HOUSING LIN BRIEFING

Understanding Homelessness and Mental Health

1. PURPOSE OF THIS BRIEFING

This briefing is a joint publication between Communities and Local Government and the CSIP Housing Learning and Improvement Network.

It is intended primarily for providers of mental health services but is also relevant to providers of accommodation and support services, and health and social care commissioners.

It describes some of the difficulties faced by:
- people with mental health problems who are homeless or living in insecure accommodation
- the mental health services with whom they are in contact and suggests ways of ensuring appropriate care and support can be delivered.

2. WHO ARE WE DISCUSSING IN THIS BRIEFING?

This briefing discusses people who are homeless such as people sleeping on the streets, in cars, in buildings not meant for habitation or in some night shelters. It also applies to people living in insecure or short term accommodation who may be at risk of homelessness. These include people living in bed and breakfast accommodation, hostels or squats or who are staying with friends. It does not include families with children in temporary accommodation.

3. MENTAL HEALTH AND HOMELESSNESS: THE EVIDENCE

People who are homeless or living in insecure accommodation have very much higher rates of mental illness than the general population. Precise figures for the prevalence of mental health problems in this population are difficult to capture through the usual channels, as they are frequently not in touch with mental health services. The last comprehensive survey in the UK (Gill et al 1996) [1]included the following key findings:

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[1]1.Gill B, Meltzer M. and Hinds K. The Prevalence of Psychiatric Morbidity among Homeless Adults OPCS Surveys of Psychiatric Morbidity in Great Britain, Bulletin No. 3. London: OPCS, 1996.

- Psychosis in 8% of hostel residents (compared with 0.4% general population)
- Neurotic disorders in 38% hostel residents (compared with 16% general population)
- Alcohol dependence in 47% rough sleepers/day centre users
- Drug use in 46% of those in night shelters
- Drug dependence in 22% of those in night shelters

Thus, the overall estimated prevalence of psychiatric disorders for people in hostels was four times greater than that in the general population .It must be noted that this study does not give the full picture as it did not give definitive diagnostic information for rough sleepers and the prevalence of personality disorders and cognitive deficits were not assessed.

Personality disorder (PD) is prevalent among people who are homeless. It is very common among those with drug and alcohol misuse, and therefore high levels of PD would be predicted in homeless populations. Since the Gill 1996 study, various authors have noted a decrease in the average age of homeless people. This would tend to result in yet higher prevalence of PD (commoner in young people) and higher rates of substance misuse especially injecting drug use. Diagnosis of PD is not straightforward, as responses to homelessness may lead to changes in patients which mimic PD but do not actually represent the disorder itself. A substantial proportion of this group will also have had experience of institutional life, particularly local authority care or prison.

Cognitive deficits are also prevalent in the homeless population, due to a variety of organic causes including alcoholic brain injury and traumatic brain injury[2]. Learning difficulties and literacy problems are also prevalent. This has major implications for case management in terms of the amount and type of support and accommodation that needs to be offered.

Mental health problems can both cause and be a consequence of homelessness. The signs of mental illness antedated their first loss of accommodation in 92% of homeless people studied by North et al (1998)[3]. Schizophrenia, in particular, is a problem, especially as it is difficult to diagnose in its early stages and, once established, is pervasively disabling. Once homeless, stigmatisation, isolation, the disruption of supportive relationships, substance use, physical illness and difficulty in obtaining medical care all combine to reduce the individual's likelihood of addressing their mental health problem successfully.

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[2] Spence S et al. Journal of Royal Society of Medicine 97 (8): 375. (2004)

[3] North C. et al "Correlates of early onset and chronicity of homelessness in a large urban population." - Journal of Nervous and Mental Disease:1998, 186, pp. 393–400.

