs higher priority. Homeless people with mental health problems are stigmatised not only in relation to their homelessness status but also because of their mental health problems. It was suggested that there are lessons that can be learnt from New Zealand where there has been a television publicity campaign about mental health encouraging the public to think about their attitudes and what they contribute to the distress, which was apparently effective.

Stigma around mental health issues runs through every sector of society. Access to employment is one of the major factors that needs to be addressed so that all of us work alongside people who experience mental health problems. The government need to create incentives to encourage employers to employ people with experience of mental illness, e.g. if people need a more flexible employment pattern to compensate employers if employees need time off. The experience of going on and off long term benefits also needs to be considerably eased as this puts people off trying employment.