

St Mungo's

Response to:

**Future Vision Coalition discussion paper:  
“A new vision for mental health”**

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## **About St Mungo's**

We are London's largest homelessness agency. We provide over 100 accommodation and support services day in and day out.

We run **emergency services** – including street outreach and emergency shelter. We support homeless people in their **recovery** – opening the door to safe housing, health care and work. We help more homeless people into lasting new homes, training and employment than any other charity.

We also **prevent homelessness** through our complex needs housing and support teams for people at real risk.

By opening our doors, and our support services, we enable 1,000s of homeless and vulnerable people to change their lives for good every year.

## **Introduction**

St Mungo's is London's leading homelessness organisation, housing over 1400 people every night. The majority of these have mental health problems – our annual Client Needs Survey shows that 37% have a diagnosed mental health problem, 25% undiagnosed and 33% present the challenging behaviour associated with mental health disorders such as personality disorder.

We run approximately 15 rough sleeper facing hostels, over 30 complex needs projects and over 30 semi independent housing projects. Our clients needs are complex – with the majority having substance use and physical health problems to overcome too. Many have endured the most extreme form of social exclusion in Britain – sleeping rough. Thankfully a significant proportion are housed with us because their vulnerabilities and deeply complex needs have been spotted, and the quality of our supportive housing for people with mental health problems is well recognised.

### **Summary of Key Points**

- 1 We welcome the recovery approach as the underpinning concept of the new vision for mental health, and the promotion of the wide concept of mental health as part of a continuum of human experience that we all share. There is however a need to include within the Future Vision mainstream proposals a vision for working with people with complex needs.
- 2 Practical priorities include access to psychological therapies, access for drug and alcohol users to mental health services and treatment, access to quality supportive housing, application of advocacy to complex needs and provision of accompaniment services.
- 3 We would like to see innovative approaches to supporting people back into employment, and the adoption of useful outcome measures.
- 4 We would like to see clinicians and social care professionals trained in the recovery approach, and an education programme in schools that helps children have a greater understanding of the factors that lead people to behave as they do, and what mental health and illness mean. We would also like to see a public anti stigma campaign.

## St Mungo's Response

### *Question 1: "Is this a vision we share? Why/why not?"*

- 1.1 We would like to say how refreshing we found your discussion paper. It is a real pleasure, and relief, to read a document which so clearly states so much that we agree with and have advocated for. St Mungo's has adopted the recovery approach as our guiding ethos across our work with our users, and we welcome it as the underpinning concept of the 'new vision for mental health'. We are pioneering the use of recovery based services in the homeless field. We believe that everybody is capable of embarking on a recovery journey, and that it is the job of organisations and institutions to support and facilitate this.
- 1.2 Similarly, we welcome your promotion of the wider concept of mental health and mental health problems as being part of a continuum of human experience that we all share, rather than dividing mental health experience (and people) along the dominant but false dichotomy of well/ill. We also strongly agree with your argument that it is the personal, interpersonal, social, economic, environmental and cultural aspects of life that impact on wellbeing, and that mental wellbeing or ill health should not be seen as narrowly contained within the individual. Our experience, derived from our clients, is that their mental health problems derive from and are associated with the very real distresses of their life stories – typically abuse, trauma, early/infantile separation, relationship breakdown, repeat trauma, homelessness – and are compounded by stigma, prejudice and mutual fear.
- 1.3 We therefore agree that we need to see mental wellbeing as a community and social development programme rather than a question of individual pathology. Rather than the 'there is no such thing as society' approach that has dominated our recent cultural life, we need to reinvigorate the belief that 'no [person] is an island', that individuals flourish within an enabling society. 'Well' communities are what we need to pursue, as your vision document argues, rather than just narrow symptom reduction in individuals. This has implications for clinical training and practice and social care and support services, as well as for public education and policy.
- 1.4 We also welcome your conclusion that self-determination is key to successful recovery, but this needs a caveat to be consistent with the 'well communities' approach. 'Self-determination' and belief must inevitably be counterbalanced by other people's self-determination and by a range of social and economic realities; it is by definition this (hopefully) negotiated compromise between the individual and society that will provide an environment for-- effective and well-functioning, socially included individuals.
- 1.5 **Alongside this general agreement, and following logically from its direction of travel, we would like to highlight the need for a new vision for mental health to include within its mainstream proposals a vision for working with people with complex needs.** Many, and possibly most, people with mental health problems have multiple needs, whether social (e.g. housing or offending) or psycho-emotional (e.g. substance dependency or eating disorder); many have two or more serious long term conditions which impact on and exacerbate each other (e.g. psychosis and crack use). At present the 'silo' thinking and practice in especially clinical but also social care leads to the effective social exclusion of individuals with dual diagnosis or complex needs. Services which categorise and reduce people to fit the definitions within their specialism, in order to work with

them according to their 'model', actually exacerbate social exclusion. We need services, both clinical and social, which work with whole people in the broad range of their experience, not just with sub-divided aspects of people which have been categorised to suit professional boundaries: nobody should have to see one specialist to get treatment for substance dependency and another for personality disorder and another for their offending behaviour, for example. Services, including clinical services, should be as generic as possible (which means professionals, including clinicians, need to be able to work with as wide a range of conditions and experiences as possible).

