

Full Report



Happiness Matters:

Homeless people's views about breaking the link between homelessness and mental ill health

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40 ST MUNGO'S
1969-2009

St Mungo's 
Opening doors for London's homeless

Contents

1	Introduction	4
2	Hey, Prime Minister!	6
3	The research	7
4	Mental health and homelessness	8
5	Mental health problems	12
6	Emotional wellbeing	15
7	Drink, drugs and mental health	17
8	People still living on the streets	19
9	Services and support for mental health	21
10	Seeing the bigger picture	29
11	Meeting the needs of homeless people with mental health problems	31
12	Recommendations	37
13	Case studies	39
14	References	42

Foreword



In the forty years St Mungo's has been working at the frontline of homelessness, a lot has changed. From our early days as a grassroots organisation running a soup kitchen, we have evolved into London's leading homeless agency, providing a wide range of housing, health and work support to over 10,000 people a year.

Yet many of the challenges we face remain the same. Over the decades we have continued to come across large numbers of people with poor mental health, which can both cause and prolong their homelessness. Official figures show that around a third of people who sleep rough have diagnoses of severe and enduring mental health problems. From our own research on the frontline we know that the actual prevalence of mental health problems is far higher; when undiagnosed mental illness and emotional disorders are included.

But bare statistics, although shocking, do not show the full picture. The highly personal and individual stories of our clients demonstrate the complex interplay of experience, circumstance and resilience which combine to affect a person's present situation. That is why we asked a group of our clients to help us design and carry out this research – our aim was to give a voice to a group who so often are off the radar of policy-makers, and fall through the gaps of service provision.

The peer research approach enables individuals to give frank and honest information about their past to a trusted interviewer who has 'been there'. The results make for powerful reading. It is clear that despite improvements in mental health service provision over the decades, homeless people are still not able to access the treatment and support they need.

The recommendations have implications for homelessness services too. St Mungo's has already pioneered innovations such as our adoption of the Recovery Approach, in which all staff are now trained, and our Lifeworks Project, which provides access to psychotherapy to clients across our projects. But as an organisation we can never be static. The recommendations of this report will inform our own internal evaluations and mental health strategy.

Mental health has historically been St Mungo's biggest specialism – we brought the Clubhouse model to the UK in the 1980s, which is a mutual self help and support group with an ethos of work for those recovering from severe mental illness, and many of our projects have their roots in the Homeless Mentally-Ill Initiative of the early 1990s. To continue this tradition, St Mungo's has adopted mental health as a priority campaign for 2009, our 40th anniversary year. We have launched a major national Call for Evidence on Mental Health and Homelessness to raise the profile of the issue, draw together the views of key stakeholders, and inform a set of recommendations for Government. The research study reported here is part of St Mungo's own submission to the Call for Evidence.

This unique report would not have been possible without the passion and enthusiasm of the 12 peer researchers who designed the questions and carried out the interviews. The findings would not have such resonance without the frank and honest input of the 200 people who agreed to be interviewed or completed questionnaires. I thank them for their commitment to the project. They took part because they would like their stories to be told, and we will continue to ensure their experiences inform our own position on this issue.

We can't eradicate the past, but we do have the opportunity to support people towards a happier and more fulfilled future.

Charles Fraser CBE
Chief Executive

I. Introduction

Mental health matters. The impact of mental ill health on the individuals affected – the personal trauma, the sheer waste of human potential and the denial of the right to a fulfilling life – cannot be overstated. Nowhere is this more evident than in the case of people who are homeless and sleeping rough on the streets.

As an influential report to the government on mental health and the need for more preventive services has said:

'Mental illness is a major source of suffering, probably worse than poverty. It leads to massive social exclusion and costs to the Exchequer... We should do all in our power to prevent people with mental illness becoming disconnected from society, and, if they have become so, to reconnect them.'
(Layard 2005)

In addition to severe mental illness, many people experience what is generally described as poor mental health – that is, they feel depressed, stressed and distressed much of the time, without being sufficiently affected to need medical help. This is what we call poor mental wellbeing. This can have a very detrimental effect on the quality of people's lives and relationships with others. For homeless people, it can prevent them getting on top of their problems and moving towards making a better life. In the words of one homeless person interviewed in the research reported here:

'[Being homeless] makes me feel low in the long run as you lose hope in getting back on track and into society'

Many factors – social, environmental, genetic – are known to impact on our mental health and wellbeing. Poor quality, insecure housing and the stark reality of being homeless are frequently the cause of much mental distress. But it is not as simple as that; just as homelessness can cause mental ill health, so can mental ill health itself lead to homelessness. Mental health problems affect many areas of a person's life and when their poor emotional wellbeing starts to affect their ability to hold down a job, a relationship and/or accommodation, the result can be homelessness or even being forced to sleep rough. Once homeless, many people, even those who start out in good mental health, find that the grim reality of their situation tips them into mental illness and thus worsens their chances of finding a route off the streets and out of homelessness.

The aim of the research study reported here was to look

at the issue of mental health specifically in relation to homelessness, and vice versa. We felt it was important to explore the role mental health problems can play in causing homelessness, and how homelessness impacts on mental health. We wanted to find out more about homeless people's access, or lack of access, to help for their mental health problems, and what they themselves say they would find helpful.

Importantly, we wanted to know not just about the needs of homeless people with diagnosed mental health problems; we also want to know about their mental and emotional wellbeing, which we defined quite simply, based on the widely recognised WHO definition, as:

'Someone with good mental health is enjoying life and can cope with the stress in their lives. They have a positive sense of feeling good and they believe in themselves. They feel valuable in their community.'

Mental health is a highly personal, and highly stigmatised subject. We wanted our research to examine issues that homeless people themselves think are important in relation to mental health and wellbeing. We also wanted our interviewees to feel able to speak openly and freely, without fear of being judged, about their mental health and mental health support needs, and about potentially painful and distressing aspects of their lives.

For these reasons, we decided to use trained peer researchers (people with their own histories of homelessness) to work with us, not just to interview clients but also to decide what questions to ask and how. We know from previous experience in St Mungo's that this approach both ensures we address the issues that homeless people feel are important to them, and enables our clients to talk more freely and honestly about themselves.

A total of 12 peer researchers were recruited from among people currently living in St Mungo's accommodation projects, many of whom had a personal history of rough sleeping and mental illness. All had been homeless at some point in their lives, and their experience guided our approach. We trained them in general interview techniques, and provided them with basic information about mental health and emotional well-being. We also supported them throughout the interview process, and ensured they had the opportunity to talk through any difficulties and emotional distress that conducting the interviews may have stirred up for them.

The impact of this report and the depth of its findings are due to these 12 peer researchers who did such an excellent job of guiding the research and conducting the interviews. Huge thanks are also due to those who agreed to be interviewed and who shared their stories so candidly.

For this report we have also drawn on the 2008 St Mungo's annual Client Needs Survey and a wide range of other published research into mental health and homelessness to set our findings in the wider context of what is already known about homelessness and mental health.



2. Hey, Prime Minister!

One of the questions asked of interviewees was: 'If you had five minutes with the Prime Minister; what would you suggest, from your experience, does he need to change to improve homeless people's mental health?' The responses were rich and highly varied. They provide a good introduction to the issues that this report explores. They also illustrate the extent to which homeless people are keenly aware that there are political and social solutions to their difficulties.

The comments speak for themselves.

'More support, listen to what we say when we're asked what we need to help us. Everyone needs different things'

'Get to the roots of people's problems, don't just put an Elastoplast on a gaping wound. Early stuff can affect people through their lives'

'More funding, more drop-in centres for mental health. Reduction of waiting lists to see professionals'

'... he needs to improve on timescales, some people think they are ready but they are not so time scales is needed'

'I really feel the Prime Minister and his colleagues don't fully understand depression, addiction and things like anorexia'

'Government's perception about mental health, more dual diagnosis clinics. More in depth counselling and psychiatry'

'He's done a bit. Some holistic remedies instead of chemical'

'Give them as much support as they can get and re-house them in appropriate accommodation as long as it's safe and secure'

'[The Prime Minister] needs to feel the pain and stop talking'

'Bigger budget and more trained staff. I think there should be 24 hour walk in centre with fully trained staff'

'More funding and more professionals that have the understanding and the TIME to listen'

'A lot of people who work with the homeless look down on us coz they've never been in that position themselves. We have the experience of living on the streets'

'Put more money into training ex users, each one teach one'

'Take all the thousands of pounds from the MPs that are claiming for second homes and expenses and rechannel it into dedicated mental health project for vulnerably housed and homeless. And ensure councils make their long term empty housing available for those in need'

'People need care and treatment that is individually needs based. Not diagnosis based. This should be intensive and for as long as necessary. Only then can you start applying the recovery approach'

'I would ask them to make sure when people are hospitalised when they're discharged they should have suitable accommodation'

'Need to house people. Acknowledge that there are people on the streets that have problems and resource more'

'Homelessness has to be understood more. Get people off the streets into hostels. Encourage people to help themselves'

'We need to be prioritised. If a strong woman like me can barely cope, how do you expect less able and vulnerable people to cope?'

3. The research

Individual, face-to-face interviews were undertaken with four groups of homeless people at different stages of recovery and with a range of diagnoses, known and unknown:

- rough sleepers (street homeless people who are resistant to going into accommodation)
- clients currently living in specialist mental health projects who have known, diagnosed mental health needs
- general hostel clients – a combination of rough sleepers and more general homeless populations
- clients known to have mental health needs who have recovered sufficiently to move on into independent accommodation.

The aim was to interview 15 people in each group, except for the hostel clients, to reach a broad cross section of the people using St Mungo's services. General hostel clients are likely to have the greatest variability in mental health needs, so we aimed to interview 55 clients in this group. The interviews were held in private, on a one-to-one basis with the interviewee and the peer researcher, who noted the answers which were then passed to the report author.

The focus of the research was on homeless people's own perceptions of their mental health and well-being, what led to their being homeless, the factors that they felt affected their mental health and wellbeing, the support and services they had received, and the support and services they felt would be helpful.

We also distributed a self-completion questionnaire across all St Mungo's accommodation projects. Staff gave copies to residents and collected back responses.

Participants

A total of 103 homeless people took part in interviews and 97 questionnaires were returned (tables 1 and 2). In addition, the views and experiences of the 12 peer researchers were invaluable in shaping and focusing the research.

In total, almost two thirds of interviewees and questionnaire respondents were living either on the streets (5%) or in hostels or emergency shelters (60%). St Mungo's hostels and emergency shelters take in people who desperately need accommodation and most of their

residents will have spent time on the streets or in precarious accommodation situations. The remainder of the people surveyed were living in high support mental health or complex needs projects (14%), or St Mungo's semi-independent housing (18%, all of whom were questionnaire respondents), or had moved out of St Mungo's into their own flats (5%). Most of these people had come through the homelessness 'system', having spent time in a St Mungo's hostel. Tables 1 and 2 show the actual numbers.

Most respondents had been living in their current accommodation for a year or less but had been homeless for two years and more.

Type of accommodation (current) - interviewees	Sample size
1. Street	9
2. Shelter	17
3. Hostel	51
4. Mental health/complex needs project	18
5. Living independently or semi-independently having experienced mental health problems	8
Grand Total	103

Table 1: interviewees

Type of accommodation (current) – questionnaire respondents	Sample size
1. Hostel	51
2. Mental health/complex needs project	9
3. Semi-independent housing	36
4. Living independently or semi-independently having experienced mental health problems	1
Grand Total	97

Table 2: questionnaire respondents

Most of the people surveyed were white men between the ages of 30 and 50 (they make up the majority of single homeless population (see Warnes et al, 2003)). Just under a third (30%) were women and approximately 25% were from black and minority ethnic backgrounds. Approximately two thirds overall were in the age range 30-50.