4. DIFFICULTIES EXPERIENCED IN PROVIDING SERVICES:

Who is responsible? : Both primary care and specialist mental health services can be reluctant to take on the care of people who are homeless or living in insecure accommodation. Specialist mental health services are usually organised on a geographical or GP practice list basis. This means that homeless people, who may not be registered with a local GP, are likely to be perceived as being 'mobile' and not 'belonging' to any particular team, and are disadvantaged when it comes to accessing specialist services. Once treated and ready for discharge, additional barriers may exist related to the availability of suitable supported accommodation, especially if there are short-lived connections with the area.

Continuity of care: For a variety of reasons, homeless people often lose touch with the services who know their, often complex, past history. This is a major challenge for those asked to assess and care for a homeless person. The process of obtaining essential background information and past history is made more difficult if the homeless person is not registered with a GP or has a number of aliases. Additional difficulties in continuity of care can arise when a patient is transferred between workers of teams, even within the same service.

Dual diagnosis: Further difficulties arise where a person with a mental health disorder also uses or misuses substances. Guidance is clear that substance misuse being the norm rather than the exception among patients with mental health problems, the management of dual diagnosis should be integrated into psychiatric care pathways and local commissioning [4] yet any voluntary sector agency and many GPs will describe how their clients have been turned away from mental health services because of their drug/alcohol problem, but simultaneously declined by substance abuse services because of their mental health problem. In practice, co-morbidity can still be a barrier to obtaining either any care at all or adequate care for both conditions, particularly in the most excluded groups such as homeless people who are difficult to engage anyway. Services need to be even more flexible in order to maximise retention in treatment, and services need to offer harm minimisation approaches as well as abstinence-based treatment options.

To admit or not to admit?: When assessing a homeless person, mental health staff can be faced with a person who, if they were living with a family or even living in their own flat where they could be seen by a home treatment team, they would not consider for admission. An inpatient ward does not seem appropriate but they are too unwell for release onto the streets or into insecure or unsupported accommodation. This creates the apparent dilemma around admission for 'social' rather than 'medical' reasons.

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[4] DH Mental health Implementation Policy Implementation Guide: Dual Diagnosis Good Practice Guide
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058

Assessing the severity of illness may also be difficult, in that hostel / shelter staff and residents may be very tolerant of challenging or unusual behaviour and this can lead to health and social care staff being inappropriately reassured. Some homeless people with chronic psychosis may appear so well adapted to their condition, albeit to living on the streets, that professionals are reluctant to undertake compulsory admission, even when there is clear evidence of self neglect and vulnerability. This reluctance can result in delays in the obtaining of key information which might, for instance, trigger the restarting of previously prescribed medication which may enable the person to accept and retain accommodation. Admission for assessment and investigation should be considered seriously in these cases.

Role of advocates: The poverty and poor social networks associated with homelessness can make access to, and delivery of, services difficult. Homelessness accommodation and support agencies are often in the position of acting as advocate or care navigator to homeless people They consistently report problems with the delivery of mental health care, mainly in terms of obtaining access to care for their clients. Furthermore, it can be difficult for non-clinicians to understand why a person who presents in obvious mental distress or with unusual behaviour may not be considered psychiatrically unwell and therefore may not have access to acute psychiatric care.

This perceived deficit in access may be a reflection of the paucity of services to address these presenting issues at a community level, which can leave homeless people and the frontline agencies caring for them, feeling exposed or neglected. The value of engaging with voluntary sector hostel and outreach agencies as advocates and sources of vital information regarding the background and ongoing mental state of the patient, as well as the means to obtain practical support for the patient, cannot be overemphasised.

Young homeless people: This group (under 25 years of age) present a particular challenge. They report high levels of mental ill health and substance misuse. There is an acknowledged high overlap with care leaving services and youth offending teams. On their part, accommodation providers report difficulties in obtaining appropriate health services for this group as they fall into the transition between Child and Adolescent Mental Health Services (CAMHS) and adult services. Additional difficulties can arise because of the difference in transition points with social care, education and health. The situation is further complicated by the co-existence of mental health and substance misuse issues which falls outside the remit of generic services.

