



HOMELESSNESS, MENTAL HEALTH AND WELLBEING GUIDE

**SECTION TWO:
UNDERSTANDING HOMELESSNESS,
MENTAL HEALTH AND WELLBEING**

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2.1 What is mental health and wellbeing

2.2 Homelessness and mental health: key statistics

2.3 Common diagnoses among homeless people

2.4 Understanding treatment and support options

2.5 Street homelessness and mental health

2.1 UNDERSTANDING MENTAL HEALTH AND WELLBEING

Nearly 70% of people accessing homelessness services state they have a mental health issue of some kind. Poor mental health is both a cause and consequence of homelessness. Understanding what we mean by mental health and wellbeing can improve our working relationship with clients and external agencies, it can also help to reduce stigma and help staff to feel more confident about supporting individuals with various needs.

A high proportion of people within services will need support with a range of issues, from mild depression and anxiety to severe and enduring issues such as schizophrenia. As government policy states, there is: **“no health without mental health”**

Thinking about mental health in a similar way to how we view physical health problems can be useful when approaching how to support people. Mental, like physical health issues exist on a continuum of severity and are interlinked. The severity of the issue, the impact it has on our lives, the treatments available, as well as individual responses to poor health of any kind, are varied and complex. Remember that people can and do make full recoveries from mental ill health. The key definitions of mental health and wellbeing as well as common diagnosis and the symptoms are outlined below. Gaining an understanding of these terms will enable you to respond effectively to clients needs and get the right referrals to external services for the people you support.

USEFUL DEFINITIONS OF MENTAL HEALTH

The World Health Organisation

“A state of complete physical, mental and social wellbeing, and not merely the absence of disease. It is related to the promotion of wellbeing, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.”

A mental illness is a psychological or behavioural pattern that someone experiences which causes them distress or disability.”

The Mental Health Foundation

“Being mentally healthy doesn’t just mean that you don’t have a mental health problem. If you’re in good mental health, you can:

- *Make the most of your potential*
- *Cope with life*
- *Play a full part in your family, workplace, community and among friends*

Some people call mental health ‘emotional health’ or ‘wellbeing’ and it is just as important as good physical health.”

Mind

“You care about yourself and you care for yourself. You love yourself, not hate yourself. You look after your physical health – eat well, sleep well, exercise and enjoy yourself.

You see yourself as being a valuable person in your own right. You don’t have to earn the right to exist. You exist, so you have the right to exist.

You judge yourself on reasonable standards. You don’t set yourself impossible goals, such as ‘I have to be perfect in everything I do’, and then punish yourself when you don’t reach those goals.”

UNDERSTANDING MENTAL HEALTH

Understanding the difference between severe mental illness and more common diagnoses can help us to support clients (table one overleaf outlines these definitions). If someone has a serious mental illness it does not necessarily mean they have poor mental health, as they may have found appropriate ways to treat and cope with the illness. Many individuals can have a serious mental illness and manage their lives well, taking appropriate medication and seeing doctors regularly to help them manage their illness. Other individuals may not have a diagnosis of any kind, but are making extremely unwise choices that are having a negative effect on their wellbeing resulting in poor mental health. In both instances support will need to be in place to help that individual within homeless services. Using the outcome star, a tool developed for effective key working can support this process. To access this tool visit: <http://homeless.org.uk/outcomes-star>. Axis 7 (shown below) of the star can help us to understand this more:

7. Emotional and mental health

This ladder is about how you are feeling. How aware you are of your emotional health, how often you feel low, depressed, stressed or anxious or experience panic attacks. Is self-harm an issue for you? You may have symptoms of post-traumatic stress or a diagnosed or suspected mental health issue that needs medication or treatment. This journey is about how aware you are of these issues and how well you manage them.

Where are you on your journey?



TABLE ONE: DEFINITIONS

This table outlines terms and definitions within the mental health field. It also outlines some important aspects of mental health and the law¹. Having an understanding of this terminology can inform our work and support clients.

TERM	MEANING	ADDITIONAL NOTES
Common mental illness	This term refers to mental distress rooted in 'everyday' human emotions, but when they become unmanageable or difficult for an individual. Reality and insight are retained, but responses can still be extreme and distressing for individuals.	This includes problems such as depression, anxiety and phobias.
Mental illness/ mental disorder – sometimes called severe mental illness (SMI)	<p>This includes diagnoses such as schizophrenia, bipolar, drug induced psychosis. It refers to diagnoses that mean people's experiences are outside of 'normal or everyday' human experience; it can mean someone's reality is changed and insight is lost.</p> <p>Diagnosis of a SMI can only be issued by a qualified professional in the field. They use the DSM-IV statistical diagnostic manual to guide their diagnosis. Having a severe mental illness diagnosis means individuals will get support from statutory services.</p>	DSM-IV is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. (Version V is likely to be out soon, but this is a highly contentious manual with serious consequences) It works across 5 areas and more information can be found here: http://allpsych.com/disorders/dsm.html
Wellbeing	A term used more and more to talk about a holistic wellness, both physical and mental. Public policy currently tries to measure wellbeing within society to improve practice. Improving wellbeing can include looking at exercise, social networks and social inclusion for example.	See definitions from various organisations above. Also see New Economic Foundation for more information: http://www.neweconomics.org/programmes/wellbeing
Psychiatry	This is a branch of medicine that specialises in treating mental illness.	
The Mental Capacity Act (2005)	The Act states that everyone should be treated as able to make their own decisions until it is shown that they are not. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problem, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity. The act safeguards both individuals and professionals and carers.	For more information on the mental capacity act: http://www.nhs.uk/CarersDirect/moneyandlegal/legal/Pages/MentalCapacityAct.aspx For useful training regarding mental incapacity: issues in supported housing, download Lemos and Crane's free briefing: http://lemosandcrane.co.uk/home/index.php?id=213501&emailid=2:82:0
The Mental Health Act (1983, amended 2007)	The amended Mental Health Act came into force in England and Wales in 2007. The act allows people with a mental disorder to be admitted and detained in hospital against their will and be given treatment to alleviate symptoms to prevent harm to themselves or others.	People may be admitted to hospital under different sections of the Act. People can either be voluntary (informal) or involuntary (formal) patients.

¹ Definitions adapted from the mental health Care website, for more details see: http://www.mentalhealthcare.org.uk/mental_health_act. In addition, the *Happy, health sorted tool kit* produced by the Foundation Foyer and definitions also adapted from the MIND website were extremely useful in putting this resource together.

