

10th June 2009

**St Mungos Call 4 Evidence
Mental Health and Street Homelessness**

Homeless Link is pleased to feed in our views to the Call 4 Evidence on mental health and street homelessness.

We recently produced a Policy briefing about homelessness and mental health. This briefing is due to be published shortly on Homeless Link's website, and looks at:

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

Many of the themes covered in our briefing correspond to the questions in your Call 4 Evidence and to avoid duplication I have attached this document as part of our submission. I hope it will provide useful statistical evidence and suggestions for changes at a policy level which will be helpful for your report.

We have also outlined some broader themes relating to some of the key questions below and highlighted links to further resources which may be useful to feed into your work.

Homeless Link would like to offer any further support to this project as it moves forward. We are delighted that a representative from St Mungos is joining the National Steering Group for our new Homeless Health Needs Audit project, which we hope will also contribute to improving access and effectiveness of health services, including mental health services, for homeless people.

Yours sincerely



**Helen Mathie
Policy Projects Officer**

1. Causes of homelessness amongst those with mental health problems

Mental health problems can be both a cause and a result of street homelessness, and as such this interplay results in a prevalence of people on the streets with mental health problems. Homeless Link's Survey of Needs and Provision (SNAP) 2009 report showed that 43% of clients in an average day centre have mental health issues; 26% have personality disorder and 59% multiple needs, which often combine mental ill health.¹ (please see the Policy briefing for more on this issue).

It is helpful to pay greater attention to the use of definitions, both in terms of mental health issues themselves, and different groups of homeless people. Existing research and statistics usually focus on different sub groups of homeless people (rough sleepers, hostel dwellers etc) that have different profiles and experiences. We are aware of existing research which is being done about homelessness and mental health amongst different client groups - for example women, older people and BME groups (please see page 7 of the accompanying Policy Briefing). We hope this will contribute to a better understanding of the specific needs amongst the diverse homeless populations our sector works with.

2. Access to services

a,b) Engagement with mental health services can be difficult due to the other challenges facing clients who are sleeping rough - for example chaotic and transient lifestyles which can prevent access to and continuation of care. On a practical level this can make it difficult for clients to keep appointments and take medication, so having supportive and flexible treatment pathways is essential. Non-engagement can often mean treatment or cases are terminated and clients become unable to access appropriate services.

There are particular challenges for those clients with substance misuse issues/dual diagnosis. Some services do not engage with clients who are using substances (for example, some crisis interventions teams) and we have heard anecdotally of services being unwilling or unable to engage with clients with enduring mental health problems - for example personality disorders. We would emphasise this latter point - personality disorders are sometimes seen as an 'untreatable' condition and support to address this remains a huge unmet need in current service provision.

Access to services is hindered by the lack of engagement with primary care services - particularly GP- which often provide the starting point and referral routes for many specialist services. Although 94% projects in SNAP reported there was access to GP services for clients, nearly 20% found problems in accessing this, predominantly due to the inadequacy of the service.

Our SNAP 2009 report showed that although mental health services were available in the majority of areas, either by referral or in-house, nearly 50% of respondents reported problems in accessing these services.² For example 50% had problems accessing CMHT services; 44% talking therapies. Reasons for these problems included ineligibility and unsuitability of some clients; internal lack of financial and staff resources and in the majority of cases inadequacy of external service.