5. OVERCOMING THE DIFFICULTIES:

People who are homeless or living in insecure accommodation need care and support packages delivered in ways which reflect individual circumstance. Furthermore, the order in which a homeless person's problems need to be addressed may be unusual due to their individual priorities.

Individual issues:

1. Assessment of mental health problems needs to be tailored to the circumstances in which a person is being seen. The clinical interview needs to take account of the specific circumstances which are generated by living in a hostel or sleeping out. For example sleep difficulties or anxiety may have a different set of implications for someone who is sleeping out, compared with a person living in secure accommodation.

2. An individual may present to services in order to obtain help with accommodation or benefit claims. They will usually see this as their immediate priority, and addressing it appropriately may be the key to continuing engagement with their mental health issues. Staff need to have an understanding of the local authority procedures and ideally to have good working relationships with the housing department

3. Individuals may be reluctant to engage with mental health services due to issues of stigmatisation, because they regard themselves as unimportant or undeserving, or because they do not regard themselves as 'crazy". The ability of services to engage informally and opportunistically is vital in these circumstances. Additionally the 'labelling' of accommodation and support options as specifically for 'mental health issues' may reduce their acceptability to clients / patients. Generally speaking, for the most entrenched homeless patients, more intensive and/or specialist in-put from ostensibly generic medical services such as primary care are likely to be the most acceptable. However, these services need to be commissioned with enhanced mental health and substance misuse provision.

4. Cognitive impairment, learning difficulties and literacy can contribute to the continuing homelessness cycle. Their prevalence has led to recommendations for routine screening[5]. Mild learning difficulties or incomplete education can result in people using words incorrectly, and particular care must be taken to distinguish genuinely odd or bizarre beliefs from simple misuse of terms, or unfamiliarity with available support services.

5. Medication can be a problem in many ways. Keeping medication safe on the streets can be difficult, and supplies are frequently lost or stolen. Hostels and other accommodation providers may have policies precluding the safekeeping and dispensing of medication on behalf of the resident; the way their services are funded and commissioned can compound the difficulty. Guidance is in preparation on this matter, but health staff need to be aware of this issue and should not assume that medication can be supervised by support staff. Cognitive impairment may reduce the patient's ability to understand instructions on obtaining medication or its use. Daily pick up or short (weekly) prescriptions made up in blister packs or similar, may be helpful but will still need to be monitored.

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[5] Spence S et al ibid

6. Other interventions including counselling and psychological therapies can be valuable but need to be planned with due regard to the person's circumstances, ensuring that they have adequate support to benefit from the therapeutic intervention.

Services

There are a number of characteristics which services catering for the needs of homeless people with mental health problems will benefit from considering:

1. Access:
Accessibility to services is important and is facilitated by co-location of mental health services with agencies used by homeless people. Some services need to be offered on a drop-in basis, with no appointment needed. People should be able to refer themselves and to be seen the same day. This specification will in many cases only be available through primary care services. However, in areas with sufficient numbers of homeless and insecurely housed people, it may be cost effective to make arrangements for direct access to specialist secondary mental health services.

All mental health services should have clear referral pathways including from primary care or from hospital general wards or accident and emergency departments, which ensure that assessment of people who are homeless can be undertaken at short notice, and, if necessary, by outreach methods.

2. Engagement:
Engagement with people who are homeless or in insecure housing requires considerable experience and skill. People in this situation have often experienced many episodes of rejection or stigmatisation and may be isolated and suspicious. It can take time and effort to build a trusting relationship.

The venue for this work may be wherever the homeless person can be found and it can be helpful to ensure that day centres, hostels, night shelters and similar gathering places are targeted by any outreach mental health work that is undertaken, as a flexible response to the needs of this group and also an opportunity to work jointly with and support the staff working at these venues. An alternative approach is to co-locate mental health services with other homeless services.

