



Frontline agencies in partnership

Policy Briefing:

Mental Health

April 2009



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Introduction

Homeless Link is the national membership organisation for frontline homelessness agencies in England. Our mission is to be a catalyst that will help to bring an end to homelessness. Our two goals are to:

- Raise standards in the services that support homeless people and tackle homelessness
- Influence the development of policy, strategy and investment at all levels of government

The policy briefings have been developed to:

- Establish our policy lines on key issues affecting homeless people so that we can continue to discuss these with our members
- Provide members with information on a range of relevant subjects to help them influence decision making in their local areas.

Homeless Link policy work is guided by the frontline experience of our member agencies. This information is collected in a number of ways including through the National Advisory Council (NAC), a quarterly forum comprised of two member representatives from each of the nine English regions. Member agencies are encouraged to contact NAC representatives or Homeless Link staff to feed in their thoughts on current policy issues. For full details of the NAC please see:

<http://www.homeless.org.uk/aboutus/advisorycouncil>

Increasingly, policy decisions are being taken at a local level. These policy briefings therefore also aim to support members in developing their positions on a range of issues so that they can effectively lobby for changes that will help end homelessness in their local areas.

Each policy briefing has 4 sections. These provide information on:

- Background, facts and figures
- An overview of responsible bodies
- Latest government policy developments
- A selection of key issues and policy lines

This briefing is on mental health. Also in the series are briefings on drugs and alcohol; social housing; criminal justice, and; engagement, education, training and employment.

We look forward to receiving your feedback on these documents so that we can continue to develop our evidence base and policy lines in consultation with member organisations.

Definitions

Mental health problems get sub-divided into numerous categories, which can be very confusing and are not always useful. However it is useful to have some understanding of what is meant by them.

Organic and functional mental illness are terms used to refer to whether the mental illness is related to organic changes in the brain. Mental illness that results from brain impairment, e.g. Alzheimer's, is usually described as 'organic'; whereas non-organic mental illness, e.g. Schizophrenia or depression, is usually described as 'functional'.

Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms, which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as 'neuroses' are now more frequently called 'common mental health problems'. Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no-one else can. People experiencing psychotic symptoms are often diagnosed as schizophrenic.

The term **dual diagnosis** covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently, typically it is used to describe the combination of severe mental health problems and the use of illicit drugs or alcohol. Homeless agencies are more likely to use the term multiple or complex needs as this also captures chaotic and challenging behaviour, physical health problems and social exclusion commonly seen in conjunction with dual diagnosis.

Personality disorder is an ill defined condition. It is a collection of behaviours, many of which are very familiar to people working with the homeless population, for example a pattern of intense and unstable interpersonal relationships, frantic efforts to avoid real or imagined abandonment, impulsive behaviour that is potentially self damaging, chronic feelings of emptiness, inappropriate or uncontrollable anger. In the past the label often used to connote that mental health services deemed an individual was not treatable. This has changed in the last few years and services for people diagnosed with personality disorder are developing.

Mental health problems also tend to be sub-divided by the **type of treatment response**. The majority of presenting mental health issues are addressed at a primary care level. Where mental health problems are defined as 'severe and enduring' the person is likely to have their treatment managed by a specialist mental health service. Due to problems accessing mainstream mental health services homeless people sometimes present with mental health problems at Accident and Emergency departments or depend on voluntary sector hostel and day centre staff without specialist training to support them.

Background, facts and figures

Mental health problems can be a contributory factor that leads to homelessness. In particular, a high prevalence of childhood neglect and abuse is indicated in the homeless population and those experiences are a likely indicator of future mental health problems¹

Mental health problems can also be caused, or compounded, by the experience of homelessness and time spent in insecure accommodation and further compounded by poor access to services.