- 1.6 This is true of work with all people who have mental health problems, but if effective ways of working with people with complex needs are developed they will also be effective for working with everyone else: they will be centred on finding effective solutions to the obstacles besetting the patient/client, rather than on providing a solution to a professionally-defined problem. For this reason, we argue that there needs to be a greater emphasis on the mainstreaming of clinical and support services for people with complex needs – it will improve services for everyone.

**Question 2: “What needs to be done locally and nationally to achieve the four aspects of the vision?”**

- 2.1 St Mungo's has recently launched our Health Strategy (September 2008). While primarily concerned with rough sleepers and other homeless people in hostel accommodation, it takes a wide view of health, including discussion of physical health, mental health, wellbeing, and drug and alcohol dependency. The key concept throughout is the promotion of recovery, and our belief that each individual is able to undertake a recovery journey with access to the right support, encouragement and influence to change. In direct terms of mental health and wellbeing, we proposed as key practical priorities:

**Access to psychological therapies**

- 2.2 There is currently little and variable access to psychological therapies for our clients, who include many people with severe and enduring psychiatric illnesses, as well as significant numbers with personality disorders, post-traumatic stress disorder, and serious depressive and anxiety disorders. Behaviours include help-avoidance, self-harm, suicide attempts/suicides, high risk-taking behaviours, poly-substance use, and so on. Some GP services offer counselling, but this is of a variable standard and is usually very short-term and ad hoc; hospital psychology/psychotherapy departments typically have long waiting lists and usually will not work with people with active substance use.
- 2.3 While psychotherapy is not what everybody wants, we believe it must be an option that everybody can access if they have a desire to. We ourselves are piloting a Lifeworks psychotherapy service for all our clients, as well as for other clients in the community who are excluded from existing services, often because of co-morbid substance use. The service is broad-based and psychodynamic, which is an approach that can work with a wide range of individual presenting needs, helping individuals to focus on understanding and overcoming both the immediate and the deep-rooted obstacles to their own success.

**Dual diagnosis**

- 2.4 We believe that it is unacceptable for mental health clinicians to be unable to work with people with substance dependencies: their training needs to be reviewed and changed to equip them with the necessary skills. That someone

uses drugs or alcohol should no longer serve as a possible excuse for turning them away from mental health services or treatment.

- 2.5 Our dual diagnosis project in Brent has shown significant cost savings to the local NHS (in reduced hospital admissions) as well as savings to the local authority (in moving people through to lower cost housing) through combining the more usual mix of quality housing, key working and drugs support with an in-house psychiatrist for clients and staff work.

### **Supportive Housing**

- 2.6 We believe that many people are ending up street homeless because of the lack of access to quality supportive housing. In particular there is a real shortage of complex needs housing for people already identified as in need, for example leavers from psychiatric hospital. Move-on options from our rough sleepers hostels, whether into lower support projects (semi independent or low support) or into longer term complex needs projects, are inadequate. We know from our own outcomes research that this housing blockage can mean people's recovery journey being halted, and even reversed. We estimate that at least half our hostel residents require medium/high or longterm support – and at the time of our survey, half were unable to find a suitable solution.

### **Advocacy**

- 2.7 It is still, sadly, often the case that the individual is not listened to, and that treatment or other services are devised and delivered around professional concepts of what the 'problem' is. At other times, people simply misunderstand each other, for experiential or cultural or language reasons. Sometimes people simply do not have the vocabulary to make themselves understood by the professionals with whom they are working, or the professionals do not have the experience or vocabulary to understand them. In all these instances, an advocate can make an enormous difference.

- 2.8 We think that the advocacy accepted as good practise in much of more mainstream mental health services needs to be applied to complex needs too and made more accessible. In the model that we practice, advocacy is provided by peer volunteers supported by a professional advocate with extensive knowledge of rights and entitlements, who also provides training and support for the peer advocates. We believe that the introduction of widespread access to advocacy would have a very big impact in supporting and encouraging clinical and other support services to adopt a person-centred recovery-oriented approach.

### **Accompaniment**

- 2.9 A very big difficulty, and one which is very excluding, for many people experiencing mental health problems is going out - getting on buses or trains (especially, in London, tubes), going into unfamiliar places, seeing professional or other powerful people, can be so daunting that it becomes an impossibility. People are often then penalised for failure to attend, or failure to engage. A simple way to alleviate this situation is the provision of accompaniment.