<p><u>Sections of the mental health act</u> Civil (compulsory) admission to psychiatric hospital</p>	<p>When someone lacks capacity and they are in fact causing an immediate risk to themselves or someone else they can be admitted to hospital against their will. Individuals can also make a voluntary admission if they feel they or someone else may be at risk.</p>	<p>Section 2 is an assessment order. Under section 2 an approved mental health professional or someone's nearest relative can apply for someone who has a mental disorder to be admitted to hospital. If admitted under section 2 one can be detained for up to 28 days for assessment and treatment and it cannot be renewed.</p> <p>Section 3 is a treatment order. This allows people who have a mental disorder to be admitted for treatment for up to 6 months if appropriate treatment is available. Again an approved professional or a nearest relative can apply for admission and two doctors have to agree.</p> <p>Section 4 can be used in an emergency if someone is causing harm to themselves or others and there isn't time to use section 2 or 3. People can be admitted for up to 72 hours.</p>
<p>Aftercare</p>	<p>If people are detained under section 3 of the Mental Health Act there is a duty of care to provide aftercare support.</p>	<p>Section 117 is the section of the Mental Health Act which states that in the case of persons who are detained under certain treatment orders, the primary care trust and local authority have a duty to provide aftercare services, in co-operation with voluntary agencies, until such time as they are satisfied that the person is no longer in need of such services. This can be extremely useful for ensuring people get the right level of support.</p>
<p>Police powers</p>	<p>The police have certain powers to take someone from a public place or a private residency to a place of safety for health and safety reasons.</p>	<p>Section 136 this part of the Mental Health Act allows people to be removed from a public space and held for up to 72 hours, usually in a hospital to prevent harm. They may then be held under section 2 or 3 or discharged.</p> <p>Section 135 allows police to gain entry into someone's premises to allow assessment under the Mental Health Act. A warrant from the magistrate's court is required for this power to be used.</p>
<p>Community treatment orders (CTOs)</p>	<p>A legal order that allows a patient to be discharged from formal detention onto supervised community treatment i.e. receive treatment in the community.</p>	
<p>Approved mental health professional (AMHP)</p>	<p>These are professional such as social workers, psychologists, doctors and nurse who can make the decision that someone can be detained under the Mental Health Act.</p>	<p>AMHPs undergo specific training and should always seek alternatives to hospitalisation.</p>
<p>Safeguarding vulnerable adults</p>	<p>Individuals with mental health issues can be victims of abuse and mistreatment. If you feel someone is at risk, safeguarding vulnerable adult powers can be another route to gain statutory support if someone is at risk</p>	<p>London's multi-agency task group has recently reviewed: <i>Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse</i>. To read more visit: http://www.scie.org.uk/publications/reports/report39.asp</p>

Useful resources for understanding the law and mental health

Lemos and Crane published an 8 page briefing written by Dr Helen Carr on Mental incapacity: issues in supported housing. This document is free to download if you register on their website at <http://lemosandcrane.co.uk/home/index.php?id=213501&emailid=2:82:0>.

Dr. Carr looks at how the Mental Capacity Act works, assessing capacity under the Act, acting in someone's best interests and under what circumstances a mentally incapacitated person may lawfully be restrained. They also offer online training resources that can up-skill staff.

2.2 HOMELESSNESS AND MENTAL HEALTH: KEY STATISTICS

Our recent research into the health needs of homeless people, the Health Needs Audit (2011), indicates that:

Seven out of ten homeless people experience mental distress, compared to one in four of the general population

The connection between homelessness and mental health issues is complicated, it has been found to be both a cause of long term rough sleeping as well as a symptom of the experience of becoming and remaining homeless. There are complex associations with issues such as trauma in childhood, drug and alcohol misuse, domestic abuse, violence, and neglect and relationship breakdown.

Mental health issues have had a long association with stigma and discrimination, therefore homeless people with mental health problems run the risk of being multiply excluded and falling between the cracks in services. Individuals' wellbeing can be seriously affected by the experience of being homeless and people who have less resilience to ensure they protect their own wellbeing may be more likely to become homeless. It is therefore crucial that all homelessness services have a full understanding of the current levels of need relating to mental health and wellbeing and know how to respond effectively. Homelessness services play a key role in promoting good mental health and wellbeing across all the work they do, as well as ensuring that if mental health becomes unmanageable for an individual they can access the help and support they require in a timely way.

HEALTH NEEDS AUDIT

Through the health needs audit that took place this year (2011), we spoke to more than 900 people from hostels, day services and those in contact with outreach teams. This revealed that:

Levels of need

- 72% of clients said they had one or more mental health need
- 45% said they had one or more long-term mental health need (61% of all those with a mental health need)
- 35% of those with a mental health need said that they would like more support with their mental health
- Other research also found that 60% of people in homelessness services have been found to be affected by complex trauma or personality disorder.

Currently

- 44% of those with a mental health problem said they self-medicate with drugs or alcohol
- 14% of clients stated that they self-harm, compared with 4% of the population
- One fifth of clients who had recently attended A&E had done so because of either mental health or self harm
- Only 10% of clients have additional support from mental health services