4. Mental health and homelessness

Mental health problems are inextricably linked with homelessness.

'Mental health problems can be a contributory factor that leads to homelessness and can also arise as a result of, or be compounded by, the experience of homelessness. People who are homeless may also have additional support needs which make accessing mental health services more difficult.' (Randall, Britten & Craig 2007)

Many of life's experiences make ending up homeless more likely. Many of these are also typical precursors of mental health problems.

Homelessness rarely springs on people out of the blue (Croft-White & Parry-Crooke, 2004; Reeve et al, 2007; Rosengard et al, 2001; Kennedy et al, 2001; Smith et al, 2007). The same issues crop up time after time in all the research. Many, many homeless people, far more than the general population, have experienced one or more of the following:

- poverty
- leaving prison
- leaving the armed forces
- leaving the care system
- relationship breakdown
- domestic violence
- bereavement
- early loss of a parent
- childhood abuse.

This extract from a recently published memoir by John O'Donoghue, someone who experienced both homelessness and severe mental illness (and who did actually spend time living in a St Mungo's hostel in the early 1980s), vividly illustrates the complexity of the issues they face. Here he is talking about his friend Robbie who, like him, had recently been discharged from a psychiatric hospital into a therapeutic community (the 'House') and who has just died of an overdose, having struggled to get on with the rest of the community.

'Perhaps Paul is right. Perhaps it is an easy equation to work out: Pub + Robbie x Heroin = Death. But I think he's forgetting one crucial operation in this tidy little formula. Two dead friends, a father he never knew, the rejection of the whole House. [...] He just looked so much stronger than the rest of us. Like he was taking responsibility. And now Robbie's gone.' (O'Donoghue, 2009)

Table 3 summarises the typical pattern of life experiences of St Mungo's clients, taken from our 2008 Client Needs Survey. In addition, many will have experienced traumatic experiences in childhood. Over half (52%) of clients using the St Mungo's Lifeworks psychotherapy project had lost a parent in early childhood (half of those in traumatic circumstances such as murder or suicide) and over half had been abused as children (Cabinet Office, in press).

	Yes	No	Unknown
Ex-offender	44%	46%	10%
Relationship breakdown	38%	42%	20%
Bereavement in past year	18%	82%	0%
Domestic violence	14%	64%	23%
Ex-care	13%	69%	18%
Ex-forces	3%	91%	6%
n=531 (Hostel/ Shelter residents)			

Table 3: Backgrounds of St Mungo's clients (2008 Client Needs Survey)

'A lot of shit happened'

We wanted to know how people came to be homeless. We didn't ask this of the questionnaire respondents because we felt it was simply inappropriate to reduce potentially traumatic life experiences to tick-box answers. However, many of the interviewees were willing to share their stories. Table 4 shows the most commonly mentioned factors in these people's lives that led to their being homeless.

	Unknown
Relationship breakdown/family problems	35%
Evicted/rent arrears/lost accommodation	22%
Drugs or drink	15%
Prison	9%
Lost job	9%

Table 4: How did you become homeless? (Interviewees)

At the top of the list are family/relationship problems, followed by loss of accommodation (often linked to either losing employment or getting involved with drugs). Many attributed their homelessness to a drug or alcohol problem. The quotes below give a more detailed picture of the range and complex interplay of often traumatic events and situations:

'I lost my business and my family and the system let me down and I found myself on the streets without any money'

'A lot of shit happened'

'Family loss, evicted from house whilst in prison'

'Lost my job through drug abuse, couldn't pay rent'

'Because my mum chucked me out because she found me using brown'

'Mother was in an abusive relationship, kicked out at 18, told I'd made myself homeless so no help given, I've been up and down ever since'

'I became homeless as I got pregnant at 14, my mum threw me out and after that I got married. My husband raped me and beat me up so I tried to kill him but it didn't work. So I ran to London to escape him and have been on the street ever since on and off between having children'

'A mixture of coming out of rehab and my friend passing away'

Many of the interviewees (12%) explicitly mentioned mental health problems as a factor in their becoming homeless:

'Through depression I found it hard to keep up with my rent and other personal issues'

'Had to quit university as my mental health was so severe, couldn't return to my family as it made it worse'

'Estranged from home, went to mental health hospital. When being alone in hospital I gathered thoughts and cleared them. Medication helped and a new person emerged and I realised people were trying to help me and I found myself reintegrating into the community'

'Drugs and depression'

In these cases there was an obvious, direct link between mental ill health and homelessness, with the mental health

problem coming first. In other cases there were more subtle connections.

'Feel I want to die and it will solve the problem'

Interviewees were asked how being homeless affected their mental health. Their answers illustrate vividly the negative effect of homelessness, even on relatively mentally healthy individuals. One in ten interviewees gave a general negative answer: 'It affects me badly,' for example. One in ten described homelessness as 'stressful'. But by far the most common response (one in five) was along the lines of 'depressing', 'makes me feel low' or 'brings me down'. Other answers described a loss of self-worth and feelings of anger, hopelessness and isolation. Overall, about two thirds of interviewees drew a link of some kind between their homelessness and their emotional wellbeing. A very few (one or two) said it didn't affect them either way.

'I feel like it's me against the world'

'Make you lose your self worth'

'Being on the street and people looking at me makes me angry'

'I feel like a low life and your friends tend to treat you differently'

'The thought of being homeless makes me feel anxious and depressed'

'Depression, boredom, dreams fade, lack of ambition'

'Makes me feel that I'm not alive. People can't get on my wavelength'

'It affects me, makes me angry'

'I just get stressed out'

'Feel I want to die and it will solve the problem'

'I feel more degraded and get very low'

'Makes me feel worthless'

'Makes me feel low in the long run as you lose hope in getting back on track and into society'

'Makes you think about or turn to drugs'

'Makes me feel low and not part of society'

'On a bad day can't do anything'

We wanted to know how interviewees felt their mental health and wellbeing affected their daily lives. Overall almost three quarters of interviewees said it had a direct impact – that when their emotional wellbeing was poor they found it difficult to cope and carry on.

The most common response (mentioned by between 15% and 16% of interviewees) was how hard it was to cope with everyday life:

'It affects every aspect of my daily life. I've always had issues so it's hard to work out what my mental health is affecting but I do need support with structuring my time, coping with daily living and stress and support with my emotional state'

'Makes every day normal tasks extremely hard - picking up my giro, going to the doctors, paying rent, washing clothes'

'Feel low in mood most days and feel unable to achieve anything with regards to my problems'

'Affects my routine - on a bad day can't do anything or get anything done'

'Makes me lazy, not showering, can't be bothered to do anything'

'Makes things harder - everyday tasks become a chore'

A few interviewees (6%–9%) talked about sleep disturbance, aggression, feelings of isolation and aggravated drink/drug problems.

'I keep quiet so I'm not judged'

Mental ill health carries an enormous social stigma – as does being homeless – and fear of stigma can stop people telling anyone about their mental health problems and so getting help.

The overwhelming majority (86%) of interviewees agreed that stigma does stop people talking about mental health problems.

Half (49%) said that stigma was a factor in homeless people not getting the help they need for mental health problems.

Their responses also showed a high level of awareness of the stigma and discrimination attached to mental ill health. Almost three quarters (73%) agreed with the statement

that people with mental health problems suffer from discrimination. Less than half (47%) agreed that 'People are generally aware of mental health issues'.

Words that cropped up again and again were 'shame' and 'being judged' - issues with which homeless people are all too familiar:

'I know people who are schizophrenic and won't go to staff because they are scared they will be locked away'

'They already know they are treated badly and the only self defence is to show they are strong and normal'

'I feel sometimes they do [keep quiet] because they feel ashamed of it and don't want to get picked on by friends'

'Personally yes, I keep quiet about mine so I'm not judged by my mental health'

'I've experienced the stigma personally and people's wrong perception'

'People will think they are different and show no respect'

'Yes, there is still a lot of stigma attached and ignorance surrounding it but it has improved a hell of a lot in the past 20 or so years'

'A lot of the public wrongly assume that all people with mental health problems should be hospitalised and are potentially dangerous'

'I think people who have mental health problems get put in a box which is bang out of order as some people cannot talk to people or authorities as they get baffled'

That said, the interviewees were in the main comfortable with disclosing information to professionals, although a significant minority (about a third) were not, or said it depended on who they were talking to:

'My doctor doesn't listen but if I had someone who would listen I would be comfortable. A couple of the staff are approachable'

'Depends on their relationship to other professionals that I trust. I'm always wary of them'

'Feel more comfortable talking to another resident than staff or professional'

'I do not feel comfortable. I have to trust them first'

Summary

Homelessness and mental health are closely intertwined. Often the causes are the same – family breakdown, debt, unemployment, crime, prison, violence and abuse. Homelessness can lead to mental ill health, and vice versa. Both issues need to be addressed. Homelessness and mental ill health both attract stigma and discrimination. A non-judgemental approach is vital when working with homeless people with mental health problems.

Recommendations:

- Stigma and discrimination badly affect homeless people and especially those with mental health problems. A non-judgmental, open attitude from the people around them will go a long way towards supporting them.
- Services need to treat the whole person, taking into account their background as well as current situation.



5. Mental health problems

One in four adults in the UK will experience at least one mental health problem over any one year; and one in six (17%) of us will have a clinically diagnosed mental illness at any one point in time (Mental Health Foundation, 2007, based on ONS Psychiatric Morbidity studies).

General population

Depression affects 10% of the population in any one year (Mental Health Foundation, 2009), and half of these will also experience anxiety.

Antisocial personality disorder affects between 2-3% of the population (NIMHE, 2003). Moreover:

'Personality disordered individuals are more likely to suffer from alcohol and drug problems and are also more likely to experience adverse life events, such as relationship difficulties, housing problems and long-term unemployment.' (NIMHE, 2003)

Schizophrenia, the most common form of psychotic disorder, affects between 1.1% and 2.4% of people at any one time (National Collaborating Centre for Mental Health, 2002, quoted in Mental Health Foundation, 2007). Bipolar disorder, another severe long-term mental illness, is rather less common than schizophrenia; it affects between 0.9% and 2.1% of the adult population at some point in their lives (NICE, 2004 quoted in Mental Health Foundation, 2007).

Post-traumatic stress disorder develops following a stressful event or a situation of exceptionally threatening or catastrophic nature (Mental Health Foundation 2007). In the general population, the risk of developing PTSD

after a traumatic event is 8.1% for men and 20.4% for women (National Collaborating Centre for Mental Health, 2005, quoted in Mental Health Foundation, 2007).

Suicide is a significant cause of death for homeless people. The Social Exclusion Unit (2004) states that one in four homeless people who die while homeless will die by suicide.

Our survey

In the St Mungo's Client Needs Survey 2008, 70% of clients across all our projects either had a diagnosed mental health problem, or staff thought they had a mental health problem that had not yet been formally diagnosed, or they had experience of depression (table 5 – the statistics are broken down to show the differences between the various client groups).

In the study reported here, rates of mental illness were overall even higher: 86% of interviewees either currently had some kind of mental health problem, whether diagnosed by a doctor or self-identified, or had in the past. Table 6 reports these diagnoses, broken down into client group. Of the questionnaire respondents, 77% had a formal diagnosis and a further 8% said they were 'worried about their mental health' but did not have a diagnosis, making a total of 85%.

So between eight and nine out of every ten people presenting at a homelessness service will very probably have a mental health problem that is likely to be currently affecting their situation. Mental health problems are clearly significantly more common among these homeless people than in the general population (Table 7).

