Homeless Link submission to the Community Mental Health Inquiry, February 2025

Who we are

Homeless Link is the national membership organisation charity for frontline homelessness services. Representing over 800 organisations ranging from Housing Associations, supported accommodation providers and hostels to day centres, night shelters and outreach, we work to improve services and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

We are pleased to provide our submission to the Community Mental Health Services inquiry. Information within our submission is drawn from numerous sources: contributions made by professionals from across the homelessness and mental health sector as part of a themed roundtable in 2024, a recent health-themed consultation with members, information from our Unhealthy State of Homelessness report (2022), and information from our Annual Review of Single Homelessness in England (2024).

We are grateful to our colleagues at Groundswell who have contributed significant information to this submission drawn from their work engaging people with lived experience of homelessness. Information provided by Groundswell is indicated throughout this document.

Context

Poor mental health is both a cause and a consequence of homelessness. Evidence from Homeless Link's Unhealthy State of Homelessness (2022) shows a significant trend in untreated mental health conditions acting as a precursor and a cause of homelessness. Once experiencing homelessness, mental health conditions frequently worsen as people are exposed to high rates of trauma and health exclusion. This can drive self-medication through substance use, creating a cycle of severe and multiple disadvantage that can ultimately lead to severe harm and early death.

The outcomes are stark. The ONS (2022) record the average age of death while homeless as just 45 for men and 43 for women – over 30 years younger than the general population. A significant proportion of these are considered 'deaths of despair': those caused by drugs, alcohol or suicide. Research conducted as part of the Dying Homeless Project (2024) found a staggering 47% of people who died while homeless in 2023 fit the definition of deaths of despair.

This picture is underpinned by the inadequacy of NHS mental health services for people experiencing homelessness. While unmet mental health needs are overwhelmingly common among people experiencing homelessness, **we are yet to see a meaningful prioritisation of homelessness within mental health planning and strategy.** The first and most straightforward action is the meaningful engagement of mental health officials in the interministerial group for ending homelessness.

Significant change is needed if we are to move towards a humane, rights-based, sensible system of support for this patient cohort. We welcome this submission as an opportunity to begin working with government to move towards system-wide improvements.

What is the current state of access for adults with severe mental illness in community mental health settings?

"General access to mental health is the biggest problem at the moment, we can't get appointments. Watch people get worse, very different people go down to a very similar path because they can't get the help. All the good ideas in the world don't work if there aren't the resources."

Research shows that mental ill-health impacts people experiencing homelessness more than any other health condition. Analysis of 31 Homeless Health Needs Audits shows a stark increase in people experiencing homelessness who report a mental health diagnosis, from 42% in 2014 to 82% in 2021. These cover a spectrum of mental health needs ranging in severity and complexity. Despite this, access to support is limited and comes primarily at the point of crisis.

Appropriate mental health support is crucial for people experiencing homelessness. Many people experiencing homelessness report being unable to access support for mental ill health. Homeless Link members report challenges in identifying appropriate mental health support to refer people to, from people who do not meet the crisis threshold to people with severe, long-term and untreated mental health conditions.

Evidence also shows that those working in homelessness services often have a good understanding of mental health, drug and alcohol support needs, while specialists in these latter fields can have little insight into each other, or into housing or homelessness issues. The threshold for support is felt to be narrow, with many perceived as either too well or too unwell for mainstream mental health provisions.

Barriers to support

Research from Groundswell (2022) outlines the multiple barriers that people with lived experience of homelessness face when accessing mental health support. These include:

- Long waiting lists
- Poor previous experiences of services
- Stigma from clinicians, including mental health specialists
- High thresholds for care and a focus on crisis response at the expense of early intervention
- Limited capacity among services meaning stringent 'compliance' requirements

Barriers include high rates of discharge due to missed appointments or perceived 'poor' engagement; a significant absence of dual diagnosis services which lock people who self-medicate with drugs or alcohol out of support, and the unchanging (or worsening) nature of structural factors such as rough sleeping, poor quality housing or welfare insufficiency which perpetuate mental illness.

"We can get a client in the right place to accept support, but referrals take too long and the support isn't available when needed. It leaves us reliant on support and contacts outside of the NHS."

Homeless Link's Annual Review 2022 found 90% of accommodation services face challenges accessing mental health support for their residents, with 69% stating waiting lists as the most significant barrier to access. This is a particular issue for rough sleepers or residents in temporary accommodation, where frequent changes of address can mean letters get lost and referrals closed for non-engagement.

Research from Groundswell found that people experiencing homelessness frequently experience feelings of stigma and judgement when reaching out for support, which was especially felt by those using drugs and/or alcohol. Many participants in this research stated a lack of trust in mental health professionals and found it challenging to build a relationship of trust, which others felt unable to navigate the mental health system. Experiences of homelessness interrupted people's motivation or ability to engage in mental health care, and frequent movement could see them moved away from the NHS trust treating them and force them to re-refer elsewhere. The research also reflects that those with ongoing mental ill-health were often only able to access support when in crisis, and were discharged without ongoing support once the crisis was deemed to be over.