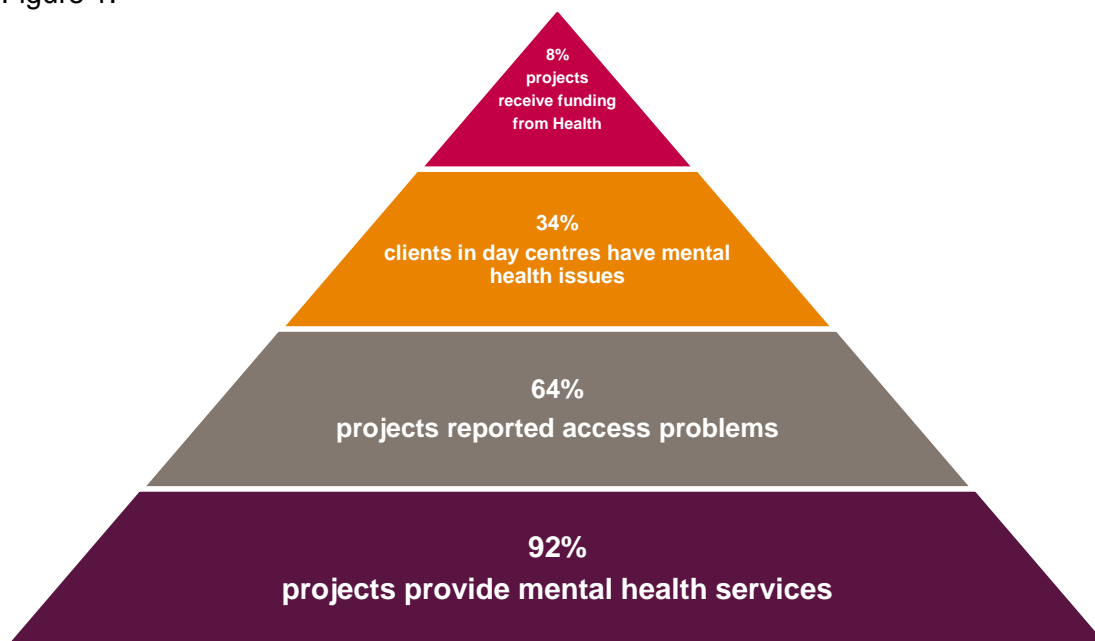
The table on the following page summarises the findings regarding mental health diagnosis, comparing the needs of homeless people with those of the general population. This table may assist you when trying to make a case for homeless and mental health services to work more effectively together. For further information on how the health needs audit can help you to influence commissioning decisions, see: <http://homeless.org.uk/health-needs-audit>.

	General population	Homeless population
% with mental distress	30%	72%
Proportion with diagnosable mental health problem at any one time	16%	70%
% of people who experience depression	10%	47% mild, 17% severe (49% with either severity)
% of people who experience anxiety	4.7%	41%
% personality disorder	-	-
% bipolar disorder	1-2% lifetime prevalence	5%
% people who experience sleep problems	29%	50%
% schizophrenia	0.2%	4%
% people who self-harm	4%	14%

Survey of Needs and Provision (SNAP)

Homeless Link's Survey of Needs and Provision (SNAP) 2011 provides an overview of the homelessness sector, offering insights into the sustainability and range of services available in England. Each year the survey is carried out to look at the needs of single homeless people and the service provision they receive. It's in its fourth year and to collect the data, 500 projects were surveyed including day centres, direct access hostels and 2nd stage accommodation projects. One of the more surprising findings of this year's survey was the fact that a large number of services still do not receive any funding from a number of specific sources, despite most projects delivering such services. Figure 1 illustrates this:

Figure 1.



For more details visit: <http://homeless.org.uk/snap-2011>.

2.3 COMMON DIAGNOSES AMONG HOMELESS PEOPLE

This section outlines some of the main diagnoses and mental health issues homeless people are likely to face taken from the health needs audit findings. This section also draws on information from a 2010 good practice paper issued by the DCLG and the National Mental health development unit, *Mental health good practice guide: meeting the emotional and psychological needs of homeless people*, which focuses on recent research done looking at the links between complex trauma and homelessness. See the research here: <http://www.nmhdu.org.uk/complextrauma>

The common diagnoses and mental health issues this guide covers are as follows:

SERIOUS MENTAL HEALTH ISSUES
2.3.1 Complex trauma and personality disorder
2.3.2 Bi-polar disorder
2.3.3 Schizophrenia
2.3.4 Depression
2.3.5 Anxiety
2.3.6 Suicidality
2.3.7 Self-harm
OTHER MENTAL HEALTH ISSUES RELATING TO HOMELESSNESS
2.3.8 Dual diagnosis
2.3.9 Sleep problems
2.3.10 Anger management

References

The description of the various mental illnesses, common signs and symptoms has been put together using a number of sources including the MIND, the Royal College of Psychiatry, NHS Live Well, and Rethink websites. These have proved invaluable sources of information for this guide, and we recommend strongly that you refer to these resources for further information. They all produce excellent easy access guides that can support clients and staff to deal with mental ill health and wellbeing issues. Using their websites will help you understand the issues further. John O'Niel, the Training Manager specialising in homelessness and mental health, from the Outreach team at SLaM NHS Foundation has also overseen this document and offered invaluable expertise.



TOP TIP

Having a good understanding of terms used, signs and symptoms will enhance your working relationship with external agencies and enable you to support clients. A top tip is to allocate a lead mental health worker who is responsible for resources and information on mental health. Also, having presentations on different diagnoses at team meeting can be highly informative and motivating. Understanding behaviour that various mental illnesses can lead to can support us to tolerate and work with challenging individuals in a more appropriate, supportive way.

Notes on guidance

This is not an assessment tool and while various symptoms may be easy to recognise unless you are a trained professional you cannot diagnose individuals. This information is meant to support you to understand the causes and symptoms to support those in need prevent poor mental health and recognise when external intervention is necessary.

SERIOUS MENTAL HEALTH ISSUES

2.3.1 COMPLEX TRAUMA AND PERSONALITY DISORDER

Personality disorder, which is sometimes – and perhaps more helpfully – understood as complex trauma is found to be common among homeless people. Recent research by the former National Mental Health Development Unit and the DCLG suggests that up to 60% of individuals living in hostel accommodation and accessing homelessness have experienced complex trauma or have an undiagnosed form of personality disorder: <http://www.nmhdu.org.uk/complextrauma>

People who have complex trauma who have experienced homelessness may display a range of behaviours that suggest underlying difficulties with relationships or with managing their own emotions. The idea that personality disorder is formed in childhood and often makes attachment extremely difficult can be easily recognisable in homeless clients. The recent research acknowledges that the process of being homeless itself is extremely traumatic and distressing and can contribute to the development of personality disorder or complex trauma. Definitions of personality disorder include:

“Personality traits which are extreme, inflexible and cause significant distress to the bearer would indicate the person suffers from abnormality.”

“An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”

Personality disorder is very often rooted in childhood abuse, deprivation, neglect or trauma, which results in an inability to function effectively as an individual or in society. Someone with a personality disorder is impaired in attaining the instinctive goals of having:

- A stable self-system (self-identity)
- Stable functioning in satisfying personal needs (attachment, intimacy and integration)
- Stable relationships (with groups and society)

Personality disorder is not usually diagnosed during childhood but emerging personality disorder in adolescents is increasingly being recognised. People with personality disorder may present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems, offending and long-standing interpersonal problems (Mind 2011).