	All St Mungo's clients	Hostels & Shelters Only
Has a diagnosed mental health condition	36%	18%
Has a suspected mental health condition	23%	25%
Has either a diagnosed or suspected mental health condition	48%	36%
Experiences depression	53%	55%
Experiences depression but without another diagnosed or suspected MH condition	22%	28%
Overall has a diagnosed or suspected mental health condition or depression	70%	64%
	n=1128	n=531

Table 5: Levels of mental health needs from St Mungo's Client Needs Survey 2008

It was also clear from the interview responses that depression, anxiety and stress are a permanent feature of these people's lives. For example (of the interviewees):

- 76% said they often felt depressed and 42% had felt depressed in the previous week
- 71% said they often felt anxious and 41% had felt anxious in the previous week
- 60% said they often felt overwhelmed by stress.

That fewer in the questionnaire group (32%) reported a diagnosis of depression could be due to many reasons but one of the most likely is that our peer researchers were able to establish a rapport with their interviewees that encouraged more of them to open up about their

experiences – a common feature of peer research.

The findings for personality disorder are very unlikely to reflect the true incidence. Estimates of how common personality disorders are among homeless people vary widely, but generally cluster in the region of 64–85%. However, as a number of studies show (e.g. Middleton, 2008; Murphy et al, 2002, quoted in Rees, 2009; Homeless Link/RIS, 2008; Mathews, 2007), not everyone who may show behaviours consistent with personality disorder has a formal diagnosis. People with personality disorder commonly have little or no insight into their problems, and will in many cases deny they have a problem.

St Mungo's 2008 Client Needs Survey asked how many clients exhibited behaviours that could, in some

	% with diagnosed mental health problem	% with self-perceived but undiagnosed mental health problem	TOTAL % with a mental health problem, either diagnosed by doctor or themselves
1. Street (rough sleepers)	44%	11%	56%
2. Shelter	76%	12%	88%
3. Hostel	75%	10%	84%
4. Mental health/complex needs project	94%	6%	100%
5. Living independently/ semi-independently	100%	0%	100%
Grand Total	78%	9%	86%
n=103			

Table 6: Diagnosed and undiagnosed mental health problems (interviewees)

	Depression/ anxiety	Antisocial personality disorder	Suicidal feelings	Schizophrenia	Bi-polar disorder	PTSD
Interviewees	48%	9%	13%	13%	5%	2%
Questionnaire	32%	2%	n/a	32%	2%	n/a
General population	10% (in past year)	2% - 3%	n/a	1.1% - 2.4%	0.9% - 2.1%	8.1% - men (who suffer traumatic event) 20.4% - women (who suffer traumatic event)

Table 7: Diagnosed mental illness (interviewees/questionnaire/general population)

individuals, be linked to personality disorder. Staff said 36% of hostel/shelter clients had challenging behaviour, 41% were 'socially vulnerable' and 27% had limited social skills – all recognised characteristics of personality disorders.

Although only two of our interviewees mentioned post-traumatic stress disorder (PTSD) by name, many of them reported symptoms that would be consistent with the diagnosis.

Women's mental health

Previous studies on homeless women (St Mungo's, 2009, Reeve, 2006; 2007) have found that, in general, homeless women have even higher levels of mental illness than homeless men, and frequently have highly complex needs.

St Mungo's clients (in hostels/shelters) comprise a roughly 70:30 ratio of men to women. Our study participants reflected that – we interviewed 33 women, and questionnaires were returned by a further 22, making 55 women in total.

These numbers are too small to draw any conclusions, but the survey did reveal some differences between men



	Average rating now	Average worst ever
Female	2.83	1.38
Male	3.43	1.43
Overall (n=103)	3.25	1.42
(n=103)		

Table 8: Average mental wellbeing ratings by gender

and woman. Women's 'worst ever' mental wellbeing ratings (table 8) were 0.8 points lower than the men's, indicating overall worse mental health. This is consistent with the findings from research, and also with other St Mungo's outcomes data (Burns & MacKeith, 2008). This is a way of measuring people's mental health according to their own perceptions of their living skills, social networks, physical and mental health and substance use. Typically, women started out with higher levels of need than men.

Summary

Our survey found extremely high levels of mental health problems among this group of homeless people, suggesting that between eight and nine out of ten people needing support from homelessness services are likely to have a mental health problem of some degree, and a great many of them will have serious illnesses. Depression and anxiety are the most common disorders, but personality disorder is also likely to be highly prevalent.

Recommendations:

- All frontline homelessness services need to be aware that their clients are likely to have a range of mental health problems.
- All frontline staff in homelessness services need training in basic mental health awareness and a thorough understanding of what to do if they believe a client may be in need of referral for assessment and treatment.

6. Emotional wellbeing

Emotional wellbeing is now recognised as fundamental to physical health, and to people's motivation to take better care of themselves. Poor emotional wellbeing can be a precursor to mental ill health, as well as significantly affecting, and reflecting, quality of life (Foresight, 2009). It is also widely recognised that poor levels of mental wellbeing are inextricably linked to social factors such as poverty, deprivation, insecure housing and social inequality per se (Friedli, 2009; Marmot & Wilkinson, 2005).

The World Health Organisation defines mental health as:

'A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.' (Future Vision Coalition, 2008)

The peer researchers asked interviewees to rate their current and worst ever levels of emotional wellbeing, using the following definition of mental wellbeing, adapted from the WHO definition above:

'Everybody has emotions and everybody has mental health. At any one time some people's is good and some people's is poor. Just like with physical health, sometimes we might have a particular illness or a long-term problem, and other times we might just be feeling rough without really knowing why. Other times we feel just fine.'

'Someone with good mental health is enjoying life and can cope with the stress in their lives. They have a positive sense of feeling good and they believe in themselves. They feel valuable in their community.'

Interviewees reported an average overall score of 3.25 (where 1=lowest and 5=highest) for current levels of emotional wellbeing.

The people in hostels/shelters reported lower levels of wellbeing than those who had moved on into more stable, specialist hostels or out into their own flats.

However the average rating dropped to 1.4 when interviewees were asked to rate their worst ever levels of

Type of accommodation	Sample size	Average current rating	% with ratings of 2.5 or below
1. Street	9	3.33	22%
2. Shelter	17	3.21	29%
3. Hostel	51	2.97	27%
4. Mental health/complex needs hostel	18	3.97	17%
5. Living independently/semi-independently	8	3.94	0%
Grand Total	103	3.25	23%

Table 9: Average self-ratings of current mental wellbeing (scale = 1–5 where 5 is the highest)

Type of accommodation	Sample size	Average worst ever rating	% 2.5 or below
1. Street	9	1.94	67%
2. Shelter	17	1.71	76%
3. Hostel	51	1.31	90%
4. Mental health/complex needs hostel	18	1.11	94%
5. Living independently/semi-independently	8	1.56	100%
Grand Total	103	1.42	87%

Table 10: Average self-ratings of worst ever mental wellbeing (scale = 1–5 where 5 is highest)

emotional wellbeing. Overall, almost nine out of ten interviewees had experienced a period they would rate as 2.5 or below.

Counter-intuitively, people still living on the streets and those in shelters (most recently off the streets) reported the highest emotional wellbeing ratings. This may be because they lacked insight into their mental health needs, or it may be because they accept as the norm a level of mental and emotional distress that to most people would be intolerable.

'Really depressed, really badly'

Interviewees were asked if they would be willing to say more about how they felt at their worst. More than one in ten (13%) interviewees said they had felt suicidal. Others talked about relationship breakdowns, bereavements, coming out of prison, the armed forces or the care system, getting involved in drink or drugs, losing a flat/house or losing a job.

'I felt my worst four years ago due to no contact with my daughter and losing my flat'

'When I was on drugs I felt so low and degraded living on the streets and taking drugs'

'I tried to kill myself because I came off my medication'

'When I was released from prison I was at my lowest, nowhere to live. All I had in my pocket was £46 and avoid getting (sic) crime'

'Really depressed, really badly'

Questionnaire respondents were asked a set of questions to describe how they felt:

- 42% had felt depressed in the last week
- 41% had felt anxious in the last week
- 29% had felt panicky in the last week
- 25% had felt like they couldn't cope with their life in the last week

- 22% had felt confused in the past week, and
- 20% had felt like they couldn't be bothered to get out of bed in the last week.

By no means all these people had diagnosed mental health problems.

Similarly, interviewees were asked if they 'often' felt certain emotions:

- 76% often felt depressed
- 71% often felt anxious
- 51% often felt panicky
- 51% often felt confused
- 49% often felt like they couldn't cope, and
- 67% often felt like they couldn't be bothered to get out of bed.

Summary

Homeless people have generally poor mental wellbeing. The people in this study reported high levels of depression, anxiety, panic, confusion and feeling unable to cope. So, even if a homeless person does not have a formal diagnosis of mental illness, they are very likely to have low levels of emotional wellbeing that, without intervention, could lead to actual mental illness and certainly undermine their attempts to achieve a better quality of life.

Recommendation:

- All services involved with homeless people need to be aware that, even if their clients do not have a formal diagnosis of mental ill health, they are likely to be experiencing poor emotional wellbeing that affects their chances of making a better life.

7. Drink and drugs and mental health

Research tells us that the relationship between drink/drugs and mental health is rather like the relationship between mental health and homelessness: misuse of drink/drugs is often a symptom of poor mental health, and it can also be a cause of worsening mental health.

NHS statistics indicate that approximately one quarter of the UK population (33% of men and 16% of women) are 'hazardous or harmful drinkers', which means their pattern of alcohol consumption carries a risk of physical or psychological harm. National surveys show that 5.9% of adults can be classed as 'dependent drinkers' (Information Centre for Health and Social Care, 2009).

The ONS Psychiatric Morbidity survey estimates that 3.4% of British adults are drug-dependent (Information Centre for Health and Social Care, 2009).

There are well-recognised links between substance use and mental health:

'There is evidence that heavy drinkers have poorer levels of mental health. Alcohol misuse often co-exists with common mental disorders, such as depression, as well as with misuse of other substances. High levels of hazardous and dependent drinking have been recorded in people being treated for serious mental health problems. Alcohol dependence and other problems associated with alcohol misuse are also frequent in homeless people and prisoners, again often in combination with poor mental health.' (Information Centre for Health and Social Care, 2009)

A report by Coulthard et al (2002) calculates that 30% of dependent drinkers and 45% of people dependent on drugs also have a psychiatric disorder (dual diagnosis).

