Mental Health Network
NHS CONFEDERATION

briefing
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Mental health and homelessness

Planning and delivering mental health services for homeless people

Key points

- There is a strong link between homelessness and poor mental health, with high rates of mental health problems and substance misuse among the homeless population.
- The Government's mental health strategy identifies addressing the mental health needs of homeless people as a priority for action.
- Access to mental health services for homeless people can be improved through improving staff awareness and delivering services differently – including use of non-clinical settings – plus through effective joint working with partner agencies.

Around 70 per cent of people accessing homelessness services have a mental health problem.[1] Homelessness charity St Mungo's estimate that 64 per cent of their clients have drug and/or alcohol problems.[2] Although the causes of homelessness are complex, mental ill health is a major contributing factor.[3] Becoming homeless can worsen existing conditions or cause a mental health problem to occur.

This *Briefing* sets out the policy context around tackling homelessness and addressing the mental health needs of homeless people. It also examines what considerations need to be made when planning, designing and delivering mental health services for homeless people and highlights examples of good practice.

Background

On any one night there are almost 2,200 people sleeping rough in England,[4] a 23 per cent increase from 2010. Figures from Crisis and the University of York estimate nearly a further 23,000 people are in emergency accommodation, including hostels.[5]

Other people, often termed 'hidden' homeless, include families or single people who live with family or friends, or squat in empty buildings. This group will not have the same level of need as those sleeping rough or in hostel accommodation, though the path to the streets often includes periods of living in this type of accommodation.[6]

This *Briefing* focuses on single homeless people (that is, those

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without dependent children), who either sleep rough or live in hostel-type accommodation.

There is a higher prevalence of mental health problems in the homeless population, both for common mental disorders and more severe conditions. In a survey of 900 homeless people, Homeless Link found that 49 per cent had depression and more than 40 per cent experienced anxiety.[7] Recent research by the former National Mental Health Development Unit and the Department for Communities and Local Government, cited by Homeless Link, suggests that up to 60 per cent of individuals living in hostel accommodation and accessing homelessness services have experienced complex trauma or have an undiagnosed form of personality disorder.[8]

Histories of childhood abuse or trauma, which may result in an inability to form enduring or stable personal relationships, is prevalent among homeless people.[9] Alcohol and substance misuse, relationship breakdowns, periods in prison and bereavements are also common experiences among homeless people. These experiences may be compounded by low educational levels, poor social skills and multiple physical health problems.

A considerable proportion of homeless people have a dual diagnosis, with both one or more mental health problems and a problem with drugs and/or alcohol. Estimates of the prevalence of dual diagnosis among the homeless population vary from 10 to 50 per cent.[10, 11]

'Homeless people are 40 times more likely not to be registered with a GP than the general population'

Policy context

No health without mental health[12] identifies addressing homelessness, and the mental health needs of this group, as a priority for action. The strategy recognises the need to improve access to mental health treatments and support.

The Government's *Vision to end rough sleeping: no second night out*[13] sets out six priority areas where Government departments and partners have committed to work together to end rough sleeping, including a commitment to help homeless people access healthcare.

The recently published public health outcomes framework[14] states the number of statutory homeless people will be used as a key indicator at national and local level. However, it should be noted that, currently, statutory homelessness figures, which are drawn from local authority data on people eligible for and in need of housing, do not cover the majority of single homeless people.

Working with homeless people

Accessing services

GPs are not the routine gateway to healthcare services for homeless people that they are for the general population. One study suggests that homeless people are 40 times more likely not to be registered with a GP than the general population.[15] As a consequence, they are more likely to access healthcare services through urgent and emergency care.[16]

There are a number of possible reasons for poor primary care access,[17, 18, 19] including:

- GP surgeries may require proof of address for registration
- the social skills and lifestyles of homeless people mean that many find it difficult to book and keep appointments
- some homeless people will not seek assistance until their health is critical, requiring urgent or emergency care. Personal barriers, such as lack of motivation to get help, low self-worth, being too drunk/high, or simply too fearful of what might happen, contribute to this, as can previous negative experiences of healthcare
- stigma, judgement and discrimination, either real or perceived
- practical barriers, such as services being a long way away and long waits for appointments.