It is a particular characteristic of mental health problems experienced by people who are homeless that they have other complex needs, for example substance dependence, chronic physical health problems, and chaotic behaviour. Some people who are homeless have also developed a help shunning, rather than a help seeking behaviour as part of their mental health condition. 'A vicious circle operates whereby this group avoids services and the services avoid this group.'²

Hostel population

It is accepted that mental health problems are at least four times more prevalent in the homeless population than in the general population. Most research into mental health and homelessness shows that 30-50 per cent of homeless people experience mental health problems. The last survey³ in the UK to compare the health of a representative sample of the homeless population with a representative sample of the general population found that mental health problems were:

- eight times as high among people in hostels and B&B's
- eleven times as high among people sleeping rough

A more recent survey in a St Mungos hostel found levels of up to 85 per cent of clients with a personality disorder, around 40 per cent with an anxiety disorder and 25 per cent with a depressive disorder or Post Traumatic Stress disorder.⁴ However a national survey carried out in 2009 by Homeless Link and RIS of provision for single homeless people and couples, SNAP, found that in the average homelessness project 14 per cent of clients are affected by personality disorder.⁵

¹ Off to a bad start: A Longitudinal Study of Homeless Young People in London. T. K. J. Craig and S. Hodson. Mental health problems among homeless adolescents. 1996

² St Mungos (2008) Health Strategy for Homeless People 2008-2011

³ The health of single homeless people, Centre for Housing Policy University of York 1994. Wendy Bines

⁴ Homelessness it makes you sick. St Mungos Sept 2008

⁵ <http://www.homeless.org.uk/policyandinfo/research/mapping>

Rough sleeping

Thirty nine per cent of people contacted by outreach or building based services and/or arriving in accommodation in London recorded by CHAIN between April and June 2008 suffered mental health problems. Many of these people experienced a combination of mental health problems and alcohol and/or drug dependence.

Needs and access to services

SNAP⁶ showed that 94 per cent of projects report having clients with mental health problems and in an average project 32 per cent of clients have mental health problems. Sixty-one percent of projects reported having clients with personality disorders.

Diverse groups within homelessness

There are specific issues relating to mental health in different homeless client groups. There is not enough space to go into each group in this briefing but publications and organisations doing specific work with these groups do exist. Below are links to relevant publications or ongoing projects. Homeless women,⁷ young people,⁸ older people,⁹ BME groups¹⁰ and people who are diagnosed with a personality disorder.¹¹

⁶ ibid

⁷ Double Exposure - Addressing the needs of homeless women with a mental illness

http://www.scmh.org.uk/publications/publications_list.aspx?SortID=a

⁸ http://www.centrepoin.org.uk/documents/Centrepoin_MentalHealth&Homelessness.pdf

⁹ The Coalition on Older Homelessness at Homeless Link works to improve services for older homeless people. Findings of recent audits show that multiple health problems are a particular issue in the older population. <http://www.homeless.org.uk/policyandinfo/issues/older/auditsummary07/>

¹⁰ The London development Centre has a delivering race equality programme designed to reduce inequalities in how people from BME communities experience mental health services

<http://www.londondevelopmentcentre.org/faqs/delivering-race-equality.aspx>

¹¹ <http://www.borderlineuk.co.uk/>

1. Responsible bodies

The Department of Health has overall responsibility for the provision of mental health services. England directs 13.8 per cent of the health budget towards mental health.¹² Commissioning of Mental Health services is carried out by PCTs, Specialist Commissioning Groups, Mental Health Trusts, Partnership Trusts, some joint commissioning with Local Authorities and sometimes by Local Authorities themselves. A substantial part of the overall mental health budget is spent in the independent and third sector.

Primary care

Most mental health problems are treated by primary care services. 90 per cent of people who get help for mental health receive it through primary care services. Homeless people can find it hard to get registered with a local GP, and/or they lose touch with the services that know their past history. The SNAP survey showed that 94 per cent of clients had access to GP registration but that 18 per cent of clients had some problems accessing GP services.¹³ Where there are issues with GP registration continuity of care can be very difficult. Some areas with a high homeless population have specialist workers for homeless people within primary care teams or specialist primary care teams for homeless people, including mental health practitioners.

Secondary care

Access to secondary mental health services, for example, Community Mental Health Teams, assessment by a psychiatrist, or in-patient services is generally through primary care. The other route that homeless people may present via is Accident and Emergency, or by being sectioned but neither are the most appropriate way of accessing a mental health assessment.

In some areas where there is no specialist homeless mental health team and where access to primary care is limited, homelessness and mental health agencies can agree a local referral protocol, which allows direct referrals to mental health services by homelessness agencies.