Most studies estimate around 10-20% of homeless people would meet the formal criteria for dual diagnosis (concurrent mental health and drink/drug dependence) (Rees, 2009). However, many more are likely to have low level problems with their mental health and substance use

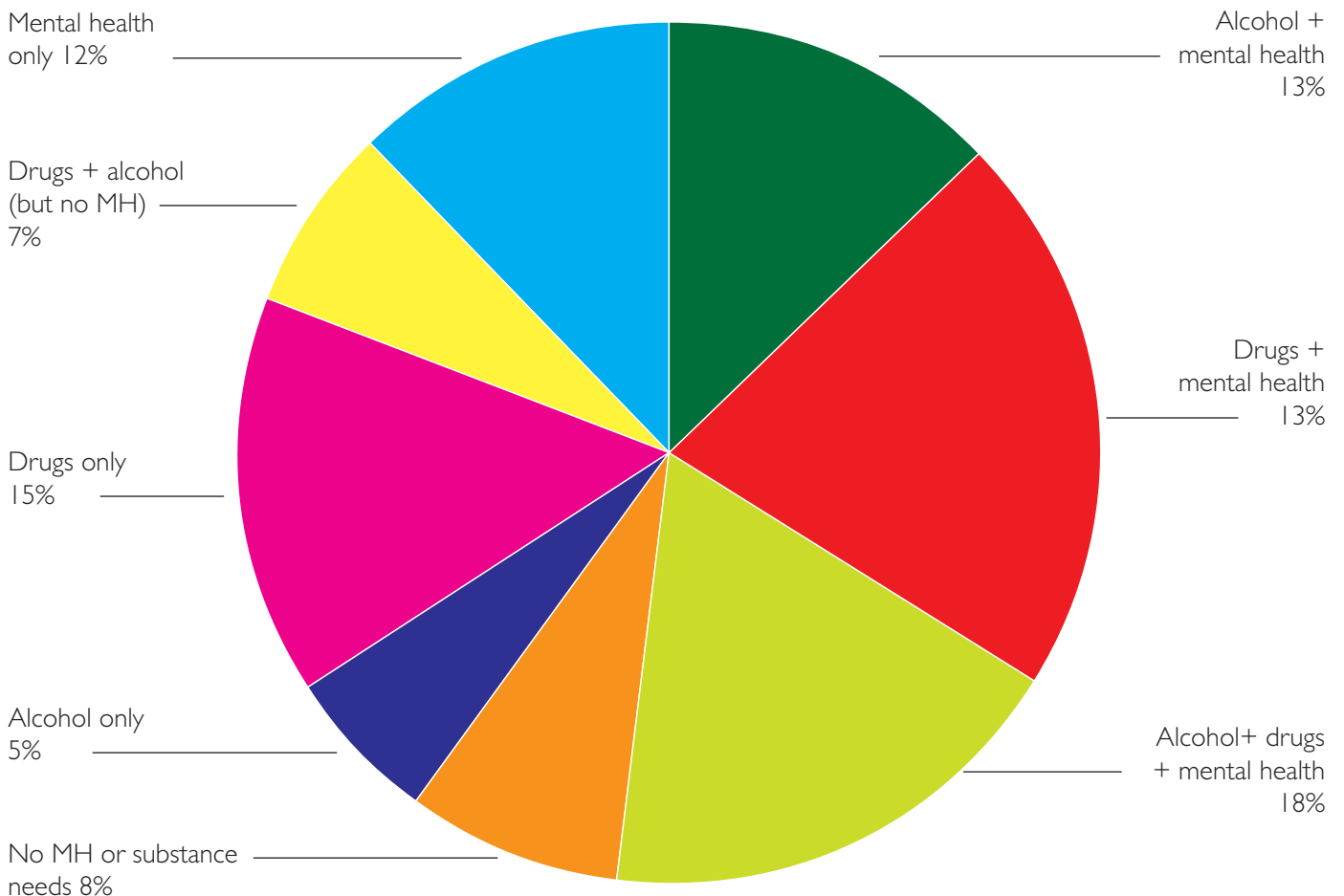


Figure 1: Multiple drug/alcohol and mental health needs (St Mungo's Client Needs Survey 2008)

that do not meet the formal threshold for a full diagnosis (Rees, 2009).

According to the St Mungo's 2008 Client Needs Survey, more than half (51.5%) of our hostel and shelter clients have both mental health and substance use needs – for this group, this complex combination of needs is pretty much the norm. Figure 1 shows the breakdown of mental health and substance use needs. Almost one in five clients (18%) use both alcohol and drugs and have a mental health problem.

We also know from the Clients Needs Survey that clients with dual diagnosis mental health and substance misuse have much poorer quality of life and expectations and much greater support needs than non-multiple needs clients.

'Drinking! As it blocks it out'

The interviews included several questions on drink and drug use – the peer researchers felt it was an important topic that we needed to explore.

Over two thirds (65%) of our interviewees agreed that they 'drink or take drugs because it is easier than coping with my life' (rising to 67% of those who had a mental health problem). This wording was used because it reflects most closely the underlying reasons, linked with emotional wellbeing, why people often abuse substances.

While this does not mean that 65% of them had a substance abuse problem per se, it does indicate very high levels of substance use as a response to their problems.

Interviewees were also asked what they did to help themselves when they were feeling low. Nearly two in five (38%) of our interviewees mentioned drinking or taking drugs as a means to help themselves when feeling low. This was by far the most common answer. Other answers included seeking company (22%), listening to music (15%) and exercise (11%).

'Drinking! As it blocks it out'

'Reading, music, smoking, a joint'

'Go and buy some drugs'

'Beer, spliff and some gear'

'Drink and drugs, blocks out the depression'

'Illegal drugs to help with my mental health'

'Reading, music, smoking, a joint'

'When things are OK [with my mental health], fine but when things go wrong I drink and take more drugs to hide the problem'

'A bottle of brandy and a joint'

'I drink a lot but I do my best'

'I keep getting flashbacks so drink to cope with the depression'

'Getting smashed'

Many interviewees (19 people – 25% of those who had sought help) had sought help for a mental health problem from rehab, detox or services for drug and alcohol use, suggesting they did not distinguish drug/alcohol services from mental health services. We saw this across many of the interviews.

Summary

The combination of substance misuse issues and mental health problems is extremely common in single homeless people. Arguably, it is the norm, not the exception.

Mental ill health and substance use are so inter-linked for many homeless people that they do not see them as separate needs.

Many homeless people may not meet the formal clinical criteria for 'dual diagnosis', but regularly use drugs and/or alcohol to cope with low emotional wellbeing.

Recommendations:

- Services need to stop approaching drink, drugs and mental health as separate issues. For the vast majority of homeless people they are a part of the individual's range of needs and must be addressed as a whole. Drink and drugs are often used to deal with difficulties in homeless people's lives – we need to tackle the addiction and the life.
- A typical homeless client, who has experience of, or is vulnerable to, sleeping rough, will likely have highly complex needs involving poor emotional wellbeing, possible mental illness, likely personality disorder and polysubstance use. 'All-in-one' approaches are the only way to deal with these issues.

8. People still living on the streets

People still living on the streets are thought to be the most vulnerable to mental health problems and alcohol and substance use issues. According to one estimate (Griffiths, 2002), 30-50% of rough sleepers have mental health problems, including serious mental illnesses such as schizophrenia and depression and personality disorders, 50% are reliant on alcohol, 70% are using drugs, and many will have poor physical and mental health alongside a drug or alcohol addiction.

Homeless people still living on the streets are the hardest group to reach for research purposes. St Mungo's has known for a long time that many of the people who are difficult to engage with services and remain on the streets long-term do so because of their mental health problems, and this was confirmed by this research.



The peer researchers did manage to interview nine rough sleepers via a day centre and 17 people in an emergency shelter, who had been sleeping on the streets until very recently. The numbers were too small to draw any reliable conclusions, but their responses did give a vivid picture of what they are struggling with on a daily basis. Five outreach workers were also interviewed to provide more information about the rough sleepers with whom they work.

As a group, the nine rough sleepers and the 17 people recently off the streets were the most likely to give the

impression that their mental wellbeing was fine and not affecting their homelessness. However the outreach workers, who work every day with clients out on the streets, painted a rather different picture.

They all said that they believed it was possible for clients to live on the streets and be mentally healthy, and that some people actively enjoy street life because of the freedom it gives them. That is exactly what some of our interviewees said, although it has to be asked why someone would choose the very dangerous alternative of sleeping on the streets to the comparative safety of a roof over their head (e.g. Newburn & Rock, 2005).

The outreach workers generally estimated that most of their clients had poor mental health (60-100%), and typically also noted extremely high levels of drink or drug abuse. They all mentioned coming across clients with severe mental illnesses such as schizophrenia, paranoia, delusions, Korsakov's syndrome (a condition linked to chronic alcohol use), bipolar disorder etc, and also mentioned a high incidence of personality disorder.

The words of this worker sum up what the others also said – sleeping rough takes a very heavy toll:

'Some are mentally ok but still finding it stressful/difficult/depressing/isolating which in turn makes it harder to cope and deal with day to day things like appointments/staff other people/procedures and the longer it goes on the more likely they are to develop further problems, mental/physical or substance use.'

This chimes with the rest of the findings in our study.

'Every day is a challenge'

The following quotes from the interviews with outreach workers illustrate what it is like having a mental health problem while living on the streets:

'I think the fact that a client has a mental health problem in itself causes some clients to stay on the streets. In other cases I reckon anger management issues can stem from clients' mental health problems and can lead to them being barred from services and/or put into prison. Some can't take care of their basic needs, such as eating reasonably healthily, regularly getting a good night's rest (due to it being unsafe to sleep out and they might get woken up and moved on etc).'

'[Mental ill health causes] poor time keeping, forgetfulness,

missing appointments, not complying with medication, victim of harassment, bullying, violence, abuse, poor diet, poor hygiene, poor social and life skills, family breakdown.'

'Can cause people to become long-term rough sleepers who become entrenched on the streets. Delusions/paranoia can create barriers to getting off the streets – eg. I can't claim benefits or go to the council because there is a conspiracy against me between those agencies.'

Clearly rough sleepers are a particularly vulnerable subgroup of homeless people with high levels of mental health needs. These are some of the responses of the rough sleepers themselves:

'Always occupied looking for food, venues and places to sleep then usually talking and socialising or sleeping'

'Every day is a challenge'

'Makes you think about or turn to drugs'

'I felt so low and degraded living on the streets and taking drugs'

'I don't look forward to night time as during the day you can always find something to do i.e. libraries, parks, indoor shopping centre etc'

'Puts me back down the ladder' (referring to their mental health)

'Makes me angry there are places people can go but the government is closing them down'

'[My emotional wellbeing is poor] especially when it rains and I'm getting wet and I have to get to Paddington station to keep a bit warm and dry'

'No! I haven't got a base' [in answer to a question about getting enough support]

Summary

Rough sleepers are even more likely than other homeless people to have high levels of mental illness and substance use, often compounded by their lack of insight into their own needs. There are significant numbers of very ill people on our streets whose needs are not being met.

Recommendation:

- People sleeping rough on the streets have mental health and substance use needs over and above those of the general homeless population. Urgent action and effective, prolonged engagement is needed to target people whose mental ill health is keeping them on the streets.



9. Services and support for mental health

It is estimated that only one in four people with a mental health problem are receiving treatment, either because they haven't sought help, or they have not been correctly diagnosed, or they have refused to accept treatment (Layard, 2005).

Psychological therapies ('talking' treatments, counselling, psychotherapy etc) are known to be much more acceptable than medication to most people with a mental health problem – but they are also in very short supply (e.g. Layard, 2005; Mind, 2003).

For homeless people - a typically vulnerable, chaotic, socially excluded group - it is almost inevitable that obtaining the kind of help they want and find useful will be even more difficult, as responses to this survey show.

Mental health services for homeless people

The Department of Health states that everyone, including homeless people, should have access to a full range of mental health treatments and therapies, access to a second opinion when a diagnosis is made about their mental health, and advice about the effects of medication. They should also be provided with enough information to enable them to give informed consent to treatment (Department of Health, 2002).

A full range of treatments and therapies is generally considered to include counselling, cognitive behaviour therapy, psychotherapy, specialist substance misuse support and social care.

Primary care services are typically the gateway to these treatments and therapies. But homeless people are known to find it very difficult to access primary care services (for example, St Mungo's 2008b, 2008c; Croft-White & Parry-Crooke, 2004; Bines, 1994; Griffiths, 2002). Add to that the stigma and lack of understanding that often attend mental health problems, and it becomes clear that homeless people are already at a disadvantage when it comes to accessing services for their mental health needs. In particular, it is known that homeless people make high use of emergency services (St Mungo's, 2008c; Rees, 2009), which is costly to the NHS and less likely to result in suitable treatment being offered.