According to a 2010 report from the Department of Health: "There may be a disincentive for individual primary care trusts to provide good primary care for homeless people where they are a mobile population and the provision of a high quality, easily accessible service may attract users from other areas, putting additional strain on resources".[20]

St Mungo's report that access to mental health services continues to be problematic for their clients with a dual diagnosis,

with a lack of joined-up services available to enable their mental health needs to be addressed in tandem with substance or alcohol misuse issues. They also report that homeless clients are sometimes escorted from premises by security staff without getting to see a health professional as a result of their behaviour or appearance.

Historically, the provision of mental health and drug and alcohol services has evolved separately. A 2009 briefing from the Mental Health Network highlighted the challenges this presents providers and commissioners in terms of providing appropriate and effective services.[21] Providing effective care requires a high degree of collaborative working between agencies. A 2002 good practice guide from the Department of Health[22] stressed the need for joint planning between mental health and substance misuse services. It also highlights the need for local strategies to recognise the importance of substance misuse in mainstream mental health services, with a lead clinician and training for staff.

The Government acknowledges that homeless people often do not receive the support they need to overcome their mental health and substance misuse problems.[23] A survey of 500 homelessness service providers found that 64 per cent reported difficulty in accessing mental health services on behalf of their clients.[24] It found that key issues hampering access included client motivation, waiting times, and clients not meeting eligibility criteria.

Improving access

Access to mental health services for homeless people can be improved through improving staff awareness and the development of models of care better able to engage with complex presentations, including passive non-engagement and aggressive behaviour.

Many homeless people have a history of abusive relationships and are therefore often acutely aware of actual, or perceived, slights or abuses of power.

'The Government acknowledges that homeless people often do not receive the support they need to overcome their mental health problems'

Homeless people cite relationship breakdown as one of the principle causes of homelessness.[25] It is important that healthcare staff treat homeless service users with dignity and respect; consistent

Case study: START – an assertive outreach team working with homeless people

The START team, within South London and Maudsley NHS Foundation Trust, accepts referrals directly from homeless charities, as well as from individuals. In so doing, they bypass the need for GP referrals – often a problematic access route for many homeless service users.

START practices assertive outreach and works in close partnership with local charities to identify homeless people who have severe mental health problems. The team, which includes two psychiatrists, three psychologists, six care coordinators and a psychotherapist from the St Mungo's LifeWorks project, works in the streets, hostels and day centres of South London to assess the mental health needs of homeless people, before making a decision whether to refer them to inpatient or outpatient care, or to provide care directly through the team.

According to consultant psychiatrist Phillip Timms, at the core of its service is engagement and building a relationship with clients. This starts with an introduction and the offer of practical assistance, for example through their benefits worker or a vocational specialist.

"You need to build up a relationship with someone, to get to know them as a person, before you go on to recommend a referral to clinical services, or offer them psychotherapy or medication." The team works with some service users for weeks, others for years, and at any one time are working with 100 service users.

Dr Timms is keen to stress that the benefits of the service are not all one way: "It is very rewarding. We have few problems in attracting or retaining good staff."

> ‘Greater staff awareness of how to communicate positively and empathically may help to prevent the exclusion of homeless service users’

respectful relationships and therapeutic alliances are a key aspect of treating people with relational problems.

Part of treating homeless clients with dignity is ensuring that staff genuinely listen to their needs, stories and, if possible, build up relationships with them over time. Homeless people often have very complex individual stories, often unheard for years, and their exclusion from family and other social institutions mean that sharing those stories in a safe and supportive environment is a vital part of their recovery. Experience of personal trauma may also mean that their communication skills are poor, for example, when dealing with reception staff. Greater staff awareness of how to communicate positively and empathically may help to prevent drop-out from treatment.

Homeless service users may arrive for appointments unkempt or unwashed, and might display challenging behaviour. Ensuring people are treated with respect and dignity may require proactive steps, for example the use of staff training and the development of formal organisational policies.