Specialist services

In addition to primary and secondary care services and specialist homeless mental health teams there are other specialist statutory health services, assertive outreach, forensic services and dual diagnosis teams. However there are few services for people with personality disorders who continue to

¹² WHO report 'Policies and practices for mental health in Europe - meeting the challenges', 2008

¹³ <http://www.homeless.org.uk/policyandinfo/research/mapping>

use drugs or alcohol, who make up a significant percentage of the hostel/rough sleeper population.¹⁴

Supporting People

Supporting People (SP) is the funding stream through which housing related support is funded which complements existing care services or wholly funds the support for people across a number of client groups. Single homelessness and mental health are two of the biggest areas of spend in the Supporting People budget and there is considerable overlap in the two areas. People with mental health problems might be living in a hostel or specialist supported accommodation or in their own home and receiving floating support. All would be funded by SP. The Supporting People budget has been ring-fenced so local authorities have only been able to spend that money on housing related support. This is changing and from 2010/11 it will be part of the area-based grant, for the transitional period 2009/10 it is a specific named grant but there is more freedom in how it is spent. It is not yet clear how these changes will impact on homeless people and people with mental health problems.

Voluntary sector

The voluntary sector runs a whole range of services for people experiencing mental health problems including day centres, floating support teams and supported housing. Some areas will have a specific directory of local mental health services. Find out through your local MIND¹⁵ or the Mental Health Providers Forum.¹⁶

Social services

Social services, run by the county council or unitary authority, also have a statutory role to assess and deliver Community Care Services to people with mental health problems where the person 'appears to need services'. Health and social services usually make joint arrangements, both agencies working together to arrange, fund and/or manage services. The Social Services system is called Care Management and the mental health system is the Care Programme Approach (CPA). Anyone needing to go into residential care will need to be assessed and funded by social services.

¹⁴ <http://www.ucl.ac.uk/gheg/marmotreview/stmungoshealth>

¹⁵ <http://www.mind.org.uk/Mind+in+your+area/>

¹⁶ <http://www.mhpf.org.uk/>

Housing departments

Local authority housing departments also play a role in assessing the impact a person's mental health problems may have on their ability to find and keep housing. People with mental health problems can be considered vulnerable and therefore in priority need under the homelessness legislation. Housing authorities should make this assessment in close co-operation with social services, mental health services and other agencies that an applicant has been in close contact with.

2. Government policy

In relation to central government the most significant intervention around homelessness and mental health was the Homeless Mentally Ill Initiative. This was launched in 1990 by the DH and consisted of four teams in London to identify and offer treatment to homeless people with mental health problems not in touch with statutory services, specialist hostels to move clients into providing a high level of care and move-on housing provided by the Housing Corporation. One of the main findings of the Evaluation of the Homeless Mentally Ill Initiative¹⁷ was that in order to work effectively with homeless people with mental health problems it was imperative to be able to offer housing solutions as well as mental health interventions and either one on their own was not effective. The initiative was later extended to some cities outside London. The specialist funding no longer exists but some of the services continue and are funded through mainstream funding. The model of specialist mental health services for homeless people is one that has been replicated in many areas.

Mental health Legislation¹⁸

The Mental Health Bill to amend the 1983 Mental Health Act completed its parliamentary stages and has become the Mental Health Act (MHA) 2007, which came into force in November 2008. The main provisions are:

- A new broad definition of mental disorder and the removal of most exclusions from the coverage of the MHA 1983
- The 'treatability test', i.e. that compulsory powers such as detention for treatment in hospital can only be used if the treatment the person is to be given in hospital is likely to "alleviate or prevent a deterioration" in their condition has been replaced by a requirement that "appropriate treatment is available which is appropriate in his case, taking into

¹⁷ Craig T, Bayliss E, Klein O, Manning P and Reader L (1995) The homeless mentally ill initiative: an evaluation of four clinical teams

¹⁸ <http://mhact.csip.org.uk/>

account the nature and degree of the mental disorder and all other circumstances of his case " for the patient concerned. The new test applies to all the long-term powers of detention. The concern expressed about this change is that appropriate treatment needs to be available the purpose of which is to relieve symptoms rather than there being a burden of proof that the treatment is likely to be effective.