Not receiving appropriate services when they are needed not only potentially worsens the condition and jeopardises any future successful outcome but also, on a macro level, puts pressure on other services, such as A&E,

employment services or housing services, that may not be designed to meet the needs of people with mental health problems (Randall et al, 2007).

Barriers to accessing mainstream services

The following factors are known to prevent homeless people from accessing mental health services (Rees, 2009):

- *a sense of being able to solve their own problems/not needing any help (Kim, 2007)*
- *low priority given to health needs in general (compared to shelter, food, warmth, occupation, for example) (Langle et al, 2005)*
- *lower priority given to mental health needs over physical health needs (Bhui, 2006)*
- *stigma (Kim, 2007)*
- *low levels of awareness of illness and/or motivation to change (Langle et al, 2005)*
- *systemic barriers such as separation of physical and mental health care and separation of housing, employment and health interventions (not referenced)*
- *financial barriers such as no access to free transport or no access to free medication (Rees, 2009).*

Other research adds these to the list (Croft-White & Parry-Crooke, 2004):

- *long waiting times*
- *cultural barriers*
- *distance from accommodation.*

All of these factors came up in our study – the lack of insight, poor motivation and stigma as well as practical considerations such as physical access and waiting times.

St Mungo's clients

In 2007/08, the St Mungo's mental health team offered mental health assessments, support and help with coping skills to 781 clients, and made 440 referrals to statutory, voluntary or culture specific mental health agencies.

St Mungo's substance use teams worked with over 700 clients and helped 127 of these into detox and rehabilitation programmes, and 445 onto appropriate substitute prescriptions. Lifeworks, our in-house psychotherapy pilot, worked with over 150 people in 2008/09, and 75% showed improvement in their mental health and wellbeing at the end of treatment.

	%
GP	43%
NHS mental health services	22%
Specialist Mental Health homeless services	18%
Mental health team in hostel	10%
Drug/alcohol services	25%
A&E department/NHS Walk in	0%
n=77	

Table 11: Where do people go for help? (interviewees)

According to the Client Needs Survey for 2008, almost half the clients who had a mental health problem (including depression) were not receiving any treatment at all. Less than one in five (18%) were receiving help from St Mungo's specialist mental health services and external mental health services, 19% were using only St Mungo's services, and 17% were receiving treatment only from external services.

Just 39% of clients with both substance use and mental health needs were receiving treatment from both mental health and substance use services (the survey does not record 'dual diagnosis' treatments). Those clients with mental health/substance use complex needs were more likely to be involved with substance use services than they were with mental health services. This is interesting in the light of the Department of Health recommendation that mental health, rather than substance use, services should take the lead on treating people with dual diagnosis (Department of Health, 2002).

For people with depression, the numbers not receiving treatment are even higher: the Client Needs Survey shows that 65% of these clients were not receiving mental health treatment, either from St Mungo's or external services – although they may have been receiving help through primary health care services such as a GP.

Results from our survey - interviewees

Overall, 75% of interviewees had sought help for a problem with their mental health, rising to 85% of those who said they actually had a mental health problem. Similarly, 70% of questionnaire respondents, including 85% of those who had a diagnosed problem, had also sought help.

Table 12 shows where interviewees had tried to get help.

	%
GP	59%
NHS mental health services	53%
Staff at hostel	43%
Specialist Mental Health homeless services	26%
A&E department/NHS Walk in	22%
n=79	

Table 12: Where do people go for help? (questionnaires)

The numbers are different here (most likely due to the different question style), they still fall into the same pattern – GP first, then NHS mental health services, then specialist mental health and homelessness services. Another interesting feature is that none of the interviewees recalled attending an A&E or NHS walk-in facility for their mental health needs, whereas one in five of the questionnaire respondents did. It is possible that the questionnaire prompted people to include non-mental health related incidents (they may have forgotten that the question was limited to mental health issues). Also worthy of note is the high percentage of interviewees who said they sought help for their mental health problems from drug/alcohol services.

These findings reflect other survey findings – that homeless people tend to use primary care services for their mental health needs.

'Gave me meds for nothing'

Interviewees were asked what happened when they sought help.

	%
Medication	42%
Psychological therapies/ talking therapies/ counselling	22%
Listening, understanding, compassion, advice, encouragement	17%
Nothing	9%
Referral to other unit	5%
n=77	

Table 13: What happens when people seek support? (interviewees)



The most common outcome was a prescription for medication, followed by referral for 'talking' therapies. However in many cases this was for drug/alcohol counselling, rather than psychological therapy for mental health issues, so the number of clients receiving talking treatments for their mental health problems is likely to be much lower.

The questionnaire respondents also reported high levels of medication for mental health problems: 44% had taken prescribed medication for a mental health problem in the previous week.

But almost one in 10 interviewees who sought help for a mental health problem came away with absolutely nothing:

'Gave me meds for nothing. Don't know what they were. Injections'

'Listened but said little. I walked away, pissed off'

'They give me the best drugs but had to give them up as I was getting smashed every day, felt like I would just sit in a chair forever'

'The doctors don't listen they just offer pills. Sometimes you need to talk to someone to try to get to the root of the problem instead of just dishing out medication which is just another drug'

'Just gave me meth'

'Counselling, harm reduction and most importantly listening and understanding'

'Gave me a fresh initiative on life'

'Jules Thorn psychiatric day hospital was incredible. It provided long-term care and in depth psychodynamic treatment. IT SAVED MY LIFE. It tailored treatment to the individual, provided flexible but safe boundaries and deep thoughtfulness about clients' needs. It dealt with practical and emotional needs'

'Need someone to talk to'

Interviewees were asked if they were getting enough support for their mental health needs. Opinion was split exactly down the middle – 50% felt they were and 50% said not:

'No. Need someone to talk to like a counsellor. No faith in my doctor'

'I'm waiting to see a psychotherapist and have been waiting for three months'

'I get excellent support from St Mungo's staff. Management support me massively with mental and emotional wellbeing by giving me time to talk (or cry!), helping me cope emotionally. Keyworker supports me practically e.g. with cleaning flat etc. Keyworkers need more training to deal with emotional and mental distress'

'Yes, the staff are good and understanding and get me help, especially my substance misuse worker'

They were also asked what was the 'best bit of support you have received'. Their responses beautifully illustrate breadth of sources of help to which people turned or help with their mental health needs.

	%
Specialist mental health services	19%
Partner, friends or family	16%
Hostel staff generally	13%
Counselling	12%
Medication	9%
n=103	

Table 14: Best bit of support (interviewees)

Many could not identify one single 'best bit', and described instead a combination of factors – friends, family, and services from staff with specialist, relevant expertise:

'Family, brother very supportive. Keeping a good social network and speaking about it. Working has helped, feel like I'm doing something with my life. Before that I felt there was no point in existing. An IT course, the St Mungo's writing group and education'

'Mixture of staff. Keyworker is great, and drug abuse worker'

'Younger brother's help, friends, the nurse at the Grove Centre'

'Counselling from my alcohol worker at the Soho medical centre and my key worker'

'Doctor, depression tablets, mental health worker St Mungo's'

'Talking to somebody. Taking medication helps'

'Once a week visits. EIS [Early Intervention Service] and

medication is great. From hospital and St Mungo's. Can't really say [which is best] because all together they helped'

So, while two in five people were prescribed medication when they sought help, only one in ten felt that was the most helpful support they had received. What people did value in terms of support came from specialist mental health services, hostel staff or counselling, and above all their own support networks – friends and family. Yet for many homeless people, these family and social links may be broken. It is likely that a combination of these elements actually made the difference.

Results from our survey – questionnaires

Questionnaire respondents were asked 'Where would you prefer to go to get help with any future mental health problems?'. As with the interviewees, most wanted to be able to get help for their mental health from their GP or hostel – ie. they wanted local, accessible services, rather than having to go to specialist mental health services or a hospital.

	%
GP	43%
Staff at hostel/day centre	31%
NHS Mental Health Services	29%
Services designed for homeless people with mental health problems	16%
A&E Department/ NHS Walk-in	9%
n=97	

Table 15: Best bit of support (questionnaires)

	% 'Strongly agree' or 'Agree'
People with mental health problems suffer from discrimination	73%
People in general are aware of mental health issues	47%
Services for homeless people with mental health problems are good	53%
I would know where to go for help with a mental health problem	71%
I think I would get all the support I needed if I had a mental health problem	61%
n=97	

Barriers to access

Questionnaire respondents were asked if they agreed with a set of statements about barriers to services.

	%
They don't realise they have a problem	53%
Stigma (fear of being labelled)	49%
Fear of treatments	44%
Lack of understanding from staff or health workers	43%
Too drunk/high	33%
Can't be bothered	33%
Not enough services available	30%
Lack of appropriate services	25%
More important things to worry about	24%
n=97	

Table 16: Barriers to service access (questionnaires)

Their responses underline the crucial importance of a non-judgemental attitude. Homeless people with mental health problems have a double challenge – stigmatised both for being homeless and for having mental health problems. It is also notable that so many did not want to access services because they were afraid of the treatment, and did not expect staff to be sympathetic.

Quality of service provision

Questionnaire respondents were asked to rate their agreement with a set of statements about quality of service provision.

Table 17: General opinions regarding service provision (questionnaires)



These figures need unpacking in the light of our other findings. Just over half of questionnaire respondents agreed that services for homeless people with mental health problems are 'good'. However, we know that homeless people encounter many barriers to accessing services, and many interviewees told us that they didn't get what they felt they needed from services. So, what are the questionnaire respondents telling us? Possibly this is what they thought we wanted to hear. More probably, it's a case of relativity – some help, however inadequate, is better than none. Homeless people may simply not think they are entitled to better, or know what is and should be available to them.

Similarly, we see that almost three quarters think they would know where to go for help. We saw earlier that frequently clients approach drug or alcohol services for help rather than mental health services (and indeed, that many services are set up that way). A classic feature of a homeless lifestyle is a highly developed sense of self-reliance, (Croft-White and Parry Crooke, 2004) which can lead to people thinking they can cope and don't need services. The lower, but still fairly high, number of people saying they think they would get the support they need also suggests this – people believe they will get help if they need it, but the findings of this study show that in reality this is often not the case.

'They could have communicated'

The peer researchers asked interviewees what they would have liked to be different about their personal experience of seeking help, and what extra support they thought ought to be available.

A frequent theme (mentioned by 14%) was an increase in either the quantity or level of services available – 'more trained staff', 'more funding', 'more one-to-one services', 'would like to meet with him more often'.

Another very prominent theme was better communication with professionals and staff. Many interviewees (17%) mentioned this:

'Doctor needed to interact more and listen more, made me feel frustrated and angry'

'Felt doctor could have talked some more'

'Could have talked to me more about the voices'

'They could have communicated and told me more'

'They should be proactive and not let me do all the talking'

'In services that made me worse/didn't help, I felt like I had a diagnosis label stuck on my forehead. The staff didn't respect me, they didn't want to get to know me and they refused to work with the difficult and distressing feelings the clients had. Acupuncture is excellent. I do best in holistic services that consider the whole person that can see how my practical issues relate to my deeper emotional/ psychological issues and will work with both at once'

'First found it scary. Staff should be more aware when you come into the system'

'Could have explained more'

'I wish I'd had more info about what was going on. There's no anchors or understanding. I wish I had some explanation of what I was, would go through. It was the unknown that made it all so difficult. Get people when they're first in a bad situation, the knowledge and info as soon as possible'

'Should not rush and apply less pressure'

This important issue of being listened to is explored further in section 8 below.