Some people who have personality disorder may for example:

- self-harm or have an uncontrolled drug and/or alcohol problem
- appear impulsive and not consider the consequences of their actions
- appear withdrawn or socially isolated and reluctant to engage with help that is offered
- exhibit anti-social or aggressive behaviour
- lack any structure or regular daily routine
- not have been in work or education for a significant period of time
- have come to the attention of the criminal justice system due to offending

Types of personality disorder

There are different types of personality disorder, which can have a range of impacts and effects on people’s lives. They can be divided in to three clusters: Cluster A (paranoid/schizoid)), Cluster B (anti-social or borderline) and Cluster C (avoidant, dependent and obsessive compulsive). See the Mind website for more information:

http://www.mind.org.uk/help/diagnoses_and_conditions/personality_disorders

Support

This client group often gets very little support from external services due to historical criteria and notions that nothing can be done with this group. Personality disorder and complex trauma should not be a barrier to support; there are successful treatment and support options and statutory mental health teams do have a duty to this client group. However, hostel staff are often extremely skilled at working with this client group because of experience and this on-going support and boundary-setting can be highly effective. High tolerance, good boundaries and understanding is demanded to appreciate that usual patterns of behavioural adjustment are not always possible for people with personality disorder.

TOP TIP

The Department of Health issues useful guidance for practitioners working with this group, for spotting diagnosis and supporting clients:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124319.pdf

Recent training to work with this client group has also been made available for practitioners. Visit the Institute of Mental Health's website for further information:

<http://www.institutemh.org.uk/-education-/the-knowledge-and-understanding-framework>

Help for personality disorder can be:

- Talking therapies
- Therapeutic communities
- Some medication

The high levels of personality disorder and or complex trauma found among homeless groups means that adopting a 'psychologically informed environment' within homelessness setting is crucial. To find more visit section four of this guide.

Further resources and training available

Personality disorder website: <http://www.personalitydisorder.org.uk/>

The Institute of Mental health: Knowledge and understanding Framework:

<http://www.institutemh.org.uk/-education-/the-knowledge-and-understanding-framework>

Department of Health guide to working with personality disorder:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124319.pdf

2.3.2 BIPOLAR DISORDER (PREVIOUSLY KNOWN AS MANIC DEPRESSION)

Bipolar is likely to affect around 5% of people accessing homelessness services, compared with 1-2% in the general population. People diagnosed with bipolar disorder often experience extreme mood swings from one overactive state referred to as mania, to another low deep depression. Moods can last for several weeks, however there can be long periods of stability for people with bipolar disorder. These are much more extreme than the general ups and downs of daily life and can be very distressing, especially if this is compounded by an unstable living environment. People who suffer from bipolar can also have visual and or auditory hallucinations or strange beliefs referred to as delusions.

Common signs of bipolar could be:

Highs (mania)	Lows – deep depression
<ul style="list-style-type: none">• extreme mood swings• intense highs	<ul style="list-style-type: none">• a sense of hopelessness• feeling empty emotionally

- talking very fast
- little concentration
- poor judgement
- risky behaviours

- feeling guilty
- feeling worthless
- suicidal feeling
- chronic fatigue
- difficulty sleeping or sleeping too much
- weight loss or gain/changes in appetite
- loss of interest in daily life
- lack of concentration
- being forgetful

Causes

Most sources (MIND, Rethink, NHS) conclude that a mixture of chemical imbalances, genetic and environmental factors are thought to be the cause of bipolar disorder.

Support available can include:

If you think a client accessing your project is suffering from bipolar it is important that an assessment is done. This can happen via the GP or through a Community Mental Health Team. They will probably be referred to a psychiatrist and get support from them. Read more about working with statutory services in section five. Bipolar is usually helped by medication along with additional support to help recognise triggers and reduce the impact of manic episodes and depression. Medication can be used to help stabilise moods; the most common are

- lithium carbonate
- anti-convulsant medicines
- anti-psychotic medicines

To find out more about treatment for bipolar disorder, please follow the link to the NHS website and NICE guidelines below:

<http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Treatment.aspx>

<http://guidance.nice.org.uk/CG38>

Other help available includes:

- Self-help groups
- General wellbeing advice
- Information about treatment - <http://guidance.nice.org.uk/CG38>
- Talking therapies

Further information

Hypomania can be less severe than mania and people may feel intense creativity or have periods of productivity. This can be useful and valuable to people, however if left untreated it can lead to more severe symptoms. There are also many different types of bipolar, to find out more about them visit the Mind website:

http://www.mind.org.uk/help/diagnoses_and_conditions/bipolar_disorder_manic_depression#what

To watch video clips that may help you understand bipolar more, visit the NHS website:

<http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Introduction.aspx>

2.3.3 SCHIZOPHRENIA

It is likely that around 4% of people accessing homelessness services will be affected by schizophrenia, and although this isn't that high it is significantly higher than in the general population. Schizophrenia can be referred to a psychotic illness or a chronic serious brain disorder. Evidence suggests that homeless clients find it hard to get appropriate treatment. Key-workers play a vital role in brokering and establishing the right support for individuals with mental health issues, especially as trigger factors for various issues could be exacerbated by homelessness.

Commons signs

- Delusional thoughts
- Hearing voices (auditory hallucinations)
- Often an inability to distinguish internal thoughts and imaginings from reality
- A sense of being controlled by outside forces
- Withdrawn
- Muddled view
- Hallucinations
- Changes in behaviour
- Unwilling to accept help (as the delusions are strong, so they cannot see what the problem is. Remember unless they are likely to harm themselves or anyone else this doesn't mean they will be guaranteed support.)
- Flattening of emotions and loss of motivation

There are many different views about schizophrenia, thus causes and treatment is a complex process for all those involved.

Causes

There are no clear answers as to what causes schizophrenia, however there is some evidence that it is genetic. Head injury or infection and brain development are also possible causes of schizophrenia. To find out more visit the NHS website. Triggers such as major life events, stress and drug use are also said to contribute to the onset of various severe mental health issues.

People who are homeless are more likely to have had stressful life events, but less likely to receive treatment around complex mental health issues. For more information on causes visit:

<http://www.nhs.uk/Conditions/Schizophrenia/Pages/Causes.aspx>

<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/schizophrenia/schizophrenia.aspx>

Further information

There is a lot of stigma around schizophrenia as it is thought to be associated with violent crime, when in fact very few violent crimes are committed by people with a schizophrenic or a psychotic diagnosis. Visit the Time To Change website for more information on myth busters

<http://www.time-to-change.org.uk/>. Schizophrenia has more recently been associated with a strong breed of cannabis referred to as skunk; to find out more about mental health and cannabis use visit the Royal College of Psychiatrists website.