Organisational policies which are overly rigid often work against the successful treatment of homeless people.[26] According to St Mungo’s, more flexible approaches orientated around recovery and a clear set of values have more success.[27] Over time, jointly developing rules for engagement with service users, with a focus on enabling access and reducing exclusion, is important for the success of an individual’s treatment.

Therapeutic environments

St Mungo’s have piloted the ‘psychologically informed environments’ (PIEs)[28, 29] approach in a range of settings. The framework has been developed by St Mungo’s, alongside the Department for Communities and Local Government, to cover five core elements:

- managing relationships
- establishing a psychological framework
- the physical environment and social spaces
- staff training and support
- evaluation of outcomes.

The ‘managing relationships’ component encompasses not only the relationship between staff and clients, but also the relationship between staff and management, as well as with partner agencies and commissioners. The approach stresses the need for positive relationships across a broad range of stakeholders to maximise effectiveness.[30]

Case study: St Mungo’s – integrating psychological therapy and housing-related support

The St Mungo’s LifeWorks project, established in 2008, offers homeless people access to fully-qualified psychotherapists regardless of diagnosis or active substance use. It provides individual psychodynamic psychotherapy to chronically excluded adults who are homeless or at risk of homelessness, including rough sleepers. Treatment, which takes place in a range of locations, including St Mungo’s sites and GP surgeries, enables clients to talk about emotional and other issues that are bothering them (such as relationship breakdown). In evaluating the service, St Mungo’s found:

- 75 per cent of clients showed an improvement in their mental wellbeing according to the SLaM Mental Wellbeing Impact Assessment Measure
- 42 per cent were in employment/training placements by the end of 25 sessions
- the costs of the LifeWorks service appeared to be offset by clients’ reduced use of other healthcare services, such as emergency and crisis services, within one year.

St Mungo’s are in the process of agreeing further evaluation of their LifeWorks project. However, the project has already demonstrated that good outcomes can be achieved by integrating clinical input into existing social care and support networks, and that accessible psychotherapy can reduce demands (and costs) on both health and social care.

Case study: Cambridge Access Surgery – integrating primary and mental healthcare

The Cambridge Access Surgery is a general practice whose 400 registered patients are all homeless, or at risk of becoming homeless. Approximately 70 per cent of patients are drug users, 50 per cent misuse alcohol and 40 per cent have a mental illness. They also experience high degree of morbidity for a range of physical health problems.

In addition to providing routine primary care, through both drop-in sessions and scheduled appointments, the surgery manages substitute prescribing for around 60 drug users. It also provides mental health support through a psychiatrist and a community psychiatric nurse, who specialises in the treatment of severe alcohol dependence. It also works closely with the mental health outreach team, provided by third sector organisation CRI (Crime Reduction Initiative).

When asked how the clinic tackles the issue of dual diagnosis, lead GP Dr Ruth Bastable says you can't tackle one issue in isolation: "All issues have to be addressed at once, and that requires good multi-agency working."

The PIE approach outlines the importance of services working within a well-communicated and understood psychological framework. It stresses that service users need to feel safe psychologically as well as physically. For St Mungo's, this is about trying to return as much control over the physical and social environment to service users as possible.

Access to psychological therapies

Evidence from Homeless Link suggests that counselling and psychotherapy can have positive results for homeless, and formerly homeless, clients.[31] St Mungo's have found that easily accessible psychodynamic psychotherapy has a high uptake and positive outcomes[32] (see LifeWorks case study on page 4). Psychodynamic psychotherapy, which stresses the importance of relationships and lived experience in shaping and triggering current behaviours, has been found to be particularly effective for people with complex conditions including personality disorder.[33]

Drop-in services are often more successful than those which require service users to keep set appointment times. Co-location of health and therapeutic staff within hostels also help to improve access for clients who find it difficult to keep set appointments, or are reluctant to enter institutional settings.[34] Delivering clinical interventions in non-clinical settings can help maximise accessibility and uptake.

Recommendations for mental health services

From April 2013, local health and wellbeing boards (HWBs) will have responsibility for setting the borough's strategic commissioning priorities through the development of joint strategic needs assessments (JSNAs) and associated strategies.