3. Information gathering:
Specialist homelessness medical teams have well-developed procedures for obtaining information on a person's past medical history. The key is often to find the last general practitioner with whom the person was fully registered and who should hold the full medical record, which can often include information going back to the person's childhood. Access to the NHS Splne allows a search for the current GP and notes can be traced via this route. Alternative strategies are to write to the medical records officers

of the psychiatric services in the areas where the person has been for any length of time. In some circumstances, a police check may be advisable, which can also be arranged if the mental health trust or PCT has appropriately developed information sharing policies.

Confidentiality may sometimes be cited as a reason for non-disclosure of such records in the absence of explicit permission from the individual concerned. If necessary, the point may need to be made that there is a strong suspicion that the individual may, by virtue of their mental disorder, not be able to make an informed choice on the matter, particularly if admission under the Mental Health Act is being considered. Issues of risk to the patient or to others may also over-ride the commitment to confidentiality

4. Assessment:

Assessment is a separate task from engagement, although they often occur concurrently. Assessment may also take place in 'instalments' over a period of time and as a result of several contacts. It should also include, wherever possible, information obtained as a result of the enquiries mentioned above and in association with other professionals working with the patient. Non-statutory agencies can play a vital role here, often knowing the patient very well and may be willing to share important and valuable information, with the patient's consent. Particularly helpful can be the observations of professionals who have known the patient for a period of time and can comment on changes in their state over time, including signs of deterioration in self care which may be difficult to assess otherwise in someone who lives in the harsh circumstances of the street.

Assessment of the mental health of homeless and insecurely housed people can be very challenging and requires appropriate knowledge, skills and attitudes about homelessness and the mental health problems which are common among this group. If assessments are allocated across a number of teams within a mental health trust, via so-called "NFA rotas' or similar arrangements, this can make it difficult to ensure that all on-call staff and their ward teams are appropriately equipped to manage what can be very complex problems. A good working knowledge of available services, procedures and information-sharing protocols is crucial. Trusts need to be aware of these issues when organising their care pathways.

5. Availability of a range of provision:

The dilemma faced by mental health staff regarding discharging their duty of care to a homeless person who is too unwell to be sleeping rough but for whom inpatient provision is not necessarily the most appropriate decision, can be reduced by the development of closer working between secondary care services and the voluntary and primary care sectors in order to set up care pathways which can offer skilled and responsive support in the community. These community-based services require support from secondary care services in order to manage the complex patients with whom they engage. Joint commissioning of health and social care should make these kinds of service easier to develop and sustain.

6. 'Phone a friend':

The development of closer working relationships with local networks and agencies in primary care and the non-statutory sector can help to maximise the use of these resources in the planning of care packages and the management of crises. Community-based agencies can often offer a solution to a problem which appears insoluble to hospital based staff, thus helping to avoid inappropriate admissions and may be a key resource for navigating a patient through the range of services with which they need to engage.

7. Admission and discharge from hospital:

Admission to hospital has special challenges for people who are homeless or insecurely housed[6]. It may be important for ward staff to make contact with the patient's shelter or hostel to investigate the accommodation situation and make sure that issues around rent etc are addressed and any care needs identified. The issue of chemical dependence may need to be addressed, to ensure that any substitute prescribing is maintained and that any withdrawal syndrome is recognised, thus preventing self discharge and / or medical complications.

An inpatient stay may be an ideal opportunity to undertake investigations into past history and tracing old notes as well as addressing physical health needs including nutritional status and screening for chronic disease, especially where a patient does not engage with primary care. If they have one, contact with the GP may help in identifying outstanding physical health issues which would benefit from being addressed while an inpatient, owing to the chaotic nature of the patient.