<http://www.rcpsych.ac.uk/mentalhealthinfoforall.aspx>

Other useful websites include:

<http://www.nhs.uk/conditions/schizophrenia/pages/introduction.aspx>

<http://www.sane.org.uk/>

http://www.mind.org.uk/help/diagnoses_and_conditions/schizophrenia#useful

2.3.4 DEPRESSION

Depression is likely to affect nearly 50% of the clients accessing homelessness services, compared with 10% of the general population. Depression can be difficult to diagnose and understand because of its breadth of severity. It can be mild, moderate or severe to the point of debilitating and individuals can fluctuate between diagnoses. Homelessness is likely to compound feelings of depression, low mood and anxiety, especially as homelessness may be a result of another distressing life event, such as relationship breakdown, job loss, bereavement or debt. However, it is extremely important that a depression that incorporates long lasting low moods, impairs the abilities to function properly, feel pleasure or enjoy things is recognised and treated appropriately.

Commons signs (feeling the below on a regular basis, bot just one off)

- Feeling of helplessness and hopelessness
- Poor concentration and reduced attention
- Self-hatred, questioning and a need for reassurance

- Low motivation and energy

More serious cases:

- Suicidal thoughts and fears (or suicidal ideation)
- Issues with food
- Delusions and or hallucinations

TOP TIP

If individuals disclose more serious symptoms such as suicidal thoughts it is crucial to seek external support from the GP, community mental health teams, or other experts.

Causes

Depression can be caused by a number of issues including brain chemistry, social and environmental factors as well as genetic makeup. It is thought that issues that often affect homeless people such as adverse childhood experiences, poor relationships, neglect, and loss of a job or partner can affect a person's ability to cope and lead to depression. Lifestyle factors such as diet, exercise and substance misuse can also have an impact on depression. Physical illness (which is likely to be higher among homeless people) and medication may also contribute towards depression. It can be difficult to get support for someone who is suffering from depression within the homelessness sector as often the life circumstances can be seen as the main cause of the depression. However depression may have in fact led someone to become homeless, i.e. they have lost their home and job because of their depression and need long-term on-going support with this to enable them to live in more settled accommodation.

Support

Remember it is important to look at someone's support needs holistically and establish appropriate support that addresses all of their needs. Some activities that might help with depression include:

- Accessing self-help groups
- Learning about depression and ways to fight it
- Physical activity
- Visiting your GP
- Alternative therapies such as reflexology massage and breathing exercises
- Medical treatment such as anti-depressants
- Talking therapies including counselling, cognitive behavioural and psychodynamic therapies
- Exercise and nutrition.

Further information

Different types of depression can occur at certain types of our lives or year, such as post natal depression or seasonal affective disorder. For more information on depression, visit the Rethink website: [http://www.rethink.org/about mental illness/mental illnesses and disorders/depression/](http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/depression/)

You can also find out tips to help with depression and take a depression test on the NHS website if are unsure how severe your problem is:

<http://www.nhs.uk/livewell/depression/pages/depressionhome.aspx>

2.3.5 ANXIETY

Anxiety is likely to affect 40% of the homeless population compared with around 4% of the general population. Social factors to do with being homeless such as instability, lack of earnings, low self-esteem, shared living and substance misuse can impact upon anxiety. It is important to understand what anxiety is and how people can seek help rather than simply viewing it as a symptom of homelessness and lifestyle. Someone's lack of emotional resilience and anxiety may have led them to become homeless in first place and therefore may need addressing before someone can move on.

Anxiety is often a normal feeling associated with change, new situations, feeling threatened or worried; this can happen when we start a new job or have something intimidating starting in our lives. Anxiety can sometimes be a useful feeling to help us deal with complex situations. However if individuals start to feel anxious a lot of the time for no obvious reason it can become problematic and difficult to deal with. Anxiety can have psychological and physical effects on individuals. When you feel anxious all the time this can be referred to as GAD – general anxiety disorder.

Commons signs of GAD

- Feeling very worried all the time
- Tiredness and an inability to concentrate
- Poor sleep
- Feeling depressed or stressed
- Feeling irritable

More serious cases could include issues such as:

- Panic attacks (shortness of breath and a irregular heart beat)
- Phobias

Causes

Anxiety can be caused by a complex range of issues such as genes, trauma, drug use and other mental and physical health problems. Current and past circumstances that have led to an individual becoming homeless may contribute to increased anxiety. Living on the streets may also have an impact: feeling isolated, in danger and weary can continue even after people leave the streets.

Support can include:

- Talking about the problem
- Self-help groups
- Seek counselling or support from your GP
- Learning to relax (breathing exercises or mindfulness techniques)
- Healthy eating and exercise
- Medication
- Assertiveness training: http://www.mind.org.uk/help/treatments/how_to_assert_yourself

More information on anxiety

Anxiety can be a really useful feeling that gives us adrenalin at times when we need it. However if it becomes too much and unmanageable it is important to get the right help. For more information and downloadable leaflets visit Mind, or the anxiety alliance websites:

http://www.mind.org.uk/help/diagnoses_and_conditions/anxiety

<http://www.anxietyalliance.org.uk/>

2.3.6 SUICIDE

Unfortunately people who are homeless are a high risk group in relation to suicide. This can be a stressful and tense environment for individuals at risk and those around them. Samaritans research shows that 85% of calls are about a multitude of problems rather than one thing in particular, suggesting that compounding factors lead to suicide. They suggest the kinds of reason people may attempt to take their lives include:

- Recent loss or the breakup of a close relationship
- An actual or expected unhappy change in circumstances
- Painful and/or disabling physical illness
- Heavy use of, or dependency on alcohol/other drugs
- History of earlier suicide attempts or self-harming
- History of suicide in the family
- Depression

Risks include

- Suicide is thought to be higher among the socially deprived, the depressed, those with severe illness, and those who are isolated or live alone
- Most (75%) of those who kill themselves have not been in touch with mental health services in the previous 12 months. Many fear stigma or hospital, especially a psychiatric ward
- Research suggests that individuals with certain types of personality disorder are at higher risk of committing suicide and self-harming. There is evidence that suggests up to 60% of people who are homeless or living within a hostel environment could be diagnosed with personality disorder. Therefore services need to be prepared to deal with these complex needs and high risks groups

Read more about who might be at risk:

http://www.samaritans.org/your_emotional_health/about_suicide/helping_others_at_risk.aspx

Things the Samaritans suggest to reduce the risk of suicide include:

- open and frank dialogue about issues that may be affecting someone
- talking generally about your feelings
- reducing stigma around accessing support for mental health issues

Good practice example

One organisation has formed links with the local Samaritans to offer free confidential sessions in-house. This offers a space outside of key work to receive one-to-one support in a safe environment.