¹ Homeless Link: SNAP 2009 www.homeless.org.uk/policyandinfo/research/mapping/

² See table 9, SNAP 2009 www.homeless.org.uk/policyandinfo/research/mapping/SNAP2

In terms of supporting clients to access services, points to consider include:

- Exploring different models of health care- for example provision in existing services such as day centres/hostels by specialist homeless health teams. Work by St Mungos has already demonstrated some of the outcomes these models can achieve to improving mental health. Westminster has also done a recent health needs assessment project which examined different models of providing health care in the borough - for example services integrated into day centres, satellite services, via specialist GP surgeries etc. The findings are due to be published shortly and will be useful in showing any challenges or good practice in facilitating access.
- Improving knowledge of available services and referral routes for staff and clients
- Improving specialist knowledge about mental health within frontline agencies- again, St Mungos have addressed this in their Health Strategy and other organisations are exploring other ways to raise awareness of mental health such as Broadway's new 'Its your Health Project' (which will develop the skills of front line staff to become experts at creating, planning and implementing health awareness sessions).³

3. Housing

a,b) Housing and mental health solutions must be viewed together if a secure pathway out of homelessness is to be achieved. Mental health is closely linked to a person's wider environmental experience. Holistic approaches are therefore required which effectively address both housing and health needs.

Data from SNAP 2009 suggests that clients in hostels are more likely to experience mental health problems, with 38% clients in an average direct access hostel with mental health problems compared to 28% in second stage accommodation.

Accessing accommodation can be challenging for clients with mental health problems due to complexity of need, which some direct hostels do not have resources to address. For example our recent survey of Emergency Accommodation found that 22% areas which report some form of emergency accommodation have no provision for clients with high support needs⁴, which often include mental health or substance misuse issues. The lack of appropriate accommodation makes it more likely that these clients will find themselves sleeping on the streets.

Even where clients can access housing, it is vital that this addresses the mental health problems they experience. For example, an audit of older people's needs in 5 local authorities conducted by Homeless Link in 2007⁵ found that 61% of clients had either severe mental illness or experiences mental health problems such as depression or anxiety. Over a third of clients had multiple needs and required a high level of support. This example highlights a broader challenge in providing appropriate housing - eg medium and high support housing. This accommodation can be expensive and challenging to commission - for example small scale units providing intensive support. However it often provides the most appropriate form

³ <http://www.itsyourmove.org.uk/SpecialProjects/ItsYourHealth>

⁴ www.homeless.org.uk/policyandinfo/issues/EA

⁵ <http://www.homeless.org.uk/policyandinfo/issues/older/auditsummary07/>

of support to those with serious and enduring mental health problems. The sector needs to continue to demonstrate how such provision contributes to priorities set as part of Local Area Agreements - for example NI 149 which is concerned with the number of adults in touch with secondary mental health services in settled accommodation.

4. Health

(please also see 'Access' section above)

b) Evidence about where the gaps in current provision are difficult to ascertain as there is limited evidence about the level of need amongst this client group:

- Many agencies collect data on health needs -eg CHAIN- but definitions of mental health and the methods of recording vary considerably
- Capturing data often relies self disclosure or assessment by outreach teams. Some conditions can therefore go undiagnosed or recognised
- Without a strong evidence base it can be difficult for the sector to lobby health policy makers, who generally require more substantial, epidemiological data sets. Homeless Link is undertaking a new project, supported by the Department of health, to develop an audit tool to better evidence the health needs - both physical and mental health- of the homeless population. We look forward to working with St Mungos as part of the project Steering group and sharing our learning. More details of the project can be found at www.homeless.org.uk/policyandinfo/healthneedsfaqs

One priority for mental health services is around meeting the needs of those with dual diagnosis. Difficulties around dual diagnosis and multiple needs, including personality disorder are now recognised nationally, but these are yet to be translated into service responses on the ground. In some areas there are mechanisms for joint working on complex cases involving mental health service, substance misuse units in psychiatric services etc. Where these joint working or case management processes exist, formal links and protocols should be developed to ensure continuity of support.

5. Work and skills

a,b) Training and work related activity is valuable for this client group and where appropriate clients should be supported to access this type of service. However, it is also important to consider meaningful activity which is not focussed on work. Some clients may not be ready to re-enter employment due to the nature of their mental health problems, and agencies should not see employment as the sole outcome of ETE services.