Planning for discharge should be proactive and integrated with housing and social care agencies. The process needs to start as soon as a patient is admitted to hospital in order to avoid inappropriate discharge to a shelter, unsupported bed and breakfast accommodation or to the streets. Specific guidelines for the admission to and discharge from hospital of people who are homeless or living in temporary or insecure accommodation have been published. [7]

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[6] The Socially Excluded Adults PSA (PSA 16) is one of only 30 agreed across the whole of Government, and is the first agreement that has focused specifically on the needs of the most vulnerable adults including adults receiving secondary mental health services. Further information is available at
http://www.cabinetoffice.gov.uk/~/media/assets/www.cabinetoffice.gov.uk/social_exclusion_task_force/chronic_exclusion/psa_da_16%20pdf.ashx

[7] Hospital Admission and Discharge: People who are homeless or living in temporary or insecure accommodation;
Joint DH/CLG guidance, available at:
http://www.homeless.org.uk/policyandinfo/issues/health/discharge/Admissions_discharge29.11.pdf

8. Continuity and care planning:
Obtaining accurate and full past history is vital to maintaining continuity of treatment. Continuity also helps to maintain engagement, in that a trusting relationship, once created, is a valuable asset in ongoing management when considering cost effectiveness of services as it avoids duplication of assessment and input. Achieving continuity of care is challenging if a patient is particularly mobile and it is worth recording which day centres or other venues the patient frequents as well as the patient's mobile telephone number. Non-attendance at appointments should not lead to automatic discharge in the case of these patients but rather to more intensive efforts to trace the patient or obtain information on their wellbeing from other agencies.

For those in the care of secondary mental health services, the insecurity that comes with homelessness, and the complexity of delivering care, are risk factors in themselves sufficient to warrant a full CPA care plan[8]. An assertive multi-agency approach to care planning and delivery involving primary care and accommodation providers is usually necessary to ensure that care is successfully delivered and follow up achieved. Some innovative arrangements have been developed with primary and secondary care working closely together and follow up taking place on primary care premises. This has the advantage of facilitating access to secondary care at a venue that is convenient and trusted by the patient, whilst enabling attention to their physical health needs including monitoring associated with drug treatment, especially lithium and atypical antipsychotic agents.

9. Specialist homeless mental health workers:
Staff with knowledge of both mental health issues and homelessness are a vital asset in managing this patient group as they can offer practical support while acting as a bridge into health services. Their role can sometimes usefully extend into the period when a homeless person is resettled and continues to need support in order to maintain their tenancy.

These workers need to have excellent links with the local generic or specialist homeless mental health services. They should also have time allocated to work peripatetically, making informal contacts with people in day centres etc and to do the tracing work which may be required to track down a mobile homeless patient. This may mean that ratios of new to follow up contacts may differ from that of community mental health teams.

Commissioners and managers need to be aware of the importance of informal contacts in achieving improved mental health and to adjust monitoring of services to accommodate a style of work which does not match standard data recording systems.

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[8] Refocusing the care programme approach: Policy and positive practice guidance available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

10. Training and information:
Most mental health teams will have exposure to patients who are homeless or living in insecure accommodation, and all staff should have an understanding of homelessness issues. Training can be usefully organised with other local services, enabling joint working and understanding. This can be further enhanced by the development, distribution and regular updating of information about local services for homeless people including advice on accommodation and benefits, practical help, access to general medical care / footcare / laundry / day centres etc to enable all staff to signpost services effectively.

11. Support and supervision:
Health professionals working with this population are at risk of isolation and burnout unless adequate opportunities for training, support and supervision are provided. There is some evidence that secondment from larger teams may be more sustainable than being employed as a sole practitioner by a non-clinical agency. [9]

7. MONITORING EFFECTIVENESS OF SERVICE DELIVERY

Improved access to settled accommodation for individuals with mental health problems is a key government priority, and collection of data to measure progress is a requirement for all local authorities and their partners.