- 2.10 Accompaniment can be organised within peer support groups, through befriending schemes, through voluntary work, or through the provision of low threshold support services – but it would make a big difference to the lives of many people if it were provided one way or another. We therefore argue for the provision of accompaniment services that are widely accessible.

2.11 We intend to pilot both advocacy and accompaniment as part of the delivery of our health strategy, but obviously this would only be a temporary local solution: accompaniment services should be funded as part of community provision across the board and better directed to individuals with complex needs.

### **Occupation**

2.12 Personally and socially valued occupation is a key to social inclusion and to personal satisfaction: it is a major area in which people with mental health problems face discrimination and exclusion.

2.13 We have long championed innovative approaches to supporting people back into employment; we introduced the 'Clubhouse' model to Britain, and would like to see this more widely available. We continue to devise innovative ways of supporting people back into employment, or in retaining existing work, and are currently piloting Pathways to Employment in our hostels. As part of our health strategy, we are seeking to ensure we employ a reasonable number of mental health service users and we are reviewing our systems for supporting existing employees who develop mental health problems so that they can retain employment.

2.14 It would be relatively simple for Government, Local Authorities, and PCTs to commit to employ people with mental health problems to a level that reflects the society from which they derive their workforce. Such a lead would go a long way to reducing stigma. Voluntary sector providers could easily do the same. This could be further embedded by commissioners making this concept a requirement within the commissioning process.

2.15 One aspect that is crucial is that people with mental health problems are employed in socially valued positions, according to their capabilities, not just marginalised into low-value employment regardless of their talents and skills.

### **Outcomes**

2.16 Key to successful work with people with mental health problems are useful outcome measures – which means outcomes recognised as useful by the people experiencing mental health problems. We welcome the vision document's proposal that all mental health services should be measured on how they contribute to an individual's quality of life: such a measure would transform clinical and social care. **We have pioneered a soft outcomes measure that we are successfully using for people with complex mental health problems – St Mungo's Outcomes Star.**

2.17 In addition to the issues we raise in our health strategy, we believe there are other key practical actions that could usefully be taken up at national level:

### **Training and education**

2.18 We would like to see clinicians and social care professionals trained in the recovery approach, and in modern perspectives on attachment and child development, giving them a broader understanding of intersubjectivity and the other social processes that can lead to mental ill health. This would help to move away from narrow definitions that pathologise the individual alone, and narrow services that treat the 'problem' as situated uniquely within the individual.

### **Children**

2.19 Most of our clients with mental health problems suffered a range of early losses, trauma, abuse, periods in care, etc. We believe that for many their

problematic situations and their difficulties in coping with life could have been picked up when they were still children, and worked with then, saving them great anguish and society great expense. We would like to see an education programme in schools that helps children have a greater understanding of the factors that lead people to behave as they do, and what mental health and illness mean; and we would like to see better support for parents and carers, including better training and education for professional carers; and we would like to see counselling available to all school children. Teachers should also be better trained to spot disturbed children, and to sensitively offer access to help.

- 2.20 Particular attention needs to be paid to the training of staff working with, and to the support and treatment provided to, children and young people in 'care', including foster care and young offenders institutions. Many of our clients have suffered trauma and abuse within these systems, compounding the psycho-emotional problems they already developed from poor/abusive parenting.

#### **Anti Stigma Campaign**

- 2.21 Despite the good work done by many members of the coalition, it would still be helpful to everyone to continue a sustained campaign of propaganda to counter the stigmatisation of people with mental health problems, redefining mental states as parts of a continuum rather than in terms of a divisive us/them well/ill dichotomy.

#### **Primary Care**

- 2.22 We believe that more should be done to work with people's mental health in primary care services, helping people to begin their recovery at an earlier stage. We would like to see a sort of 'general practice' counselling service that could work with people with the whole range of conditions experienced by GP's patients in every primary care practice. We believe that to provide limited psychological therapies that focus on, for example, anxiety and depression excludes a large proportion of people and exposes them to the risk of worsening mental ill health: it means that for our client group, for example, there would be little or no point in attending psychological therapy in primary care. We believe that experienced clinicians capable of working with most conditions should staff these counselling services, so that the first port of call is likely to meet the need of most people.

#### **Question 3: "What do you think are the top three priorities for the next ten years of mental health policy?"**

- 3.1 Adoption of a quality of life outcomes measure as the performance standard across clinical and social care services, and across the statutory and voluntary sector.
- 3.2 Broader training for clinicians and social workers, and other mental health professionals, steeped in the recovery approach, focusing on the interpersonal, intergenerational, social and cultural aspects of mental health and mental illness and moving away from the narrow diagnosis/treatment model.
- 3.3 Propaganda aimed at reducing discrimination and fear, backed by a solid employment programme led by the big public sector employers.

I hope this response is helpful. Should you wish us to expand or clarify any of the points made in this document please contact me using the details below.

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