- Supervised community treatment will be created through the introduction of a new Community Treatment Order for certain patients. The idea of this is that patients who would be detained in hospital can be treated in the community under Supervised Community Treatment but if things start to go wrong and they do not attend appointments they can be recalled to hospital, and if they are considered a risk to themselves or others, can be treated compulsorily in hospital.
- New safeguards have been introduced, including a provision for advocacy and amendments to the provisions for displacing and appointing nearest relatives
- The roles of approved social worker and responsible medical officer will be replaced by new roles which will be open to a wider range of professionals
- Provision will be made for powers to reduce the time limits for the automatic referral of some mental health patients to the Mental Health Review Tribunal

Aftercare

Section 117 of the Mental Health Act 1983 is still in force and concerns the provision of aftercare for patients who have had a period of compulsory hospital treatment. If a person is homeless or can't be expected to return to where they previously lived, accommodation should be arranged for them, probably in a hostel, care home or other supported housing, as part of the section 117 aftercare plan. If they have been a voluntary in-patient the Care Programme Approach (CPA) see below) should apply and their housing needs should be planned for if they are in need of care and attention in their accommodation.

Services will only be provided under CPA if the person is assessed as 'needing' them, and if it is 'necessary to provide them'. The final decision as to 'need' rests with health and social services. If the person is entitled to section 117 aftercare their position is stronger but even here it is up to health and social services to decide what the aftercare package includes.

Care Programme Approach

In March 2008 new guidance was produced about the application of the Care Programme Approach. The CPA used to apply to everyone in touch with

secondary mental health services, recent changes have been introduced abolishing the standard level of CPA and putting the enhanced CPA in place for a more restricted group of people.

The new guidance has an increased focus on people who are homeless. For those in the care of secondary mental health services, the insecurity that comes with homelessness, and the complexity of delivering care, are risk factors in themselves sufficient to warrant a full CPA care plan.

Government policy now requires health and social services to completely integrate the CPA and Care Management for people with mental health problems. This means that Community Care Assessments and CPA assessments are carried out as a single assessment for users of mental health services. There will be a single care plan setting out how health and social services will meet the service user's needs. The plan will set out the community care services and community mental health services the service user will receive. Services from the NHS are free, community care services are means tested and may be charged for. The key worker is now known as the 'care co-ordinator'.

Shortly to be introduced is the Common Assessment Framework (CAF) which brings together and builds on the current Single Assessment Process (SAP) for older people and the Care Programme Approach (CPA) in mental health. CAF aims to improve outcomes for all adults with complex, longer-term health and social care needs. Its unified approach is designed to be helpful to those who previously had to deal with separate health, social care and other support systems. The consultation on the CAF has recently closed but details can be found on the DH website.¹⁹

Public Service Agreements and Local Area Agreements

There are 30 Public Service Agreements, these set out the top priorities of the government and are the basis of the Performance management framework for local authorities. PSA 16 concerns ensuring access to and maintenance of settled accommodation and employment for four groups considered to be at risk of social exclusion. Adults in contact with secondary mental health services are one of these groups. Underneath the broad PSA's are a National Indicator set which are the means of measuring the national priorities that have been agreed by Government. NI150 is concerned with the number of adults in touch with secondary mental health services in employment. This indicator has been chosen as a priority by 30 out of 150 authorities. National Indicator 149 is concerned with the number of adults in touch with secondary mental health services in settled accommodation. This has been chosen as a priority by 9 out of 150 authorities.

¹⁹ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_093438

Joint strategic needs assessments

Other recent changes include the duty, from April 2008, on upper-tier/unitary local authorities and Primary Care Trusts (PCTs) to carry out Joint Strategic Needs Assessments (JSNAs). This involves identifying the health and well being needs and inequalities of the local population, including both current and future needs. In the short term (3-5 years) JSNAs will inform Sustainable Community Strategies and Local Area Agreements , and in the longer-term (5-10 years) they are intended to inform strategic planning. Homeless Link has been funded by the DH to develop a tool to identify the health needs of homeless people in nine regions and to inform the JSNA's with the aim of improving the response of health services to homeless people.

Rough sleeping

The new rough sleepers strategy 'No One Left Out'²⁰ recognises that rough sleepers with multiple needs, often including mental health problems, draw on a lot of resources but often fail to get effective help and that finding solutions requires intensive and often long-term support from a range of partners.