This research recommends access to safe and secure accommodation for everyone as a foundation to begin working on their mental health; on ensuring homelessness is prevented whenever possible; the need for personalised and holistic plans for people experiencing homelessness and the identification and implementation of ways to reduce stigma in both homelessness and mental health services, as a basis from which people could begin to recover from mental ill health. For people experiencing severe health exclusion and homelessness, evidence-based interventions such as Housing First can be a lifechanging first step in recovery.

What does high-quality care look like for adults with severe mental illness and their families/carers?

- *How can community mental health services work with social care, the third sector and local government to better address service users' health and wider social needs that are wider determinants of mental health outcomes?*
- *How could the funding system be reformed to more effectively drive transformation in the delivery of integrated and person-centred community mental health services?*

Embedding best practice

The NICE Guideline 214, 'Integrated health and social care for people experiencing homelessness', provides sound, thorough and evidence-based advice on how health systems should deliver best practice when working with people experiencing homelessness. Community mental health settings should embed the recommendations as standard.

At the centre of the NICE guideline is the role of peer support, which is consistently highlighted by people with direct experience as central to their recovery. Services should seek the meaningful involvement of people with direct experience of mental illness and homelessness at all levels, ensuring they are integrated in the design and delivery of support.

Prioritising homelessness prevention and relief

For people without a home, prioritising mental wellbeing is often extremely challenging in the face of other more immediate needs such as securing accommodation. Lack of accommodation worsens mental health, while simultaneously making it harder for people to access mental health support (*Knowing Where to Turn,* Groundswell, 2022). The most important step government can take to improve the mental health and wellbeing of people experiencing homelessness is therefore to ensure they have access to safe, secure housing and the support they need to keep it.

We are glad to see the Health Minister engaging with the interministerial group on ending homelessness. The NHS has a vital role to play in the Government's upcoming homelessness

strategy. Our foremost ask is that health take up responsibility in the design and delivery of the upcoming homelessness strategy, with accountability for delivering on improved mental health and trauma services to support prevention and relief, breaking the cycle of homelessness caused by mental ill health.

The role of third sector homelessness providers

Homelessness providers play an essential role in supporting people with some of the most severe forms of mental ill-health. The acuity and severity of mental ill-health encountered by homelessness services is rising, as are levels of co- or multi-morbidity.

But too often, those accommodated in homelessness settings are discounted for mental health support. Providers are too often the only support available, expected to fill the gaps in the absence of specialised mental health support. While amazing support takes place in homelessness settings, there is no requirement that their workforce be skilled to work with complex mental health, and the severity and diversity of need which the homelessness system responds to is not reflected in its commissioning, resourcing, or regard within wider systems.

Despite the challenges faced in delivery, homelessness services are often keen to be recognised as key partners in delivery of mental health and trauma support. Homeless Link members expressed their desire to support the NHS to deliver care in the community, but reflected the challenges they may face in enabling this.

First and foremost, services reflected that the continued financial challenges faced across the sector placed their ability to support this at risk. For the homelessness sector to meaningfully support the NHS in its efforts, they must be acknowledged for the essential role they play and outline how homelessness and mental health services will be secured through long-term funding and support the transition to a new funding model which supports the viability of services.

Shared responsibility, shared commissioning

The delivery of mental health care for people experiencing homelessness is too often treated as a hot potato, with patients shunted between services – mental health services, safeguarding teams, health and wellbeing boards, adult social care, homelessness and the justice system. It is the latter services which too often end up holding responsibility for people with severe and multiple disadvantage where other, more appropriate services have avoided responsibility.

This can mean people with significant and disruptive needs being accommodated in settings designed – and funded – to deliver low-level support. As well as meaning acute mental health needs going untreated, this can be incredibly disruptive for other residents and unsafe for staff.

Some of the most successful services in supporting mental ill-health and preventing and ending homelessness are those which work flexibly across sectors to deliver holistic support. This should begin with safeguarding adults boards, who should be expected to universally engage housing teams to support effective multi-agency working. Mental health workers should be embedded within homelessness services, with joint commissioning arrangements between homelessness and health services to enable truly integrated working.

For people experiencing homelessness, evidence shows that a ‘one stop shop’ approach works well, delivered within the community. These were felt to hold capacity for flexible, holistic support outside of clinical settings, with space to support with multiple determinants of health.

"It's a good place. They do mental health there. It's a drink and drugs place as well. So everyone can help, with their drinking or drug taking. You can get your prescriptions there. So, I take a script as well there…The place is great. I go every couple of weeks, or once a month, sit down and have a chat with them. See what's going on with me." – Groundswell peer

Mental health workers in the community can and should work with housing options and homelessness services to identify housing risk early and engage appropriate support whenever possible. This requires homelessness services to hold resource to deliver community-based support for those at risk of homelessness through outreach or 'floating' support. Unfortunately, such services have been cut significantly in recent years due to financial pressures pushing providers to focus resources to crisis services at the cost of preventative support.