Another interesting theme was that of medication. Here we found comments illustrating both sides of the issue.

For example:

'Change medication, they prescribed too much'

'Got me addicted to Valium, that's not good'

but

'Would change - trying to get back onto anti-depressants and anti-psychotic medication'

Overall, slightly more people talked about not wanting to take medication, or preferring to be offered other treatments first and not being given medication as a first resort. However, there were also those who wanted medication and found it helpful.

Interviewees offered a huge variety of answers to the question about what other services they thought should be available, mostly personalised to their own circumstances (more/less medication, more counselling etc). However, a strikingly common theme was, once again, the lack of accessible, available, good quality services offering a personalised, positive response:

'Not enough mental health workers'

'It's there if you seek help but sometimes people should be offered more and should be pushed a bit'

'Get people who have been there and done it, not people who read leaflets'



'I don't feel there is enough help'

'I wish people would take time out to talk to me'

'Staff need to give more time'

Rough sleepers

Research and our own findings suggest that a very high proportion of rough sleepers would be in need of services that can cope with their combinations of very complex needs.

The problem of dual diagnosis seems to be even worse for rough sleepers, who typically find it even more difficult to keep appointments and are frequently described as especially hard to engage.

All the outreach workers we interviewed mentioned how difficult it is to access services for their clients with drink/drug use and mental health problems.

'A problem with clients with a dual diagnosis is it's often very difficult to get them any mental health treatment unless they give up drinking/taking drugs – which in some cases are very unrealistic'

'Services passing clients around e.g. if client has a dual diagnosis the mental health team seem to point fingers at the substance use and the substance use team point fingers at the mental health'

One worker suggested that the Prime Minister's top priority should be:

'The need for a mental health outreach service that is capable of understanding and dealing with dual diagnosis and providing a first class service that would cater for their social needs as well without jargon'

Research also indicates that services for people with personality disorder are severely limited, and that more specialist services are desperately needed. With specific reference to rough sleepers, St Mungo's recently found that:

'There are almost no services for people with personality disorders who continue to use drugs and alcohol, for example –but such individuals make up the majority of the intake to many of our rough sleeper hostels.' (St Mungo's, 2008b)

This comment from an outreach worker illustrates just

how much of an issue personality disorder is in terms of service provision for rough sleepers:

'It shouldn't matter which kind of mental health diagnosis you have. A problem our team has encountered is that we have these very mentally unwell people on the streets, they get sectioned, but are found to not have a psychotic or depressive illness – but maybe personality disorder, so are quickly discharged back onto the streets! Being no better off and in many cases worse off. I think that people with Personality Disorders should be eligible for the same sort of support as the other groups! I believe there are quite a few of our current street homeless that suffer from PD and they are crying out for help (self-harming etc) but there is not much on offer for them'

Summary

Homeless people all too frequently fail to get access to appropriate services for their mental health needs. There are too many gaps into which this group of vulnerable people fall. Services for people with complex mental health and substance use needs and for those with personality disorder are particularly lacking. Overall, homeless people want access to both mainstream and specialist services, to medication and 'talking therapies'. It is also clear that a whole raft of factors, including the support of family, friends and hostel staff, is needed to help them cope with and recover from mental illness.

Recommendations:

- We have to remove the known barriers to services for homeless people. The interviews identified access to mainstream services as a priority. The particular needs and circumstances of homeless individuals and the, formal, inflexible way services are set up means that they may be unable or unwilling to use traditional access routes. Special provision (such as walk-in services) is needed, but ensuring local access through GPs and hostels is the most important.
- Mental health treatment on its own cannot solve an individual's problems. Homeless people also need good support from the people around them (hostel staff, friends, family etc) in order to get better. What really works is a combination of approaches.
- Medication has its place, but 'talking' therapies are very much in demand and are not so widely available.
- Not just 'more' but 'better' services are needed – better communication, better focus, better co-ordination.



10. Seeing the bigger picture

We felt it was important to look more widely at other factors that can impact on mental health and wellbeing. A number of factors were identified by the peer researchers and emerged from the interviews and questionnaire responses as key issues for homeless people.

Feeling safe

Personal safety is a significant factor in emotional wellbeing but (75%) of interviewees said they did feel safe. Physical surroundings also make a big difference and those who had moved on to more independent accommodation spoke warmly of the difference it made to their mental wellbeing to have their own space and a decent flat.

The outreach workers stressed the importance of safety for their rough sleeping clients too. They said that many of their clients will not move indoors because they feel the accommodation is not safe enough, and feel safer outdoors.

Accommodation and services

It is not hard to understand the link between run-down, dark and shabby hostels and poor mental health. Comfortable, bright, open spaces with good facilities are much more likely to induce positive emotional wellbeing and help people make their lives better. This is something the homelessness sector has been working on for some time now, and the 'Place of Change' capital improvement programme is critically important in making hostels better places to be (Department for Communities and Local Government, 2006).

'Listen to people rather than empty promises'

Homeless people want to be listened to. It sounds so simple, and yet in practice, in a busy, under-resourced service, it can be very difficult to do. But its importance for homeless people cannot be over-stated: they want to feel that someone is listening to them, that someone actually cares about what they are telling them, and will act on it. Our interviewees echoed what countless homeless people have told us in this and other studies (e.g. St Mungo's 2008a; 2009), in reference to policy makers, homeless services and health service professionals:

'The doctors don't listen, they just offer pills. Sometimes you need to talk to someone to try to get to the root of the problem instead of just dishing out medication which is just another drug'

'My doctor doesn't listen but if I had someone who would listen I would be comfortable'

'Doctor needed to interact more and listen more. Made me feel frustrated and angry'

'More funding and more professionals that have the understanding and the TIME to listen'

'[Best bit of support was] being really listened to'

'Need someone to talk to like a counsellor. No faith in my doctor'

'Listening' also came up as a significant theme when interviewees were asked what they would change or improve about mental health services. In fact, across all the questions, a quarter of interviewees made at least one mention of needing to be listened to. It also came up in the 'Hey Prime Minister' question, where many interviewees said they wanted the government to listen to homeless people more and find out what they need:

'Get people to start listening. I think drop-in centres for people with mental health'

'Employ more people to listen'

'Listen to people rather than just say empty promises'

'Spend more money and listen'

'To listen to them more and house them quicker'

Only 17% of interviewees said that, when they sought help for a mental health issue (see table 14), what they got was 'listening, understanding, compassion, encouragement, advice, support'. Too often homeless people are asked to tell their stories over and over again to more and more people, but nothing seems to get done – so it is hardly surprising that they feel no one listens. They don't just need someone to listen; they need someone who can really listen, and interactively respond – evidently this is a rare skill.

Given the obvious importance of person-to-person contact in dealing with mental health issues, it is also significant that just 45% of questionnaire respondents

reported having someone they could talk to about their problems in the past week. In the interviews, half of all respondents said they found it difficult to talk to people about their problems. Isolation is a common feature of homelessness; more than one in 10 of our interviewees mentioned isolation or loneliness in the context of their emotional wellbeing.

'Get to the roots of people's problems'

Interviewees made repeated references to what can be described as a 'holistic' approach to meeting homeless people's needs. That is, they wanted to be seen as a whole person, not just a set of discrete needs to be addressed separately. As outlined earlier in this report, it is impossible to address homeless people's needs without reference to their backgrounds and their exposure to potentially traumatic events. The following quote, from one of our 'successes', shows the power of this 'whole person' approach:

'I do best in holistic services that consider the whole person, that can see how my practical issues relate to my deeper emotional/ psychological issues and will work with both at once'

Similarly, another 'success' told us:

'Get to the roots of people's problems. Don't just put an Elastoplast on a gaping wound. Early stuff can affect people through their lives'

Research supports this approach:

'Whatever the intervention the patient's state should be seen and understood in the context of his overall development and history. Mental health professionals need to try and take a long term view of their patients.' (Evans 2006)

Summary

To set off on the road to recovery from poor mental health, homeless people need to feel safe, be in comfortable surroundings, be really listened to and above all to be treated as a person, not as lots of different unrelated problems.

Recommendations:

- Holistic approaches are the only way to tackle the multiple needs of homeless people. The people we spoke to wanted to be seen as people first and foremost, and their problems tackled as a whole. Their entire history needs to be taken into account.
- Real, empathetic listening, followed up by an appropriate service response, is crucial in addressing homeless people's needs. Specialists need more time to talk and listen – this is above all what homeless people want from services.
- Personal safety and the quality and condition of buildings may seem comparatively unimportant but in fact have a huge impact on homeless people's emotional wellbeing and their motivation to make their lives better.



11. Meeting their needs

The responses to this survey offer plentiful evidence of the ways in which current service provision (or lack of it) fails homeless people with mental health problems. But there are ways of doing it better. This section describes just some of the programmes and initiatives that are attempting to provide services for homeless people that help their mental health and wellbeing.

'Housing first' – accommodation services

'Housing first' is basically what St Mungo's does already – provide shelter and accommodation services first, and then address the individual's other needs, including mental health problems and substance use. This approach has been shown to provide significantly more stable housing outcomes for homeless people with mental health problems (Tsemberis 2004; 2005, quoted in Rees, 2009). St Mungo's own recent peer researched project What Works? also tells us that trying to address people's more complex needs is futile until their basic needs for shelter, safety and food are met (St Mungo's 2008a).

Specialist services for homeless people with mental health needs

Dedicated specialist mental health services for homeless people really do help where there are sufficient numbers to make such a service cost-effective (i.e. most cities and towns). Where there is a demand, the team may include professionals such as mental health nurses, social workers, psychologists, psychiatrists, counsellors and support workers (Randall et al 2007).

There are several examples of excellent teams set up to provide homeless-specific mental health services. Many of the people in our study sample had used specialist homelessness mental health services and the overall general consensus was quite clearly that they were good, but overstretched/ under-resourced and therefore unable to deliver the benefits they promised. It is notable that almost one in five of our interviewees rated specialist mental health services as their 'best bit of support'.

Randall et al (2007) highlight the key features of successful mental health services for homeless people. These are:

- *health promotion activities*
- *care navigators*
- *in-house mental health services*

- *open-access (walk-in) mental health services – in terms of hours available, tolerance of missed appointments and in terms of who can attend*
- *assertive approach to engagement*
- *'street-based' services*
- *dedicated specialist homelessness mental health practitioners and teams*
- *holistic support (Randall, Britten & Craig, 2007)*

As we saw earlier, a holistic approach, addressing all the person's needs together and in relation to each other, is key to successful outcomes. Randall et al suggest such holistic support should include:

- *Holistic assessment of needs not just clinical diagnosis*
- *Ensuring that other health needs are addressed, usually through primary care services*
- *Service to help people with mild to moderate mental health problems which are impacting on their homelessness but may not qualify them for mainstream services*
- *Access to a wide range of treatment including talking therapies*
- *Links into mainstream services*
- *Access to generalist support by non-clinical staff where needed*
- *Help with practical problems such as benefits and accommodation as a way of gaining trust and easing stress*
- *Working closely with housing agencies to prevent users losing their accommodation and becoming homeless again. (Randall et al 2007)*

The evidence we have gathered through this project certainly supports all of these as key elements in effective, accessible and acceptable services.