The strategy commits to developing street audits to develop better information about the needs of people on the streets. In London a commitment is made in the strategy to work with London PCT's and boroughs to ensure appropriate health services are commissioned to meet the needs of rough sleepers. Within the strategy it is recognised that many rough sleepers, particularly drug users and those with chaotic behaviour, have an underlying history of childhood trauma and neglect. It commits the DH and CLG to jointly exploring this issue and identify evidence of effective interventions from the UK and internationally. It also commits to looking at training and support for hostel workers on this issue.

The new rough sleeping strategy states that work will be done with the Department of Health to gather data that can strengthen the case for commissioning better planned and integrated services and that a comprehensive health and homelessness website and interactive resource will be developed for people involved with the provision or commissioning of services.

The strategy has been criticised for failing to address adequately 'the regrettable situation whereby vulnerable members of society suffering from severe mental illness are sleeping rough.' St Mungos, one of the largest homelessness charities, along with others, have delivered a petition to the prime minister and are calling on the Government for an urgent plan to

²⁰ <http://www.communities.gov.uk/documents/housing/pdf/endingroughsleeping>

address this and to ensure the resources are there to turn rhetoric into reality.²¹

Access to services for homeless people

The DH and CLG have produced a useful guide 'Getting through - Access to Mental health services for people who are homeless or living in temporary or insecure accommodation.'²² The DH Housing LIN has published a guide²³ (November 08) called Understanding Homelessness and Mental Health. This is intended primarily for providers of mental health services to enhance their capacity to work with the homeless population and increase their understanding of the issues. It is a helpful guide and at every point encourages better joint working with the homeless sector and the professionals that have close contact with homeless clients with mental health problems.

Personality disorder

In the past a diagnosis of personality disorder was considered untreatable and put people outside services. This situation has changed. '*Personality disorder: no longer a diagnosis of exclusion*'²⁴ was issued by the Department of Health in 2003. It encouraged all Trusts delivering mental health services to consider how to meet the needs of patients with a personality disorder with the aim of enabling people with a personality disorder to get appropriate clinical care and management from specialist mental health services. There is now a National Personality Disorder Programme, which promotes information on innovative psycho-social approaches that promote personal recovery, is mapping services around the country, disseminating research and useful resources and helping to develop improved services.

In January 2009 The National Institute for Health and Clinical Excellence (NICE) has called on mental health trusts to establish specialist, multi-disciplinary personality disorder services. The recommendation is one of many to be found in two newly published NICE guidelines on the treatment and management of borderline personality²⁵ disorder and antisocial personality disorder.²⁶ These new guidelines are to be welcomed, they are useful documents and should be used by homelessness agencies working

²¹ http://www.mungos.org/press_office/265_st-mungo-s-response-to-the-government-s-rough-sleeper-initiative

²² <http://www.socialinclusion.org.uk/publications/Gthroughguide.pdf>

²³ http://networks.csip.org.uk/_library/Resources/Housing/Support_materials/Briefings/Briefing24_Homelessness.pdf

²⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009546

²⁵ <http://www.nice.org.uk/Guidance/CG78>

²⁶ <http://www.nice.org.uk/Guidance/CG77>

with this client group to make the case locally for increased support for those individuals.

ACE pilots - Adults facing chronic exclusion

The Cabinet Office is running a £6 million programme of 12 pilots working with chronically excluded adults. A number of these include homeless people with long-term mental health problems. It is hoped that these pilots will provide some valuable lessons about working with this client group. The final findings of the evaluation of these pilots is due to be published in the Summer of 2010.

Psychology services

Increasing Access to Psychological Therapies (IAPT) is a new government programme aimed at massively increasing access to Cognitive Behavioural Therapy through GP surgeries for people with mild to moderate depression in the general population. Treatment for homeless people remains problematic to access. SNAP showed that although over 90 per cent of projects had access to community mental health services and other talking therapies around one half of projects found talking therapies problematic to access and over 80 per cent of those projects felt that the external services provided were inadequate.²⁷ There is activity stimulated by this new funding stream, which may make it more relevant to homeless people. The London Development Centre has commissioned Turning Point and their partner organisations to deliver a programme of capacity building, organisational training and development to six third sector organizations. The aim is to improve commissioners' confidence in the third sector and showcase its ability to deliver effective IAPT contracts. The involvement of third sector organisations increases the likelihood of service delivery reaching the homeless client group.