At an operational level, this includes ensuring the existence of:

- Written agreements or protocols for referrals to mental health advice, care and support.
- Written agreements or protocols between specialist homeless and other mental health and primary care services
- Written agreements or protocols between accident and emergency and mental health and primary care services and other transfer of care arrangements.
- Written agreements or protocols for the allocation to teams of people who do not have an address
- Written protocols to ensure that the physical health needs of homeless mentally ill people are met
- Hospital admission and discharge policies to ensure that no one is discharged to the streets or other unsatisfactory accommodation.
- Evidence that caseloads are appropriate for staff working with people who are homeless.
- Evidence that appropriate health and social care staff are maintaining a presence in places regularly used by people who are homeless.
- Written agreements for care and support covering people who have personality disorders.
- Written agreements regarding the care of people with comorbid mental health and substance misuse problems

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[9] Taylor, Stuttaford and Vostanis (2007) Journal of Integrated Care

- Written agreements to ensure access to mental health care for 16-17 year olds and seamless transition from CAMHS to adult mental health services

At a policy development and commissioning level, this includes ensuring that data on hard-to-meet needs is collected via:

- Initial assessments in the Mental Health Minimum Dataset
- CPA review documentation and data systems
- Delayed Discharge (SITREPS) recording
- Supporting People Client Records and Outcomes data

Conclusion:

When assessing the needs of an individual who is homeless or insecurely housed and has mental health problems, the individual's readiness to engage with services, and also the readiness of other services to engage with the individual will be key to successful intervention, as are an understanding of homelessness and a willingness to be patient-led in terms of care-planning. Those working with the most excluded must aim to help that person negotiate services, and a thorough assessment and care plan will need to involve discussions with the full range of other workers already involved with that individual, including primary care staff and support staff such as floating support workers, hostel, outreach and resettlement staff.

But the key resource will still often be the relationship that is formed with the care professional. The importance of the care planning task should not eclipse the need to ensure that the individual in question feels listened to, and helped, in terms that they themselves can relate to. Being able to trust, and to feel understood, is the basis for all mental health work, and most especially in working to engage the most excluded.

Related materials and information

- Reaching Out: An Action Plan on Social Exclusion
  (Social Exclusion Task Force policy statement, available at:
  http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out.aspx

- Getting through: access to mental health services for people who are
  homeless or living in temporary accommodation; a good practice guide.
  (NSIP briefing, available at:
  http://www.socialinclusion.org.uk/work_areas/index.php?subid=98)

- "Doing the Right Thing", Timms, P. Journal of Mental Health, Volume
  10 Issue 4 2001, 419 – 426.
  http://www.informaworld.com/smpp/content~content=a713679529

- Personality Disorder - No longer a diagnosis of exclusion NIMHE 2003
  http://www.personalitydisorder.org.uk/assets/Resources/56.pdf

- Making the link between mental health and youth homelessness
  Mental Health Foundation/Centrepoint joint report, available on:-
  http://www.centrepoint.org.uk/documents/Centrepoint_MentalHealth&Homelessness.pdf

- Extra Care Housing models and older homeless people: Factsheet 16.
  CSIP Housing LIN briefing on providing and accessing housing, care
  and support for older people who have been homeless or at risk of
  homelessness, available at :-
  http://www.olderhomelessness.org.uk/documents/extra_carefactsheet16.pdf

- Access to Housing; information sharing protocol
  Housing Corporation recommended protocol for local housing services,
  available at:
  http://www.housingcorp.gov.uk/server/show/ConWebDoc.12842

- Prevention of Homelessness: the role of health and social care
  (CLG/CSIP Networks policy briefing, on
  http://www.icn.csip.org.uk/_library/Resources/Housing/Support_materials/Briefings/Briefing11_rev.pdf

- A report on health promotion and homeless hostel provision on:
  http://networks.csip.org.uk/IndependentLivingChoices/Housing/Topics/browse/Homelessness/?parent=980&child=2423

- Joint CLG/Housing LIN briefing on Improving Access to Health and
  Social Care Services for people who are homeless (forthcoming)

If you would like further to receive further briefings from the Housing LIN
and/or information on our national/regional events and associated learning
tools and resources, please email us at housing@csip.org.uk or write to
Housing LIN, Wellington House, 3rd Floor North, 133 -155 Waterloo Road,
London SE1 8UG or visit www.icn.csip.org.uk/housing

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mental health problems, physical or learning disabilities or people in the criminal justice system. We work with and are funded by

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