There are countless examples of effective partnership working across the country. However, these are often the result of one or two 'heroic enthusiasts' who develop and deliver effective working at local level. To make this universal ICSs must take a leadership role in creating sufficient and high-quality mental health care for people with severe and multiple disadvantage.

Dual diagnosis

A key blocker that should be urgently addressed in community mental health reform is access to dual diagnosis services. At current, people with a dual diagnosis of mental ill health and substance use are frequently locked out of support:

"Whenever we try and request a mental health assessment, so as people can get the right support, they will often say… they need to cut down on their drug use first. And you just think, well they are using the drugs to manage their mental health. And it's kind of a difficult one – which came first, the chicken or the egg. But we do find a lot is no mental health services will touch you until you stabilise… or cut down on your drug or alcohol use." – Groundswell, 2022

Mental health services should ensure a dual diagnosis pathway is available in all trusts, at a scale which can meet local need.

Housing First

"Things are working out for me on a personal basis quite well at the moment, you know, mental health support […] I'm in the right frame of mind, and the support helps me stay in that positive frame of mind." – Housing First resident

We know that there is a cohort of people for whom the enduring health needs caused by trauma and homelessness mean they require long-term, continuous care. The open-ended, evidence-based support of high-fidelity Housing First is therefore more clearly defined as a health and care intervention than a simple homelessness intervention.

The mental health benefits of Housing First are significant: the programme is targeted at those whose health is severely compromised by long histories of multiple disadvantage, and support often results in improved engagement with routine healthcare, improvements to mental health and stabilisation and reduction of substance use. Research from Homeless Link found 55% of Housing First residents showed improved mental health after working with Housing First for three years, alongside an 18% drop in safeguarding concerns across the same period.

Perhaps most importantly, Housing First shows people with histories of complex trauma and instability building a sense of home, agency and self-worth. Research from Homeless Link shows that only 9% of Housing First residents said they had hobbies or interests at the point of entry – and that this jumped to 37% after 3 years of engagement. During this same period, the number of people reporting positive social networks more than doubled. A different research paper found that rates of begging dropped from 71% to 51%. The recovery effect of Housing First goes well beyond just physical recovery – with residents showing emotional recovery, increased resilience and an improved quality of life, accessible because of the support of the scheme.

Investment in Housing First would significantly improve the mental health outcomes of people experiencing homelessness with severe and multiple disadvantage, and mean key workers had sufficient time to offer support with navigating and engaging in healthcare. In recognition of Housing First's role in delivering long-term care and supporting with significant mental health needs, the NHS should invest in its rollout across England, ensuring access to everyone who needs it.

Trauma informed practice

Embedding trauma-informed principles in health services can support people experiencing homelessness to engage with healthcare more consistently and improve outcomes and engagement. The NICE guidance on integrated care for people experiencing homelessness (2022) outlines the basic principles of responding to people in a consistent, non-stigmatising and trauma informed manner. Further measures should be rolled out to integrate the recommendations from this guidance into practice across the country and appropriate training to ensure staff have the skills to implement recommendations effectively.

Homeless Link have produced a trauma-informed toolkit for services working with people experiencing homelessness (2024), the learning of which can be adapted across healthcare settings.

Data visibility

The mental health sector has led on enacting changes to routine data capture to identify housing status. Mental health staff must be given adequate training and guidance to confidently include questions around housing status and risk of homelessness as part of routine enquiries and, where relevant and with consent, share this information with other support agencies. It is also essential that the data collected are used to map need and assess how well services are reaching marginalised people.

What blockers or enablers should policy interventions prioritise addressing to improve the integration of person-centred community mental health care?

- Centre homelessness as a health and social care issue and support efforts to ensure everyone has access to a safe, secure home and the support they need to keep it.
- Officials with responsibility for mental health should engage closely with the interministerial group on ending homelessness and the upcoming homelessness strategy, ensuring mental health needs are reflected in this.

- ICSs should take a leadership role in ensuring the recommendations of NG214 are embedded in all community mental health settings.
- Improve early intervention and support for poor mental health as a key part of homelessness prevention.
- Include homelessness providers as partners in the delivery of mental health services including joint commissioning, integrated working and collaboration.
- Delivery of a joined-up, systems-wide approach that is flexible enough to allow for a diversity of solutions, without having to endure repeated/multiple referrals.
- Ensure every trust has a dual diagnosis pathway sufficiently scaled to meet local need.
- Peer-led and co-produced training for everyone working within a joint-up system, to combat stigma and promote inclusion.
- A diverse range of housing solutions, including low density longer term supported accommodation for those who have had long in-patient stays.
- The scale-up of Housing First so that it is available to everyone who needs it.