3. Issues and policy lines

In general Homeless Link recognises that mental health is linked to a person's wider environment and life experience. We argue for more holistic approaches that recognise the need to bring together effective treatment, good quality housing and opportunities to build resistance and recovery.

²⁷ <http://www.homeless.org.uk/policyandinfo/research/mapping>

Ending rough sleeping and the rough sleeping strategy

People who sleep rough who experience mental health problems can be the most complex section of the population to reach and to offer positive alternatives to. The rough sleeping strategy 'No One Left Out' commits to supporting better coordination of local voluntary and statutory services, including mental health services, so that their expertise and resources can be directed to people who are sleeping rough.

Ending rough sleeping by 2012 will require reducing to zero the number of people with mental health problems sleeping rough. Homeless Link believes that this must include: an increased focus and increased investment in specialist services outreaching to homeless people with mental health problems; improved access to mental health services for the hostel population; and an increased understanding and access to high quality training around mental health for people working in the homeless sector.

Multiple needs and dual diagnosis

Homeless agencies frequently report difficulty in getting the mental health problems of their client group recognised and in getting access to services. Multiple needs, particularly mental health and substance use problems, and personality disorder in combination, continue to make treatment problematic. Guidance is clear that the management of dual diagnosis should be integrated into psychiatric pathways and local commissioning and that services for people with personality disorders should be developed. However, mental health services continue to experience difficulties engaging people in treatment who also have drug and alcohol problems and chaotic behaviour. These individuals simultaneously find it hard to get treatment from substance misuse services because of their mental health problems. Additionally statutory services can tend to use non-engagement by the client as a reason to close a case. This often leaves the voluntary sector coping with those with multiple needs. Non-engagement is one of the fundamental problems of this client group and needs to be one of the issues statutory agencies are working with.

'Clients with complex needs' - a resource book on inter-professional practice'²⁸ identified a fundamental problem as a lack of information about overlapping populations and shared patients who are problematic between different agencies. It promotes ideas of shared data and shared practice with shared clients and is a useful illustration of the barriers to working with this client group and the solutions.

²⁸ Clients with complex needs - Inter-professional practice J. Keene 2001

Homeless Link will support the initiatives outlined in the strategy 'No-One Left Out'. We will work towards getting the needs of homeless people with multiple needs recognised in the National Service framework for Mental Health and to encouraging the delivery of mental health services in a way that works for homeless people with multiple needs. This will include the active engagement and joint delivery of services by primary care, secondary and specialist mental health services, drug and alcohol services, criminal justice and social services, all of whom have an important role to play in helping homeless people access appropriate mental health services.

Mental Health Act 2007 and supervised community treatment

A Mental Health Alliance, made up mainly of voluntary and user led organisations, but with the support of some mental health statutory providers, led a sustained campaign to remove new compulsory treatment in the community from the legislation. This did not succeed and the new system of supervised community treatment is now law. The result of this is that following a period of detention in hospital people can be discharged from hospital care on a community treatment order. If they don't comply with the treatment in the community, for example stop taking medication, or stop seeing a nurse they can be compulsorily recalled to hospital. A condition for everyone on a CTO is that they make themselves available for a medical examination when needed to consider whether the CTO should be extended. The idea behind the provision is that it will help to address the issue where some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again - the so called 'revolving door'. The Mental Health Alliance has stated that 'the powers must be used proportionately and sensitively if they are to benefit people with mental health problems' and have expressed concerns about how these new powers will work.²⁹ The main concerns are:

- That those in charge of discharge decisions will act defensively and overuse Supervised Community Treatment as a precautionary measure.
- That the powers will lead to an over-reliance on drug treatments as the only readily available treatment that can be enforced effectively.
- That the capacity to impose Supervised Community Treatment will damage the trust that should be inherent in a therapeutic relationship.

There are safeguards built into the Act about when and how compulsory treatment is used and a right to an independent mental health advocate for anyone subject to the Act.