But people in our study also said they wanted to be able to use mainstream services – to get help from their GP, just like anyone else. Randall et al (2007) provide some good practice guidelines for ensuring that NHS mental health services are accessible to homeless people, at both primary and secondary care levels (remembering that primary care is typically the gateway to specialist secondary care):

- Implementation of Royal College of General Practitioners' guidance on homelessness and primary care
- PCTs ensuring that local GP practices will register people without a settled address
- PCTs allocating enhanced services funding to services for these client groups
- Specialist workers for these client groups within primary care teams
- Specialist primary care teams for these client groups (Randall, Britten and Craig, 2007)

Randall et al recommend several improvements for secondary (specialist mental health) care, including shared assessment procedures between teams and services, clear referral procedures, protocols to allow homelessness agencies to make direct referrals to community mental health teams and better discharge procedures to ensure that homeless people do not get caught in a cycle of hospital admission – homelessness – hospital admission.



Communication

Communication between services is essential. As mentioned above, homeless people are likely to have 'story fatigue' – they have been asked to tell their history and unpack their problems again and again to different sets of professionals who seem never to speak to each other. They are also likely to be highly disillusioned if none of these assessments have turned into any practical help, and this also contributes to their feeling of not being listened to (for research showing how this impacts on people in prison, see Edgar & Rickford 2009). This can also be the case in homeless hostels, and may be made worse because many clients dip in and out of services so frequently that all continuity of care is lost.

Services need to strike a balance between maintaining client confidentiality and sharing knowledge on a practical level so that the focus is on treating and supporting the client, not making them go over and over their problems.

Access

In the general population, mental health services are typically accessed via an appointment system. Failure to attend appointments is often seen by mental health professionals as a sign of lack of commitment to treatment. However, it is not always realistic to expect homeless people to make or keep appointments. Missing an appointment may highlight hidden problems such as not knowing how to get there, not being able to physically get there, poor timekeeping, unidentified learning difficulties, or lack of motivation caused by severe depression. Or, as we saw in earlier sections, the problem may lie with the services themselves and be to do with unwelcoming settings, long waits, unsympathetic and judgemental staff, and homeless people's loss of belief that anyone will ever do anything helpful. This is possibly why, in response to the 'Prime Minister' question, so many of our interviewees said they wanted a walk-in style of service and why, in general, open access services work better. These comments show what our interviewees said about accessing services:

'Appointments shouldn't be so pushy'

'Should not rush and apply less pressure'

'[Would prefer] just going to a community centre instead as there would be things to do'

'At first found it scary' [referring to seeking help]



'I wish I'd had more info about what was going on. There's no anchors or understanding. I wish I had some explanation of what I was, would go through. It was the unknown that make it all so difficult. Get people when they're first in a bad situation the knowledge and info as soon as possible'

'[My poor mental health]' makes every day normal tasks extremely hard, picking up my giro, going to the doctors, paying rent, washing clothes'

'[My poor mental health]' makes things harder, everyday tasks become a chore'

'When I wake up I'm sometimes aggressive, short term memory loss'

'Sometimes I feel I'm unable to express myself adequately'

'The doctors don't listen, they just offer pills'

*'Treated me like a ****, no help'*

Homeless people are often excluded from specialist services set up to deal with a particular diagnosis (and we have seen that many do not have a diagnosis). Frequently services exclude people who misuse substances (which we know to be extremely common among homeless people) and ex-offenders.

Person-centred care

One of the main policy strands in current mental health and social care is patient choice, which is generally allied with person-centred care and user involvement, both in their own care and treatment and in helping shape better service provision.

Mind has defined user involvement as:

'Equal citizenship: dignity and respect in mental health services; full information on treatments and rights; involvement in treatment and care; independent advocacy in every area; broad participation of users through equal opportunities employment and service delivery practice; involvement in planning, running and evaluation of services; policies to ensure it is safe to get involved; training of workers by users; practical commitment and resources for user involvement.' (Mind 1993)

Mind says that 'care and treatment are likely to be more effective when patients are empowered to take control over their lives and participate in making decisions about the treatment they will receive'. This is also the conclusion reached by St Mungo's in its peer-researched What Works? report (St Mungo's 2008a) and is one of the

fundamental premises of the 'recovery approach' recently adopted by St Mungo's.

These interviewees comments show that for these people, not infrequently, person-centred care was not on offer:

'Gave me meds for nothing, don't know what they were'

'Gave me medication and then took me off it too quickly'

'Just gave me meth'

'Listened but said little, I walked away, pissed off'

'I wish I'd had more info about what was going on'

'I'd like to get my own medication to feel more independent'

Training for frontline housing/homelessness staff

Randall et al (2007) say it is crucial that all frontline staff are trained in mental health awareness so they can identify the symptoms of mental health problems. Given the extremely high prevalence of mental health needs among homeless people, this would clearly pay enormous dividends in ensuring they access appropriate services before reaching crisis point. It is also important when we know stigma and discrimination and lack of awareness and understanding among staff can also block access to services.

Many of our interviewees mentioned staff training as a key area for improvement of services, and some mentioned how much they valued the support from former homeless people who have been trained as support workers (in fact one of the interviewees was a trainee project worker himself).

'Keyworkers need more training to deal with emotional and mental distress'

'Put more money into training ex users, each-one-teach-one'

'There is no quality trained people within the system'

'[We need] more trained staff for mental health'

'[My best bit of support was] from other people who've been in my position'

'A lot of people who work with the homeless look down on us coz they've never been in that position themselves'

Complex needs involving drink or drugs and mental health problems

As we saw earlier, mental health needs combined with substance misuse issues are extremely common among the homeless population. Services for 'dual diagnosis' can be excellent but are notoriously hard to find and access. Most people with multiple needs of this type are treated either in mental health or substance use services, which has obvious limitations; even where dual diagnosis is accepted as the responsibility of mental health services, users are often told that they have to sort out their substance use before they can have treatment for their mental health problems.

Many do not have mental health problems severe enough to reach the threshold for treatment (or these are masked by substance use). However their mental health or substance use may be impeding their progress towards a more settled life. Experience from St Mungo's dual diagnosis projects and our work with clients using the Outcomes Star recovery approach (see Burns & MacKeith 2008 and section 3) also provides ample evidence that substance and mental health needs should be addressed concurrently.



A Crisis report on the 'invisibility' of homeless people's health needs (Croft-White & Parry-Crooke 2004) highlights the issue as follows:

'Where multiple needs were present, professional boundaries frequently intervened, as a 'dispute' appeared to arise between healthcare specialists as to which need should be addressed first.'

Many mental health services, both community and hospital based, are set up to deal with serious mental illnesses, not the more low level issues with which homelessness services deal, which are typically compounded by drink or drug misuse. The Mental Health Foundation (2007) estimates that 40% of drug users with a psychiatric disorder receive no treatment for their mental health problem. When you consider how many homeless people are drug users, and the poor access to services, that amounts to a large number of very vulnerable people.

Again we see the potential for people falling into the gaps between services: 'Treating people in sequences, rather than providing an integrated service, can allow many people to slip through the net' (Edgar & Rickford 2009). Homeless people may also have different priorities. For example, data from the St Mungo's Lifeworks project (Cabinet Office, in press) shows that over 60% of its clients use three or more substances, but very few regard this as a problem – for them, it's simply a response to their situation. But when they seek medical help, services focus on the substance use. Their view is, sort out the other problems and the substance issue won't be a problem either. But if they do not comply with the demand to stop using substances first, they are seen as 'lacking motivation' or 'lacking engagement'. Many of our interviewees spoke about encounters with services where they felt their real needs were not addressed, and

even if they didn't actually say so, they very probably did not go back.

'[We need to change] Government's perception about mental health, more dual diagnosis clinics. More in depth counselling and psychiatry'

'In services that made me worse/didn't help, I felt like I had a diagnosis label stuck on my forehead. The staff didn't respect me, they didn't want to get to know me and they refused to work with the difficult and distressing feelings the clients had. Acupuncture is excellent. I do best in holistic services that consider the whole person that can see how my practical issues relate to my deeper emotional/ psychological issues and will work with both at once'.

*'[Rehab did] f*** all. Nothing for drink, drug'*

'Detox just gave me medication'

'Sometimes you need to talk to someone to try to get to the root of the problem instead of just dishing out medication which is just another drug'

Summary

Holistic, specialist services work well for homeless people but they need to be available alongside ordinary mainstream services. Homeless people encounter significant barriers to accessing health care in general and consideration of their needs when designing services is crucial. The needs of the individual need to be central to any service provision. Given the extremely high level of mental health needs among homeless people, all service providers (whether or not they see their role as 'mental health') need training and awareness of mental health issues. Services combining treatment and support for both mental health and drug/alcohol abuse are very much needed.

Recommendation:

- Services need to take as their starting point the needs of homeless individuals, and shape their design and delivery around that, rather than professional assumptions. This is best done by seeking the active input of those who will use the services.



12. Recommendations

It is clear from the responses to our study that homeless people have a very clear idea about what helps, and what they would like. They also had some very good ideas about what they would like the Prime Minister to do (not all of them publishable).

We presented the peer researchers with some early results of the findings at their debrief session, and asked if these tallied with their initial impressions based on the interviews they themselves had conducted. One of the researchers commented: 'Well, we didn't find anything unexpected'.

And that is right. The results of this study provide concrete evidence for what St Mungo's has known all along – that mental health services for homeless people are simply not doing the job. Too many people are not getting the treatment they need for serious mental health problems. For too many people, depression, anxiety and generally poor emotional wellbeing are the norm – far more than in the general population. In fact we could even go so far as to say that the 'norm' according to our findings, is personality disorder and mental illness combined with substance abuse. Too little is being done about the things that homeless people know make a difference. And people working in homeless, health and mental health services – and, indeed, the government, are not making and taking the time to listen.



There are several clear recommendations arising from what the homeless people in this study have told us:

- Stigma and discrimination badly affect homeless people and especially those with mental health problems. A non-judgmental, open attitude from the people around them will go a long way towards supporting them.
- Services need to treat the whole person, taking into account their background as well as current situation.
- All front line homelessness services need to be aware that their clients are likely to have a range of mental health problems.
- All frontline staff in homelessness services need training in basic mental health awareness and a thorough understanding of what to do if they believe a client may be in need of referral for assessment and treatment.
- All services involved with homeless people need to be aware that, even if their clients do not have a formal diagnosis of mental ill health, they are likely to be experiencing poor emotional wellbeing that affects their chances of making a better life.
- Services need to stop approaching drink, drugs and mental health as separate issues. For the vast majority of homeless people they are a part of the individual's range of needs and must be addressed as a whole. Drink and drugs are often used to deal with difficulties in homeless people's lives – we need to tackle the addiction and the life.
- A typical homeless client, who has experience of, or is vulnerable to, sleeping rough, will likely have highly complex needs involving poor emotional wellbeing, possible mental illness, likely personality disorder and polysubstance use. 'All-in-one' approaches are the only way to deal with these issues.
- People sleeping rough on the streets have mental health and substance use needs over and above those of the general homeless population. Urgent action and effective, prolonged engagement is needed to target people whose mental ill health is keeping them on the streets.
- We have to remove the known barriers to services for homeless people. The interviews identified access to mainstream services as a priority. The particular needs

and circumstances of homeless individuals and the, formal, inflexible way services are set up means that they may be unable or unwilling to use traditional access routes. Special provision (such as walk-in services) is needed, but ensuring local access through GPs and hostels is the most important.