Providers of NHS services may want to partner with organisations with expertise in working with homeless people to consider how they can work with the HWBs to ensure the mental health needs of homeless people are addressed as part of that process, and that HWBs have access to any information that will help them assess need. Evidence of unmet need, and linking the provision of services for homeless people to other local authority priorities, such as housing and community wellbeing, may help to get the issue on the agenda.

In 2007 the government published a good practice guide, *Getting through*,[35] aimed at mental health practitioners as well as homeless service providers. This makes a series of recommendations about improving access to mental health services for homeless people. These included:

- identifying and assessing the mental health needs of homeless people at an early stage
- ensuring effective joint working with other agencies to plan, deliver and evaluate service delivery
- investing in ways to improve access, such as street-based services, open access clinics or services co-located in homeless agencies
- secondary mental health providers to have clear protocols for referrals to community

mental health teams and to follow Department of Health guidance[36] on the discharge of homeless people from hospital

- having a named individual responsible for leading on homelessness issues
- ensuring the right teams are in place to enable homeless people into treatment; for example, specialist teams or outreach provision
- monitoring and evaluation to support continual improvements in care; outcome measures could include the percentage of service users with an improved mental health status, service user satisfaction, and the number of people who leave the service without completing treatment.

The Homeless Health Faculty, part of the College of Medicine, has published a series of standards for healthcare providers when working with homeless people. It states that all community mental health services should be ready to work with people who have drug and/or alcohol problems, and that service users should not be excluded on the basis of substance misuse. It also argues that psychological therapies should be easily accessible and that staff need to engage service users through person-centred approaches.[37]

Key questions for boards

For mental health providers

- What training do our staff have in the needs of homeless people?
- What reasonable adjustments do we make in our services to meet the needs of homeless people?
- How well do we integrate our services with local homelessness services, and drug and alcohol services? How effectively do we ensure service users get access to the right kind of support for their housing and substance misuse issues?
- How easy is it to access our services and can our staff work with the full range of presenting issues, including co-morbid drug or alcohol dependency?

Key questions for boards

For clinical commissioning groups and health and wellbeing boards

- Do we know how many homeless people there are in our area and what needs they have? Do we use both statutory and non-statutory data sources?
- Are the mental health needs of homeless people's mental health adequately reflected in our Joint Strategic Needs Assessment?
- Do we monitor whether homeless people, or people with dual diagnosis, have difficulty accessing local services?
- Where are the opportunities for developing integrated services which meet the needs of homeless people?
- Are appropriate local services available including access to psychotherapy for people with complex presenting issues, including co-morbid substance use?
- How are the views of homeless people themselves and of homelessness service providers integrated into the design, planning and delivery of services?

Mental Health Network viewpoint

Providing mental health services to homeless service users requires sensitivity and a recognition that the majority of homeless people not only experience mental health problems, but often experience a complex and overlapping range of conditions including substance dependency. At best, it requires proactive steps be taken to ensure these vulnerable service users are able to access the services they need – including drop-in sessions and redesigned environments. It also requires closer joint working between providers of NHS services and specialist organisations working with homeless people – and a willingness to engage in a recovery-oriented, individualised, and holistic approach to mental healthcare.

One of the key objectives of the national mental health strategy is

that more people will have good mental health. Homeless people often have extremely poor mental health. Monitoring improvements in outcomes for this group over future years will be a key test of how successfully the strategy has been implemented.

For more information on the issues covered in this *Briefing*, contact mentalhealthnetwork@nhsconfed.org

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St Mungo's

St Mungo's opens doors for homeless people. Mainly based in London and the South, we provide emergency shelter, support towards recovery and help to prevent rough sleeping. We run over 100 projects and help thousands of homeless people make life changes every year.

For more information, please see **www.mungos.org** or telephone 020 8762 5500.

The Mental Health Network

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

For further details about the work of the Mental Health Network, visit **www.nhsconfed.org/mhn** or email **mentalhealthnetwork@nhsconfed.org**

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The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 744 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org