Support

Risk assessment and support plans often include sections about suicide and self-harm; this can be hard for staff to ask about, however staff need to ask the right questions to reduce risk. Training and support should be provided to help people feel confident in asking the right questions about suicide but this doesn't have to be costly; practising in team meetings and shadowing opportunities can really help. Staff should ask questions sensitively and in the right environment, but should not shy away for fear of upsetting people. It can be explained that you are simply asking a standard form to gain an understanding to support them as best you can. If you think about going to the doctors this often happens and while it can feel a little uncomfortable it is necessary to understand someone's issues. It is very important that a staff member is concerned that someone is suicidal either because a client has disclosed this information or they have concerns about an individual that they tell someone. Staff must inform their manager and then a GP or CMHT must be involved.

Other resources to help with support around self-harm and suicide include:

NHS Direct: <http://www.nhsdirect.nhs.uk/>

Maytree <http://www.maytree.org.uk/index.php>

Samaritans:

http://www.samaritans.org/your_emotional_health/about_suicide.aspx?qclid=CJK_m4Le1qoCFZRc4Qodu3ha5w

More information

National mental health development unit - <http://www.nshn.co.uk/>

Young people and self harm <http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm>

MIND http://www.mind.org.uk/help/diagnoses_and_conditions/self-harm

2.3.7 SELF-HARM

Self-harm is likely to affect 14% of people accessing homeless services, compared with 4% of the general population. Self-harm is difficult to understand and can be extremely distressing for those self-harming and the people around them. Many people who self-harm, are not attempting to commit suicide and are in fact using self-harm as a method of release from emotional pain, or a

coping mechanism rather than attempt to end their life. However self-harming is obviously a high risk behaviour and individuals who do self-harm are potentially putting their lives at risk. Self-harm is a broad term that covers lots of behaviours and actions, Mind describe self-harm as:

“Self-harm is a broad term. People may injure or poison themselves by scratching, cutting or burning their skin, by hitting themselves against objects, taking a drug overdose, or swallowing or putting other things inside themselves. It may also take less obvious forms, including unnecessary risks, staying in an abusive relationship, developing an eating problem (such as anorexia or bulimia), being addicted to alcohol or drugs, or someone simply not looking after their own emotional or physical needs.

Talking about self-harm may alleviate some of the associated stigma and discrimination towards this behaviour. It's often viewed as attention seeking behaviour, this is over simplistic. For most people self-harm is a private act and individuals make a lot of effort to hide it from others. People who self-harm are often in deep distress; it may be a way to communicate this pain and should always be taken seriously. Trying to ensure people feel comfortable talking to keyworkers and their GP about such issues means that measures can be put in place to support people reduce self-harming and also reduce the risks of self-harming. Therefore questions about self-harm should be built into risk assessments. Remember if you are concerned about someone's safety and wellbeing always tell someone, contact your manager and seek additional support from GP's, CMHT or A&E in an emergency.

Resources on self-harm:

Working with people who self-harm, do's and don'ts:

<http://counseling.uchicago.edu/vpc/uchicago/self-injury.html#tips>

Other resources:

http://www.rethink.org/living_with_mental_illness/coping_in_a_crisis/suicide_self_harm/

<http://handbooks.homeless.org.uk/resettlement/risks/seriousincident/suicide>

<http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm>

<http://www.selfharm.net/>

http://www.mind.org.uk/help/diagnoses_and_conditions/self-harm

<http://www.nshn.co.uk/misconceptions.html>

Homeless Link also offer training on self-harm, for more information;

<http://www.homeless.org.uk/training-suicidal-clients>

COMMON MENTAL HEALTH ISSUES RELATING TO HOMELESSNESS

2.3.8 DUAL DIAGNOSIS

This term comes from psychiatry; it is a focus on mental health and health and literally means two diagnoses. Dual diagnosis is a term that refers to people who have both a diagnosed mental health illness and addiction issue or two different types of mental health diagnoses. Within mental health services and drug and alcohol services this is very specific and refers to individuals who have a primary:

- psychiatric illness leading to substance misuse
- substance use worsening or altering the course of a psychiatric illness
- Intoxication and/or dependency leading to psychological symptoms
- Substance use and/or withdrawal leading to psychiatric symptoms

This is an area fraught with contention and diagnostic dilemmas for practitioners, and is prominent within the homeless client group. Services are stretched and trying to establish the primary need can often mean individuals are passed between services. *The symptoms of psychosis brought on*

by drug use (“drug-induced psychosis”) and psychotic illness can overlap and even mask each other making an accurate diagnosis difficult (Rethink website 2011).

Hostels play a key role here in helping individuals navigate the services and working out how the support needs can be dealt with holistically. If dual diagnosis services don’t exist in your area, then staff play an important role in assuring support is joined up. Support agencies need to work together to support your client, and utilise the expertise out there. Establishing which need is the primary concern either drugs and alcohol or a mental health issue, monitoring behaviour and then making a case for support based on knowledge and evidence will help you to get the right support for an individual.

It can be very challenging working with this client group, as clients who are making unwise decisions around drug and alcohol use can be distressing and exhibit harmful and challenging behaviour. Having a clear understanding of the *Mental Health Act* can assist you with understanding how mental health diagnosis stands relating to addiction and the ‘unwise’ decisions individuals often make.