²⁹ <http://www.mentalhealthalliance.org.uk/aboutus/index.html>

In relation to the role of hostel workers the main implication may be that a resident could have conditions attached to his/her Community Treatment Order which the hostel are expected to monitor and to contact a care co-ordinator if they are breached. This could then prompt recall of that person to hospital. For details of the provisions in the Act see the Mind website³⁰ and for a practitioners guide to the act see the Mental Health Act website.³¹

Homeless Link will encourage agencies working with homeless people to monitor the new provisions of the 2007 Mental Health Act and the impact on the client group.

Access to advocates is important and homelessness agencies should ensure that homeless people understand how to access and use the advocacy service described in the Act.

Homeless Link believes that better access to mental health services for homeless people is vital, but that compulsion is generally antithetic to a therapeutic relationship and should be avoided except in very restricted circumstances.

Care Programme Approach

A number of changes have recently been made the CPA and there are plans to link it to adult social care via the Common Assessment Framework (see section 3).

Homeless Link welcomes the increased emphasis in the CPA guidance on insecure housing but has concerns that removing the standard CPA represents a cut in services and a move away from preventative work. As a result there is a danger that more people may fall through the net and potentially into homelessness.

We will monitor along with our membership, the effectiveness of the new CPA. We will aim to ensure that housing issues are fully examined in the Common Assessment Framework.

Supporting People

From 2010 Supporting People will no longer be a ring fenced fund but part of the Area Based grant paid to local authorities. A transition arrangement

³⁰ <http://www.mind.org.uk/Information/Legal/MHAlawbriefing2.htm>

³¹ <http://mhact.csip.org.uk/>

will remove the ring fence from April 2009. The funding changes open up opportunities to respond more holistically to need. There will potentially be increased capacity for joint working with mental health and a breaking down of some of the barriers imposed by the limitations of SP housing related support. However there is concern about what impact this will have on politically unpopular client groups such as homeless people with mental health problems.

Supporting People has been a successful programme and vital to the continuing development the homeless sector and to improving the lives of homeless people. Homeless Link has expressed concerns that funding could flow away from services for homeless people to those with greater statutory protection once the ring-fence is taken away from Supporting People. We are calling for strengthened monitoring of the impact of the changes over the next three years in local areas to ensure that socially excluded and homeless people are protected. We will work with member agencies to prepare for the change and to develop more joined up services for people who need more holistic support.

Psychology Services

Psychological therapies include services such as psychodynamic approaches, cognitive behavioural therapy (CBT) and counselling.

Currently there is limited access to psychological therapies for homeless people and limited support for front line staff from psychology services. There is increasing evidence of the high prevalence of neglect and abuse in childhood among the homeless population. The new rough sleeping strategy states that the DH and CLG will carry out work to further explore this link and to identify effective interventions.

Homeless Link will encourage work done to further understand the link between childhood trauma and neglect and homelessness. We will promote recognition of the training needs of staff and the need to make training available in therapeutic relationships and psychological and other psychosocial interventions.³²

We will encourage improved collaborative working across housing, health and mental health and joint arrangements for training and supervision. We support an expansion of counselling services across the country accessible to homeless people.

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<http://www.homeless.org.uk/developyourservice/moving/therapies/Therapy%20and%20homelessness.pdf>

Case study

Counselling service

Westminster Primary Care Trust runs an award winning counselling service for homeless clients. It allows 'critical' clients to be slotted in for a holding assessment without delay, maintaining counseling whilst clients are going through the housing process from homelessness. The service is very versatile in its approach in coping with other issues, e.g. housing, debt, addiction. The acceptance it has received from NHS colleagues represents a major achievement. The evidence of effectiveness is strong, and the audit of how people have fared after using the service demonstrates that the service has used innovation to create positive change in a number of lives.³³

Case study

Psychological interventions

A West Midlands pilot project is using some of the Increasing Access to Psychological Therapies money for a pilot on 'psychological mindedness' in the homeless/ supported housing sector. This initiative aims to develop, promote and enhance the psychological intervention and therapeutic support skills of housing staff and housing related support staff working with people experiencing mental health difficulties.