- Mental health treatment on its own cannot solve an individual's problems. Homeless people also need good support from the people around them (hostel staff, friends, family etc) in order to get better. What really works is a combination of approaches.
- Medication has its place, but 'talking' therapies are very much in demand and are not so widely available.
- Not just 'more' but 'better' services are needed – better communication, better focus, better co-ordination.
- Holistic approaches are the only way to tackle the multiple needs of homeless people. The people we spoke to wanted to be seen as people first and foremost, and their problems tackled as a whole. Their entire history needs to be taken into account.
- Real, empathetic listening, followed up by an appropriate service response, is crucial in addressing homeless people's needs. Specialists need more time to talk and listen – this is above all what homeless people want from services.
- Personal safety and the quality and condition of buildings may seem comparatively unimportant but in fact have a huge impact on homeless people's emotional wellbeing and their motivation to make their lives better.
- Services need to take as their starting point the needs of homeless individuals, and shape their design and delivery around that, rather than professional assumptions. This is best done by seeking the active input of those who will use the services. The voices of homeless people should be central to this process, as they have a sophisticated understanding of 'the system' and how it could work better for them – as this report has demonstrated.



13. Case studies

Zac, the rough sleeper's tale

Zac, 37, calls himself an 'Earthling'. He has been sleeping in London's doorways and hidden corners since January 2009. Before that he was sofa-surfing for about two years, and lived in "countless" squats for more than 12 years. "Some lasted longer than others. I stayed in one in Dalston for about five years. Another year I moved 12 times in 12 months."

He became homeless at 18. Born in Battersea and brought up in Camden, his life changed following his mum and dad's divorce. His mum then became involved in an abusive relationship. "I hated her boyfriend, I threatened to kill him, but she wouldn't leave him so I had to go instead."

Now he sleeps in a few places across north London. "There's a covered space by an office block in Oxford Street, under the stairs. I also bed down in a safe, open place around Regents Park and another place in Primrose Hill. My worst time was in a doorway in Charing Cross Road. It was raining really heavily so the cardboard was getting soaked. Somebody gave me some coronation chicken to eat but it made me sick all night. It was bad in the cold weather too."

He has an NVQ level 2 in forestry and has been a gardener and a bouncer in his time. He spends his days keeping himself occupied. He's reading a book that he liked from his childhood but says it takes time to finish a book as he's dyslexic. "I visit the day centre, say hello to people, look for food, listen to music. I draw when I can but that's hard as your hands get dirty being on the street."

Heath, the hostel resident's tale

Heath, 43, has lived in a St Mungo's hostel for just over a year. He says he enjoyed talking to the peer researcher: "She asked the right kind of questions. I could answer them properly."

He says that since school "life just sort of passed by without me". He came to London for the first time at 16, then returned a couple of years later and has been in the capital since, in squats, flats, hostels, or rough sleeping.

Before his current hostel he was in a supported flat in Kilburn but he found this a terrible time. "It was awful. I stayed there for a few years but the isolation was too much, it was desolate. I didn't know the area or anyone there and I kept having to travel back to the centre. It was killing me. I couldn't live in the quietness."

How is he coping with his situation? "I'm stubborn. And I believe in mind over matter. Everyone has up and down days but most of the time I'm fine. I don't let myself be miserable. If I did, I'd probably die. I think everyone has some sort of mental health problem but to different degrees. With some people it's obvious but you can't tell with everyone."

He says he receives support from friends but "not from so-called professionals." He'd rather tell people as little as possible about his mental health. "I've never had counselling but I get through things by talking to friends. The best help is a good hug from a good friend. Counselling can be very much a crutch." He sees a doctor in the day centre if he needs to - his leg's been playing up since the cold weather - and thinks women doctors tend to be "much more caring" than men.

He's critical of the government and councils, and has no time for health professionals or staff in homeless shelters who he perceives lack sympathy or are rude. "A lot of people who work with the homeless look down on us because they've never been in that position themselves. We have the experience of living on the streets. There's a lot of community feeling among homeless people. People in houses are maybe more isolated, and under pressure from councils to pay rents they can't afford."

After half a lifetime homeless, does he see himself in his own flat or house in the future? "I'm 37 now, so no, I can't see much changing."

He describes hearing voices when he felt isolated and suffering "lots of mental pain". He says taking methadone used to help make the day "bearable".

Now his body is starting to heal. "I was injecting so much that the veins in my legs were gone. My legs have taken almost two years to heal. I put cream on them now."

He's also starting to enjoy watching TV and DVDs - "I couldn't do that before" - and his big passion is taking photos. "I've taken about 1,500. Lots of London in the snow, and pictures around Finsbury Park and Regents Park. I want to get a portfolio together, take lots more."

"If you're stuck in a bad time, you want to check out of your body. I look after myself more now."

Martyn, the interviewer's tale

Martyn was one of the peer researchers. Previously a rough sleeper, he is now in treatment for drink and drug use and has become an active member of St Mungo's client group, Outside In, a voice for clients across the organisation.

"The peer training was good fun. We talked about how to do it, and what questions to ask. Doing the actual interviews was sometimes hard. When people realised you weren't staff, that you'd been homeless like them, they just opened up. But you were aware that you could be opening a can of worms. The interviews were meant to take 20 minutes each but most took 40 and one woman spoke to me for nearly two hours."

He himself came to London from Somerset in the 80s to study plant biology at university. But his mum suffered from a hormone disorder, which impacted on his parent's relationship and led to them separating. Because of these family troubles, Martyn had a nervous breakdown at college and left about half way through the four year course. He then worked for a while before being accepted for a place at St Martin's College of Art, only for grant funding to be withdrawn four days before he was due to start. He was renting a flat that was being illegally sub-let and at 22, found himself with nowhere to live.

"I slept rough for about three months. It was scary. After a few kickings you learn how to take care of yourself, sleep during the day and stay awake at night."

One day a Big Issue seller gave him some breakfast and told him how to get involved. He and a friend ended up looking after 37 vendors across 14 pitches in Camden. "I was working from 6 in the morning till about 11 at night. But one by one I saw people die, eight of the 37 sellers that I worked with."

At that time he went to live in Bracknell, where his dad was. He met a woman and they had a daughter, Hope, but his daughter was born with Down's Syndrome and other problems and sadly died when she was only a few days old.

"My partner went to the doctors and got counselling. I went to mine and he wanted me to stop smoking and take anti-depressants. I wasn't keen as I knew people who'd got addicted to them and had a lot of trouble getting off them. So I didn't take them. I just tried to be

the man of the house, to be strong for my partner. I put my feelings in a box and buried it deep inside me for a long time. I didn't actually realise how it had affected me though. I knew I got moody around the time she died but it was only later that it clicked that the times I was arrested for possession of drugs were always around the anniversary of her death."

After his daughter's death, Martyn began taking amphetamines and ecstasy. He broke up with his partner, came back to London and ended up staying in a 450 – bed hostel with a friend. Then his friend had a stroke and ended up in hospital. This made Martyn decide to come off drugs but he says his drinking then started to go through the roof. "I'd drink three week's worth of units of white cider in one day... "Finally I got a room in a St Mungo's hostel where I was referred to an Alcohol Recovery Unit. I went down to three litres of white cider a day. That might still sound like a lot but it was about a fifth of what I was drinking before. I was at that level in the hostel for about three months. Then I woke up one day and decided, right, I'm going cold turkey. It was awful, terrible. Each day was slightly better though and I kept going.

"While I was in the Unit, I was talking to someone about my daughter's anniversary coming up and one of the mental health workers overheard me. She had a word with me separately, talked to me about counselling and managed to get me in to see a counsellor in Camden. That really was the turning point for me. Counselling made such a difference to me, that and acupuncture."

Martyn has been clean of drugs since April 2007 and gave up drinking in October last year. "When I think about it, the last 12 years of my life could have been an awful lot different. Rather than shutting down, I could have talked about my daughter's death more. That was part of the reason I was homeless and turned to drugs and drinking. I've not been back to her grave yet but two years ago I couldn't have talked about it and now I can."

He's hopeful about the future. "Working with the St Mungo's client group Outside In has helped keep me busy, given me things to do. I'm dyslexic so I've never been good at reading but talking to people, that's my bag, so I want to be a project worker and learn more about teaching and training people. I feel I've really improved the way I deal with things now, through counselling but also having the support of good friends."

Kerri, the hostel resident's tale

Kerri*, 25, suffered mental, physical and sexual abuse through her childhood and teens. She has been diagnosed as having a multiple personality disorder with psychotic tendencies.

Half Turkish, half Greek, Kerri was born and first lived around Rotherhithe. Her mother came to London to escape family disapproval of the pregnancy. But an uncle followed her, introduced Kerri's mother to heroin, and forced her mum into prostitution. "He was constantly beating her up and assaulting her, and he hospitalised me on a number of occasions."

Her uncle, and subsequently her mum's long-term partner abused Kerri from when she was a toddler to the age of seven. She tried to protect her brother, 18 months younger than her, from the violence in the home. "I took all of the attention so he didn't get any of the hassle. He still got beaten up and, as he grew older, my uncle made him drink alcohol but I took all the sexual and mental abuse. I was threatened that if I told anyone I would be skinned alive. He showed me a skull and showed me a knife and kind of scared the hell out of me."

During that time she was in and out of care, moving to different areas, but says her uncle usually managed to find them. From seven to 15, she was adopted by a family but was sexually abused by her adopted father. "I couldn't turn to anyone so I turned to drink and drugs. I had a very serious coke habit from about the age of ten. I got involved with gangs, started to fight a lot." She says she tried to tell people for years that things weren't right but people kept asking her for more specific reasons which she didn't feel able to give. Finally she again asked social services to be moved and this time when they asked why, she told them. "I shouted at them 'It's happened all over again and you've done nothing.'"

At this time she was pregnant. She stopped using drugs completely during the pregnancy. Still only aged 16, she moved into a foster home and lived between there and her boyfriend's home. Her daughter was born but died at six months old. "She became ill on Christmas Eve and passed away on New Year's Eve. I had to turn her life support machine off."

"When I lost her, I was very, very depressed. I got heavily into cocaine and drink and pills and basically anything I could get my hands on but not heroin – because of my mum. I've always sworn that I wouldn't ever touch heroin and I haven't."

Two years after this experience she was diagnosed with ovarian cancer. Doctors removed a malignant cyst, she had chemotherapy treatment and she continues to be monitored.

What does she think about her mental health? She remembers a lot of her childhood experiences and says you have three options when you've been through that much trauma. "You either block it all out and don't deal with any of it; or you block parts out and deal with some of it; or you don't block any of it and try to deal with all of it – and that's what I've ended up doing."

It's caused her some "big battles". She says, "I've tried to commit suicide, I've had serious, serious drug problems – but I'm still here. This is the first year I've not tried to commit suicide around the anniversary of when I lost my daughter. That's because of my current partner. I'm so grateful to him. We fight like cats and dogs sometimes but we want the best for each other."

Have mental health or other services helped? "I've had counselling from a very young age but they always made me feel it was my fault, that I could have stopped it. I just didn't appreciate that."

"I'm fighting at the moment to get medication from the doctor. Then I can do what they want me to do in therapy sessions which is talk about everything. But I cannot do it mentally or physically without the medication. I know myself, I know how my mind works."

"I went into rehab once and that was alright as it was all organised for you. But when you're out on your own, it's difficult. I still get anxious walking to the shops, thinking that I can't trust anyone, that everyone's working against me and that my uncle will be waiting for me. I know it's not going to happen but I can't help thinking it."

Kerri has business experience and is studying for an IT qualification through distance learning. She has lived in St Mungo's hostels for around a year and also enjoyed doing a St Mungo's peer facilitation course last year and is applying for a trainee project worker position.

"The day that I want is when I get a job and am in my own place with my partner. Somewhere where I can play my music and have a dog - I love my animals. Things have got a lot better in the last year, and yes, I'm just about coping at the moment."

(Kerri is not the resident's real name)*

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The people in the photos included in this report are St Mungo's clients, but are not necessarily affected by mental health problems or substance use issues. All have given their permission for their image to be used.

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