Resources on dual diagnosis:

[http://www.patient.co.uk/doctor/Dual-Diagnosis-\(Drug-abuse-with-other-psychiatric-conditions\).htm](http://www.patient.co.uk/doctor/Dual-Diagnosis-(Drug-abuse-with-other-psychiatric-conditions).htm)
<http://users.erols.com/ksciacca/>
<http://www.dualdiagnosis.co.uk/>
<http://www.turning-point.co.uk/inthenews/Documents/DualDiagnosisGoodPracticeHandbook.pdf>
http://www.mind.org.uk/help/diagnoses_and_conditions/dealing_with_anger#useful
<http://www.rethink.org/dualdiagnosis/>

TOP TIP

Turning point and Rethink have produced a dual diagnosis toolkit that can support the work you do. Ensure you support clients to navigate statutory services that can offer support and expertise. See: <http://www.turning-point.co.uk/inthenews/Documents/DualDiagnosisGoodPracticeHandbook.pdf>

2.3.9 SLEEP PROBLEMS

Unsurprisingly, not getting enough sleep was found to be a common issue among people accessing homelessness services, affecting nearly 50% of those surveyed in the health needs audit. Sleep can have a serious impact on mental health, mood and our ability to manage situations rationally. Sleep can be affected by noise, light, the use of substances, mental health issues, medication, the food we eat, stress levels, and partners. All of these issues can be addressed within hostels and should be taken seriously.

- This sample drugs policy and guidance notes contains detailed information about the effects of sleep on mood and mental health. It also offers top tips around how substance misuse and the food we eat affect sleep. It offers some very practical resources that can be used with individuals on a one-to-one basis or for group discussions.

<http://homeless.org.uk/evictions-abandonment-toolkit-sample-drugs-policy>

The mental health foundation has also recently published lots of useful information and guidelines on sleep: <http://www.mentalhealth.org.uk/our-work/mhaw/>

2.3.10 ANGER

Anger is a common and frustrating emotion, especially for people living in homelessness services who may feel frustrations linked to their current housing situation. Anger can be expressed in shouting, threatening or violent behaviour as well as silence, withdrawal and passive aggressive actions. Anger can be challenging to deal with as it can be threatening and potentially dangerous.

Some people need extra support in finding ways to effectively express anger. Remember anger is a horrible emotion to experience and some people find it extremely hard to control and cannot see the potential consequences of their behaviour. People with complex trauma or personality disorder may have difficulty controlling their anger due to emotional deregulation. This means they may lack the ability to regulate their emotions in the way other people can and therefore lash out in unpredictable ways seemingly never learning from their mistakes.

Also people's individual circumstances may lead them to feel extreme anger and this can be a useful emotion to help people take control and want to change their lives, however if anger becomes increasingly a problem, is threatening, or creates a risk then steps need to be taken to work with this individual. It may be useful to work with someone around what triggers their anger and help someone manage these triggers. Increasing self-awareness and offering alternative coping mechanisms may be useful. If anger becomes problematic people can be referred to the GP for extra support.



**TOP
TIP**

Help clients to understand the feeling of anger and look at finding ways to reduce this. You could run a simple workshop, just by using useful online information. Check out the calm zone:

<http://www.thecalmzone.net/talk/issues/anger/?qclid=COX28sSH96oCFUdTfAod0wIZLQ>

More resources on dealing with anger include:

MIND leaflet on how to deal with anger:

http://www.mind.org.uk/help/diagnoses_and_conditions/dealing_with_anger

Mental health foundation:

<http://www.mentalhealth.org.uk/help-information/mental-health-a-z/A/anger/>

2.4 UNDERSTANDING TREATMENT AND SUPPORT OPTIONS

Treatment and support for various mental health issues is once again a contentious and complex area. A multitude of medical treatments, talking therapies and alternative treatment and support options are available. However access to these various forms of treatment and support may vary depending on where you live and your local health services' approach. This section outlines the various approaches to treatment and support that are available, while section four and five will offer more practical ways to implement support.

The table below outlines some of the treatment and support options available to clients with varying needs. This section also introduces some key terms that it may be helpful to be familiar with. Understanding what approaches there are to treating mental ill health and wellbeing issues will enable you to support clients effectively and ask for extra support from agencies if you feel someone is not being supported adequately.

TOP TIP

Evidence suggests that counselling and psychotherapy can have great results working with homeless and ex homeless clients who have underlying problems related to childhood abuse or neglect.

Some understanding of the terms used within primary and secondary support will be helpful for supporting individuals. Below is a table to help you:

Treatment and support	When appropriate and who can provide it	Benefits	Risks
Hospital treatment (psychiatric ward)	Only an approved mental health professional can admit someone to hospital, although sometimes people can self-refer if they feel they are at risk to themselves or others	Safe and secure Offers respite Get immediate support	Previous negative experiences May remove choice and control (if a secure unit)
Medication	Only an approved mental health professional can prescribe and administer controlled substances	Can provide immediate relief Can be stabilising Can offer long term solutions if reviewed and monitored	Various side effects, depending on type of medication. For more information visit the Mind website.
Talking therapies, such as counselling and or psychotherapy	Psychotherapists, counsellors with suitable training and supervision in place	Can get to the route of the problem Equips people with long lasting coping mechanisms	May make things temporarily worse before they get better
CBT/DBT - Cognitive or dialectical behavioural therapies	People who have received appropriate levels of training. (Keyworkers should have some skills associated with talking therapies such as an introduction to CBT methods or motivational interviewing)	Can have relatively quick results Equips people with long lasting coping mechanisms	Can't always address more deep rooted issues and not always sufficient
Relaxation techniques	For low level stress and anxiety and generally to help build resilience and coping strategies	Can be done taught easily using online tools	As above
Alternative treatments such as massage, reflexology, homeopathy	Trained professionals in various fields. Can help with a range of issues, especially around stress and anxiety	Avoid hospital treatment Can be relatively cheap (although not always available via the NHS)	As above

There are many more forms of treatment and support available. To find a comprehensive A-Z list please visit the MIND website as well as the NHS guide to treatment for mental health issues: http://www.mind.org.uk/help/medical_and_alternative_care