Research has suggested how important meaningful activity and achieving 'softer' outcomes are for helping homeless people make positive changes to their lives and moving away from homelessness - for example Homeless Link's work around meaningful activity has interesting findings about what models of activity work best to engage and benefit clients; Broadway has also found through their 'Keeping

Homes' research⁶ that meaningful activity is a key factor in a client's ability to achieve positive longer term outcomes.

The Places of Change agenda, with its focus on moving service users forward, including improving their access to meaningful occupation and training and employment opportunities, provides useful lessons about how this can be achieved.

There is a section of Homeless Link's website which is dedicated to education, training and employment services for homeless and socially excluded people. It features good practice guidance and considerations for a wide range of services and activities, from engagement and stabilization activities, to volunteering, placements, self-employment and social enterprise.
<http://handbooks.homeless.org.uk/ete>

This can offer helpful contributions to your Call 4 Evidence. We have also outlined a number of key issues relating to ETE services in a separate Policy briefing:
www.homeless.org.uk/policyandinfo/briefings/eete

6. Designing and Delivering services

a,b)The new opportunities for influencing commissioning should be welcomed by the sector. However, many agencies feel under-involved in these processes and feel frustrated at the lack of cross cutting funding which could better support integrated mental health and housing support services. Viewing mental health services, housing related support and substance misuse support in silos, which can lead to multiple pathways and access points to treatment for an individual, needs to be challenged as it undermines achieving more integrated support.

Developments like the LAAs and ABG provide an opportunity for more cross cutting commissioning which meet these different needs. JSNAs also place a greater responsibility on PCTs to gather evidence about health inequalities and unmet need in their communities. A recent progress report of JSNAs, however, acknowledged that engagement from the community was 'limited' and that while steps have been taken to draw in the views of third sector partners, many have been 'under-involved.'⁷We need to closely monitor the use of these processes ensure they adequately take homelessness and mental health into account, particularly in light of the move to ABG. We will continue to support agencies to help influence these strategies - for example through initiatives such as the Health Needs Audit project which will strengthen the evidence based for local influencing.

As outlined in our Policy briefing, while we welcomed the PSA on social exclusion we believe the current PSA does not cover homeless people and others with multiple problems. Through the Making every Adult Matter coalition (MEAM) 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.

c) In terms of the roles and responsibilities of central, regional and local government, as outlined in our Policy Briefing, we believe that a national health and homelessness strategy is needed. Recent national strategies have focussed the

⁶ www.broadwaylondon.org

⁷ <http://www.idea.gov.uk/idk/aio/9606722>

need to improve access to health care for homeless people (see for example Action 5 of No-one left Out: Communities Ending Rough Sleeping' which explicitly commits to 'improving access to health and social care services for people with multiple needs'), and a national strategy would build on this commitment and overcome some of the local variation which can undermine the effectiveness and availability of services. This does not preclude the requirement for local responsiveness and commissioning, but while local areas have greater responsibility for assessing and addressing local need, a national context and strategic direction would be beneficial.

d) Placing clients' views at the heart of any work to develop outcomes is essential. The Outcomes Star approach is an example of how clients can be involved in identifying and working towards positive change, by supporting a client to plot his or her progress, and planning the actions he or she needs to take. Mental and emotional health is one of the core areas measured by the Star.⁸

The mental health sector has a strong tradition of user involvement in service development, delivery and commissioning and while homelessness agencies continually demonstrate good practice in this area there is scope for improving shared learning between the two sectors. Projects focussing on Peer education and advocacy, such as those developed by St Mungos and Broadway, are also beneficial and should be encouraged in the sector.

7. General

It will be useful to look at the good practice guide 'Getting Through' which helps mental, housing and homelessness practitioners improve access to mental health services for people who are homeless or living in temporary or insecure accommodation. The guide identifies practical solutions and models of good practice, based on information from mental health and homelessness services around the country:

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

⁸ www.homelessoutcomes.org.uk