Front line housing staff, staff within housing, supported housing, generic tenancy support and homelessness services do a great deal to support people with mental health problems to help sustain them in community settings and yet appropriate links are rarely formed with mental health services where there is expertise to support the work.

Contact : Joe Z Mairura
PD & Service Improvement Lead CSIP East Midlands

Public Service Agreement (PSA) 16 and Joint Strategic Needs Assessments

The homeless sector has welcomed a PSA on social exclusion but would have liked to have seen a focus on homeless people with multiple needs who are not currently in touch with statutory services. While this group is not directly covered by the PSA there is an acceptance from government that actions taken under the PSA should help to further develop services for this group.

One of the positive spin offs from these national indicators on mental health is that there is action at a government level on issues like collecting data in

³³ <http://handbooks.homeless.org.uk/daycentres/individuals/therapeutic>

a way that captures housing status. For example, the mental health minimum data set will now collect data about housing status and reports on delayed discharge from hospital will acknowledge issues around availability of supported housing. Homeless Link have been involved in discussions about measuring mental health inequalities and capturing data on housing status and we will continue to feed into this process.

The minimum data set for the JSNA does not identify people who are experiencing homelessness so data about people who are homeless will have to be actively sought in local areas. Agencies working with homeless people are encouraged by Homeless Link to make contact with those in their area responsible for the JSNA and feed in their data to the process. Homeless Link has funding from the Department of Health to develop a tool to collect health information about homeless people and find ways to feed that into JSNA's locally.

Through the Making Every Adult Matter (MEAM) Coalition³⁴, Homeless Link will continue to make the case that the current PSA does not cover homeless people and others with multiple problems that are not in contact with statutory services.

We will work towards having a social exclusion PSA that covers homeless people with multiple needs, including those with mental health issues who are not in touch with secondary mental health services. We will also work to capitalise on the opportunities provided by PSA 16 to improve access to services for the client group in contact with secondary mental health services.

We will work for better monitoring of housing status by health services, in order to make the case that homeless people make a disproportionate demand on mental health services and therefore need improved access to more appropriate services.

Work and Meaningful Occupation

There is increasing evidence that employment and meaningful occupation are central to the mental health recovery process, and there is evidence that work is a preventive factor in clinical depression, but currently only 20 per cent of adults in secondary mental health care are in paid work.

There is also evidence that self esteem, ability to assert oneself and to interact socially are built through meaningful activity other than work, creative activities, arts, gardening and outdoor pursuits.

Recent research by Broadway³⁵ looking at factors in successful resettlement

³⁴ MEAM is a coalition of Clinks, Drugscope, Homeless Link and Mind

³⁵ <http://www.broadwaylondon.org/ResearchInformation/Research/LongerTermOutcomes>

of homeless people found that eight in ten respondents were in work, education or training, and half of respondents rated work or college as one of the best things in their lives.

‘No one left out’ the government rough sleeping strategy commits the Department for Work and Pensions, the CLG and the Department of Innovation, Universities and Skills (DIUS) to working together to ensure people who move away from the streets get the targeted help they need to find and keep a job.

The Places of Change agenda is supporting hostels throughout the country to prioritise access to training learning, employment and meaningful occupation opportunities for homeless people. We will work to ensure that these opportunities are equally open to people experiencing mental health problems.

However it is also equally important that the agenda around employment is flexible and that in addition to employment opportunities there are structured meaningful activities, which do not have a relationship to paid employment, open to people who are not yet ready for work.³⁶

A national health strategy for homeless people

A very significant proportion of the homeless population experiences mental health problems, and a range of other complex health problems. There is no national health strategy for homeless people and the issues are dealt with in a piecemeal way with enormous local variation in available services. At PCT level there is no clear contact point for homeless agencies.

Homeless Link will continue to make the case to central government for a national health and homelessness strategy and for clear points of access at a local PCT level for agencies working with homeless people to register the issues that need to be addressed to improve the health of the homeless population.

³⁶ See forthcoming COHP work on Meaningful Activity on www.homeless.org.uk

Homeless Link is the national membership organisation for frontline homelessness agencies in England. Our mission is to be a catalyst that will help to bring an end to homelessness.

Our two goals are to:

- **Raise standards in the services that support homeless people and tackle homelessness**
- **Influence the development of policy, strategy and investment at all levels of government.**

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