Approaches to be aware of when working with clients with MH and wellbeing needs

Useful terms	Brief explanation
Personalisation	An approach developed in the social care sector mostly, but becoming increasingly good practice across the board. Involves working with clients individual needs in a personalised way and providing opportunities for choice and control around care and treatment. For more information please visit our website: http://homeless.org.uk/personalisation
Care programme approach	An approach adopted in the late nineties within mental health and is around continuous and on-going support for people with diagnosed mental health issues. It demands clients' treatment is reviewed regularly and people's changing needs are met. Most people currently receiving support from mental health teams will be under the care programme approach.
Recovery	Recovery from a mental health problems means different things for different people depending on the issue. However more and more services are focusing on ensuring people recover and find meaningful and fulfilled lives regardless of poor mental health experiences. Recovery or the recovery approach is a new initiative therefore, which is currently being implemented in mental health teams across the country. It is outlined within the 'No health without mental health strategy' 2011. The focus is on a cultural change within mental health teams to adopt the recovery model. Some agencies are leading the way with the Implementing Recovery Organisational Change (ImROC) Project To find out more see: http://www.nhsconfed.org/NETWORKS/MENTALHEALTH/OURWORK/Pages/NMHDU-Implementing-Recovery-Organisational-Change-Project.aspx
Safe guarding/ SOVA	Other powers may ensure you get the necessary support for a homeless client at risk. If you believe a client is the victim of abuse (e.g. physical, financial, sexual, psychological, neglect) you should raise an alert with the local authority's Safeguarding of Vulnerable Adults lead, who will often work in Social Services or the CMHT. You will need to provide details of the suspected incident(s) of abuse and why the client is vulnerable. The SOVA lead will assess the client's vulnerability and the evidence of abuse. If the answer is yes to both, they will call a case conference of professionals to agree what support is required to safeguard the client and implement an action plan. SCIE have put together some guide lines on; Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse http://www.scie.org.uk/publications/reports/report39.asp
IAPT (improving access to talking therapies) programme	This is a national programme aimed at increasing the amount of talking therapies (counselling, psychotherapy and Cognitive behavioural therapy CBT) available to people with mental health and wellbeing needs. To find out more about services in your area see: http://www.iapt.nhs.uk/

2.5 STREET HOMELESSNESS AND MENTAL HEALTH

Teams working with rough sleepers can face challenging situations in which they feel a person clearly lacks capacity to make wise choices and is neglecting themselves in a way that is likely to cause harm in the long run. Having a good understanding of the *Mental Health Act* and the *Capacity Act* is crucial to get the appropriate support for individuals. Statutory services can work in different ways across the country depending on resources, which means people can get very different responses depending on where they are found rough sleeping, however the Mental Health Act is there to protect individuals from harming themselves and other people.

Below are two case studies that illustrate that rough sleeping in itself can be a reason to utilise the *Mental Health Act* and admit individuals to hospital for more care and support. These may enable you to work with your local authority around developing such an approach, however remember that these powers can have serious implications for individuals and everyone's case will need to be dealt with on a case by case basis. Homelessness services that develop successful working relationships with mental health teams appear to work best at delivering effective support for individuals. The specialist homelessness mental health team worked for nearly ten years to develop a more proactive approach to the hospitalisation of rough sleepers, it required effective multi-agency work to have beneficial results and constantly requires reviewing.

Using the Mental Health Act – an example from the Joint Homelessness Team

The Westminster Joint Homelessness Team was set up to work with rough sleepers in Westminster. Through intensive work and on-going evaluation it became apparent that firstly, compulsory admission was indeed often an effective form of intervention. (It often resulted in permanent improvements in the quality of life of rough sleeping clients). Secondly, definite patterns emerged to explain why they ended up detaining some people under the Mental Health Act and not others, which the team sought to address.

Certain triggers were needed to prompt the team to taking the steps towards assessing the client under the Mental Health Act. A group of people who did not present with these triggers did not get assessed and were neglected. It was difficult to identify the characteristics which distinguished those who had been housed without the need for compulsory admission. However the quantitative study showed that a willingness to engage early on generally indicated that progress could be made without compulsory intervention. The team felt that in both groups the availability of suitable housing that was acceptable to the clients and offered a flexible level of support was essential to achieving a positive outcome.

The team felt that their instincts were validated: with people who were clearly mentally ill and refusing all offers of help, a more assertive approach was necessary, and adopting a planned approach to compulsory admission rather than waiting for a crisis to present was the way forward.

The JHT used the evidence based they had collected around this approach to ensure the hospital staff understood the long term benefits of admission and treatment for rough sleepers. They continue to work effectively with rough sleepers applying these more proactive methods towards assessment and hospitalisation of rough sleepers with excellent results

Another recent development in Westminster has seen the setting up of training and support sessions by the local personality disorder service, to give expert advice and guidance to those working with homelessness agencies and help meet the needs of their service users with personality disorders. To read more about this see the case study in SECTION FOUR.

Rough sleeper refusing shelter

Craig was first found by the outreach team mid-November in 2010, he reported that he been rough sleeping for 20 years in various locations across the country. The team had immediate concerns for his mental health and referred him to the local Community Mental Health Team (CMHT) for an assessment. Craig also presented with poor physical health including scabies. Craig refused to engage with any services and refused any medical attention. The outreach team arranged for services such as the St John Ambulance to visit him on his sleep site. They also involved the local police team who also used a targeted approach to try and engage with Craig on a regular basis. Some weeks later Craig was assessed under the Mental Health Act. He was not found to be detainable. Craig however was still extremely unwell, showing signs of deterioration and continued to refuse all offers of accommodation, despite the plummeting temperatures.

Discussions continued between all the teams involved; outreach, CMHT, the drug and alcohol action team and the police regarding Craig's safety and wellbeing. Services considered the options available to maintain his safety in cold weather if he continued to refuse accommodation. These options included repeat mental health assessments and the use of the Vagrancy Act. The Vagrancy Act could be used to arrest a rough sleeper following refusal of accommodation, allowing the police to keep Craig in custody overnight if all other options fail and there is genuine concern regarding potential loss of life.

Staff worked hard to put forward the risk that Craig presented to himself and demonstrated their concerns by illustrating his behaviour to the CMHT in an accurate way. Craig was assessed under the Mental Health Act again one week later and this time Craig was detained under Section 2. Craig was therefore taken to hospital where he received appropriate treatment and support. Craig has since stabilised, receiving support from a partnership of agencies: he takes his medication regularly and is maintaining accommodation accessed through mental health services. His physical health has greatly improved and he is planning for his future.

Lessons learnt

Craig was extremely unwell and homelessness services fought hard to ensure he got the support he was entitled to. Mental health services needed to ensure his human rights were protected and he was correctly diagnosed, which can take time and it means presenting cases in-depth. The joint working and intelligence use of external services and the law meant that Craig got the response he required. The use of the Vagrancy Act wasn't necessary in the end, but understanding it meant the agencies had options to protect the individual if they felt the wrong decision had been made by the CMHT. Through this complex case working, relationships between the various teams have been forged and well enable future cases to be addressed in a joined up way.